Mombasa – KENYA

Report of the 78th Performance Based Financing Course

April 1-13, 2019

The 26 course participants in Mombasa with the First Lady of Kilifi County **Mrs Elizabeth Kingi**

First version, 17th of April, 2019
Mombasa, Kenya

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1. SUMMARY

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The next English PBF course in Mombasa will take place from Monday October 28 to Saturday November 9, 2019

1.1 Who attended and village authorities

The 78th international PBF course organised by SINA health in Mombasa-Kenya, welcomed 26 participants from five countries: four African countries (Nigeria, Ethiopia, Cameroon, CAR,) and one European country – the Netherlands. Fourteen participants came from Nigeria; seven from Ethiopia; two from Cameroon; one from Central African Republic and two from the Netherlands.

Twenty-five participants came from the health sector (both at national and sub-national levels), and one worked in the administration sector (security and justice)

The Nigeria team consisted of fourteen participants, from Ministries of Health in Adamawa, Borno, Kebbi, Kwara, Nasarawa, Ondo and Yobe States.
The Ethiopia teams consisted of three participants from the Ministry of Health at federal level and four from a PBF pilot in Borona Zone in Oromia region, supported by Cordaid. The two participants from Cameroon were from the North West region; both were already involved in PBF implementation. We welcomed one participant from CAR, working with CORDAID in the area of security and justice. From The Netherlands, two participants attended; one working at CORDAID head office in The Hague, involved with the PBF pilot in Ethiopia, and the other a senior general practitioner in Holland.

We were honoured to welcome the Commissioner of Health of Kwara State and two permanent secretaries, from Kwara and Yobe States, Nigeria.

The facilitation team consisted of:

1. Dr.Godelieve van Heteren, senior health, governance and PBF expert, former member of the Dutch Parliament and Director of the Rotterdam Global Health Initiative Erasmus University, now working as senior health systems consultant for various agencies (WHO, World Bank).
2. Dr. Robert Soeters, the director of SINA Health and overall course coordinator.
3. Dr. Fanen Verinumbe, PBF consultant of the National PHCDA in Nigeria.
4. Mrs. Anne Wairimu, Kenyan psychologist from Mombasa, who assisted the team with the daily organisation and support of the participants. And Caroline Atieno, technical assistant.
5. Mr. Tom Njieri, who assisted with the logistics, transportation, recruitment of staff and the events.

The "Village 78" authorities consisted of the Village Chief, Dr. Omar IBRAHIM; the Deputy Village Chief, Flora KWIZERA; the time keeper, Buzinel Gudisa Mijena; the Finance Ministers, Kinyuy Margaret Gham and Kees Melcherts and the Energizers Baba Laminu, Abubakar Abana and Mekdelawit Mengesha.
They actively supported the facilitation process and contributed to a congenial atmosphere while maintaining "order" in the village.

1.2 Evaluation of the course venue and the course

Twenty-six participants conducted the final exam. The average test score result was 67% with six certificates of distinction and six certificates of attendance.

This was the third course in the 4-star Traveller's Hotel, which provided a professional and pleasant ambiance. This justified the higher full board tuition fee. The Mombasa North Coast is an attractive conference environment with a friendly population, clean and safe beaches, frequent flight connections to the rest of the world as well as smooth visa regulations. Kenyan contributions to the course deepened during this course through the warm relations with Kilifi County health authorities, and a special visit by the First Lady of Kilifi County. And through more tasks for the local partner Tomasi and the two Kenyan support staff Anne Wairimu and Caroline Atieno.

The daily evaluations yielded scores, which were 1,6% above the previous 24 English courses and 6% above the previous French-spoken course. **Methods and facilitation** scored 87,5% (the same as the previous courses). **Participation** scored 87.2% (the same as the previous courses). **Organization** scored 86.6% (0,3% *above* the average of the previous courses). The subject of **timekeeping** scored 78,8% (6,2% above the average of the previous courses).

The final evaluation indicated that for 88% of the participants the content of the course related well to their regular professional activities. Yet, only 52% said that they were well-informed in advance about the course and some indicated that the course book should have been distributed 1-2 weeks in advance of the course. The fact that some participants' names were only known a week before the commencement of the course contributed to this score. Participants were satisfied with the methodology and the organization. In October 2018 a large proportion of 43% of participants thought the course to be too short and nobody thought that the course was too long. This course we added one day (the Saturday) to the course duration and this worked better to reduce the time pressure to finalize the action plans as well as the course modules. The extra day was appreciated, leading to a solid score around the course's duration being right.

1.3 Summary of the action plans of the course groups

1.3.1 Central African Republic Security and Justice Sector

- Providing security is one of the core functions of the state and directly linked to its legitimacy. However, security state actors such as the national police can also be considered to be a threat by their citizens based on their behaviour and their way of operating.
- In CAR, despite all efforts being made, state security forces are demotivated due to diverse reasons: low salaries, personnel not educated enough, limited facilities & equipment, etc and hence less dedicated to their jobs. This leads in some cases to violation of human rights and ineffectiveness in service delivery with a high level of corruption.

Recommendations

- CORDAID to visit authorities from the Ministry of Interior & Public Security for presenting PBF solutions to some of the problems. A PBF pilot could be considered following the standard approach of developing output-, quality- and

geographic equity indicators. Lessons may be learned from a similar PBF approach in the Democratic Republic of Congo.

1.3.2 Cameroon RFHP North-West Region - problems and recommendations

- As the result of the war, the quality reviews are not conducted regularly and some health workers abuse this situation to start buying medicines from unauthorized sources in order to increase their profits. The socio-political crisis has put a hold to economic activities rendering many people poor and forcing health workers into private practice where they try to make extra money to take care of their basic needs.
- There are delays in payment of the subsidies and this further contributes to staff being not adequately motivated.
- Linked to the above problem health workers tend not to report on certain sales of drugs and pocket money privately instead of putting funds into a common basket. This leads to lower income for the health facilities and tensions among staff.
- Low quality of care related to counterfeit medicines availability in some health facilities.

Recommendations Regional Fund for Health Promotion North-West

- Health facility managers should be guided by the professional code of ethics. To stimulate this, the regulator should conduct regular quality reviews and provide feedback to staff from the community verification interviews.
- Ensure that the personal needs and motivation are not neglected. This can be achieved through the more regular payment of the subsidies and by the regular coaching on financial management whereby enough reserves are set aside for the rainy days.
- The Regional Delegation of Public Health should regularly update the list of accredited sources of drug procurement. They and the district health authorities should also make surprise visits to these sources for drug quality control. Samples of their product could equally be collected for quality control.
- The District Health Authorities should undertake efforts to conduct their quality reviews by making use of the safer moments during the war. They should control the drug invoices as to verify the source of the medicines and to identify whether the distributors are on the list of accredited distributors.
- Health-facility managers should supervise the pharmacies regularly and to ensure that perpetrators of parallel sales of drugs are identified and punished. This is done by using the indices tool through performance bonuses in which a higher weight is given to the non-private sale bonus. This is going to reduce the staff individual performance and consequently a lower bonus for him or her if he or she sells drugs in a parallel manner. To ensure this, health facilities should paste up signs to indicate drug prices and that all drugs should be purchased only from the facility pharmacy.
- To the consumers, to ensure that they receive receipts upon consumption of services especially drug sales.
- The government should ensure that subsidies are promptly paid in order to maintain a level of quality in Health Facilities. When the subsidies are promptly paid this will motivate workers at all levels and enhance their individual and

collective performance. The timely payment of subsidies could also reduce or completely eradicate the issue of private practice and therefore enhance quality of care in all dimensions.

1.3.3 Cameroon CDV Agency North-West - problems and recommendations

There is a high rate of non-submission of the indices tool of 35% and 22% consecutively for two quarters. There is an average low score for the quality of the use of the indices tool of 38% and 43% for two consecutive quarters. One of the reasons for this poor performance is that the deputy managers of the CDV Agencies in practice conduct their coaching activities at best once per year or not at all due to the security reasons and the fact that they do not reside in the district such as the verifiers. Yet, the CDV Agency verifiers (with the supervisors of the district health authorities) are the closest actors for the health facilities and the community. The verifiers visit the health facilities on a monthly basis, which provides them with the possibility for regular interactions. It also provides the possibility to coach on the indices management tool.

Recommendations CDVA Cameroon

- To the national PBF technical unit, to amend the clause which indicates that only coaching done by the Manager or Deputy Manager is payable
- To the CDVA Manager, organize training for CDV verification officers on the indices tool and on coaching skills. A post-test should then be administered and officers who scored above 80% should be selected for particular axes.
- To the CDV verification officers regular coaching should be done and the Manager or Deputy should be invited for risk-based coaching or coaching on pertinent issues like conflicts or adherence issues.
- The CDVA verification officers should monitor the progress in indices tool submission rate and score.

1.3.4 Ethiopia - problems and recommendations

Ethiopia is the second most populated country in Africa with 102 million inhabitants. Health service delivery and indicators in Ethiopia have been improving over the last 25 years. Yet there are still important caveats such as that 1 in 3 children are chronically malnourished and that the MMR is high with 412 per 100,000 live birth.

The Federal Ministry of Health under the Health Sector Transformation Plan addresses Universal Health Coverage (UHC) as a key component, aiming at coverage for all essential health services, for everyone without financial hardship. As part of this overall strategy, Performance-based financing (PBF) is mentioned in the HSTP chapter on efficiency and in the draft Health Financing Policy. Cordaid carried out a showcase PBF project since 2015 in Borena Zone in Oromia Region for a population of 186,000 with encouraging results and now aims to expand the PBF program to a larger population of between 1 and 2 million people in Jimma health zone. Yet, Ethiopia as a country is not yet engaged in a full PBF strategy and the first priority is to engage together with World Bank in the collective exploration of feasibility of results-based strategies in Ethiopia in relation with the three directorates to this collective exercise.

Recommendations

- To map and compare the current system of Ethiopia with a system informed by PBF and results-based strategies

- Design a national PBF proposal on a potential pilot, with a target population selected from Addis Ababa (Urban) 3,433,999, Somali (Special support region) 5,748,998 and Oromia (Rural) 35,467,001 from total population 94 million. We consider that PBF budget should not be below 4 USD per capita. The needed budget for those regions would then amount to USD 22.995.992 for the Special Support region, for Oromia USD 141.868.004 and for Addis Ababa USD 13.735.966.
- For the Jimma pilot supported by the Oromia Regional Health Bureau and FMOH, with support from the Dutch government and Cordaid: revisit the current design, based on PBF best practices.

1.4 Nigeria

1.4.1 General observations

- A range of causes lies at the root of the *poor quality* health services and inefficient use of public and private resources in Nigeria: 1. Central planning and financing of inputs; 2. The existence of multiple monopolistic distribution systems of government and partners; 3. Poor coordination with the private sector ; 4. Lack of autonomy of health facilities and ; 5. Highly centralized human resource policy.
- Several vertical health programs of government and partners aim at similar objectives *but which lack coordination*. Thus resources are wasted and they give different orientations to health workers at the facility level.
- The World Bank currently finances three large but *conceptually opposing and 'verticalized' projects*: 1. Safe One Millions Lives; 2. The NSHIP PBF program and; 3. The newly introduced nutrition program ANRiN. The course participants felt these programs should be better coordinated through a unified conceptual framework for implementation to attain positive reforms in Nigeria.

1.4.2 Encourage reforms in Nigeria – based on the PBF best practices

- Change the current input financing towards performance contracting ;
- Break the monopolies of the drugs management agencies and allow facilities to buy their inputs from accredited distributors operating in competition ;
- Inject more funds directly in the health facilities and allow them more decision power on the use of public funds instead of leaving the decision powers to central administrators ;
- Provide more autonomy for health facilities for human resource management and the setting of user fees ;
- Collaborate more closely with the private sector and offer them contracts as equals to government health facilities, under similar quality regimes ;
- Allow health facilities to open their own bank accounts to which they are also signatories and stop the practice whereby revenues must be transferred to the single treasury account.
- Rethink the single treasury account practice whereby health facilities must deposit their revenues at the treasury to which they have little access. This is the opposite of providing more (financial) autonomy to health facilities.

1.4.3 Change some features of the PBF design in Nigeria

- Domicile the *PBF unit at the Federal and State Ministries of Health* rather than in National and State Primary Health Care Agencies/Boards for better coordination,

the inclusion of the hospital level and for the regulatory stakeholders to ensure sustainability.
- *Modify existing laws* so that: 1. Health facilities retain and use their cost recovery revenues in PBF dedicated accounts ; 2. The managers of the facilities are the signatories of these accounts ; 3. Facility managers can choose their supplies from any accredited supplier.

1.4.4 Recommendations concerning the advocacy for PBF in Nigeria

- Better document the encouraging results of PBF in some high-performing States such as Adamawa - where PBF has existed since 2011 - and Gombe State which only started in 2017, but is showing promising signs of improvement, so that they can be used for advocacy purposes ;
- Present these results during the National Council of Health (NCH), the National Planning Commission (NPC) ;
- Encourage State authorities to make PBF the preferred reform approach to achieve Universal Health Coverage;
- Integrate the different vertical programs into one harmonized health strategy following the PBF best practices approach;

1.4.5 Political update

After the February 2019 presidential elections, Nigeria is currently establishing its federal and state governments for the coming years. The Universal Health Coverage agenda has been embraced by the Nigerian government, and the current challenge in all states and at federal level is to come up with a sustainable proposition for health systems strengthening and health financing to lead to UHC. Federal government and state governments are looking into the various financing modalities. They are looking in how for instance a Basic Health Care Provision Fund - as a percentage of the consolidated oil revenues, could contribute to domestic health financing, i.e. of primary health care. Other large schemes, based on loans and grants from external partners such as the Save a One Million Lives program also form part of the equation. The new state and federal governments which will take office by the end of May 2019 will all have to turn to further integration and domestic management of the health system, which will turn the next 18 months into a crucial policy period in Nigerian health politics. Various Nigerian states represented in the April 2019 course had sent senior SOML staff to engage in the exploration of PBF for this debate of integration and UHC. Several of the States present were also involved in implementing the NSHIP program, the RBF program in Nigeria, and expressed an interest in introducing further RBF/PBF elements in the states' policies.

Below follow the individual states recommendations, which all seem to revolve around further integration and taking domestic control of the agenda.

1.4.6 Adamawa State Nigeria - problems and recommendations

- The failure – despite several years of NSHIP implementation - to define a sustainable mechanism to create State ownership and local financing
- Challenges to coordinate the partners
- Failure to move away from the input system carried out by the government and the partners.
- Each ward has only one PHC centre of excellence that operates 24 hours

Recommendations Adamawa

Advocacy and discussion with the Hon. Commissioner of Health on the future architecture and financing of PBF program. Issues to be discussed are:

- Rearranging the State architecture by having a Technical Coordination unit in the MOH for basket funding.
- Coordinate activities in the state which now run in parallel but which could be integrated into the PBF program, such as SOML and other partners.
- Advocacy and lobby with the State Government to increase and release budgetary allocation for health funding.

1.4.7 Borno State, Nigeria - problems and recommendations

- Human resources gaps do exist across all levels of the health facilities.
- Most things are still 'centrally controlled', instead of left to local autonomous management: e.g. recruitment and re-deployment is now centrally controlled, infrastructural development in the health sector is centralised including the PBF contracted facilities, supply of drugs and equipment across all health facilities is still centralised.
- The NSHIP PBF Interventions in the state are operating in only 8 out of the 27 LGAs. Contracted health facilities include both private and public; primary and secondary health facilities.
- There is inadequate knowledge of PBF by most of the stakeholders, healthcare service providers and general population.
- There is a standing committee of traditional leaders on PHC supporting demand creation and social mobilization across the state
- There is a free maternal, new-born and child health service. However, this is not covering all the facilities and is not enough even for the health facilities covered.

Recommendations Borno

- Integration of state financial resources for funding the PBF program
- Analysis of the available funds and the population that can be covered by PBF
- To propose an institutional set-up on how the system could operate under PBF
- Stakeholders' sensitization on PBF
- Advocacy to policy makers on PBF, traditional institutions, faith-based organisations, community based organisations, civil society organisations and professional bodies sensitization.
- Scaling up PBF in other the currently non-contracted health facilities across the state
- Make free MNCH services to high quality subsidised user fee paid services

1.4.8 Kebbi State, Nigeria - problems and recommendations

- Kebbi State continues to record poor health indices despite considerable contributions of partners (UNICEF, USAID and the Global Fund). The services are not efficient, they lack quality and continue to be difficult to access. Financial accessibility also plays a role due to the dominance of the "out-of-pocket expenditure". The strategies of most programs are input-based, vertical and uncoordinated leading to the duplication of efforts and, as a result, the wastage of resources. Facilities depend on the central distribution of inputs such as essential

drugs due to the non-confidence of Government in other drugs sources especially those from open drug markets.

- The partner contributions in the State are uncoordinated without reference to the State's needs and priorities and they introduce different indicator sets and propose different strategies.
- The States are backed by laws to establish Hospital Management boards, SACA (State Action Committee on AIDS), Primary Health Care Development Agencies, KECHES (Kebbi Contributory Healthcare Scheme). Therefore, the introduction of PBF may be regarded by these organizations as an attempt to override their functions which most will struggle to maintain their stands.
- Lack of knowledge on PBF among key stakeholders. As a result, the PBF set-up may be considered complex by some State policy makers due to the need to create new structures such as the CDV agencies and the procedures such as paying of performance instead of for inputs, the breaking of the monopolies for the pharmaceutical suppliers. There may be a tendency for the policy makers wishing to control the supply of inputs.
- Facility managers may not be allowed to spend cash due to the introduction in 2018 of the Single Treasury Account on all revenues including those generated on services rendered by hospitals of which Government remits only 70% of the total output.

Recommendations Kebbi

- Advocate with policy makers on the need to accept the PBF programme as reform strategy and explain the difference with previous reform approaches that have not achieved the desired objectives such as the Alma Ata primary health care and the Bamako Initiative.
- Prepare a Memo to the National Council on Health to advocate for National Policy on PBF which all states are obliged to implement
- Group all programs such as the Primary Health Care Under One Roof (PHCUR) and the KECHES under the 'ONE' State Steering Committee and Technical Consultative Group in the Office of the Permanent Secretary.
- Engage consultants when necessary to support the feasibility study and the implementation of PBF with support from the SOML
- Calculate and propose to the government a PBF budget of more than 20% to reduce donor dependency in order to achieve $4-$6 per capita for the catchment population of the State
- Integrate all vertical programs such as KECHES which is just at the verge of implementation and marry it with the PBF programme in order to achieve individual programs goals and ensure sustainability. The two programmes can go hands in hands with support from Government, SOML and donors
- The SOML may shoulder the responsibility for the conduct of study tours to some states that are already implementing the PBF programme.
- Since the PBF set-up may be considered to be complex by some State policy makers there is need to create an innovation to consider KECHES as the CDV agency and being backed by law, it can initiate the payment of performance instead of for inputs, the breaking of the monopolies for the pharmaceutical suppliers. Authorities may also not feel threatened by the separation of the functions of provision, regulation and contract development & verification
- Pilot PBF in selected LGAs of the state using SOML funds;

- Advocate to the Ministry of Budget and Economic Planning and the Ministry of Finance to exempt the health care facilities in 5 pilot LGAs under the PBF approach to remit their cost recovery revenues from going into the treasury single account but into the health facility bank account on which the facility operators are signatories.

1.4.9 Kwara State, Nigeria - problems and recommendations

- Weak partner coordination in the State in which partners operate in a parallel fashion without the oversight of the government.
- There is a skills-gap among the inadequate number of health professionals in Kwara State.
- There are decayed physical facilities and insufficient equipment in the State. Yet, rehabilitation and purchase of inputs are done by the SMOH through centralized rehabilitation and purchasing.
- The health system remains overstretched by the quickly growing population.
- There is an inadequate data generation system, leading to weak evidence-based planning, policy formulation and health systems management.
- Kwara State originally adopted a Community Health Insurance Scheme (CHIS), but was only able to cover less than 5% of the poor rural dwellers, a scheme which contained several input financing elements. The scheme was voluntary. Judged by similar schemes elsewhere, such schemes have poor. The scheme stopped in 2014 due to poor adhesion rate and bankruptcy. It prompted the government to enact a law of mandatory health insurance scheme which is still in its pre-implementation phase. This institutional set up of an obligatory insurance scheme could be used but should be strengthened by introducing PBF inside the scheme: that is assure the quality of the services, create a solid verification mechanisms and cost containment by paying subsidies which remain within the available budget.
- Skilled staff per 1000 inhabitants is 1:2070 (the standard is 1 / 1000) with over 60% in the urban area.

Recommendations Kwara

- Better coordination of all partners activities
- The expenditure per capita per year using the state expenditure on health has been consistently below $ 3. Therefore, funds for PBF will have to be made available in the State's budget to fund 20% of the project. User fees will also be introduced for cost recovery purposes and to allow managers handle cash.
- The SOML unit can be given the responsibility to function as the PBF unit, hence, will be domiciled within the office of the Permanent Secretary. This will address issues around signing performance contracts with other directorates – the unit has the requisite experience
- The PBF unit will come up with output, quality and composite indicators in answer to the state's needs, and as recommended by PBF best practices
- A Contract Development and Verification Agency will be established in the State Supported Health Insurance Agency.
- The payment unit may be established within the SMOH.
- Laws impeding the implementation will be set aside and pilot will be in 3 LGAs.

1.4.10 Nasarawa State - problems and recommendations

- There is a considerable human resources gap in terms of quantity (no adequate, skills and attitude).
- The state suffers from inadequate knowledge of PBF by the service providers and the community.
- Poor infrastructure exists in non-PBF accredited health facilities.
- Both NSHIP and SOML are externally funded, but this funding will probably stop by 2020. So far, there has not yet been any contribution from the State government for the PBF budget. Therefore, there is a serious sustainability problem with the PBF program.
- The National PBF Unit is *not* integrated into the State Ministry of Health in such a manner high enough to allow the coordination of all activities of the health system in the State such as also the Directorates and the Health Programs. Moreover, the current PBF set up leads to sustainability problems because only a set-up through SMOH could make PBF nationally financed.
- The existing government funds are mainly used to finance inputs instead of buying performance from the different health actors. The government funds disbursements are often delayed and frequently not fully utilized.
- Inadequate coordination and harmonization of partners activities in the state
- Lack of autonomy in the health facilities. For example, the Ministry of health staff are centrally posted, managed and paid. There is only autonomy for the contracted staff in the PBF health facilities.

Recommendations Nasarawa

- Nasarawa's State Government should scale up PBF in the health sector with the SMoH as the regulatory body and the State Health Insurance Program as the CDV Agency.
- A sustainable PBF financing should be planned for the 361 PBF health facilities that lose their NSHIP financing in 2020
- Allocate 70% of the State health budget towards the PBF system of financing directly the health facilities for their performance
- Definition of roles and responsibilities of actors at all levels such as identified in the institutional set-up below
- Advocacy to the relevant stakeholders for making the PBF program in Nasarawa sustainable
- Sensitization and dissemination meetings to keep the stakeholders well informed.
- Awareness creation among population.

1.4.11 Ondo State - problems and recommendations

Conflict between the ministry and the agencies.
There is conflict between the Ministry of Health and its Agencies which include Ondo State Primary Health Care Development Agency and Hospitals Management Board. This is as a result of the conflict in roles and responsibilities.

Human resources gap in terms of quantity, skills and attitude.
There is inadequate skilled health personnel in the non- PBF accredited health facilities. The attitude of the health personnel is also not satisfactory leading to poor quality services.

Inadequate knowledge of PBF by some stakeholders.
There is inadequate knowledge of PBF among some stakeholders in the health sector. Although, PBF is operational in the State, there is inadequate knowledge in areas where the program does not cover. PBF is operational in 9 out of the 18 Local Government Areas of the State and 289 of the 302 Primary Health Care facilities. It is not all the Directorates of the Ministry of Health and HMB are well informed about the program.

*Poor infrastructure in non- PBF accredited health facilities***.**
There is structural upgrade in all the PBF accredited health facilities whereas there is poor infrastructure in the non- PBF accredited health facilities.

Inadequate budgetary allocation and budget release to health.
There is usually inadequate budget allocation for health in the State and budget release is poor. For instance, the State Health Budget was 12% of the Total State Budget in 2018. Even though this was less than the 15% recommended, less than 40% was released. More so, more than 70% of the State health budget is on personnel. There is opinion held by players in the other sectors that Health is not the only sector in the economy and that other sectors also needs funds; the health sector has a lot of Partners supporting their programmes, so they do not need extra funds; and that the health sector does not generate revenue. They have not put into consideration the fact that partners interventions are time-bound.

Lack of full autonomy in the health facilities.
Staff are centrally deployed in all the health facilities in the State except for PBF Primary Healthcare Centres that have control over contract/temporary staff and their inputs.

Problem of sustainability of the PBF program in state.
The NSHIP that funds the PBF program in the State is an external fund and has a limited life span. There will be a sustainability problem when the PBF scheme, which is seen as a 'project' will end. PBF Unit is in the State Primary Healthcare Development Agency, a parastatal of the Ministry. This has created a lot of issues in terms of regulation. For any health program to be sustainable, it must be instituted at the highest hierarchy of the Health System.

Inadequate coordination of partners.
Partners still run an input system and fund similar program, all leading to duplication of efforts and a substantive waste of resources.

Recommendations Ondo

- Institution of PBF in the Ministry of Health.
- Scaling up of PBF to all the health facilities.
- Definition of roles and responsibility
- Institution of PBF in the Health Insurance Program
- Advocacy to the relevant stakeholders
- Sensitization and dissemination meetings to keep the stakeholders well informed.
- Awareness creation among populace about PBF.

1.4.12 Yobe State - problems and recommendations

- In Human Resources for Health there are gaps across all levels of the health facilities.
- Centrally controlled recruitment and redeployment is an issue

- Centralised infrastructural development in the health sector including for the PBF contracted facilities
- Centralised supply of drugs and equipment across all health facilities is
- Inadequate knowledge of PBF by most of the stakeholders, healthcare service providers and general population.

Recommendations for Yobe State

- Stakeholders' sensitization on PBF
- Advocacy to policy makers on PBF
- Sensitization of traditional institutions, faith-based organisations, community based organisations, civil society organisations and professional bodies
- Scaling up PBF in other non-contracted health facilities across the state
- Make Free MNCH services to high quality subsidised user fee paid services.

1.5 The Netherlands – General Practitioner

The Netherlands is one of the richest countries in the world. Health care is well organized. Expenditure per capita is close to € 4.000. Health care depends heavily on primary care. It makes the system affordable and sustainable. Without primary care patients would have to go straight to the hospitals. With huge costs as a result. With people already spending 15% of their net income on health, the system would get too expensive with no room for other expenditures. This situation of full coverage is now under threat because of the retirement of a large number of GP's in remote areas. Young doctors tend not to be willing to work in those areas. Therefore there is a need to stimulate starting GPs to work in those areas. An extra problem is the giving situation that mostly male GPs, who have full working weeks of 50-60 hours are retiring. This retiring population will majorly be succeeded by young female doctors who tend to work part time, e.g. 25-30 hours a week. With the current situation, to replace one leaving doctor you will then need 2 or 3 doctors to fill the practices.

From the PBF feasibility scan above, the health system in Holland resembles a PBF system, with a score of 46 (92%).

The main issues were:

- There are no performance contracts within the ministry and the directorates.
- Provider managers are not allowed to influence cost sharing tariffs. Tariffs for consultation and the quarterly payments are set by the central government. They are so calculated that the total sum of primary care in a given year does not exceed the macro budget. Like this there is no incentive to distinguish your practice from another health facility in your area.

Recommendations

- Awaken all actors, by mobilizing the public and sensitizing GP's to take their responsibility and aim to cover the whole country.
- Use the geographically equity bonus and investment bonus to stimulate GP's to start their practice in named areas. There is already a system whereby the regular, quarterly payments are increased in so called poor, city areas. On top of that we can use other incentives. E.g. recently provincial authorities in Zeeland have provided so called summer houses to attract doctors to work in summertime in Zeeland.

- Pass a motion in the national assembly of general practitioners to extend the system to more areas.
- Work out the height of the extra payment by the union and representatives from the designated areas; GP's, council members, representative of the dominant health insurance company in that area, and negotiate this with the MoH
- Seek approval from the Ministry of Finance, for a raise in the macro budget spent on primary care.
- Seek corporation with the local health insurance company. The insurance company is having a duty by law to insure sufficient health care in their respective areas.
- Make adjustments to the existing system of postal code pricing. An additional investment bonus can be paid by the local health insurance company and sometimes local authorities such as counsels and provincial administration.

2. RESUME EN FRANCAIS

Le prochain cours d'anglais PBF aura lieu à Mombasa du lundi 28 Octobre au samedi 9 Novembre, 2019

2.1 Qui a assisté et les autorités du village

Le 78ème cours international PBF organisé par SINA Health à Mombasa-Kenya a accueilli 26 participants de cinq pays: quatre pays africains (Nigeria, Éthiopie, Cameroun, RCA) et un pays européen - les Pays-Bas. Quatorze participants venaient du Nigéria; sept d'Éthiopie; deux du Cameroun; un de la République centrafricaine et deux des Pays-Bas.

Vingt-cinq participants provenaient du secteur de la santé (aux niveaux national et sous-national) et un travaillait dans le secteur de l'administration (sécurité et justice)

Les autorités du «village 78» étaient composées du chef de village, le docteur Omar IBRAHIM; le chef de village adjoint, Flora KWIZERA; le berger, Buzinel Gudisa Mijena; les ministres des Finances, Kinyuy Margaret Gham et Kees Melcherts et les animateurts d'énergie Baba Laminu, Abubakar Abana et Mekdelawit Mengesha.
Ils ont activement soutenu le processus de facilitation et contribué à créer une atmosphère agréable tout en maintenant « l'ordre » dans le village.

2.2 Évaluation du lieu et du cours

Vingt-six participants ont passé l'examen final. Le résultat moyen du test était de 67% avec six certificats de distinction et six certificats de présence.

Il s'agissait du troisième cours de l'hôtel 4 étoiles Traveller's Hotel, qui offrait une ambiance professionnelle et agréable. Cela justifiait des frais de scolarité plus élevés en pension complète. La côte nord de Mombasa est un environnement de conférence attrayant avec une population accueillante, des plages propres et sûres, des liaisons aériennes fréquentes vers le reste du monde et un système des visas sans faille. Les contributions du Kenya au cours se sont approfondies grâce aux relations chaleureuses avec les autorités sanitaires de Kilifi « County » et à une visite spéciale de la première dame de Kilifi. Et par le biais de plusieurs tâches supplémentaires pour le partenaire local Tomasi et les deux assistants au Kenya, Anne Wairimu et Caroline Atieno.

Les évaluations quotidiennes ont donné des notes supérieures de 1,6% aux 24 cours d'anglais précédents et de 6% au cours précédent de langue française. La facilitation et méthodologie ont obtenu un score de 87,5% (identique aux cours précédents). La participation a obtenu 87,2% (identique aux cours précédents). L'organisation a obtenu 86,6% (identique aux cours précédents). Le respect du temps a obtenu 78,8% (6,2% au-dessus de la moyenne des cours précédents).

L'évaluation finale a révélé que pour 88% des participants, le contenu du cours était bien lié à leurs activités professionnelles habituelles. Pourtant, seulement 52% ont déclaré qu'ils étaient bien informés à l'avance du cours et certains ont indiqué que le livre de cours aurait dû être distribué une à deux semaines avant le cours. Le fait que les noms de certains participants n'aient été connus qu'une semaine avant le début du cours a contribué à ce faible score. Les participants étaient satisfaits de la méthodologie et de l'organisation. Dans le cours précédent d'octobre 2018, 43% des participants estimaient que le cours était trop court et personne ne pensait que le cours était trop long. Ce cours nous a ajouté un jour (le samedi) à la durée du cours et cela a mieux

fonctionné pour réduire la contrainte de temps liée à la finalisation des plans d'action ainsi que des modules du cours.

2.3 Résumé des plans d'action des groupes du couts

2.3.1 Secteur de la sécurité et de la justice RCA - problèmes et recommandations

- Assurer la sécurité est l'une des fonctions essentielles de l'État et directement liée à sa légitimité. Toutefois, les acteurs de l'État de sécurité tels que la police nationale peuvent également être considérés comme une menace par leurs citoyens en fonction de leur comportement et de leur mode de fonctionnement.
- En RCA, malgré tous les efforts déployés, les forces de sécurité de l'État sont démotivées pour diverses raisons: salaires bas, personnel insuffisamment éduqué, infrastructure et équipements limités, etc. et donc moins dévoués à leur travail. Cela conduit dans certains cas à la violation des droits de l'homme et à l'inefficacité de la prestation de services avec un niveau de corruption élevé.

Recommandations

- CORDAID doit rendre visite aux autorités du ministère de l'Intérieur et de la Sécurité publique pour leur présenter des solutions PBF à certains problèmes.
- Un projet pilote PBF pourrait être envisagé selon l'approche standard consistant à élaborer des indicateurs de production output, de qualité et d'équité géographique. Des enseignements peuvent être tirés d'une approche PBF similaire en République démocratique du Congo également exécuté par Cordaid.

2.3.2 Cameroun RFHM Nord-Ouest - problèmes et recommandations

- En raison de la guerre, les revues de la qualité ne sont pas effectués régulièrement et certains agents de santé abusent de cette situation pour commencer à acheter des médicaments auprès de sources non autorisées afin d'accroître leurs profits. La crise sociopolitique a mis un frein aux activités économiques, rendant beaucoup de personnes pauvres et obligeant les agents de santé à exercer dans un cabinet privé où ils essaient de gagner un revenu supplémentaire pour subvenir à leurs besoins fondamentaux.
- Il y a des retards dans le paiement des subsides, ce qui contribue également à une motivation faible du personnel.

Recommandations Fonds régional de promotion de la santé Nord-Ouest

- Les gestionnaires d'établissements de santé devraient se conformer au code d'éthique professionnel. Pour stimuler cela, les autorités de la régulation devrait procéder à des revues réguliers de la qualité et fournir un retour d'information au personnel issu des entretiens de vérification avec la communauté.
- Assurez que les besoins personnels et la motivation ne sont pas négligés. Cet objectif peut être atteint par le versement plus régulier des subsides de gouvernement et par le suivi régulier de la gestion financière, qui prévoit suffisamment de réserves pour les jours de pluie.
- La délégation régionale de la santé publique devrait mettre à jour régulièrement la liste des sources d'accréditation des achats de médicaments. Elles et les autorités sanitaires de district devraient également faire des visites surprises à ces sources pour contrôler la qualité des médicaments. Des échantillons de leurs produits pourraient également être collectés pour le contrôle de la qualité au laboratoire.

- Les responsables des établissements de santé doivent superviser les pharmacies régulièrement et s'assurer que les auteurs de ventes parallèles de médicaments sont identifiés et punis. Pour ce faire, l'outil des indices utilise des bonus de performance qui accordent une plus grande importance au bonus de vente non privé. Cela va réduire les performances individuelles du personnel et, par conséquent, une prime moins élevée pour lui s'il vend des médicaments de manière parallèle. Pour ce faire, les établissements de santé doivent coller des pancartes indiquant le prix des médicaments et indiquant que tous les médicaments doivent être achetés uniquement à la pharmacie de l'établissement.
- Aux consommateurs, pour s'assurer qu'ils reçoivent des reçus lors de la consommation de services, en particulier de ventes de médicaments.
- Le gouvernement devrait veiller à ce que les subventions soient versées rapidement afin de maintenir un niveau de qualité dans les établissements de santé. Lorsque les subsides sont versées rapidement, cela motivera les travailleurs à tous les niveaux et améliorera leurs performances individuelles et collectives. Le versement ponctuel de subsides pourrait également réduire ou éliminer complètement le problème de la pratique privée et donc améliorer la qualité des soins dans toutes ses dimensions.

2.3.3 Cameroun CDVA Nord-Ouest - problèmes et recommandations

Il y a un taux élevé de non-soumission de l'outil des indices de 35% et 22% consécutivement pendant deux trimestres. L'une des raisons de cette pauvre performance est que les directeurs adjoints des ACV mènent leurs activités de coaching au mieux une fois par an ou pas du tout pour des raisons de sécurité et du fait qu'ils ne résident pas dans le district, tels que: les vérificateurs. Pourtant, les vérificateurs des ACV (avec les superviseurs des autorités sanitaires de district) sont les acteurs les plus proches des structures de santé et de la communauté. Les vérificateurs visitent les structures de santé une fois par mois, ce qui leur permet d'interagir régulièrement. Il offre également la possibilité d'accompagner l'outil de gestion des indices.

Recommandations pour les ACV de Cameroun

- À la Cellule Technique Nationale PBF, pour modifier la clause indiquant que seul le coaching effectué par le coordinateur ou son adjoint est payable
- Au responsables des ACV : Organisez une formation pour les agents de vérification ACV sur l'outil des indices et sur les techniques de coaching. Un posttest devrait ensuite être administré et les officiers ayant obtenu une note supérieure à 80% devraient être sélectionnés pour des axes particuliers.
- Les vérificateurs de l'ACV devraient faire un coaching régulier sur l'outil indices et le plan de business et le coordinateur ou son adjoint de l'ACV devraient faire un contrevérification basé sur le risque ou sur des questions pertinentes telles que les conflits ou les problèmes d'adhérence.
- Les vérificateurs de l'ACV doivent surveiller les progrès du taux et du score de soumission de l'outil d'indices.

2.3.4 Éthiopie - problèmes et recommandations

L'Éthiopie est le deuxième pays le plus peuplé d'Afrique avec 102 millions d'habitants. Les services de santé et les indicateurs en Éthiopie se sont améliorés au cours des 25 dernières années. Il reste cependant des problèmes importantes, à savoir qu'un enfant sur trois souffre de malnutrition chronique et que le taux de mortalité maternelle est élevé (412 pour 100 000 naissances vivantes).

Dans le cadre du Plan de transformation du secteur de la santé, le ministère fédéral de la Santé considère la couverture universelle en matière de santé comme une composante essentielle, visant à couvrir tous les services de santé essentiels, pour tous ceux qui ne souffrent pas de difficultés financières. Dans le cadre de cette stratégie globale, le financement basé sur la performance (FBP) est mentionné dans le document de politique national de financement de la santé. Cordaid a mené un projet pilote PBF depuis 2015 dans la zone de Borena dans la région d'Oromia pour une population de 186 000 habitants, avec des résultats encourageants. Il vise en 2019 à étendre le programme PBF à une population plus grande comprise entre 1 et 2 millions de personnes dans la zone de Jimma. Cependant, l'Éthiopie n'est pas encore pleinement engagée dans une stratégie PBF et la première priorité est de s'engager avec la Banque mondiale dans l'exploration collective de la faisabilité de stratégies axées sur les résultats en Éthiopie en relation avec les trois directions de cet exercice collectif.

Recommandations

- Cartographier et comparer le système éthiopien actuel avec un système éclairé par le FBP et des stratégies axées sur les résultats
- Élaborer une proposition nationale de FBP sur un pilote potentiel, avec une population cible sélectionnée parmi 3.4 millions habitants d'Addis-Abeba (zones urbaines), 5.7 millions en Somalie et 35.5 millions habitants d'Oromia (zones rurales). Nous estimons que le budget du PBF ne devrait pas être inférieur à 4 USD par habitant. Le budget nécessaire pour ces régions s'élèverait alors à 23 millions USD pour la région de soutien spécial, pour 142 millions USD pour Oromia et pour 13.7 millions USD pour Addis-Abeba.
- Pour le projet pilote Jimma soutenu par le bureau régional de la santé d'Oromia et le Ministère de Santé Fédéral, avec le soutien du gouvernement néerlandais et de Cordaid: revisiter la conception actuelle, basée sur les meilleures pratiques de PBF.

2.4 Nigeria

2.4.1 Observations générales

- La mauvaise qualité des services de santé et l'utilisation inefficace des ressources publiques et privées au Nigéria sont à l'origine de plusieurs causes: 1. Planification et financement centralisés des intrants; 2. L'existence de multiples systèmes de distribution monopolistiques du gouvernement et des partenaires; 3. mauvaise coordination avec le secteur privé; 4. Manque d'autonomie des établissements de santé et; 5. Politique des ressources humaines hautement centralisée.
- Plusieurs programmes de santé verticaux du gouvernement et des partenaires visent des objectifs similaires mais qui manquent de coordination. Ainsi, les ressources sont gaspillées et elles donnent des orientations différentes aux agents de santé au niveau des établissements.

- La Banque mondiale finance actuellement trois grand projets, mais qui sont conceptuellement opposés et « verticalisés »: 1. Safe One Millions Lives; 2. Le programme NSHIP PBF et; 3. Le programme de nutrition nouvellement introduit, ANRiN. Les participants au cours ont estimé que ces programmes devraient être mieux coordonnés grâce à un cadre conceptuel unifié pour la mise en œuvre en vue de réaliser des réformes positives au Nigéria.

2.4.2 Encourager les réformes - sur la base des meilleures pratiques PBF

- Modifier le financement des intrants actuel en faveur des contrats de performance;
- Briser les monopoles des agences de gestion des médicaments et permettre aux structures de santé d'acheter leurs intrants à des distributeurs agréés opérant en concurrence;
- Injecter plus de fonds directement dans les structures de santé et leur donner plus de pouvoir de décision sur l'utilisation des fonds publics au lieu de laisser les pouvoirs de décision aux administrateurs centraux;
- Collaborer plus étroitement avec le secteur privé et leur proposer des contrats sur un pied d'égalité avec les structures de santé publics ;
- Permettre aux structures de santé d'ouvrir leurs propres comptes bancaires sur lesquels ils sont également signataires et mettre fin à la pratique selon laquelle les revenus doivent être transférés sur un compte de trésorerie unique.
- Repenser la pratique du compte unique du trésor en vertu de laquelle les établissements de santé doivent déposer leurs recettes au trésor auquel ils ont peu accès. C'est le contraire qui consiste à donner plus d'autonomie (financière) aux établissements de santé.

2.4.3 Modifier certaines caractéristiques du montage PBF au Nigéria

- Domicilier une Cellule Technique PBF auprès du ministères de la Santé fédéral et des États plutôt que dans le « National and State Primary Health Care Agencies / Boards » pour une meilleure coordination, l'inclusion du niveau hospitalier et pour les acteurs de la réglementation afin d'assurer la durabilité.
- *Modifier les lois existantes afin que*: 1. Les structures de santé conservent et utilisent leurs revenus de recouvrement des coûts dans des comptes dédiés au PBF; 2. Les gestionnaires des FOSA sont les signataires de ces comptes; 3. Les responsables des FOSA peuvent choisir leurs intrants auprès de tout distributeur agréé.

2.4.4 Recommandations concernant le plaidoyer en faveur du PBF

- Mieux documenter les résultats encourageants du FBP dans certains États très performants tels que l'Adamawa - où le FBP existe depuis 2011 - et l'État de Gombe, qui n'a commencé qu'en 2017, mais montre des signes prometteurs d'amélioration, de sorte qu'ils puissent être utilisés pour le plaidoyer. fins;
- Présenter ces résultats au Conseil national de la santé, à la Commission de planification nationale.
- Encourager les autorités des États à faire l'approche PBF la réforme privilégiée pour atteindre la couverture sanitaire universelle;
- Intégrer les différents programmes verticaux dans une stratégie de santé harmonisée suivant l'approche des meilleures pratiques PBF;

2.4.5 Mise à jour politique de Nigeria

Après les élections présidentielles de février 2019, le Nigéria est en train de mettre en place son gouvernement fédéral et celui de ses États pour les années à venir. Le gouvernement nigérian a adopté le programme de couverture universelle en matière de santé et le défi actuel dans tous les États et au niveau fédéral consiste à élaborer une proposition durable de renforcement des systèmes de santé et de financement de la santé pour aboutir à la CSU.

Le gouvernement fédéral et les gouvernements des États étudient les différentes modalités de financement. Ils étudient par exemple comment un fonds de fourniture de soins de santé de base - en pourcentage des recettes pétrolières consolidées, pourrait contribuer au financement de la santé au niveau national, c'est-à-dire des soins de santé primaires. D'autres grands projets, fondés sur des prêts et des subventions de partenaires externes, tels que le programme Sauvez un million de vies (SOML), font également partie de l'équation. Les nouveaux États et gouvernements fédéraux, qui entreront en fonction d'ici la fin du mois de mai 2019, devront tous se tourner vers une intégration et une gestion nationales du système de santé plus poussées, qui transformeront les 18 prochains mois en une période décisive pour la politique de la santé au Nigéria. Plusieurs États nigérians représentés au cours d'avril 2019 avaient envoyé des cadres supérieurs de la SOML se lancer dans l'exploration du PBF dans le cadre de ce débat sur l'intégration et la CSU. Plusieurs des États présents ont également participé à la mise en œuvre du programme NSHIP, du programme RBF au Nigéria, et ont manifesté leur intérêt pour l'introduction de nouveaux éléments RBF / PBF dans leurs politiques.

2.5 Pays-Bas - Médecin généraliste

Les Pays-Bas sont l'un des pays les plus riches du monde. Les soins de santé sont bien organisés. Les dépenses par habitant sont proches de 4 000 €. Les soins de santé dépendent fortement des soins primaires. Cela rend le système abordable et durable. Sans soins primaires, les patients seraient obligés d'aller directement à l'hôpital. Avec des coûts énormes en conséquence. Avec des personnes qui consacrent déjà 15% de leur revenu net à la santé, le système deviendrait trop coûteux sans possibilité de dépenses supplémentaires. Cette situation de couverture totale est maintenant menacée par le départ à la retraite d'un grand nombre de généralistes dans des zones reculées. Les jeunes médecins ont tendance à ne pas vouloir travailler dans ces domaines. Il est donc nécessaire d'inciter les praticiens débutants à travailler dans ces domaines. Un problème supplémentaire est la situation de générosité qui fait que la plupart des médecins généralistes, qui ont une semaine complète de travail de 50 à 60 heures, prennent leur retraite. Les jeunes femmes médecins qui ont tendance à travailler à temps partiel, par ex. 25-30 heures par semaine. Avec la situation actuelle, pour remplacer un médecin sortant, vous aurez alors besoin de 2 ou 3 médecins pour remplir les cabinets.

D'après l'analyse de faisabilité PBF ci-dessus, le système de santé néerlandais ressemble à un système PBF, avec un score de 46 (92%).

Recommandations

- Utiliser les bonus d'équité géographique et d'investissement pour inciter les médecins généralistes à commencer leur pratique dans des zones défavorisées. Il existe déjà un système en vertu duquel les paiements trimestriels réguliers sont augmentés dans les zones urbaines dites pauvres. En plus de cela, nous pouvons utiliser d'autres incitations. Par exemple, récemment, les autorités provinciales de

Zélande ont mis en place des résidences d'été pour inciter les médecins à travailler en été en Zélande.

- Passer une motion à l'assemblée nationale des médecins généralistes pour étendre le système d'incitation des zones défavorisées
- Déterminer le montant supplémentaire du paiement supplémentaire par les acteur concernés ;
- Demander l'approbation du ministère des Finances pour une augmentation du budget global consacré aux soins primaires.
- Rechercher la collaboration avec les compagnies d'assurance maladie locaux. La loi impose à la compagnie d'assurance d'assurer suffisamment de soins de santé dans leurs régions respectives.
- Adapter le système existant de tarification par code postal. Une prime d'investissement supplémentaire peut être versée par la compagnie d'assurance maladie locale et parfois par les autorités locales telles que les conseils et l'administration provinciale.

3. INTRODUCTION

3.1 Performance-based financing (PBF), a reform approach in progress

Performance-based financing has been steadily replacing input-based centrally planned health systems, on which the PHC and Bamako Initiative paradigms were based. Since the late 1990s, PBF initiatives and pilots, formerly known as the contractual approach, have been gradually introduced in around 40 countries worldwide. A number of them - such as Rwanda, Burundi, Cameroon and Zimbabwe - have adopted PBF as their national policy. Other countries are in the process of making PBF their national strategy. As part of a focus on universal health coverage and sustainable health systems and development goals, interest in PBF has been growing in English-speaking countries such as Nigeria, Tanzania, Lesotho, Uganda, Malawi and Kenya as well as in Asia such as in Afghanistan, Tajikistan, Kyrgyz Republic and Laos.

There is no longer much controversy around the main theories and concepts of the PBF reforms. PBF's primary aim is to provide quality care and secondly to capture the efficiency of a regulated market economy to distribute scarce resources and assure more sustainable systems. Its effects on transparency, good governance and ownership are comparing favourably to the top-down and hierarchical styles of many existing (health) systems.

PBF has proven to be effective in improving the quality of care by making use of a mix of revenues such as public subsidies and cost sharing. PBF also developed standards on the revenues and staff per capita that are required to deliver the full packages of good quality in health and education. This implies that health facilities (or entities in other social sectors to which PBF could be applied, such as schools) in low- and middle-income countries sometimes need to increase their revenues and qualified staff by a factor 3-5.

The challenge of any PBF-led transformation is that it requires change that is not always easy to manage. It entails informing key stakeholders and changing their terms of reference including those of Ministries. The need to increase provider revenues will under most circumstances also require maintaining direct fee paying for patients and parents. This will inevitably constitute financial access problems for the very poor. Hence, we need to include in the design of new PBF interventions demand-side support for the vulnerable in the shape of geographic and individual equity funds. These new PBF instruments are somewhat comparable to the traditional voucher and conditional cash transfer systems but they are more efficient. In PBF, we tend to avoid inefficient blanket approaches or populist usage of free health care mechanisms. Rigorous empirical research and impact evaluations on the pros and cons of various methods remain necessary and welcome.

3.2 Aims and objectives of the Mombasa PBF course

General aims of the PBF course

- To contribute to the improvement of the health status and the educational level of the population by providing accessible and equitable services of good quality while respecting the free choice for public & private providers and by making rational and efficient use of limited government and household resources.
- To contribute to the understanding of the advantages of using market forces in distributing scarce resources and of how to address market failures by applying market-balancing instruments such as subsidies (and taxes), regulatory tools and social marketing.

Specific Objectives

- To reach a critical mass of people, who wish to be change agents, are looking for tools for improvement and who – once they understand their roles – can be implementers, advocates and guides in the execution of performance-based financing.
- To provide participants with an understanding of the relationships between health and national economic policies, the potential for economic multiplier effects and of the ways in which these are influenced by performance-based financing.
- To assist participants to master the objectives, theories, best practices and tools relevant to putting performance-based financing into practice.

3.3 The April 2019 Mombasa course

The 78th group consisted of a mix of people with a variety of implementation experience in PBF in four different countries across Africa from Nigeria (seven states), Ethiopia, Cameroon, to Central African Republic and two participants from The Netherlands

Throughout the course, the participants were assigned to develop a "business or action plan", following a number of steps: (a) Elaboration of the country background of the particular PBF initiative; (b) Analysis of specific PBF implementation challenges through the application of the PBF feasibility scan of module 9; (c) Development of an action plan for the participants and country groups on how to tackle the various problems identified, following the logic of the PBF modules.

The updated course guidebook "PBF in Action: Theory and Instruments" was distributed among the participants before the start of the program, upon confirmation of participation. The course materials (a hard copy of the course book, pdf latest version of the course manual, the PowerPoint presentations and country presentations, photos of the course and articles) were distributed during the course, together with the participants' contact details list. On Friday April 5, 2019, field excursions were organized – with great support from Kilifi County Health Office - to five health facilities: Mtwapa Health Center, Kadzinuni Dispensary, Vipingo Health Center, Tagaungu HC and Kilifi County Hospital.

3.4 The pre- and post-test

SINA Health issues a Certificate of Merit to those who pass the exam at the end of the course. Those who do not score 53% or more, obtain a Certificate of Participation. The exam for this course was conducted on Saturday April 13th and consisted of 30 multiple-choice questions, tailored around the main subjects treated during the course.

The average score for the exam was 67%. Participants obtain distinctions when the score is 87% or more. We congratulate the following participants, who passed with distinction. The proposition of distinctions (23%) was relatively high during this course.

1. Dr AJIBOYE Rhoda Funmilayo, Secretary General, Kwara State MOH, Nigeria
2. Ms SAMA Paltiel Yeti, Verifier CDV Agency North West Region Cameroon
3. M. HALAKE DJARSO Galgalo Cordaid Ethiopia, Jimma Health Zone, Ethiopia
4. OMAR Ibrahim Hassan SOML Manager, Kwara State MOH, Nigeria
5. SCHAKELCarmen Cordaid The Hague, The Netherlands
6. KINYUY Margaret Gham NW Reg Fund Health Promotion.Bamenda Cameroon

Three participants deserved a "merit-mention" of having scores of 80% or 83%, while six participants obtained less than 53%.

Scores	Nbr	%	Certificate
87% - 100%	6	23%	Distinction
80% - 83%	3	12%	Merit - mention
70% - 77%	3	12%	Merit
53% - 67%	8	31%	Merit
0% - 50%	6	23%	Participation
TOTAL	**26**	**100%**	

3.5 Who attended the October - April 2019 PBF course?

14 from Nigeria; 7 from Cameroun, 2 from Cameroon, 1 from CAR and 2 from the Netherlands.

The list of participants to the 78th PBF course

SN	Surname	First name	Profession	M/F	Status	Organization	Country
1	KINYUY	Margaret Gham	Accountant	f	Parast	North West Reg Fund Health	Cameroon
2	SAMA EPSE NDZENYUY	Paltiel Yeti	Field Supervisor	f	CDVA	CDVA North West Region	Cameroon
3	KWIZERA	Flora	Program Manager	f	NGO	Cordaid	CAR
4	ASHAGRIE	Magdelawit Mengesha	Health Informatics Expert	f	publ	Fed Ministry of Health	Ethiopia
5	BIZUNEH GUDISA	Mijena	Health Educator	m	NGO	Cordaid	Ethiopia
6	HAJIBEDRU ABADULA	Kunuz	Health Administrator	m	publ	Jimma Zone Health Office	Ethiopia
7	HALAKE DJARSO	Galgalo	Public Health Officer	m	NGO	Cordaid	Ethiopia
8	MEKONNEN LIGDI	Kenea	Nurse/MPH/HRH/	m	publ	Jimma Zone Health Office	Ethiopia
9	ANEMUTE ALAMINEH	Simachew	Finance Man. Officer	m	publ	Fed Ministry of Health	Ethiopia
10	HIRPESA	Genet Mulugeta	Health Economics Financing	f	publ	Fed Ministry of Health	Ethiopia
11	MELCHERTS	Kees	Medical Officer	m	priv	Private Health Facility	Netherlands
12	SCHAKEL	Carmen	Controller / Junior PBF Expert	f	NGO	Cordaid	Netherlands
13	ABANA	Abubakar	M&E Officer SOML	m	publ	Adamawa State MOH	Nigeria
14	ABBA	Babagana	Program Manager SOML	m	publ	Yobe State MOH	Nigeria
15	AJIBOYE	Rhoda Funmilayo	Permanent Secretary	f	publ	Kwara State MOH	Nigeria
16	BUKAR	Bunu	Program Accountant	m	publ	Yobe State MOH	Nigeria
17	JOSHUA	Anna Iyefu	Program Manager SOML	f	publ	Nasarawa State MOH	Nigeria
18	KAKALE	Musa	Director Proc & Ess Drugs	m	publ	Kebbi State MOH	Nigeria
19	LAMINU	BABA	Program Manager SOML	m	publ	Borno State MOH	Nigeria
20	M. ALHAJI	Hamidu	Permanent Secretary	m	publ	Yobe State MOH	Nigeria
21	MAINA BUKAR	Fatimah	Nurse/Midwife	f	publ	Yobe State MOH	Nigeria
22	OBAADO	Ola Esanmbo	Director Plan Research Statistics	m	publ	Ondo State MOH	Nigeria
23	OMAR	Ibrahim Hassan	Program Manager SOML	m	publ	Kwara State MOH	Nigeria
24	USMAN	Kolo Rifun	Hon. Commissioner	m	publ	Kwara State MOH	Nigeria
25	YAKUBU HASSAN	Hassan	Nurse/Midwife	f	publ	Yobe State MOH	Nigeria
26	ZIRA	Jeremiah	Economist / TA SOML	m	publ	Adamawa State MOH	Nigeria

3.6 Facilitation team

The facilitation team consisted of:

1. Dr. Godelieve van Heteren, MD, Public Health Specialist, previous Member of Dutch Parliament and Director of Cordaid. Currently working as senior health systems and governance consultant for WHO and World Bank.
2. Dr. Robert Soeters, MD, PhD, Director SINA Health - chief course facilitator
3. Dr. Fanen Verinumbe, A medical doctor and PBF consultant at the National PBF Unit in Nigeria
4. Mrs Anne Wairimo, Logistic Coordinator from Kenya
5. Mrs Caroline Atieno, Logistic Assistant from Kenya
6. Mr. Tom Njieri, General logistics, transportation and events.

3.7 Next English PBF course Monday 28th of October, 2019

Consult www.sina-health.com for the announcement and application form

4. DAILY EVALUATIONS BY PARTICIPANTS

4.1 Daily evaluations by participants

Every day, the participants gave their evaluation of the course based on four assessment criteria:

1. Methods & facilitation;
2. Participation;
3. Organization;
4. Time-keeping.

The overall average score for the four criteria combined was 85,0%. This is 1,6% *above* the previous 24 English spoken courses, and 6,0% *above* the 44 previous French spoken courses.

Daily evaluation topics as scored during 10 days	French speaking courses (44x)	English speaking courses (24x)	Mombasa April 2019	Comparison Mombasa April 2019 / Previous 24 English courses	Comparison MombasaApril 2019 / Previous French courses
Methodology and facilitation	85,0%	87,5%	87,5%	0,0%	2,5%
Participation	82,4%	87,4%	87,2%	-0,2%	4,8%
Organization	72,5%	86,3%	86,6%	0,3%	14,1%
Time – keeping	76,2%	72,6%	78,8%	6,2%	2,6%
Overall score	**79,0%**	**83,5%**	**85,0%**	**1,6%**	**6,0%**

Table 1: Overall daily evaluation scores of the course.

4.2 Methods and facilitation

Methods and facilitation was on average the same with 87,5% compared to the previous 24 English courses (87,5%) and 2,5% above the average of the French spoken courses (85,0%). Satisfaction with the methods and facilitation remained at around 90% with the exception of D1 and D6.

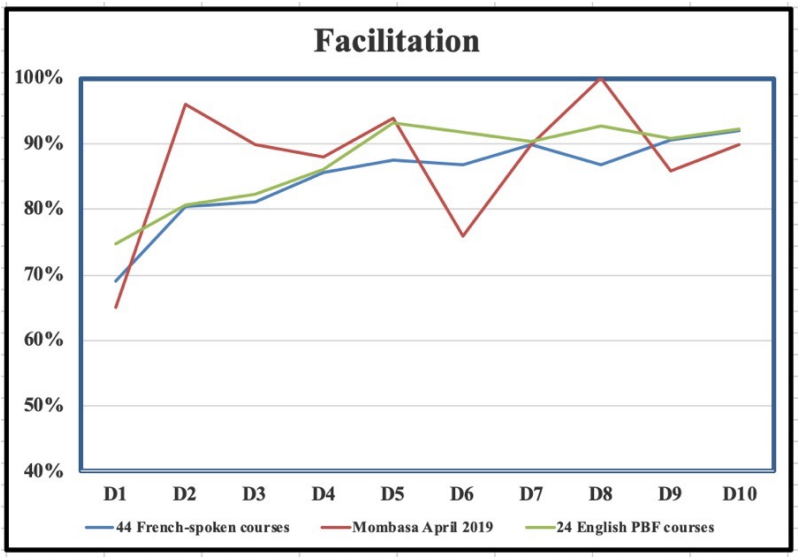


Figure 1: Evolution of the daily evaluations: *methods and facilitation.*

4.3 Participation

The satisfaction with the level of **participation** was 87,2%. This was 0,2% lower than the previous English courses (87,4%) and 4,8% above the French courses (82,4%).

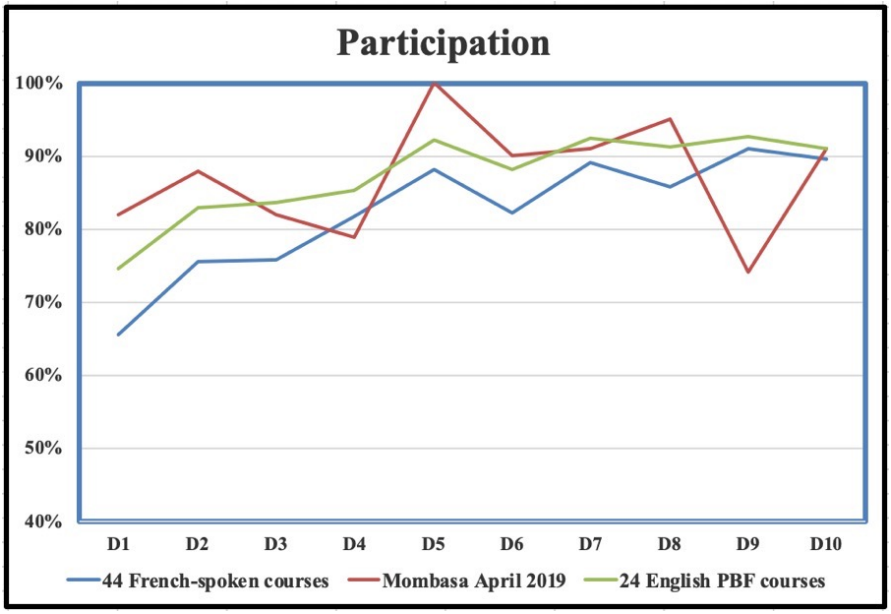


Figure 2: Evolution of the daily evaluation: *participation.*

4.4 Organization

The **organization** of the course in Mombasa had an average score 'very positive or positive' of 86,6%, which is 0,3% *above* the average of 86,3% of the previous English courses and 14,1% *above* the average of 72,5% of the previous French courses. Organization dipped slightly during the second week to the lowest point of 76%. This was due to the power failure that took a couple of hours to solve. The hotel was generally evaluated as excellent and the cooks even cooked Nigerian *very hot* food.

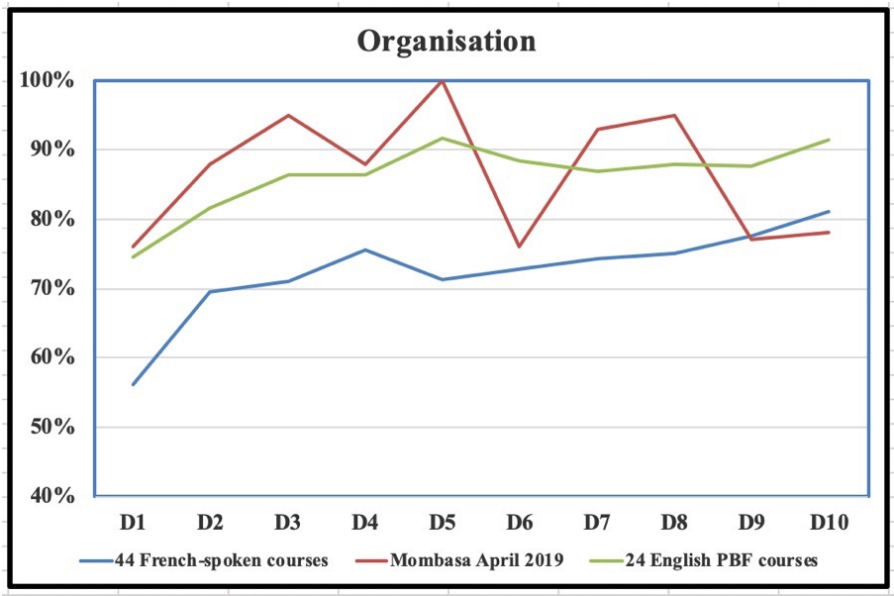


Figure 3: Evolution of the daily evaluation: *organization.*

4.5 Time keeping

Satisfaction with time keeping was 78,8%, which was 6,2% above the previous 24 English courses and 2,6% above the previous French courses.

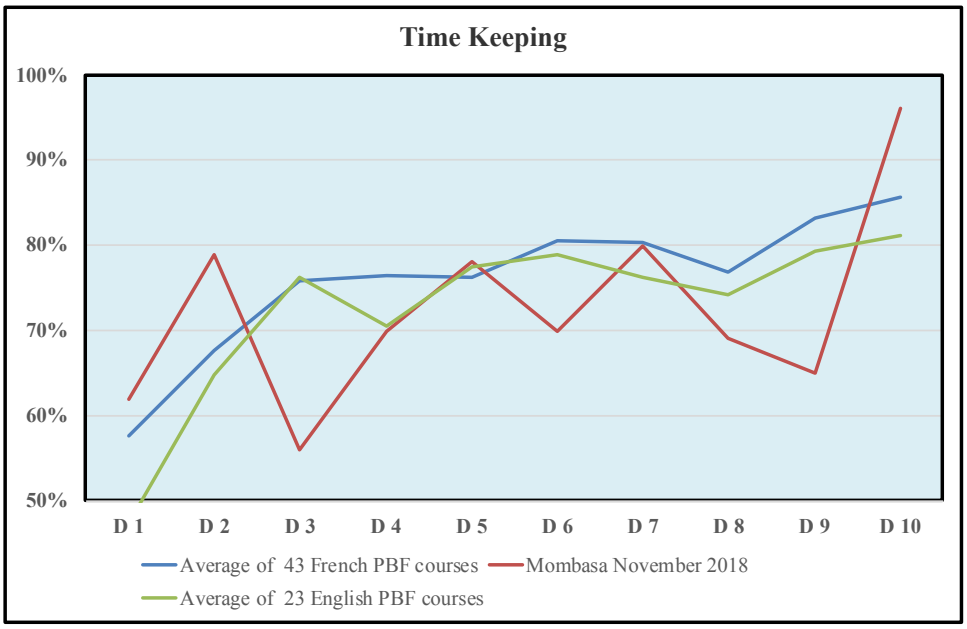


Figure 4: Evolution of the daily evaluation: *time keeping*.

5. DESCRIPTION of the COURSE

Arrival day: Sunday March 31st 2019

Daily Recaps

During this course, the daily recaps were made by the facilitators, through structured questions and answer sessions in PowerPoint, highlighting the key messages of the previous day. This gave participants more time in the evenings to study as well as to work on the main output of the course, which was their action plans.

This methodology was found to be effective, especially in emphasizing the key messages of the modules.

Daily Evaluation and Feedback from Participants

At the end of each day, during the daily evaluation, participants were encouraged to give written feedback to help facilitators and the hotel improve on the quality of the course, as well as any problems they face with the hotel, etc.

Every morning, feedback was given to participants about in how far the issues they raised have been solved "a feedback on their feedback".

Facilitators' Meeting

In the evening after the days' activities, for 10-20 minutes, the facilitation team met to discuss what went well, what could be improved, and in general ways to improve the quality of the course.

Evening Sessions

Evening sessions with country groups were organised which allowed one-on-one dialogue with the facilitators to understand country specifics, including challenges and way forward on action plans. During the first week, the facilitators met with 2 or 3 country groups every evening, to know the participants better, understand what they do, get their impression of the course so far and discuss the development of their action plans. During the second week of the course, the group exercises within the modules were organised such that they were carried out in the evenings.

The extra day of the course worked well as participants had sufficient time to work on their action plans and sufficient time was also available to cover all the course modules.

Below was the schedule for evening country meetings

Evening country meetings		
Monday April 1, 2019	17:30 – 18:30hr	Nigeria – Kwara State
Monday April 1, 2019	18:30 – 19:30hr	Nigeria – Ondo and Nasarawa States
Tuesday April 2, 2019	17:30 – 18:30hr	Nigeria – Yobe State
Tuesday April 2, 2019	18:30 – 19:30hr	Nigeria – Borno and Kebbi States
Wednesday April 3, 2019	17:30 – 18:30hr	CAR
Wednesday April 3, 2019	18:30 – 19:30hr	Cameroon
Wednesday April 3, 2019	19:30 – 20:30hr	Netherlands - Kees
Thursday April 4, 2019	17:30 – 18:30hr	Ethiopia - Cordaid
Thursday April 4, 2019	18:30 – 19:30hr	Ethiopia - FMoH
Friday April 5, 2019	17:30 – 18:30hr	Nigeria – Adamawa State

Arrival day: Sunday March 31st 2019

The 78th international PBF course organised by SINA health in Mombasa-Kenya, welcomed a total of 26 participants from 5 countries, including 4 African countries (Nigeria, Ethiopia, Cameroon, CAR) and one European country – the Netherlands. All

participants arrived on Sunday the 31st of March and were warmly welcomed by facilitators and the hotel.

During this course, most participants came from the health sector, but the facilitation team was also happy to welcome one participant working in the security and justice sector in CAR.

Other participants had background working in various ministries of health, at national and sub-national levels; government parastatal agencies; from Cordaid (Ethiopia and the Netherlands) who are implementing PBF in some parts of Ethiopia; as well as a general practitioner from the private sector in Holland.

This team welcomed a delegation of high level participants including 1 commissioner of health, and 2 permanent secretaries of Ministries of health in Nigerian states.
Upon arrival, participants settled in quickly, and were asked to fill out a pre-course questionnaire to enable facilitators to tailor the content of the course to the needs of the participants. The course book was also distributed, so participants started to study immediately.

In terms of knowledge of PBF, most participants had limited or no knowledge, and were mainly on the course to understand better what the system was and whether it could be applied to their health systems. Other participants were already implementing PBF in their countries and were in the course to understand the principles, theories and best practices better.

Monday April 1st

All participants were in class by 9:00am, where the program started with registration of all and distribution of the course agenda. Dr. Godelieve Van Heteren then welcomed the participants, after which she presented the course outline as well as the training methodology, so participants would have a feel of what the 2-week interaction might look like.

This session was followed by the "getting acquainted" exercise, where participants were asked to profile themselves in terms of their key strengths and weaknesses in a poster. This session served as an ice-breaker session, as participants enthusiastically carried out the activity and go to know each other.

The pre-test, comprising of 15 multiple-choice questions was then conducted to test participants existing knowledge on PBF. The country groups were then established, after which participants broke out to conduct a brief diagnosis of their various health systems in how far the system was cost-effective, and if they thought PBF could be a solution to some challenges that they have to confront in carrying out their respective duties. In total, 11 country groups were established, with a chance that some of the groups could be split further if they were not homogeneous.

During the first exercise of the course, most participants rated their health systems to be moderately inefficient, in the sense that the health indices in most countries are still poor, despite increasing investments in the sector. Some participants were optimistic that PBF could be a solution to some challenges they face, others were eager to learn more about PBF before make such conclusions.

Following the feedback on the exercise, the Mombasa village was established and the village officials elected to assist facilitators maintain the ground rules during the workshop.

The following were the Mombasa 78th village officials:

Chief:	Dr. Omar Ibrahim
Deputy Chief:	Flora Kwizera
Internal affairs Minister / Time keeper:	Mijana
Finance Minister:	Margret and Kees
Energizers:	Baba Laminu, Abubakar Abana and Mekdelawit

Next, the module 1 PBF in context in the era of UHC, a comparison between Alma Ata and Bamako Initiative, as well as the evidence for PBF was presented. This topic, unlike groups in previous years, did not generate many discussions. Participants were already convinced that new strategies are necessary to achieve UHC.

The day ended at 17:00 with the daily evaluation of the course and the selection of the best debater of the day. In the evening, from 17:30 onwards, the facilitators met with the participants from Kwara State and then Ondo and Nasarawa States to better understand their specific objectives of being in the course and to support them in developing a concrete action plan. Discussions with the Kwara State team focused around challenges of the health system, being a state with no form of PBF implementation. The group were however optimistic that a new government following the recent elections would be an opportunity to push the PBF agenda in a position paper that the ministry of health is preparing.

With the Nasarawa and Ondo team, already implementing PBF in 50% of their states through the Nigeria State Health Investment Project, discussions were around integration of health programs, as well as PBF sustainability, seeing that the current PBF project will round up in slightly over a year.

Tuesday April 2nd

The day started at 8:30am with a feedback on the issues raised by the participants during the evaluation of day one by Anne. The daily recap was made by Dr Robert, of the main messages of the previous day. This was in an interactive session with the participants stating the key messages which was delivered the previous day followed by discussions around these.

Following the recap, the summary of the outcome of the pre questionnaire was presented. This analysis showed that most participants came from various ministries of health, involved in the regulatory role. The expectation from most members of the group was to understand PBF better, in terms of the theories, best practices, tools, as well as its applicability in conflict or war situations. This exercise was helpful as it helped facilitators to tailor the course towards meeting the specific needs of the group.

Fanen Verinumbe presented module 2, “a simple example of PBF and definition” followed by module 3 “institutional set-up and change topics”. The Turning Point Questions (TPQs) stimulated some discussion as expected, as participants related to the challenges that some of these change issues may pose. Participants agreed that in principle, the changes are necessary, but in reality, there may be challenges in its implementation.

As part of Module 3 also the topic of “Equity” was presented and the seven equity instruments proposed by PBF were shared with the group.
The day ended at 16:30 with the daily evaluations, written feedback from participants and selection of the best debater of the day.

During the evening, for 17:30 onwards, facilitators met with the participants from Yobe, Borno and Kebbi States (Nigeria). Discussions with the groups focused around integration of vertical health programs, as well as on better coordination of partner support for health.

Wednesday April 3rd

The day started at 8:30 with Anne who presented a feedback on the issues raised by participants during the evaluation. The daily recap was then facilitated by Robert, highlighting the key messages of the previous days' interaction.

Module 4 on PBF theories (systems analysis, Public choice, contracting, decentralization and governance) was then presented by Godelieve and this took most of the morning. The module 5A on microeconomics then followed. Basic economic principles were presented as a foundation to understanding how markets operate as well as to relate some of the concepts also in the health care market. Following this, the module 5B on health economics was started, shortly before day ended.
The session closed at 16:30 with the daily evaluation and selection of the best debater of the day.

In the evening, facilitators met with participants from CAR, Cameroon and Holland.
Discussions with the participants from CAR and from the Netherlands focused on how PBF can principles and help improve their current work, while discussions with the group from Cameroon focused on how to improve on the operations of PBF in their region, since PBF is already national policy in Cameroon.

Thursday April 4th

The daily recap was this time presented by Fanen Verinumbe, after which the module on health economics was completed. These included the presentation on the concepts of opportunity costs, the economies of scale and of scope, efficiency, the various failures that exist in the health market and how sound economic instruments (taxes and subsidies) could be used to appropriately correct some of the market failures in health.

The course on this day received a special visit by the first lady of Kilifi County, Mrs. Elizabeth Kingi, to welcome all participants and to officially declare the course open.
Later during the day, participants were introduced to the module on roles of various actors / stakeholders in the PBF system, starting with the role of the regulator at various levels of the system and how this is organised in the PBF institutional arrangements.
The session closed at 16:30, with the daily evaluation of the course and the selection of the best debater of the day.

In the evening from 17:30 onwards, facilitators met with the 2 groups form Ethiopia, Discussions focused on extending the Cordaid PBF pilot in one region of Ethiopia, and around the possibility of having a national program.

Friday April 5th

The day started early at 8:15 am with the daily recap of modules covered during the previous day. This was followed immediately by a brief introduction of the terms of reference of field visits by Godelieve and Robert.
The groups then set out on the field to visit Five Kilifi County facilities for a tour and guided interviews with the facilities' in-charges and other staff.

The facilities visited and teams were:

Vipingo Health Centre	Kadzinuni Dispensary	Tagaungu Health Centre	Mtwapa Health Centre	Kilifi District Hospital
Anna Joshua Abubakar Abana Abba Babagana Ola Obaddo	Flora Kwezira Carmen Schakel Fumilayo Ajiboye Bunu Bukar Mekdelawit Mengesha	Zira Jeremiah Kees Melcherts Galgalo Halake Mairo Yakubu	Omar Ibrahim Simachew Anemute Fatima Maina Godelieve	Margret Gham Baba Laminu Musa Kakale Hamidu M. Alhaji Usman Kolo Rifun

Each team was led by one member of the group as facilitator. The facilities were of different sizes (from dispensary/health posts to a county hospital), so groups got different, but complementary findings regarding the staffing, sources of financing, supply and expenditures.

Upon return, the groups gave feedback on the questionnaire, which helped to assess the vitality and PBF readiness of the facilities. This was similar to feedback received by other groups during previous courses and is summarised below:

- All health facilities received their inputs and equipment from KEMSA but with variable support from other partners and donors. Some facilities had some autonomy to purchase inputs from accredited distributors only if they were using their internally generated resources to do so and up to a certain amount of money.
- The procedure of receiving drugs and other inputs from the KEMSA was tedious, took a long time and health facilities frequently experienced stock-outs.
- User fee tariffs for the hospital are fixed at county level.
- For all health facilities visited, except Vipingo, revenue per capita does not meet required standards of 7 USD per capita, with most facilities generating less than USD 4 per capita.
- No health facility had autonomy to set user fees, manage their financial resources or to hire and fire their staff.
- Generally there was no proper separation of functions.
- Some form of PBF implementation was reported to have started in some health facilities, even though payment of subsidies was said to be irregular
- Some form of client satisfaction using suggestion box, direct patient interviews and feedback through community committees, which was found to be ineffective. This aspect needs to be strengthened as per PBF.
- Most health facilities did not meet the recommended staffing levels of 1 technical staff per 1000 population

After the feedback session, module 6 on the role of the regulator was completed. The day ended at 16:30 with the daily evaluations and selection of the best debater of the day. In the evening, from 17:00 onwards, the facilitators met with the team from Adamawa State (Nigeria). Discussions with this team focused on sustainability of the existing PBF project in the state.

Saturday April 6th

The morning started at 8:30 with a recap of previous day activities.
Module 6B on quality assurance of health facilities was then presented, after which presentation of module 7 the role of the CDV Agency commenced.

At midday, the module 9 on “PBF project development and feasibility scan” was then presented. As part of this module, participants were asked in their country working

groups to score the PBF feasibility matrix, identify killing assumptions and develop advocacy plan, to be presented in a role play (on Monday). Participants continued to work on their action plans using the results from the feasibility scan.

The day ended at 13:00 hours, with daily evaluations and a selection of best debater of the day. Participants were then invited to enjoy a bus ride to the city of Mombasa, including the market for shopping of some souvenirs and a visit to the historic Fort Jesus – which is also a UNESCO world heritage site.

Sunday April 7th

On Sunday, the team went out on a journey through history, to Jumba La Mtwana which told the story of how the Swahili sailors lived and traded in Mombasa over 700 years ago. This was followed by some exciting exercises and games on the beach, including beach volley ball and tug of war. The day was completed with a visit to Haller Park in Mombasa, which has a remarkable history of being a reclaimed quarry site. Some animals at the park include tortoise, hippopotamus, antelopes, a variety of snakes, buffalos, etc. Highlights of visit to the park include feeding of the giraffes and crocodiles. The team returned to the hotel at about 17:00.

Monday April 8th

The morning started at 8:30, with the daily, after which the module 7 on the role of the CDV Agency was completed. Following this, additional time was given to the groups to complete the work on the feasibility scans and preparation of the role plays.

Each group, during the role plays, identified their most difficult area of change, and presented an advocacy for this change. Some groups advocated for a change in their central procurement of inputs, for increasing autonomy of providers to influence cost sharing tariffs, hire and fire staff, and to be able to use revenues at the point of collection. Feedback was given to each group on how well they presented the topic, time management (5 minutes !), follow-up strategies proposed, as well as whether they demonstrated good communication skills.

The day ended at 16:30 with the daily evaluations and selection of the best debater of the day. In the evening, participants were encouraged to continue working on their action plans, and facilitators were available to give feedback and support.

Tuesday April 9th

After the daily recap, module 8 on the role of the community as a stakeholder in PBF was discussed. Here, facilitators presented two ways in which the community can be implicated in the PBF logic; through social marketing activities as well as in collecting feedback during client satisfaction surveys. Participants agreed that the traditional method of community involvement did not work well and that new approaches need to be considered.

Following this, module 10 on conflict resolution and negotiation techniques in PBF was presented. This was followed by a group work, where participants were asked, in their country groups to identify the ‘last mile’ for PBF implementation. In this exercise participants in groups to designed a negotiation strategy to deal with the toughest barriers to change and reform in the system. Participants found this exercise interesting, and helpful in structuring a realistic road map for the proposed action plan.
The day ended at 17:00 with the daily evaluation. In the evening, participants continued to improve upon their action plans.

Wednesday April 10th

After the daily recap, the module on conflict resolution was completed.
This was followed by presentation of module 12 on the output indicators. Here the various quantitative indicators in PBF were presented, including the criteria for selection as well as how the targets for each are being established.
Time was allocated during the day, for participants to work on their action plans, while facilitators circulated round the groups, to provide support.

From 16:00 onwards, the exercise on the output indicators was explained and participants were asked to work on the exercise in the evening for presentation in plenary on Thursday morning. The day in plenary ended at 16:00 with the daily evaluations and selection of best debater of the day.

Thursday April 11th

On this day, the group faced technical challenges with power cuts at the conference venue. This significantly affected the program for the day. Despite the power failure, the daily recap was presented, after which participants were encouraged to work on their country action plans for the most parts of the morning. Presentation of the module 15 on indices management tool then commenced, but was not completed. Participants were asked to work on the exercise on the indices management tool, while facilitators circulated to give support to the groups. Finally, the exercise was worked out in plenary with discussions around these. The day ended at 16:30, with the final evaluation of the day.

Friday April 12th

This day, being the last day of class work, started at 8:30am and was confined to the morning, to enable participants study for the exam. The day was dedicated to presentation of the PBF instruments; modules 14 the "business plan" and 15 on the "indices management tool". After the morning coffee break, participants made a presentation of the key messages of their individual or group action plans in a poster session. A round was made, where each group presented their poster in plenary with facilitators supporting each group in coming up with smart recommendations.
This was found to be a very interactive session that was found to be highly valued by most participants and facilitators.

These recommendations are summarised below:

Country / State	Feasibility Score	Key recommendations
CAR	28%	- Design a PBF program for the security and justice system in CAR
Cameroon – CDVA Supervisor	88%	- Allow PBF supervisors to also conduct the coaching of their assigned health facilities
Cameroon – Regional Fund for Health Promotion (NW)	92%	- Update the accredited list of pharmaceutical distributors - Assure quality of medicines in the public and private sector - Push for prompt payment of subsidies to health providers
Ethiopia - FMoH	32%	- Establish an assembly of key stakeholders to institutionalize PBF as national health reform approach
Ethiopia – Jimma Zone	60%	- Positioning of the PBF unit at the Ministry of Health for sustainability
Netherlands	92%	- Design an incentive approach to encourage young GPs to move to the rural areas for good coverage of primary care.
Nigeria – Adamawa	64%	- Establish PBF as national Health reform strategy
Nigeria – Borno	38%	- Better coordination of partner activities in the state

		- Establish a basket funding for health activities – leveraging on the tripartite fund already established. - Transform to PBF the free health care budget
Nigeria – Kebbi	44%	- Decentralize the procurement of inputs to accredited distributors within the state.
Nigeria – Kwara	20%	- Coordination of partner activities in the state - Set-up a PBF pilot - Explore the sources of funding for this pilot and design a sustainable institutional set for a state owned PBF program.
Nigeria – Nasarawa	92%	- Scale-up and institute PBF unit in the State MoH - State funding of PBF (20% of the PBF budget)
Nigeria – Ondo State	80%	- PBF scaling in the state; - Advocacy for a state PBF budget, towards PBF sustainability in the state.
Nigeria – Yobe	76%	- PBF scaling in the state; - PBF sustainability.

During this course, module 11 on the baseline and evaluation studies for PBF programs, module 13 on costing, module 16 - PBF in emergency and 17 – PBF in Education were not presented in class. Participants were encouraged to study these on their own.
The overall evaluation on the course was carried out before the class broke up at 12:45 to work on finalizing their country action plans, as well as for the general revision in the afternoon in order to prepare for the exam.

Saturday April 13th

The exam day started at 8:00. 26 participants took the final exam.
In the morning from 9:30 onwards the exam was reviewed. This was followed by a ceremony to hand out the certificates at 12:00 to allow the 3 participants who needed to travel back home time to get to the airport.
In the evening from 20:00, a dinner was organised at the restaurant to give all participants and facilitators an opportunity to say their goodbyes.

Sunday April 14th

Most participants left on Sunday on different flights out of Mombasa.

6. FINAL COURSE EVALUATION BY PARTICIPANTS

6.1 General impression of the course

The score for 'general impression of the course' was with 73.3%, 10,3% *below* the average of the 25 previous English-spoken courses. The criterion "I was sufficiently informed" scored 52%, which is 25% below the average of the previous English courses. The criterion: "program answered my expectations" scored 88% (= 3% *above* the previous courses). The criterion "the course objectives related well to participants" professional activities" scored 80% (= 9% *below* the average).

Preparation	The 41 previous French-spoken PBF courses	The 25 previous English-spoken PBF courses	Mombasa April 2019	Comparison Mombasa April 2019 / 41 previous French-spoken PBF courses	Comparison Mombasa April 2019 / 25 previous English-spoken PBF courses
Q1. I was sufficiently informed about the objectives of the course	88%	77%	52%	-36%	-25%
Q2. The program has answered my expectations	84%	85%	88%	4%	3%
Q3. The objectives of the course relate well to my professional activities	89%	89%	80%	-9%	-9%
Average	**87,1%**	**83,7%**	**73,3%**	**-13,8%**	**-10,3%**

Table 2: Course information and expectations linked to current professional activities.

The participants' appreciation of the methodology and the contents scored well with 93%, which was 5% above the average of the previous English courses and 10% above the previous French courses. The criterion "content helped me to attain my objectives" scored 93%, "methodology" scored 90%, the "balance between lectures and working groups" scored 87%. The criterion "interaction in working groups" scored 97% and the "working methods stimulated my participation" scored 96%.

Methodology and contents of the course	The 42 previous French spoken PBF courses	The 24 previous English spoken PBF courses	Mombasa November 2018	Comparison Mombasa Nov 2018 / 42 previous French spoken PBF courses	Comparison Mombasa Nov 2018 / 24 previous English spoken PBF courses
The content of the PBF modules has helped me to attain my objectives	83%	90%	93%	10%	3%
The methodology of the course	84%	87%	90%	6%	3%
Balance between lectures and exercises	70%	78%	87%	17%	9%
Interaction and exchanges in working groups	89%	91%	97%	8%	6%
The working methods adopted in the course have stimulated my active participation	86%	90%	96%	10%	6%
Average	**82%**	**87%**	**93%**	**10%**	**5%**

Table 3: Overview general impressions of participants in different PBF courses.

6.2 Appreciating the duration of the course

In October 2018 a large proportion of 43% of participants thought the course to be too short and nobody thought that the course was too long. This course we added one day (the Saturday) to the course duration and this worked better to reduce the time pressure to finalize the action plans as well as the course modules. This time 92% of the participants thought that the course duration was about right. We conclude that the addition of one day to the course duration was successful.

Duration of the course	The 41 previous French-spoken PBF courses	The 25 previous English-spoken PBF courses	Mombasa April 2019	Comparison Mombasa April 2019 / 41 previous French-spoken PBF courses	Comparison Mombasa April 2019 / 25 previous English-spoken PBF courses
Too Short	33%	24%	4%	-29%	-20%
Fine	61%	64%	92%	31%	28%
Too Long	6%	12%	4%	-2%	-8%

Table 4: Perception of participants concerning the duration of the course.

6.3 Comments on the organization of the course

For "organization", the overall score of 95% was 17% *higher* than the previous 25 English courses with 77% and 25% *above* the 43 previous French courses. The conference centre (96%) and the food (96%) scored respectively 21% and 34% higher than the previous courses. The lecture room scored 100% and the friendliness of the hotel staff as well as the facilitation team scored 96%. Transportation scored 92%. The quality of the educational material scored 88%.

How do you value the organization of the training ?	The 43 previous French-spoken PBF courses	The 25 previous English-spoken PBF courses	Mombasa April 2019	Comparison Mombasa April 2019 / 43 previous French-spoken PBF courses	Comparison Mombasa April 2019 / 25 previous English-spoken PBF courses
Quality and distribution educational material	80%	88%	88%	8%	0%
The lecture room	67%	68%	100%	33%	32%
Conference center in general	57%	75%	96%	39%	21%
How were you received and friendliness	88%	92%	96%	8%	4%
Food and drinks, including tea/coffee breaks	61%	62%	96%	35%	34%
Transportation	66%	79%	92%	26%	13%
Average	**70%**	**77%**	**95%**	**25%**	**17%**

Table 5: Evaluation of the organization of the course.

6.4 Comments on the execution of the course and the facilitators

The three indicators for the "execution of the program" scored 95%, which was 17% above the average of the previous 25 English courses. The question in how far facilitators were open minded was evaluated at 88%, which was 14% *above* the average of the previous English spoken courses. The satisfaction with the time allocated for group work was 100%, which was 23% *above* the scores of the previous courses and this reconfirmed that the extra day to the course duration was appreciated (in October 2018 this score was only 67%). Time for discussions was evaluated at 90%, which was 13% above the average of the previous English courses and which

also confirmed that the addition by one day to the course duration was an improvement.

Aspects related to the execution of the program and the facilitation	The 43 previous French-spoken PBF courses	The 25 previous English-spoken PBF courses	Mombasa April 2019	Comparison Mombasa April 2019 / 43 previous French-spoken PBF courses	Comparison Mombasa April 2019 / 25 previous English-spoken PBF courses
The facilitators had an open mind towards contributions and criticism	80%	74%	88%	8%	14%
Time allocated to group work was adequate	63%	77%	100%	37%	23%
Time for discussions was adequate	76%	83%	96%	20%	13%
Average	**73%**	**78%**	**95%**	**22%**	**17%**

Table 6: How was the facilitation?

6.5 Evaluation per module

The overall satisfaction of the course modules by the Mombasa participants was high with 93,1%. This was 6.5% above the average (= 86,6%) of the previous 25 English courses and 10,3% above the 43 previous French courses. Four modules obtained 100% including module of the first day "What is PBF?", "negotiation techniques & conflict resolution", "community voice empowerment & social marketing" and the module on the "PBF feasibility scan". Economics this time scored relatively lower with 79% as well as the module "business plan and the individual action plan" with 84%. We did not evaluate the modules "baseline studies" and "costing" as they were not presented during the course.

Appreication of Course Modules	The 43 previous French-spoken PBF courses	The 25 previous English-spoken PBF courses	Mombasa April 2019	Comparison Mombasa April 2019 / 43 previous French-spoken PBF courses	Comparison Mombasa April 2019 / 25 previous English-spoken PBF courses
Why PBF & What is PBF?	93%	93%	100%	7%	7%
Notions of micro-economics and health economy	64%	83%	79%	15%	-4%
PBF Theories, best practices, good governance and decentralisation	86%	93%	96%	10%	3%
Baseline research – household survey launching process	77%	80%	NA	NA	NA
Output indicators in PBF interventions	87%	89%	91%	4%	2%
CDV agency, data collection, audit	86%	89%	87%	1%	-2%
Regulator – quality assurance	82%	93%	91%	9%	-2%
Negotiation techniques and conflict resolution	88%	90%	100%	12%	10%
Black box Business Plan & Action plan	85%	90%	84%	-1%	-6%
Black box Indices tool: revenues – expenditure – performance bonuses	79%	81%	96%	17%	15%
Community voice empowerment and social marketing	80%	88%	100%	20%	12%
PBF feasibility, killing assumptions & advocacy	87%	91%	100%	13%	9%
Elaboration of a PBF project - costing	65%	67%	NA	NA	NA
Average for all modules	**82,8%**	**86,6%**	**93,1%**	**10,3%**	**6,5%**

Table 7: Evaluation per module.

6.6 Written comments during the final evaluation by the participants

Pre-Course Preparations

- The course book to be supplied in advance (2-4 weeks). This will give more time for the theories to sink in and for the faster assimilation during the course itself.
- I only received information beforehand on travel and not on course objectives

About Course methodology

- The exercises were too heavy at the end
- Courses should be organised for specific areas like education and administration

Course book, modules and other course materials

- The principles to apply PBF are general, however, most of the examples and exercises are focusing on health sector only. This made understanding a bit difficult.
- Need more time to adapt and apply PBF in other sectors than health and education
- The USB stick was corrupt so I lost all materials
- The same PBF design cannot be applied everywhere. Context should be considered
- Work was not always done evenly
- The USB was corrupt
- Course bag is needed for the documents

Hotel

- The water in the taps was salty

7. COUNTRY & STATE PRESENTATIONS

7.1 Kebbi State

7.1.1 Context

Kebbi State has 21 local governments with a combined projected population of 4.9 million and 31 health facilities embedded within these localities of 225 political wards. The facilities are 29 General Hospitals and 2 specialized centres. Twenty-seven years since the creation of Kebbi State in 1991, successive governments of the State have made tremendous efforts to improve the structural facilities of most Hospitals across the State. In order to improve healthcare at local government level the State Primary Healthcare Development Agency was created with the objective to having Primary Healthcare Under One Roof (PHCUOR).

7.1.2 Organisation of health system

Health care in Nigeria is administered through three tiers: primary, secondary and tertiary levels. The local government is responsible for the primary level, the secondary by the state, while the tertiary is run by the federal government. The responsibility for management of health facilities and programs is shared by the State Ministries of Health, State Hospital Management Boards, and the Local Government Areas (LGAs).

The Federal Government is responsible for:

- Providing policy guidance, planning and technical assistance;
- Coordinating state-level implementation of the National Health Policy and establishing health management information systems.
- Disease surveillance, drug regulation, vaccine management and the training of health of professionals.
- The management of teaching, psychiatric and orthopaedic hospitals and also runs some medical centres.

The States are responsible for :

- The operation of the secondary health facilities (general hospitals) and in some cases tertiary hospitals, as well as some primary health care facilities.
- The training of nurses, midwives, health technicians;
- The provision of technical assistance to local government health programs and facilities

7.1.3 The PBF program

The timing of the PBF scheme is appropriate. This support will include an initial assessment of the capacity (human resources, infrastructure and funding potentials) to reach every facility at the ward level, training of key and relevant staff from State, LGA and facility levels and develop an implementation plan to roll out to all Primary health care facilities.
This will improve access to quality health services to urban and rural communities and build their confidence in the health facilities for other services like routine immunisation, IMCI, CORPs and VCM support and so on.

7.1.4 Financing

The Nigerian health system has a number of programs financed by the World Bank such as the SOML (with six indicators and performance contracts with the States), ANRiN (nutrition program, mainly for supplementary feeding), NSHIP (PBF program). Other financing comes from the Basic Health Care Provision Fund (BHCPF), which persist of 1% of the Nigerian government revenues.

7.1.5 Problem analysis

- Kebbi State continues to record poor health indices despite considerable contribution of partners (UNICEF, USAID and the Global Fund). The services are often not efficient, they lack quality and continue to be difficult to access. Financial accessibility also plays a role due to the dominance of the "out-of-pocket expenditure". The partner contributions in the State are uncoordinated without reference to the State's needs and priorities.
- Patients receive poor quality care in the hands of quasi-spiritual healers and dubious non-orthodox healthcare attendants.
- The strategies of most programs are input-based, vertical and uncoordinated leading to the duplication of efforts and, as a result, the wastage of resources.
- Several programs are donor-driven and partners introduce different indicator sets and propose different strategies.
- The States are backed by laws to establish Hospital Management boards, SACA (State Action Committee on AIDS), Primary Health Care Development Agencies, KECHES (Kebbi Contributory Healthcare Scheme). Therefore, the introduction of PBF may be regarded by these organizations as an attempt to override their functions which most will struggle to maintain their stands.
- Lack of knowledge on PBF among key stakeholders;
- The PBF set-up may be considered complex by some State policy makers due to the need to create new structures such as the CDV agencies and the procedures such as paying of performance instead of for inputs, the breaking of the monopolies for the pharmaceutical suppliers. There may be a tendency for the policy makers wishing to control the supply of inputs. Authorities may also not accept the separation of the functions of provision, regulation and contract development & verification
- The PBF programme has to go hand in hands with other programme that are still undergoing implementation such as the Primary Health Care Under One Roof (PHCUR) and the KECHES with multiple legal implications.
- Facilities depend on the central distribution of inputs such as essential drugs due to the non-confidence of Government in other drugs sources especially those from open drug markets.
- Facility managers may not be allowed to spend cash due to the introduction in 2018 of the Single Treasury Account on all revenues including those generated on services rendered by hospitals of which Government remits only 70% of the total output.

Yet despite these problems the question of in how far PBF can solve these problems is answered with "yes".

7.1.6 What is the best strategy to introduce PBF in Kebbi State

To start the PBF program in Kebbi State, the government, partners and other stakeholders must come together and agree on certain principles to redirect the funding of the various health interventions following the PBF approach to solve most of the problems and inefficiencies recorded in the various health programmes. The SOML can, due to its flexible nature, support conducting a feasibility study on the PBF programme. The result of this study can be used to convince the various stakeholders to start a PBF programme in Kebbi State.

The SOML programme is flexible and is directly managed by the Ministry of Health and is at the liberty to implement the PBF approach. However, the current SOML funding is unstable because once a target is achieved there cannot be further progress that liberates new funding. An example is Borno State, which earned USD 3 million while Kebbi State earned only USD 160,000. Moreover, the latter amount was so far also not received. In PBF the health facilities and other stakeholder receive performance-based payments for their activities of good quality, they provide free services for activities with externalities and support the poor. For this to work the fund flows must be stable and predictable.

The best strategy to introduce the PBF approach is by marrying it the with the KECHES programme in Kebbi State. This Kebbi Contributory Healthcare Scheme (KECHES) is another name of what in other states is the State Social Insurance Scheme. Yet due to Islamic perspective, citizens are not allowed to insure themselves but they can receive contributions. KECHES has been signed into law by the Kebbi State Government.

7.1.7 Feasibility score of the existing or designed PBF program

The feasibility score is The following criteria should be used to demonstrate how far the programme is:

Criteria to establish in how far the programme is "PBF"	Points	Actual Score	Proposed Score	Comment
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	0	4	The total PBF programme budget can be targeted to be $5 per capita.
2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	2	0	2	Calculate and propose to the government a PBF budget of more than 20% to reduce donor dependency
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	0	2	The State will request the National PBF to furnish it with the guidelines in order for the Ministry to integrate into the Ministerial activities
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	0	2	The designated Unit in the Ministry should have performance contracts with standard output and quality indicators. The unit should be just above the Department Level and possibly directly under the Office of the PS.
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	0	2	25 output indicators will be spelt out for the receipt of subsidies
6. The PBF program contains the community indicator "visit to household following a	2	0	2	The PBF program will contains the community indicator "visit to household

protocol" to be applied by all primary level principal contract holders.				following a protocol" to be applied by all primary level principal contract holders.
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	0	2	The LGA regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. The annual mapping of health facilities is already a routine activity and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	0	2	To further develop the LGA Validation Committee to bring together the District regulators, the CDVA and a representative of the providers.
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	0	0	This might only be possible when the programme pick up
10. Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the FOSA are the signatories.	2	0	2	To advocate the Ministry of Budget and Economic Planning and the Ministry of Finance to exempt the health care facilities in 5 pilot LGAs under the PBF approach to remit their cost recovery revenues from going into the treasury single account but into the health facility bank account on which the facility operators are signatories.
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	0	2	We propose to apply the same exemption agreement that operates the NSHIP program between the government and the World Bank. Yet, this also implies that the State must accredit the wholesale distributors from which the health facilities are allowed to buy in order to assure the quality of the drugs.
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	0	2	The new PBF project will introduce the business plan that includes the Quality Improvement Bonuses to create quality assurance
13. The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2	0	2	The Project will propose indices tool for the management of revenues and transparent staff performance bonuses
14. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2	0	2	The role of the CDV agency is played by KECHES
15. Provider managers are allowed to influence cost sharing tariffs	2	0	2	This will be included in the programme design
16. Provider managers have the right to hire and to fire	2	0	0	To make an advocacy.
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	0	2	A CDV Agency will be established within the KECHES, which will be independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	0	2	A clear separation between the contracting and verification tasks of the CDV agency and the payment function will be designed
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	2	2	In my State the acceptance of the promotion of the full government determined packages such as Family Planning has been in existence and no issues.
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	0	2	The new PBF system will introduce infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans
21. Public religious and private providers have an equal chance of obtaining a contract	2	0	2	The system will advocate to the Government to allow public, religious and private

				providers have an equal chance of obtaining a contract
22. There are geographic and/or facility specific equity bonuses	2	2	2	In Kebbi State, due to the remoteness of some facilities locations, the State has the provision of Rural Posting allowance for some designated facility staff
23. The project provides equity bonuses for vulnerable people	2	0	2	The project will advocate for the provision of equity bonuses for vulnerable people
TOTAL	**50**	**4**	**44 = 88%**	

7.1.8 Recommendations

- Advocate with policy makers on the need to accept the PBF programme as reform strategy and explain the difference with previous reform approaches that have not achieved the desired objectives such as the Alma Ata primary health care and the Bamako Initiative.
- Group all programs under the 'ONE' State Steering Committee and Technical Consultative Group in the Office of the Permanent Secretary.
- Engage consultants when necessary to support the feasibility study and the implementation of PBF with support from the SOML
- Calculate and propose to the government a PBF budget of more than 20% to reduce donor dependency in order to achieve $4-$6 per capita for the catchment population of the State
- Integrate all vertical programs such as KECHES which is just at the verge of implementation and marry it with the PBF programme in order to achieve individual programs goals and ensure sustainability. The two programmes can go hands in hands with support from Government, SOML and donors
- The SOML may shoulder the responsibility for the conduct of study tours to some states that are already implementing the PBF programme.
- Since the PBF set-up may be considered to be complex by some State policy makers there is need to create an innovation to consider KECHES as the CDV agency and being backed by law, it can initiate the payment of performance instead of for inputs, the breaking of the monopolies for the pharmaceutical suppliers. Authorities may also not feel threatened by the separation of the functions of provision, regulation and contract development & verification
- Pilot PBF in selected LGAs of the state using SOML funds;
- Advocate to the Ministry of Budget and Economic Planning and the Ministry of Finance to exempt the health care facilities in 5 pilot LGAs under the PBF approach to remit their cost recovery revenues from going into the treasury single account but into the health facility bank account on which the facility operators are signatories.
- Prepare a Memo to the National Council on Health to advocate for National Policy on PBF which all states are obliged to implement

7.1.9 Action plan

This action plan is oriented towards solving the coordination issue with government machineries, policy makers and partners organisations and to provide through PBF programme an efficient and quality-oriented framework for implementation.

How	Who	When
- PM submit report of the course to the Honourable Commissioner with convincing approach to call for a stakeholder's meeting. - The stake holders meeting will include the Ministry of Health, the PHCDA, the KECHES and our Development Partners (eg. UNICEF, USAID/GHSC-PSM)	Advocacy team (those that attended the PBF course)	3rd week April
- A draft information memo will be drafted for HCH to present at the SEC. This include the copy of the course content with an attached Executive summary. Also, the requirement in term of funding so as to make a budgetary provision for a quick off of the pilot PBF Programme in some selected health facilities (both Secondary and Primary Health facilities).	PM	4th Week April
- The SOML/ Ministry of Health shoulder the responsibility for the conduct of study tours by the stakeholders to some state/s that are already implementing the PBF programme		
- The HCH will call for the integration and harmonization of all vertical programs such as the KECHES, Drug Revolving Fund, the Sustainable Drug Supply System, the Free Drug Programme for Pregnant Women and Children under the age of 5 years, the MNCH programme supported by the UNICEF and GHSC-PSM using PBF model of implementation which will go along with the achievement of individual programs goals and ensure sustainability	Top management meeting State Steering Committee	2nd Week June
- All programs and supports to be reorganized towards reuniting under "one" State Steering Committee and Technical Consultative Group. This SSC-TCG should be headed by One Senior Personnel in the State Ministry of Health with the rank of a Director (preferably a participant in the PBF course) and residential in the office of the Permanent Secretary. The Chairman SSC-TCG with oversee the Establishment of the PBF pilot set up with all the criteria in the programme set up.	Chairman (HCH and PS)	4th Week June
- Engage PBF consultants if necessary, to work with Ministry appointee for the PBF and support its implementation	TCG	3rd quarter 2019
- Orientation training of stakeholders to adapt the PBF institutional set up in the State	TCG	3rd quarter 2019
- Orientation training for relevant Stakeholders (at facility level)	TCG	3rd quarter 2019
- Pilot PBF in the facilities of 5selected LGAs of the State with the initial grant from the SOML using KECHES as the CDV Agency and the Ministry of Health as the Regulator	TCG	4th Quarter, 2019
- Raise a Memo for the National Council on Health to advocate for National Policy to adopt PBF as a Health policy in all the States of the Federation	HCH	4th Quarter, 2019
Advocate for an increase in budgetary allocation to Scale up the programme to more LGAs health facilities.	HCH	

7.2 Yobe State

7.2.1 General context

Yobe State is located in the North-Eastern part of Nigeria with an estimated population of 3.8 million. It has 17 LGAs and 178 political wards. There are 556 PHC facilities, 13 secondary Health facilities and 3 tertiary Health facilities. The state allocation to health sector is 15% of the state annual budget which based on the Abuja declaration. The Budget performance is usually appreciable, 50%-60% being released on input financing basis. The state health sector is also being funded by saving one million lives Programme (SOML), Nigerian State Health Investment Project (NSHIP) and other development partners.

7.2.2 The health system of the state

The Health Sector consists of the Ministry of Health as the head, responsible for the formulating policies and supervising the following parastatal institutions :

1. Hospitals Management Board (HMB) over seeing the secondary health facilities
2. State Primary Healthcare Management board (SPHCMB) over seeing the PHC facilities
3. Yobe State Aids Control Agency (YOSACA)
4. The Health training institutions;College of Medical Sciences ; College of Nursing and Midwifery and ; College of Health sciences and Technology

There is a good working relationship and mutual understanding between the ministry and the parastatals, thus good leadership and coordination.
There is high political will and commitment by the state government in terms of investment in the health sector.
There is good mutual relationship and coordination between the state and partners.
There is a free maternal, New-born and Child Health service though not covering all the facilities and is not enough even for the health facilities covered.
There is standing committee of traditional leaders on PHC supporting demand creation and social mobilization across the state

7.2.3 PBF program

- PBF Interventions in the state under NSHIP is operating in 12 out of the 17 LGAs. Contracted health facilities include both Private and public; Primary and secondary Health facilities.
- Other non PBF facilities in 5 out of the 17 LGAs will be scaled up in the Q2-Q3 of 2019.
- There is inadequate knowledge of PBF by most of the stakeholders, healthcare service providers and general population.

7.2.4 Problem Analysis

- Human Resources for Health gaps do exist across all level of the health facilities.
- Centrally controlled recruitment and redeployment.
- Centralised infrastructural development in the health sector including for the PBF contracted facilities
- Centralised supply of drugs and equipment across all health facilities is
- Inadequate knowledge of PBF by most of the stakeholders, healthcare service providers and general population.

Possibilities of solving these problems with PBF
Yes.

7.2.5 Feasibility score

76%

Criteria to establish in how far the programme is "PBF"	Points	Score	Comments
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	0	Government may adopt and scale up the strategy since the PBF programme currently being implemented in some facilities across the state which are being implemented by NSHIP-AF

2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	2	2	State health allocation is currently at 15% of the total annual budget and Government may accept the strategy to allocate 20% for the programme
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	2	With the level of the current coordination and integration between the MOH, its parastatals and Partners, it is feasible.
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	2	PBF is currently ongoing supporting some facilities by NSHIP Project DPRS would take charge following advocacy
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	2	PBF is currently ongoing supporting some facilities by NSHIP Project DPRS would take charge following advocacy
6. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	2	PBF is currently ongoing supporting some facilities by NSHIP Project DPRS would take charge following advocacy
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	2	PBF is currently ongoing supporting some facilities by NSHIP Project DPRS would take charge following advocacy
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	2	PBF is currently ongoing supporting some facilities by NSHIP Project DPRS would take charge following advocacy
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	2	PBF is currently ongoing supporting some facilities by NSHIP Project DPRS would take charge following advocacy
10. Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the FOSA are the signatories.	2	2	PBF is currently ongoing supporting some facilities by NSHIP Project DPRS would take charge following advocacy
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	2	Applied in PBF supported facility
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	2	Exist in PBF supported facilities and there is good quality improvement.
13. The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2	2	The tools are in place in all the PBF supported facility and it has make positive impact
14. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2	2	Yes in PBF supported facility but owners (Government) play all role of signing the contract in the remaining facilities
15. Provider managers are allowed to influence cost sharing tariffs	2	0	Might be possible
16. Provider managers have the right to hire and to fire	2	0	In some PBF supported facility and that applied for only the temporary workers
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	0	Yes in some facilities that supported by PBF project

18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	2	Yes in all the facilities but PBF supported facilities have the output approach
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	2	Present in all Health facilities both primary,secondary and tertiary.
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	2	All PBF facilities
21. Public religious and private providers have an equal chance of obtaining a contract	2	2	All have an equal chance in obtaining contract
22. There are geographic and/or facility specific equity bonuses	2	2	Applicable to all HFs offering PBF
23. The project provides equity bonuses for vulnerable people	2	2	Yes
TOTAL	**50**	**38 = 76%**	

7.2.6 Recommendations

- Stakeholders' sensitization on PBF
- Advocacy to policy makers on PBF
- Sensitization of traditional institutions, faith based organisations, community based organisations, civil society organisations and professional bodies
- Scaling up PBF in other non-contracted health facilities across the state
- Make Free MNCH services to high quality subsidised user fee paid services

7.2.7 Sources of financing and Sustainability of the programme

Sources of funding

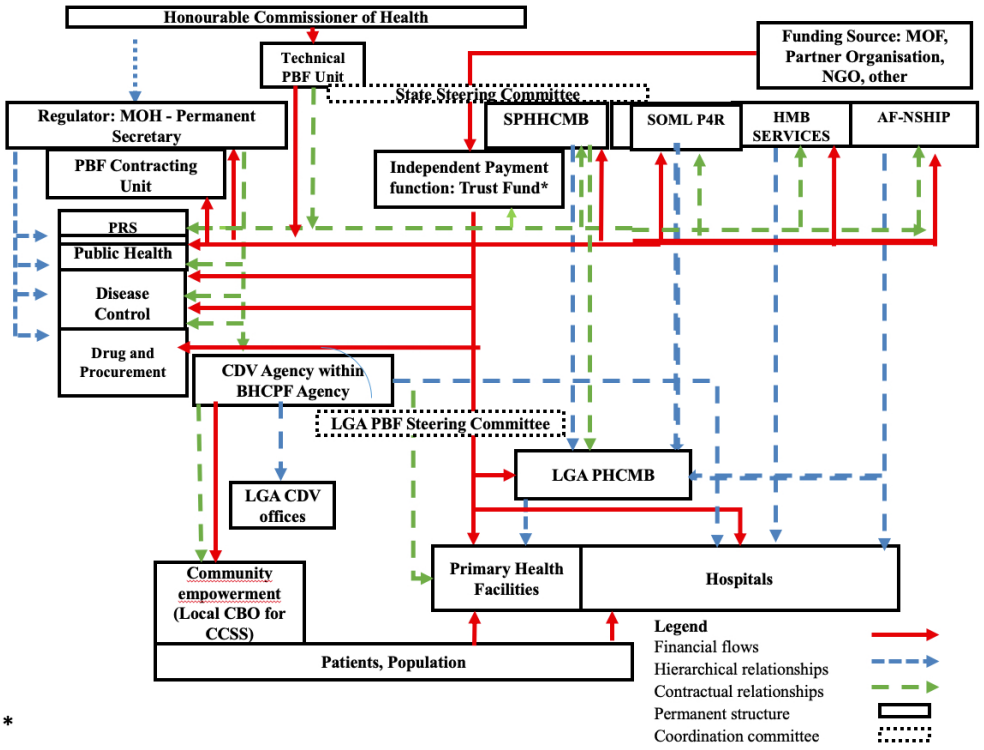
- State Government
- Basic Healthcare provision funds
- Nigerian State Health Investment Project (NSHIP)
- Saving One Million Lives Programme (SOML)
- Tripartite fund
- Development Partners

7.2.8 Action Plan

The issues	Action Point	Time frame	Responsible Person
Poor knowledge of PBF by the stakeholders, Policy makers and the community structure	Sensitization of the stakeholders on PBF on their support to buy the idea	**June 2019**	**PC NSHIP**
	Advocacy to the policy makers on PBF on their support for implementation	**August, 2019**	**HCH**
	Sensitization of the traditional institutions, CBOs, FBOs and professional bodies for understanding the PBF and supporting the programme	**June, 2019**	**SOMTEC**
Scaling up of the PBF in all the Health facilities across the state	Writing a memo to His Excellency the Executive Governor on request to expand the programme across the state	**Sept, 2019**	**HCH**
	Continues follow up of the letter to secure approval	**October 2019 upward**	**PS**
Free MNCH to high quality subsidized user fee paid services	Sensitization of the stakeholders on the importance of transition from Free MNCH to user paid quality healthcare services and secure their support	**November, 2019**	**ES PHCMB**

	Advocacy to the policy makers on importance of user fee quality healthcare services and their support for implementation	**December 2019**	**HCH**
	Sensitization of the traditional institutions, CBOs, FBOs and professional bodies for understanding the concept and supporting the programme	**November, 2019**	**SOMTEC**
Financing the programme	I. Advocacy to the policy makers to increase budgetary allocation to health sector from 15% to 20%	**December 2019**	**HCH**
	II. Writing memo to His Excellency the Executive Governor on request to approve increase in budgetary allocation to Health sector	**December 2019**	**HCH**
	III. Development of guidelines on activities of development partners		
	IV. Engagement of stakeholders and development partners on PBF central account	**January, 2020**	**MOBEP**
		January, 2020	**MOBEP**
Sustainability	Short to medium term: I. The government's health allocations II. Funds from state programmes (SOML, NSHIP, BHCPF) III. Funds from development partners Long term: I. Review of the state Health policy to consider PBF as health financing mechanism for sustainability	**From January, 2020**	**HCH**
		February 2010 to July 2010	**Legislature**

7.2.9 Yobe state PBF institutional set up



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7.3 Ondo State

7.3.1 Context

Ondo State is located in the South-west part of Nigeria with a population of 3,5 million. The State Health System consists of the Ministry of Health as the head, formulating policies, and supervising the Parastatals which consists of the Hospitals Management Board (HMB) (in charge of secondary health facilities), State Primary Healthcare Development Agency (SPHCDA), State Emergency Medical Service Agency (ODEMSA).

There are 591 PHCs, 20 Secondary Health Facilities and two Tertiary Health facilities (one owned by Federal Government) and 256 Private Health facilities. Less than 30% of the private health facilities meet minimum accreditation standard. The health facilities have some level of autonomy. They are given freedom to buy some of their inputs such as drugs and laboratory reagents and recruit contract staff and retention of revenue.

The State Contributory Health Scheme Commission (Health Insurance Agency) is about to commence. The Law establishing it and the office complex have been put in place and some of the staff have been recruited.

NSHIP is operating PBF in 9 out of the 18 LGAs covering 289 PHCs, DFF in 302 PHCs. Yet to be extended to Private Health Facilities. SOML PforR is in place.
The State Health budget is 12% of the State total budget but the release is usually low. Budget per capital per annum is more than $4.

7.3.2 Problem analysis

Conflict between the ministry and the agencies.
There is conflict between the Ministry of Health and its Agencies which include Ondo State Primary Health Care Development Agency and Hospitals Management Board. This is as a result of the conflict in roles and responsibilities.

Human resources gap in terms of quantity, skills and attitude.
There is inadequate skilled health personnel in the non- PBF accredited health facilities. The attitude of the health personnel is also not satisfactory leading to poor quality services.

Inadequate knowledge of PBF by some stakeholders.
There is inadequate knowledge of PBF among some stakeholders in the health sector. Although, PBF is operational in the State, there is inadequate knowledge in areas where the program does not cover. PBF is operational in 9 out of the 18 Local Government Areas of the State and 289 of the 302 Primary Health Care facilities. It is not all the Directorates of the Ministry of Health and HMB are well informed about the program.

Poor infrastructure in non- PBF accredited health facilities.
There is structural upgrade in all the PBF accredited health facilities whereas there is poor infrastructure in the non- PBF accredited health facilities.

Inadequate budgetary allocation and budget release to health.
There is usually inadequate budget allocation for health in the State and budget release is poor. For instance the State Health Budget was 12% of the Total State Budget in 2018. Even though this was less than the 15% recommended, less than 40% was released. More so, more than 70% of the State health budget is on personnel. There is

opinion held by players in the other sectors that Health is not the only sector in the economy and that other sectors also needs funds; the health sector has a lot of Partners supporting their programmes, so they do not need extra funds; and that the health sector does not generate revenue. They have not put into consideration the fact that partners interventions are time-bound.

Lack of full autonomy in the health facilities.
Staff are centrally deployed in all the health facilities in the State except for PBF Primary Healthcare Centres that have control over contract/temporary staff and their inputs.

Problem of sustainability of the PBF program in state.
The NSHIP that funds PBF program in the State is external fund and has life span. There will be sustainability problem when the project ends.
PBF Unit is in the State Primary Healthcare Development Agency, a parastatal of the Ministry. This has created a lot of issues in terms of regulation. For any health program to be sustainable, it must be instituted at the highest hierarchy of the Health System.

Inadequate coordination of partners.
Partners still run input system and fund similar programs leading duplication of efforts and waste of resources.

Is it possible to solve the problems with PBF? Yes.

7.3.3 PBF feasibility scan Ondo State

Feasibility Score = 42 (84%)

Criteria to establish in how far the programme is "PBF"	Points	Score	Remarks
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	4	
2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	2	0	PBF is largely donor dependent. However the Government is about to commence Compulsory Health Insurance Scheme to reduce donor dependency
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	0	PBF Unit is at Primary HealthCare Development Agency.
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	2	
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	2	
6. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	2	
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	2	

8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	2	
9. The program includes a baseline household and quality study, which establishes priorities and allows to measure the impact of the program.	2	2	
10. Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the FOSA are the signatories.	2	2	
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	4	
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	2	
13. The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2	2	
14. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2	2	
15. Provider managers are allowed to influence cost sharing tariffs	2	2	
16. Provider managers have the right to hire and to fire	2	0	Providers can only employ Contract Staff. Health workers are employed centrally and deployed to the Health facilities. It is only the Private Facilities managers that can hire and fire.
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	2	
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	2	
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	2	
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	2	
21. Public religious and private providers have an equal chance of obtaining a contract	2	0	The Public Providers have more chance of obtaining a contract.
22. There are geographic and/or facility specific equity bonuses	2	2	
23. The project provides equity bonuses for vulnerable people	2	2	
TOTAL	**50**	**42 = 84%**	

7.3.4 Recommendations

- Institution of PBF in the Ministry of Health.
- Scaling up of PBF to all the health facilities.
- Definition of roles and responsibility
- Institution of PBF in the Health Insurance Program
- Advocacy to the relevant stakeholders
- Sensitization and dissemination meetings to keep the stakeholders well informed.
- Awareness creation among populace about PBF.

7.3.5 Sources of funding

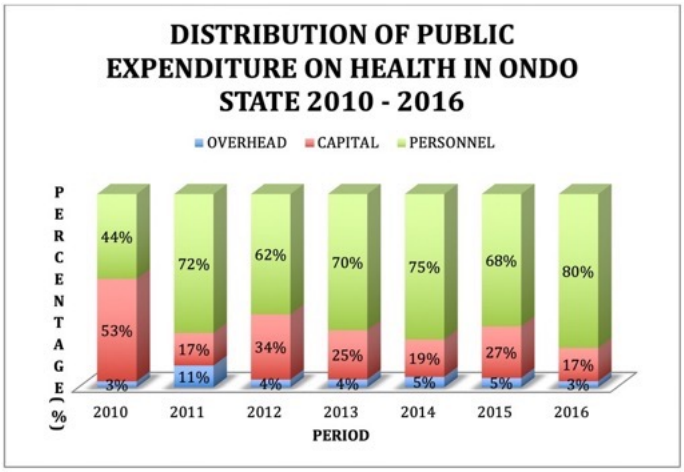
- State Government (State Health Budget, the Government already budgeted for the vulnerable in the health insurance scheme)
- Compulsory Health Insurance Scheme
- NSHIP
- SOML PforR
- Basic Health Care Provision Fund (BHCPF)
- Direct Payments through user fees in the health facilities.
- Donors/Partners e.g. UNICEF
- Capitation from National Health Insurance Scheme (NHIS). Some secondary Health facilities are accredited under the National Health Insurance Scheme and they receive funds through based on the number of enrolees.

State health budget = ₦7,972,744,768.53 ($22,146,513.25)
Total Personnel Recurrent =₦485,235,6897.00
Nigerian State Health Investment Project NSHIP = ₦2,327,730,667.46 ($6,465,918.52)this is alredy being used to fund PBF in 9 LGAs of the State.

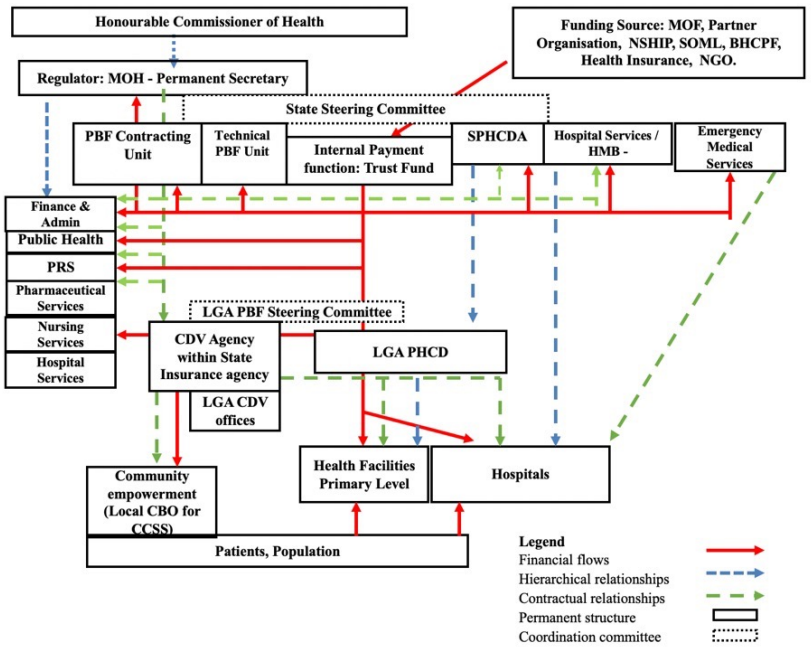
These are available for PBF Program
Total State Capital Budget for Health =₦3,268,000,000.00
Non-personnel Recurrent =₦339,235,687.00
Basic Health Care Provision Fund = ₦1,400,000,000.00 ($3,888,888.89)
Direct Payment to Health facilities (Users fees) =₦1,500,000,000.00
Contributory Health Scheme =₦500,000,000.00
SOML PforR =₦100,000,000.00

TOTAL = ₦7,107,235,687.00
Population of the State = 3,460,877
Per capita per year: ₦7,107,235,687.00/3,460,877 = ***₦2,053.59 ($5.70)***

Trends showing Distribution of expenditure on health 2010-2016



7.3.6 Proposed Institutional Set-up PBF program for Ondo State



7.3.7 Action plan

WHAT	HOW	WHEN	WHO
Resolution of conflict between the Ministry and the Agencies	Advocacy to the Commissioner for Health, Permanent Secretaries MoH, HMB and ES SPHCDA	3rd week April 2019	Director Planning, Research and Statistics.
	Dialogue meetings between the MDAs	3rd week April 2019	Commissioner for Health, Permanent Secretaries MoH, HMB, ES,SPHCDA, ODEMSA, ODCHSC
	Definition of roles and responsibilities	4th Week April 2019	Commissioner for Health, Permanent Secretaries MoH, HMB, ES,SPHCDA, Heads of ODEMSA, ODCHSC
Increasing Knowledge of Stakeholders on PBF.	-Advocacy and sensitization meetings with Directors of the MoH and the Agencies, Heads of Facilities, Professional Associations and Unions-Awareness creation through the media.	1st & 2nd weeks of May 2019	Commissioner for Health, Permanent Secretaries MoH, HMB, ES,SPHCDA, Heads of ODEMSA, ODCHSC
	Organize conferences and seminars	3rd & 4th week May 2019	MoH led by the Permanent Secretary
Institution of PBF in the Ministry of Health and scale-up PBF to all the health facilities.	Put in place the PBF Structure and define roles and responsibilities.	1st – 2nd week of June 2019	MoH led by the SCH, GM of the Health Insurance Agency and his team,
	Institution of CDV Unit in the Health Insurance Agency	2nd week June 2019	Hon Commissioner and GM, CHSC
	Scale-up PBF to all the health facilities in Phases	1st week July to Dec 2019	HMB, SPHCDA, Heads of Facilities and their teams.
Funding and Sustainability	Advocacy to the Ministry of Finance, other Commissioners, House Committee on Health and the Governor to increase budget allocation to health from 12 to 15% of the total State Budget and also appropriate release.	3rd week of May 2019	MoH led by the SCH.

	Create Trust Funds at the Ministry of Health to harness all funds for the program. All MDAs will have access to the Funds and there will be transparency and accountability.	1st - 2nd Week of June 2019	MoH, Governor, State Executive Council.
	Development of Memo for the establishment of the Trust Fund to be presented at the State Exco	1st -2nd week June 2019	Ministry of Health, by the Commissioner
	Put in place an enabling law for the Trust Fund.	1st -3rd June 2019	MoH, Ministry of Justice, House Assembly, State Executive Council.
Coordination of Partners.	Strengthen the Partners Coordination Forum so that they key into the PBF program		MoH led by the Permanent Secretary.
	Sensitize the Partners on PBF Program in the health sector	3rd Week June 2019	MoH led by the Permanent Secretary.
	Meetings with Partners	Quarterly	MoH led by the Permanent Secretary, Partners
	Submit their workplans in conformity with the PBF program		Partners

7.3.8 Slogans for change

1. PBF, change in health workers attitude
2. PBF, improvement in quality of healthcare services
3. PBF, accountability and transparency.
4. PBF leads to cost effectiveness.
5. PBF ensures highly motivated workers.

7.4 Kwara State

7.4.1 General context

Kwara State was created in 1967 as one of the 12 federating units of Nigeria. It is in the North Central geo-political zone of Nigeria. It has an international boundary with the Republic of Benin. Kwara State had a population of 3.5 million in 2017 with an annual growth rate of 3.0%. About 1.7 million of the people in the State live in the rural areas. The State has 16 Local Government Areas (LGAs), 872 health facilities, and 193 political wards. There are more than 15 ethnic groups in the State.

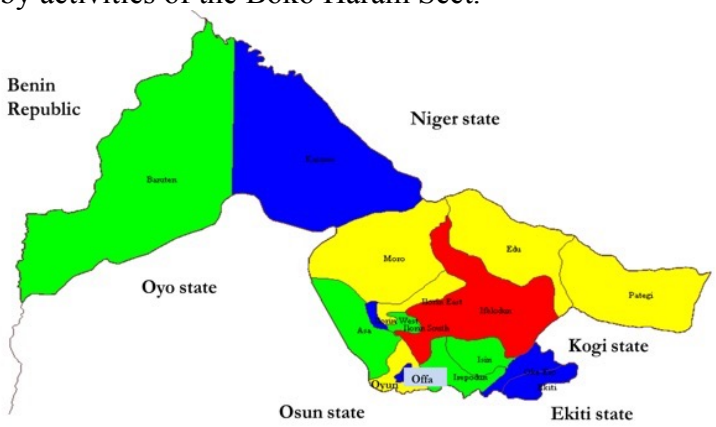
Kwara State serves as gateway between the Northern and Southern parts of Nigeria and a lot of commercial activities are taking place in the State. There are many junction towns and villages in the State where long distance and truck drivers service and refuel their vehicles. This has implication for communicable disease transmission. The major occupations are farming, trading and public service.

The demographic and geographic features include scattered and sparse population especially in rural parts. There are nomadic population in several LGAs. Major ethnic groups are Yoruba, Hausa, Fulani, Nupe, Baruba, Bokobaru and others like Igbo who settle in the State for economic activities.

Kwara State is majorly a civil servant State, few private industries and traders while the rural population mainly engage in subsistence agriculture. Other sources are from small and medium scale enterprises and civil servants. There are ten institutions of higher learning in the State. Poverty level has remained high despite significant national economic growth that spanned decades. This reflects the development paradox that

paints the picture of a small proportion of the population in great wealth co-existing with the vast majority of the population in great poverty. The poverty, unemployment and under employment situation is likely to worsen with the current economic challenges that will also impact the disease burden and health seeking behaviour and health service utilization.

Kwara State tagged as the State of Harmony has enjoyed a relative peaceful environment despite the growing violence in some parts of the country especially insurgency by the sect called Boko Haram. However, Kwara State has its share of clashes between the nomadic Fulani herdsmen and indigenous farming communities. The population of the State is growing rapidly because of the migration of people from states affected by activities of the Boko Haram Sect.



7.4.2 Kwara state key indicators

In Kwara State, as at 2016, 63% of the population were in rural areas compared with 37% in urban. Social determinants of health in the State reveal that the literacy level of women in Kwara was 73.5% which is above the national average of 59.3%. Similarly, that for men was 81.0%, compared with national average of 70.9% (MICS 2016-17). About 63.1% of women in the State were engaged in one job or the other, while 73.6% of men reported being employed.

Table 1: Summary of Kwara State Indicators

Variable	Achieved	Source
Population		Projected from 2006
Total population	3,482,024	population census
Female	1,689,559	
Male	1,792,464	
Education		NDHS 2013
No formal education (female)	26.6%	
No formal education (male)	12.9%	
Completed Primary (female)	12.3%	
Completed Primary (male)	22.1%	
Completed Secondary (female)	13.4%	
Completed Secondary (male)	17.3%	
More than secondary (female)	10.5%	
More than secondary (male)	18.9%	
Household population by wealth quintiles		MICS 2016-17
Poorest	7.5%	
Second	13.6%	
Middle	19.9%	
Forth	29.4%	
Richest	29.6%	

Employment		NDHS 2013
Employed last 12 months before survey (female)	63.1%	
Employed last 12 months before survey (male)	73.6%	

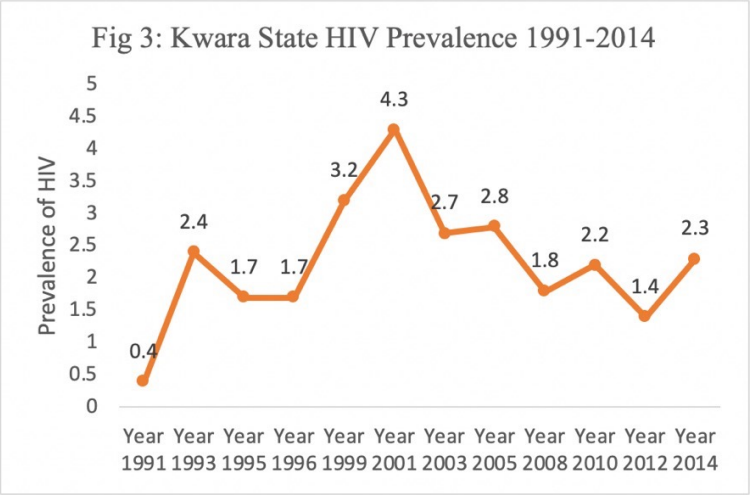
7.4.3 Health status of the population

The women of child bearing age and children less than five years are the most vulnerable in the State and they constitute 22% and 20 % respectively. Infant mortality rate was 40/1000 while national was 70, similarly, the U5% MR was 45 compared with 120 for national.

Table 2: Kwara State early childhood mortality and morbidity rates.

Mortality/ morbidity parameter	Achieved	Source
Neonatal Mortality Rate	27/1000	MICS
Post-Neonatal Mortality Rate	12/1000	2016-17
Infant Mortality Rate	40/1000	
Child Mortality Rate	6/1000	
U5MR	45/1000	
Low birth weight infants		MICS
Very small	5.1%	2016-17
Smaller than average	4.9%	
Average	56.6%	
Larger than average	33.3%	
Below 2.5 kg	13.4%	
Weighted at birth	43.1	
Nutritional status of children under 5 years		MICS
Under weight	22.3%	2016-17
Stunted	31.5%	
Wasted	9.4%	
Over weight	2.6%	
Infant and young child feeding practices for 6-23 mnths		MICS
% who received minimum dietary diversity	47.5%	2016-17
% who received minimum meal frequency	20.8%	
% who received minimum acceptable diet	13.2%	

Infant Mortality rate in the state was 40/1,000 in the year 2016 compared with national average of 70/1000 live birth.



There has been fluctuations in the prevalence of HIV in the state. In 2014, the prevalence was 2.3%.

The prevalence of underweight reduced from 21.5% in 2011 to 17.2 % in 2015. The proportion of malnourished children reduced from 13.8% to 5.1% in 2015.

Table 3: Kwara State childhood morbidity

Mortality/ morbidity parameter	Achieved	Source
% of children 0-59 months whom the mother reported an illness 2 weeks before the survey An episode of diarrhea Symptom of acute respiratory infection Episode of fever	 5.7% 1.1% 7.3%	MICS 2016-17
% of mothers / caretakers of children age 0-59 months who think that a child should be taken immediately to a health facility if the child is not able to drink or breast feed Becomes sicker Develops fever Has fast breathing Has difficulty breathing Has blood in stool Is drinking poorly	 30.0% 48.8% 62.0% 32.9% 41.8% 26.6% 20.0%	MICS 2016-17
Mothers/ caretakers who recognize at least one of the two danger signs of pneumonia (fast/difficult breathing)	62.2%	MICS 2016-17
Immunization coverage Penta3 Measles Fully vaccinated Card seen % of women who received at least 2 doses of Tetanus toxoid during last pregnancy	 49.1% 67.0% 34.0% 20.0% 50.4%	MICS 2016-17

7.4.4 Overview of the State health system

The health service in the State is coordinated by the State Ministry of Health (SMOH) with the Honourable Commissioner for Health as the Chief Executive Officer. Kwara State operates a pluralistic health care delivery system with the orthodox and traditional health care delivery systems operating alongside each other, albeit with hardly any collaboration. Both the private and public sectors provide orthodox health care services in the State. Kwara State has 845 health facilities accounting for private and public health facilities. The private health facility constitute 35 % of health facility and providing 60% of health care services. The State presently has 8,017 bed spaces with of 1 beds per 410 population. More than 60% of the health work force reside in Ilorin, the State capital

The public health service is organized into primary, secondary and tertiary levels. While the Constitution is silent on the roles of the different levels of government in health services provision, the National Health Policy ascribes responsibilities for primary health care to local governments, secondary care to states and tertiary care to the federal level. Primary Health Care (PHC), which forms the bedrock of the national health system, is in a prostrate state because of poor political will, gross under funding, and lack of capacity at the LGA level, which is the main implementing body. The PHC is coordinated by SPHCDA and in each LGA there is PHC Coordinator to provide technical and administrative direction for primary health care activities. Health workers at LGA level provide primary health care services and these are available in each of the 193 political wards in the State.

The Hospital Management Bureau (HMB) under the coordination of SMOH supervises activities of the State Government owned health facilities. This level provides the secondary health care and specialised services in the State. There is one tertiary health facility in the State owned by the Federal Government. This provide specialised care, research, training and community service. This facility is blessed with enormous human and material resources and serves as referral centre to many neighbouring States in the

country. Research activities in health programmes are not supported in the State except those commissioned by partners. This created vacuum in evidence-based decision for health care services.

The health care delivery services in the State are supported by development partners. The World Health Organization (WHO) provides support in areas of immunization, disease surveillance, epidemic response and polio eradication. UNICEF supports the State in immunization, maternal and child health among others. HIV/AIDS programme in the State is supported by World Bank, MSH, FGH and collaboration with NACA. Mario stopes supports the State in family planning programmes. Maternal and child nutrition is also supported by Vitamin Angels, while Global Fund and Sight Savers support malaria and other Neglected Tropical Diseases in the State respectively. There were palpable evidences that community members and other stakeholders including NGOs, CSOs were involved in health care services at various levels in the State.

Community involvement in health care was active at time but their involvement has withered with time for obvious extrinsic reasons. Although during their active time, noticeable were traditional and religious institutions playing an active role in programme planning and implementation. Also, Community members volunteer in various capacities during health intervention programmes. The Ward Development Committee and existing Village Health Committee played key roles in immunization programmes for polio, measles, and yellow fever among others. In addition, they catalysed the implementation programme of LLIN distribution.

Table 4: Distribution of health facilities in the State

Health facility type	Public Primary	Private Primary	Public Secondary	Private Secondary	Public tertiary	Private tertiary
Number of facility	514	232	34	64	1	0

Table 5: Kwara State Ministry of Health distribution of personnel by cadre and year.
Skilled staff per 1000 inhabitants is 1:2070 with over 60% in the urban area

Cadre of Staff/Year	**2009**	**2014**	**2015**	**2016**
Medical Officers	54	146	148	205
Consultants	0	13	15	15
Nurses/Midwives	501	756	754	820
Physiotherapy Tech	2	2	2	2
Dental Surgeon/Tech	5	8	7	7
X-ray Tech	7	11	13	13
Public Health Officer		15	13	13
Lab. Scientists		14	14	20
Lab Tech.	44	70	70	79
Pharmacists	11	14	14	20
Pharmacy Tech.	45	36	36	55
Pharmacy Attendants		16	16	16
Nutrition Officer	1	5	5	4
Nutrition Tech.		0	3	20
CHO, CHEW,JCHEW	154	304	303	303
Health Planners	11	4	5	6
Health Records Officers	3	3	3	3
Record Technicians		46	46	60
Health Records Assistants		12	12	12
Card issuer		9	6	4
Planning Officers		3	4	4
Statisticians		4	5	5

Health Attendants		250	250	250
Scientific Officers		23	23	16
Health Education Officers	7	3	3	2
Health Education Tech.		12	12	15
Admin. Officers		153	153	153
Lab. Attendants		5	5	5

7.4.5 Budgetary allocation to health sector

Kwara depends largely on oil revenue from monthly Federal Allocation. However, recent challenges to macroeconomic management related to weakening oil revenue and volatile short-term capital flows, gross foreign and fiscal reserves declined steadily. The major health financing comes from the government in the form of recurrent and capital expenditures.

The budgetary allocation to health sector in the State as a proportion of total State budget declined from 9.3% in 2012 to 2.6% in 2016. The economic recession, competing needs explains this reduction in the amount of fund made available, but proportional allocation to health could not be explained by this. It implied that the commitment of 15% budgetary allocation to health is still a mirage. **The per capita annual government expenditure has been consistently below USD 3**. The private Out-Of-Pocket-Expenditure (OOPE) in Kwara State accounts for a very high percentage of the estimated per capita expenditure on health, limiting equitable access to quality health care.

Table 5: Kwara State Budgetary allocation to Health Sector 2016-2018

Year	Total State Budget (Naira)	Total Amount released to Health	Percent allocation to Health
2016	107,703,808,208	2,851,339,512.70	2.6
2017	166,105,047,405	3,766,811,176.00	2.3
2018	156,043,339,799.00	3,148,023,323.00	2.0

Table 6: Cost per capita of budget

Year	Total Amount released to Health (N)	Total Amount released to Health ($)	Per Capita Per Year
2016	2,851,339,512.70	9,348,654.14	2.9
2017	3,766,811,176.00	12,350,200.58	3.8
2018	3,148,023,323.00	10,321,387.94	3.1

7.4.6 Problem analysis

- Weak partner coordination in the State whereby partners operate in a parallel fashion without the oversight of the government.
- There is a skill-gap among the inadequate health professionals in Kwara State.
- There is a decayed physical facilities and insufficient equipment in the State. Yet, rehabilitation and purchase of inputs are done by the SMOH through centralized rehabilitation and purchasing.
- The health system remains overstretched by the quickly growing population.
- There is an inadequate data generation system, leading to weak evidence based planning, policy formulation and health systems management.
- Kwara State had adopted Community Health Insurance Scheme (CHIS), but was only able to cover less than 5% of the poor rural dwellers there was poor and contained several input financing elements. . *This scheme was voluntary, and had a very poor feasibility in similar schemes elsewhere inside and outside Nigeria. The scheme stopped in 2014 due to poor adhesion rate and bankruptcy, this*

prompted the government to enact a law of mandatory health insurance scheme which is still in its pre-implementation phase. This institutional set up of the insurance scheme could still be used but be strengthened by introducing PBF inside the scheme. This will assure the quality of the services, it will create a solid verification mechanisms and cost containment by paying subsidies which remain within the available budget.

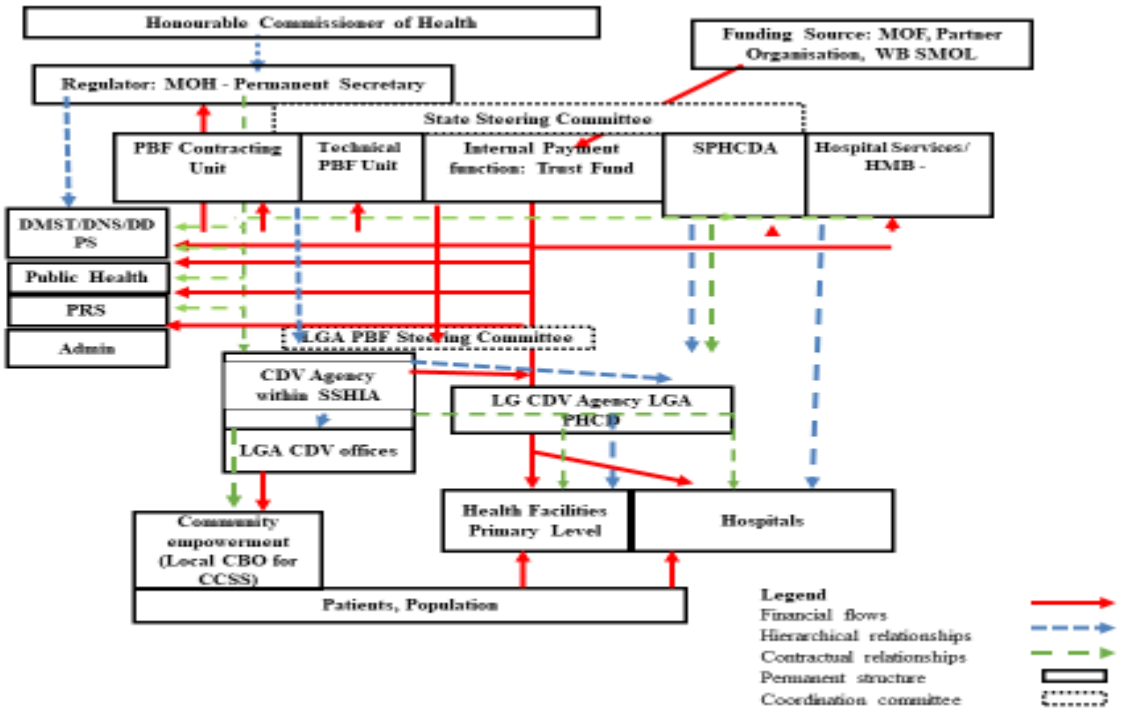
- Skilled staff per 1000 inhabitants is 1:2070 with over 60% in the urban area.

7.4.7 Can PBF solve the problems?

Yes, because the PBF ensures effective budgeting for health and incentivizes health care workers based on quantity and quality of service delivery. This reform can be extended to the various departments and agencies in the Ministry of Health as this may ensure effective budget implementation and performance at that level.
PBF restructures the institutional arrangements within the health sector through th separation of functions to create more transparency. It also promotes a more efficient health system through competition and improves allocative efficiency by injecting more funds to the periphery of the health sector.

Institutionalizing private sector management in public health facilities and inclusion of private health facility will allow for competition amongst providers which will promote quality service delivery within these health facilities.

Below is a proposed institutional arrangement for the State. Review the set-up. Put the CDVA inside the State Health Insurance Agency



7.4.8 Feasibility Score of the existing or designed PBF Program

Table 6: Criteria to establish in how far the programme is "PBF"

Criteria to establish in how far the programme is "PBF"	Points	Actual	Proposed	Comments
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per	4	0	4	

capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units				
2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	2	0	2	
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	2	2	
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	0	2	
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	0	2	
6. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	0	2	
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	2	2	
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	0	0	This can only become operational after laws have been set aside to implement in the proposed pilot LGAs
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	2	2	
10. Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the FOSA are the signatories.	2	0	0	This can only become operational after laws have been set aside to implement in the proposed pilot LGAs
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	0	0	
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	2	2	
13. The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2	0	0	Implementation will only begin if the requisite laws are set aside
14. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2	0	2	
15. Provider managers are allowed to influence cost sharing tariffs	2	0	0	This can only become operational after laws have been set aside to implement in the proposed pilot LGAs
16. Provider managers have the right to hire and to fire	2	0	0	This can only become operational after laws have been set aside to implement in the proposed pilot LGAs
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	0	2	
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	0	2	
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	0	2	
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	2	2	
21. Public religious and private providers have an equal chance of obtaining a contract	2	0	0	This will become operational after the pilot has been approved by the government
22. There are geographic and/or facility specific equity bonuses	2	0	2	
23. The project provides equity bonuses for vulnerable people	2	0	2	

TOTAL	**50**	**10**	**34 68%**	

The feasibility score is 20% (10) for Kwara state. This indicates PBF may not be operable unless improvements are made along the set criteria. Proposed improvement are mainly along the institutional reorganization, the score may then be improved to 68%.

7.4.9 Recommendations

- Better coordination of partners activities
- The per capita per year using the state expenditure on health has been consistently below $3.Therefore, fund for PBF will be made available in State's budget to fund 20% of the project. User fees will also be introduced for cost recovery purposes and to allow managers handle cash.
- The SOML unit can be given the responsibility to function as the PBF unit, hence, will be domiciled within the office of the Permanent Secretary. This will address issues around signing performance contracts with other directorates – this is because the unit has requisite experience
- The PBF unit will come up with output, quality and composite indicators as recommended by PBF
- Contract Development and Verification Agency will be established in the State Supported Health Insurance Agency.
- The payment unit may be established within the SMOH.
- Laws impeding the implementation will be set aside and pilot will be in 3 LGAs.

7.4.10 Action plan

What to do	How to do	Time Line	Responsible
Seek for Executive approval to commence PBF	Put up a position paper for the incoming Executive Governor emphasizing the need and advantages of PBF	i. Development of the plan will be 2 weeks of completion of Mombasa training ii. Submission will be 2 weeks of the Executive Governor assumes office	Kwara State Ministry of Health
Set up PBF committee at the Ministry of Health	Inaugurate a technical team comprising representative from SMOH, SPHCDA,HMB, Ministry of Justice, Ministry of Planning and Ministry of Finance	3 weeks after completion of PBF course in Mombasa	Kwara State Ministry of Health
Get legislative approval to set aside laws impeding implementation of PBF	Lobby legislators especially the House Committee on Health to set aside laws on central procurement and revenue collection and expenditure	A month after the State House of assembly assumes legislation	Kwara State Ministry of Health Lead by the Honourable Commissioner

Prepare to begin Pilot of PBF in 3 3LGAs	Memo to Executive Governor to pilot in 3 LGAs	A month after assumption into office of the Executive Governor	Kwara State Ministry of Health (PBF committee)
Make fund available for implementation in the 3 LGAs for subsidies.	Provide budget line for PBF by converting input expenditures into output expenditures	Next year. The laws must have been set aside before this can be effective	Kwara State Ministry of Health. Kwara State Ministry of Planning and Economic Development
Establish the PBF State Steering Committee	By involving all key actors that will be responsible for implementation	Immediately Laws are set aside and budget are approved (Next year)	Kwara State Ministry of Health, Hospital Management Bureau and Kwara State Ministry of Health
Begin PBF in 3 LGAs.	One LGA from each Senatorial district to cover at least 300,000 population	After the budget has been appropriated into law and fund released for implementation	Kwara State Ministry of Health, Hospital Management Bureau and Kwara State Ministry of Health
Scale up to the remaining 13 LGAs within 5 years	Scale up will follow the best practices of PBF through contracting after quality evaluation of facilities	This will begin a year after pilot from the initial 3 LGAs	Kwara State Ministry of Health (PBF State Steering Committee)

7.4.11 Negotiation strategy

Achieving the implementation of PBF in Kwara State will no doubt face difficulty due to various factors like personal interest, lack of understanding, fear of loss of roles and responsibilities et cetera resulting into various degrees of resistance to outright rejection in some quarters.
Different strategic approaches will be executed as a last mile strategy to make PBF acceptable in the state.

Hardest issues that are likely to impede the acceptance and implementation are as follows:

- Issues around autonomy of Health facilities, majorly human resources and finances.
- Issues around central procurement of pharmaceutical drugs and medical equipment

Major players who are likely to resist and their arguments and counter arguments

MAIN PLAYERS	ARGUMENTS	COUNTER ARGUMENTS
Kwara State Internal Revenue	Drop in the state's Internally Generated Revenue	PBF will cause a boost in economic activities due to increase in cash transaction within those communities and an eventual increase in Tax revenues of the state through direct and indirect taxes.
Kwara State Civil Service Commission	Loss of power to hire, fire and discipline staff	The commission will continue with their recruitment but will be

		on need base from public health facilities
Kwara State Ministry of Finance	Loss of power to centrally control funds	Reports of expenditures will be sent to them and the facilities will be audited at regular intervals
Hospital Management Bureau	Loss of power to control procurement and distribution of drugs. The bureau will bring up issues on quality of drugs	Accredited pharmaceuticals will be the ones allowed to do business with health facility. Health facilities will be able to acquire drugs on need and stock outs will be avoided
Kwara State Primary Health care Development Agency	Loss of Power over PHC and the argument of domiciling such intervention in the agency. Examples of states implementing PBF may be sited.	The KWSPHCDA will be informed that the CDV Agency will be within the Agency, hence, such powers will not be lost.

7.4.12 Allies who can assist

- Private hospitals
- Pharmaceutical companies
- Local NGO's who will have interest in carrying out community verification and satisfaction surveys during implementation of PBF

7.5 Nasarawa

7.5.1 General context

Nasarawa State is located in the north central zone of Nigeria with 13 LGA and 147 wards and with a population of about 2.7 million. The State health budget is about 10% of the total budget,

7.5.2 Health related context

The State health system consists of the Ministry of Health as the head, formulating policies, and supervising the parastatals which consists of the Hospitals Management Board (in charge of 18 secondary health facilities), State Primary Healthcare Agency (728 PHCs), and NASACA (Nasarawa State AIDS Control Agency) the State Contributory Health Insurance Scheme Agency (Health Insurance Agency), which is about to commence. The State has two tertiary health facilities : one Federal and one State government

7.5.3 The PBF program in Nasarawa

PBF in Nigeria started in 2011 with a small pilot covering one LGA each in the three States of Adamawa, Ondo, and Nasarawa. It was scaled up within the three States in 2014 and in 2017 the PBF approach expanded towards five additional States in the fragile and unstable North East of the country. Several States now consider starting PBF type intervention with own finding.

The PBF-NSHIP project intervention in Nasarawa State is operating in 7 out of the 13 LGAs and contracts 261 health facilities (235 are public, 14 are private and 12 are public hospitals).

7.5.4 Feasibility scan

Using the PBF framework, the feasibility score is 88%.

Criteria to establish in how far the programme is "PBF"	Points	Score	Remarks
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	4	
2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	2	0	No provision for counterpart fund in the state
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	0	PBF is current in the Primary health Care Development Agency
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	2	At Primary Health Care Development Agency
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	2	
6. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	2	
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	2	
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	2	
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	2	
10. Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the FOSA are the signatories.	2	2	
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	4	
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	2	
13. The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2	2	
14. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2	2	
15. Provider managers are allowed to influence cost sharing tariffs	2	2	
16. Provider managers have the right to hire and to fire	2	2	
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	2	
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	2	
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	2	
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	2	
21. Public religious and private providers have an equal chance of obtaining a contract	2	2	
22. There are geographic and/or facility specific equity bonuses	2	2	
23. The project provides equity bonuses for vulnerable people	2	2	
TOTAL	50	46 = 92%	

7.5.5 Problem analysis

- Human resources gap in terms of quantity (no adequate, skills and attitude).
- Inadequate knowledge of PBF by the service providers and the community.
- Poor infrastructure in non-PBF accredited health facilities.
- Both NSHIP and SOML are externally funded, but this funding will probably stop by 2020. So far, there has not yet been any contribution from the State government for the PBF budget. Therefore, there is a serious sustainability problems with the PBF program.
- The National PBF Unit is *not* integrated into the State Ministry of Health in such a manner high enough to allow the coordination of all activities of the health system in the State such as also the Directorates and the Health Programs. Moreover, this lead to sustainability problems because it is through SMOH that could make PBF nationally financed.
- The existing government funds are mainly used to finance inputs instead of buying performance from the different health actors. Moreover, their government funds disbursements are often delayed and are often not fully utilized.
- Inadequate coordination and harmonization of partners activities in the state
- Lack of autonomy in the health facilities. For example, the Ministry of health staff are centrally posted, managed and paid. There is only autonomy for the contracted staff in the PBF health facilities.

Is it possible to solve the problems with PBF? Yes.

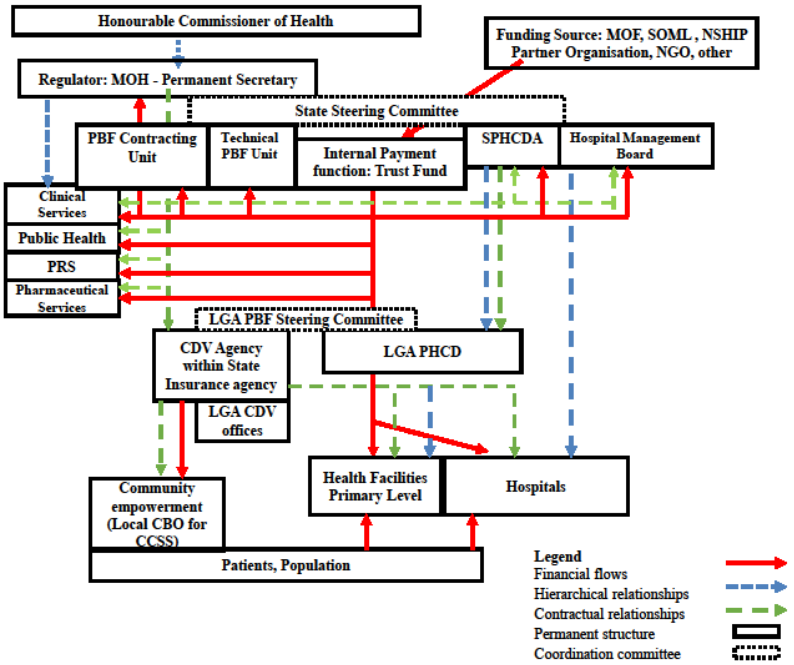
7.5.6 Recommendations

- Nasarawa State Government should scale up PBF in the health sector with the SMoH as the regulatory body and the State Health Insurance Program as the CDV Agency.
- A sustainable PBF financing should be planned for the 361 PBF health facilities that lose their NSHIP financing in 2020
- Allocate 70% of the State health budget towards the PBF system of financing directly the health facilities for their performance
- Definition of roles and responsibilities of actors at all levels such as identified in the institutional set-up below
- Advocacy to the relevant stakeholders for making the PBF program in Nasarawa sustainable
- Sensitization and dissemination meetings to keep the stakeholders well informed.
- Awareness creation among population.

Sources of funding

- State Government
- Proposed compulsory Health Insurance Scheme
- NSHIP
- SOML
- Bill & Melinda Gates Foundation
- Basic Health Care Provision Fund
- Donors/Partners e.g. UNICEF

7.5.7 Institutional set-up of PBF



7.5.8 Action plan

Problem (WHAT)	Recommended Action (HOW)	Time-Frame (WHEN)	WHO Responsible Persons
Scale up PBF in the health sector with the SMoH as the regulatory body and the State Health Insurance Program as the CDV Agency.	For the State to develop a State PBF programme	August 2019	Commissioner of Health
Inadequate knowledge of stakeholders about PBF	Advocate to 20 key stakeholders by 3-man committee (1-day Visit)		SOML PM and PC NSHIP
Inadequate knowledge of stakeholders about PBF	Conduct 1-day each sensitization and dissemination meetings.		SOML PM and PC NSHIP
Inadequate knowledge of stakeholders and general population about PBF	Create Awareness through media programs.		SOML PM
Human Resources Gap in terms of skills and attitude.	Strengthen of health care workers capacity through Training and re-training mentorship, ISS, workshops and seminars		Human Resource and Program Officers
Inadequate budgetary allocation and untimely release of budget	Advocate to State House Committee on Health to increase the budgetary allocation and timely release for the PBF program		Hon. Commissioner for Health
Inadequate coordination of partners.	Conduct Quarterly partners forum meeting	17th June 2019	SMoH

7.6 Adamawa State

7.6.1 Background

Adamawa State is located in North Eastern part of Nigeria with a growth rate of 2.9% and a projected population of 4.6 million. The State has borders with Borno State to the North, the Republic of Cameroun to the East, Taraba State to the South and to the West by parts of Taraba State and Gombe State. Adamawa has 21 Local Government areas which is made up of 226 political wards and is operating the 2 Health Facilities per ward system.

The Nigeria State Health Investment Project (NSHIP) is a $170m World Bank assisted project that became effective in August 2013. It reaches a total of 403 primary health care facilities spread across the wards of the state.. With the support of World Bank through NSHIP, 11 LGAs benefit from the Performance Based Financing (PBF) while the remaining 10 benefits from decentralized facility financing (DFF).

The PBF program in Adamawa realized encouraging achievements in terms of improved quality and effective use of scarce resources and contributed to the revitalization of the health system. However, the program has also experienced financial challenges that have disrupted its operation, originally designed to end 2020.

7.6.2 Problem analysis

- The failure to define a sustainable mechanism to create State ownership and local financing
- Challenges to coordinate the partners
- Failure to move away from the input system carried out by the government and the partners.
- Each ward has only one PHC centre of excellence that operates 24 hours

7.6.3 Feasibility scan:

A feasibility scan for Adamawa State scored 32 points (=64%) out of 50. The recommendation is a minimum score of 80%. The problem areas are highlighted in red in the table below. The issue that need to be needs to be addressed are:

- The budget for the PBF program currently stands at $ 3 per capita per year which is below the recommended $ 4 - $ 6 per capita to provide the full health packages at primary and hospital levels
- The State budget and release for Health by the Government is below the recommended 20% which makes the PBF programme donor dependent.
- The NSHIP program is not integrated into the State MOH

Criteria to establish in how far the programme is "PBF"	Points
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	0
2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	0
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	0
4. The Directorates and Programs of the central Ministry have performance contracts with	0

standard output and quality indicators.	
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2
6. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2
10. Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the HF are the signatories.	2
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2
13. The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2
14. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2
15. Provider managers are allowed to influence cost sharing tariffs	2
16. Provider managers have the right to hire and to fire	2
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2
21. Public religious and private providers have an equal chance of obtaining a contract	0
22. There are geographic and/or facility specific equity bonuses	2
23. The project provides equity bonuses for vulnerable people	2
TOTAL	**32**

7.6.4 Killing Assumptions

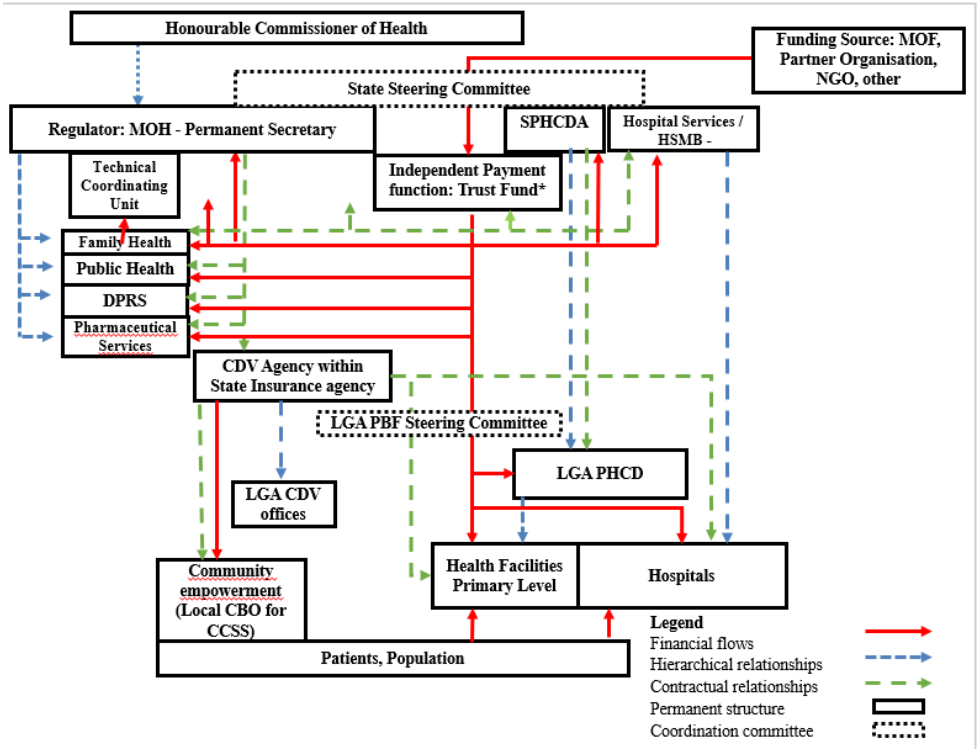
- The PBF program is not integrated into the SMOH (separation of functions).
- Inadequate budgetary allocation and release for health sector.

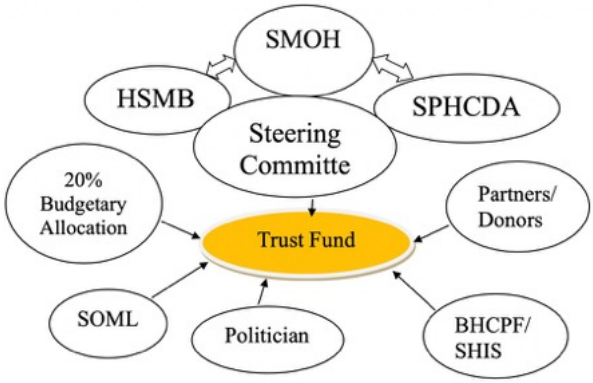
7.6.5 Recommendations

Advocacy and discussion with the Hon. Commissioner of Health on the architecture and financing of PBF program. Issues to be discussed are:

- Rearranging the State architecture by having a Technical Coordination unit in the MOH for basket funding.
- Coordinate parallel activities in the state which can be integrated into the PBF program such as SOML and other partners.
- Advocacy and lobby with the State Government to increase and release budgetary allocation for health funding.

7.6.6 Institutional set-up for PBF program in Adamawa State





Issues to change	Main Actors	Reasons	Argument/Justification	Allies
Low budgetary allocation and fund release	- Hon Commissionairs of other Ministries - Legislators - State Governor	- Other sectors are competing for available funds - Low revenue generation by the state - Presence of partners that support the Health sector - Health Sector is not a revenue generating body.	- Improved health leads to economic multiplier effect which improves standard of living positively, with spill over effects in developing other sectors such as education, agriculture etc - Partners intervention is time-bound with limited scope of operation. - Good national health rating due majorly to the existence of Programs like the SOML and NSHIP (PBF).	- SPHCDA - HSMB - Professional bodies in Health - Health Institutions
Non integration of the NSHIP program with the State MOH	- SPHCDA	- Loss of power and control	- Establishment of a Technical Program Units in the State Ministry of Health as coordinating body - Establish a basket fund where resources can be drawn from SOML, BHCPF and other partners to finance health program (PBF).	

7.6.7 Next Phase for Sustainability: Action Points

Action Points	Responsible Person	Timeline
1. Advocacy visits to the Hon Commissioner of Health to update her on the outcome of the training and the importance of sustaining the PBF program in the state	M&E and TA SOML	23rd April, 2019
2. Advocacy to ensure that PBF program is sustained, locally owned and to reduce donor dependency, the state government must increase its budgetary allocation and timely release.	Hon Commissioner of Health	June 2019
3. Stakeholder engagement meeting to establish a coordinating unit for harmonizing health interventions, source of funds and entry point for partners	DPRS	June 2019
4. Key technical officer of all programs especially the NSHIP program should be in the State Ministry of Health while the administrative unit is maintained at the SPHCDA	Hon Commissioner of Health and Executive Chairperson	August 2019

7.7 Borno State

7.7.1 General context

Borno State is located in the north-eastern part of Nigeria with an estimated population of 5.6 million. It has 27 LGAs and 311 political wards. The state allocation to the health sector is 12% of the total state annual budget. The state health sector is also funded by the Saving One Million Lives Programme (SOML), the Nigerian State Health Investment Project (NSHIP) and other development partners.

7.7.2 The Insurgency in the state

The state has been affected by violence of the insurgency of Boko Haram since 2009 to date. As a result several health facilities across the state do not function or are in a dilapidated state. Some have been vandalised by the insurgents. This has led to gross instability in health care service delivery to the population especially the most affected and no-go areas. However, the state government is committed to renovate those facilities. Currently more than 2 million people have being displaced from their communities and live in the metropolis as internally displaced persons who receive free healthcare from the state government.

7.7.3 Health context

The Health Sector consists of : 1. The Ministry of Health as the head, responsible for the formulating policies and overall supervisor of the health sector; 2. Hospitals Management Board (HMB) over seeing the secondary health facilities; 3. State Primary Healthcare Management board (SPHCMB) over seeing the PHC facilities; 4. The Borno State Aids Control Agency (BOSACA) and ; 5. The Health training institutions; Consisting of the College of Nursing and Midwifery and the College of Health sciences and Technology.

7.7.4 Strong points in the State

- There is good working relationship and mutual understanding between the ministry and the parastatals, thus good leadership and coordination.

- There is high political will and commitment by the state government in terms of investment in the health sector.
- There is good mutual relationship and coordination between the state and partners.

7.7.5 Problem analysis

- Human resources gaps do exist across all level of the health facilities.
- Recruitment and redeployment is centrally controlled.
- Infrastructural development in the health sector is centralised including the PBF contracted facilities.
- Supply of drugs and equipment across all health facilities is centralised.
- PBF Interventions in the state under NSHIP is operating in only 8 out of the 27 LGAs. Contracted health facilities include both private and public; Primary and secondary Health facilities.
- There is existing inadequate knowledge of PBF by most of the stakeholders, healthcare service providers and general population.
- There is standing committee of traditional leaders on PHC supporting demand creation and social mobilization across the state
- There is a free maternal, new-born and child health service though not covering all the facilities and is not enough even for the health facilities covered.

7.7.6 Feasibility Scan

Are there possibilities of solve the above problems with PBF => Yes.

PBF is already being implemented in some parts of the state through a World Bank funded project, this feasibility scan was conducted to ascertain the feasibility of having a locally owned state-wide PBF program.

We came to a feasibility score is 76%

Criteria to establish in how far the programme is "PBF"	Points	Score	Comments
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	0	Government may adopt and scale up the strategy since the PBF programme currently being implemented in some facilities across the state which are being implemented by NSHIP-AF
2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	2	2	State health allocation is currently at 12% of the total annual budget and Government may accept the strategy to increase the health budget allocation to 20% for the programme
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	2	With the level of the current coordination and integration between the MOH, its parastatals and Partners, it is feasible.
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	2	PBF is currently ongoing supporting some facilities by NSHIP Project Department of community health services would take charge following advocacy
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	2	PBF is currently ongoing supporting some facilities by NSHIP Project Department of community health services would take charge following advocacy
6. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	2	PBF is currently ongoing supporting some facilities by NSHIP Project Department of community health services would take charge following advocacy
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure	2	2	PBF is currently ongoing supporting some facilities by NSHIP Project

the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.			Department of community health services would take charge following advocacy
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	2	PBF is currently ongoing supporting some facilities by NSHIP Project Department of community health services would take charge following advocacy
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	2	PBF is currently ongoing supporting some facilities by NSHIP Project Department of community health services would take charge following advocacy
10.Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the FOSA are the signatories.	2	2	PBF is currently ongoing supporting some facilities by NSHIP Project Department of community health services would take charge following advocacy
11.Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	0	Applied in PBF supported facility
12.The project introduces the business plan that includes the Quality Improvement Bonuses	2	2	Exist in PBF supported facilities and there is good quality improvement.
13.The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2	2	The tools are in place in all the PBF supported facility and it has make positive impact
14.CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2	2	Feasible for PBF supported facility but Government play all role of signing the contract in the remaining health facilities
15.Provider managers are allowed to influence cost sharing tariffs	2	0	Might be possible
16.Provider managers have the right to hire and to fire	2	0	In some PBF supported facility and that applied for only the temporary workers
17.There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	2	Yes in some facilities that supported by PBF project
18.There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	2	Yes in all the facilities but PBF supported facilities have the output approach
19.CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	2	Present in all Health facilities primary, secondary and tertiary.
20.The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	2	All PBF facilities
21.Public religious and private providers have an equal chance of obtaining a contract	2	2	All have an equal chance in obtaining contract
22.There are geographic and/or facility specific equity bonuses	2	2	Applicable to all HFs offering PBF
23.The project provides equity bonuses for vulnerable people	2	2	Yes
TOTAL	**50**	**38 = 76%**	

7.7.7 Recommendations

- Integration of state financial resources for funding the PBF program
- Analysis of the available funds and the population that can be covered by PBF
- Propose an institutional set-up on how the system will operate
- Stakeholders' sensitization on PBF
- Advocacy to policy makers on PBF, traditional institutions, faith based organisations, community based organisations, civil society organisations and professional bodies sensitization.
- Scaling up PBF in other non-contracted health facilities across the state
- Make free MNCH services to high quality subsidised user fee paid services
- Financing and sustainability of the programme

Sources of funding

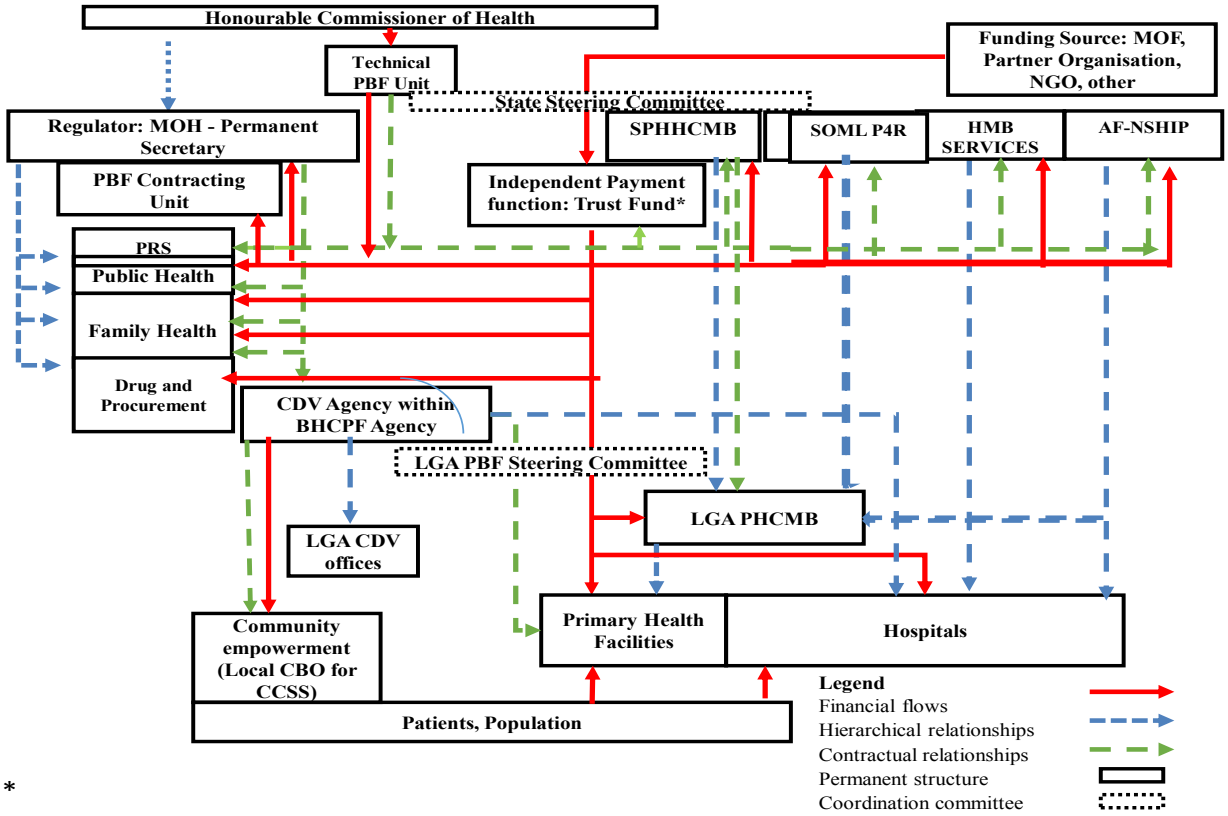
- State Government
- Basic Healthcare provision funds

- Nigerian State Health Investment Project (NSHIP)
- Saving One Million Lives Programme (SOML)
- Tripartite fund (Govt, Dangote foundation and BMGF)
- Development Partners

7.7.8 Action plan

The issues	Action Points	Responsible Person	Time frame
Poor knowledge of PBF by the stakeholders, policy makers and the community structure	Sensitization of the stakeholders on PBF on their support to buy the idea	Department of community health services	Jun 2019
	Advocacy to the policy makers on PBF on their support for implementation	HCH	Aug 2019
	Sensitization of the traditional institutions, CBOs, FBOs and professional bodies for understanding the PBF and supporting the programme	PC-NSHIP	Jun 2019
Scaling up of the PBF in all the Health facilities across the state	Writing a memo to His Excellency the Executive Governor on request to expand the programme across the state	HCH	Sept 2019
	Continues follow up of the letter to secure approval	PS	From Oct 2019
Free MNCH to high quality subsidized user fee paid services	Sensitization of the stakeholders on the importance of transition from Free MNCH to user paid quality healthcare services and secure their support	HCH	Nov 2019
	Advocacy to the policy makers on importance user paid quality healthcare services and their support for implementation	HCH	Nov 2019
	Sensitization of the traditional institutions, CBOs, FBOs and professional bodies for understanding the concept and supporting the programme	Department of community health services	Aug 2019
Financing the programme	Advocacy to the policy makers to increase budgetary allocation to health sector from 12% to 20%	HCH	Nov 2019
	Writing memo to His Excellency the Executive Governor on request to approve increase in budgetary allocation to Health sector	HCH	Dec 2019
	Funds from development partners and state programs should be contributed in to the state PBF account to ensure integration of service delivery	HCH	Jan 2020
Insurgency	Government is committed from federal and state level to ensure stability through security operatives, funding and commitment	HE the Executive Governor	continues
Sustainability	***Short to medium term:*** The government's health allocations Funds from state programs (SOML, NSHIP, BHCPF) Funds from development partners ***Long term:*** Amendment of the Health law binding the PBF	MOF Legislatures	continues

7.7.9 PBF institutional set up



7.8 Ethiopia

Kunuz Haji, Kenea Mokenin, Galgalo Halake, Bizuneh Gudisa, Carmen Schakel

7.8.1 Health context

Ethiopia is the oldest independent and second most populous country in Africa. It has a unique cultural heritage with a diverse population mix of ethnicity and religion. It served as a symbol of African independence throughout the colonial period, and was a founding member of the United Nations and the African base for many international organizations. Projections from the 2007 population and housing census estimate the total population for the year 2015 to be 90 million (CSA, 2015). Ethiopia is the home of a variety of nations, nationalities and peoples with more than 80 different spoken languages. There were Health Sector Development Plans (HSDPs) since 1997 in four phases. Despite the impressive progress made, Ethiopia still has high rates of morbidity and mortality from preventable causes.

There is also disparity in uptake and coverage of high impact interventions amongst different regions and woredas. The quality of health care in terms of improving patient safety, effectiveness, and patient-centeredness, in both public and private facilities, is often inconsistent and unreliable. The health sector transformation plan, in line with the country's second growth and transformation plan (GTPII), has set ambitious goals to improve equity, coverage and utilization of essential health services, improve quality of health care, and enhance the implementation capacity of the health sector at all levels of the system. A national health care quality strategy will be developed to guide our investment towards safer, more effective, more accessible, and more equitable care for every Ethiopian by 2020.

Ethiopia is implementing HSTP as part of four interrelated transformation agendas. These are transformation of quality and equity of health care, woreda transformation, a movement towards compassionate, respectful, and caring health professionals, and information revolution. The key features are quality and equity; universal health coverage and transformation. To achieve the health sector mission and vision there are four pillars, Excellence in health service delivery, quality improvement and assurance, leadership and governance and health system capacity.
The performance of HSTP has been reviewed critically using its annual performance reviews, relevant reports, including Health Information Management System (HMIS/DHSI2), the Mid-Term Reviews (MTR), and different population and facility-based surveys.

Ethiopia has made steady improvements in achieving its main health goals by implementing high impact interventions such as its flagship community focused programme knows as the "*Health Extension Program*". Over the past 15 years, under-five mortality has declined from 166 deaths per 100,000 live births in 2000 to 88 deaths per 100,000 live births in 2011, and to 67 deaths per 100,000 live births in 2016. Infant Mortality Rates has declined from 97 deaths per 100,000 live births in 2000 to 59 death per 100,000 live births in 2011, and to 48 deaths per 100,000 live births in 2016. Despite improvements in childhood morbidity and mortality, nearly one in three children is chronically under-nourished.

More than one-third (36%) of married women age 15-49 use any method of family planning - 35% use a modern method and the fertility rate is 4.2%. Only 26% of births occur in a health facility, primarily in public sector facilities. Only 17% of women age 15-49 receive a postnatal check within two days of delivery, while 81% did not have a postnatal check within 41 days of delivery. Merely 13% of new-borns receive a postnatal check within two days of birth. Maternal mortality declined from 871 deaths per 100,000 in 2000 to 412 deaths per 100,000 live births in 2016 according to Demographic and Health Survey.

Part of the multiple current challenges is the existence of a drug supply monopoly by the Ethiopian Pharmaceutical Supply Agency (EPSA). They have monopolized the drug market and in general health facilities are not allowed to buy pharmaceuticals from other suppliers unless there is an official letter from the EPSA explaining there is a drug stockout.

The Health Sector Transformation Plan (HSTP) is the current five-year national health sector strategic plan, which covers EFY 2008-2012 (July 2015– June 2020). The Health Sector Transformation Plan (HSTP) is therefore the first phase of the ***—Envisioning Ethiopia's Path towards Universal Health Coverage*** through Strengthening Primary Health Care and as part of the second Growth and Transformation Plan (GTP-II) of the country.

7.8.2 Problems investigated by the Ministry of Health

1. What would a PBF strategy in the Ethiopian context look like?
2. What would a pilot for a PBF strategy look like. A current exploration by the World Bank for the government of Ethiopia will assess how to start a PBF strategy which may involve in the future a pilot. The PBF pilot in Ethiopia context will have to be in more than one region. In this course we present a preliminary assessment

3. Sustainability, Any PBF strategy should not be without the sustainability strategy which means that too much grant or donor dependency should be avoided. Sustainability mechanisms will have to be designed.

Is it possible to solve the problems with PBF? Yes

7.8.3 Focus: Pre-piloting PBF in Oromia Region

Start in Borana

In May 2015 Cordaid started the implementation of phase-I of a PBF pre-pilot project in the Borana zone in the Oromia Region of Ethiopia. The project covered 8 Health Centres and 1 Primary Hospital across 4 Woredas reaching a catchment population of 125,918. After positive results, in July 2018 a Phase-II of pre-pilot was continued with an expansion to 8 Woredas and a catchment population of 488,556.

From the PBF pre-pilot experience several lessons have been learned:

- The engagement of the Oromia Regional Health Bureau and Federal Ministry of Health, particularly in the planning, implementation, and monitoring to sustain the project results and scale-it up to the areas was inadequate. These bureaus should be involved from the start.
- The Zonal PBF Steering Committee was changed to Validation Committee at the Zonal level to include more technical staff for proper review
- Note was taken that pre-pilot was in line with government strategies of the Health Sector Transformation Plan
- There was significant increase in quantity and quality but still more room for improvement on quality of health facilities
- There was significant improvement of health data once health staff were coached by the verifiers to properly fill out the registers
- The pre-pilot was missing the aspect of refresher trainings on PBF
- A sustainability strategy should be developed involving integration into the health system

The Jimma PBF Pilot Extension

During a PBF workshop, jointly organized by the FMoH and Cordaid, the subject discussed was the need to scale up PBF in a non-pastoralist area. This to showcase that PBF also works in other settings than the arid and pastoralist Borana Zone to generate additional evidence about the effectiveness of PBF. It was decided to scale up to the Jimma Zone within the Oromia Region. The population of the Jimma zone in 2019 is 3,4 million with 20 districts and 1 town administration with health facilities consisting of: 3 general, 3 primary hospitals, 3 hospitals under construction, 122 health centres and 515 health posts.

The Jimma Zone faces multiple healthcare challenges including:

- ***The utilization of healthcare services:*** The community often does not seek healthcare services due to low quality of care.
- ***The quality of health services:*** The low quality is related to low staff motivation, shortage of health professionals and high staff turnover. Additionally, the lack of drugs and equipment means basic healthcare services are not always available.
- ***The lack of utilization of health information for decision making at district level:*** This issue is related to the lack of knowledge by the Health Centre and Woreda

Health Office staff on proper reporting procedures and ambiguity in documents. Additionally, data is often collected manually due to lack of computers and internet.

In October 2018, an initial project proposal for the PBF pilot was approved for 16 million Euros (18,1 million USD). The project duration is for 4 years. This includes a 6 month inception phase and a final 3 months for exit procedures. The proposal suggested a target population of 2 million inhabitants or 60% of the Zonal population. This is the equivalent to 2 Euros (2.25 USD) per capita for the full project implementation. Much of project proposal was based on the pre-pilot in Borana, including the lower amount per capita in respect to the lower costs in Ethiopia. The Jimma PBF pilot, like in Borana, will also start with a Cordaid Field office in Jimma acting as the CDV agency with the intension to integrate this role into the existing Ethiopian health structure.

7.8.4 Feasibility Scan: Federal Ministry of Health

Feasibility study is analysis and evaluation of proposed project to determine if it is technically feasible, is it feasible within the estimated cost, will be profitable.

Criteria to establish in how far the programme is "PBF"	Points	Score
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	4
2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	2	2
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	0
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	2
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	0
6. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	2
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	0
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	0
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	0
10. Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the FOSA are the signatories.	2	2
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	0
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	0
13. The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2	0
14. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2	0
15. Provider managers are allowed to influence cost sharing tariffs	2	0
16. Provider managers have the right to hire and to fire	2	0
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	0
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	0
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	0

20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	0
21. Public religious and private providers have an equal chance of obtaining a contract	2	0
22. There are geographic and/or facility specific equity bonuses	2	2
23. The project provides equity bonuses for vulnerable people	2	2
TOTAL	**50**	**16**
		32%

7.8.5 Killing Assumptions Federal level

- Provider managers are not allowed to influence cost sharing tariffs, in our country context government has the sole power to allow influencing cost sharing tariffs.
- No freedom to buy drugs, The health facilities have to submit their priorities to the EPSA but only if it is out of stock, the EPSA mandates the facilities to buy their inputs from the private accredited distributors.
- Lack of autonomy, health facilities are not autonomous, since the Health Care Financing strategy is not approved yet.

7.8.6 Feasibility Scan: Jimma Zone PBF Pilot

The feasibility scan below is based on the approved PBF initial proposal for the Jimma Zone. Contextual activities not fully worked out in the proposal were scored based on what is believed to be feasible within the existing health system in Ethiopia and our past experiences

Criteria to establish in how far the programme is "PBF"	Points	Score	Comments / Recommendations
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	0	Could reduce catchment population to increase amount per capita and increase impact. Cost currently at 2 USD per capita for a catchment population of 2 million.
2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	2	0	Totally funded by donor. Need to create sustainable plan to integrate in existing Ethiopian health system
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	0	No national PBF unit exists as part of PBF showcasing project. PBF Unit currently exists at Cordaid Addis level. Create sustainability plan.
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	0	This is a project to upscale PBF in 1 zone. Create sustainability plan to integrate PBF into current Ethiopian health system.
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	2	Between quantity and quality indicators (based on existing Borana project) more than 25 output indicators will be included.
6. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	2	This is something we could possibly include as part of the PBF program. Activity performed by HF worker. Additional worker will need to be hired for this activity. HF will need to autonomy to hire this person. Catchment population may need to be lowered to allow for enough subsidies.
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	2	Woredas will do this. 196 composite indicators currently exist in Borana project. Will need to decide which to include or if additional composite indicators need to be added as part of the quality verification.
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	2	Currently included as part of the Jimma project proposal. Need to decide which stakeholders will attend the meeting.

9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	2	Baseline of all Health Facilities has been included as part of the proposal and budgeted for. Need to assess how we want to measure the baseline.
10. Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the FOSA are the signatories.	2	2	Yes, health facilities have their own bank accounts. The subsidies are transferred directly from the fundholder to HFs.
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	0	Currently drugs are centrally distributed from the Ethiopian Pharmaceutical Supply Agency (EPSA) unless there are drug stockouts. However, we can negotiate with MoH to decentralize drug suppliers, for this PBF project, to have the ability to buy from multiple distributors. In the Borana pilot this is currently happening but with a very bureaucratic approval system each time drugs are purchased.
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	2	Can include as part of PBF project. May need to reduce the catchment population to have enough USD per capita.
13. The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2	2	Yes, this will be included. Verifiers will coach HFs how to use this indices tool.
14. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2	2	Yes, initially the Cordaid field office in Jimma will act as the CDV agency. They will sign contracts directly with the chosen HFs.
15. Provider managers are allowed to influence cost sharing tariffs	2	0	No, the Regional Health Bureau sets services prices. Across the region prices are the same.
16. Provider managers have the right to hire and to fire	2	0	No, the RHB and Zonal Health Office hire staff. We can try to negotiate with the RHB and allow provider managers this autonomy for the pilot.
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	2	Yes, initially Cordaid field office in Jimma will act as the CDV agency and perform these tasks. In order to create sustainability we should integrate this agency with an existing entity in the Ethiopian health system. The Ethiopian Health Insurance Agency (EHIA) could be a possibility.
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	2	Yes, the Fund Holder Agency at Cordaid Addis level will make payments. Purchasing Agency in Jimma will contract and verify HFs.
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	2	Yes, an indicator package will be selected that will contribute to the Transformation Agenda. We will consider the most important of the 32 KPIs.
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	0	We can consider to include this indicator. However, this will likely require a reduction in the catchment population due to the expensive nature of this indicator.
21. Public religious and private providers have an equal chance of obtaining a contract	2	0	Faith based and private providers are not currently part of the health system. Only private providers exist, but they are below standards because they are smaller than Health Centers and are unable to perform all the services of a HC. These clinics have licensing but no accreditation. They do not report in the DHIS system, so not sure if possible to include in PBF program. Need to further assess.
22. There are geographic and/or facility specific equity bonuses	2	2	Yes, we can assume, like in the Borana pilot, we will include an equity indicator for remoteness/accessibility of a Health Facility.
23. The project provides equity bonuses for vulnerable people	2	0	We can include if lower catchment population and increase in amount per capita is realized. Need to further assess how to implement.
TOTAL	**50**	**30 (60%)**	

7.8.7 Killing Assumptions / Challenges Jimma PBF program Cordaid

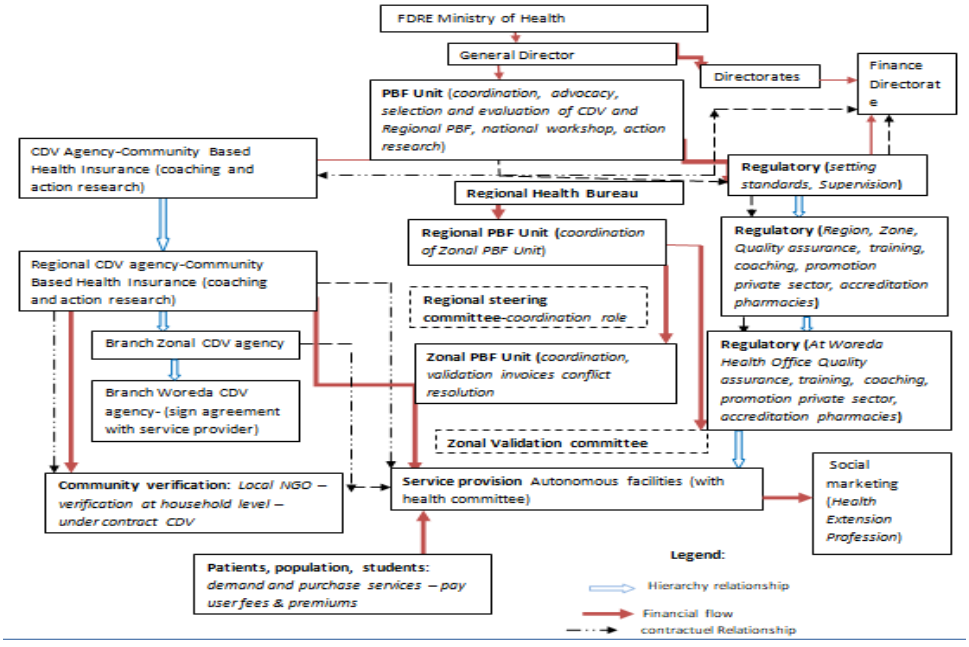
- ***Central Drug Supply***: The drug monopoly in Ethiopia can have adverse effects to the PBF program such as drug stock outs. From our experience in Borana drug stock outs lead local pharmacies to significantly increase prices for the consumers.
- ***2.25 USD per Capita*:** If a pure PBF design is to be implemented based on the most recent PBF best practices, the current budget per capita is not sustainable. On the other hand, if a pure PBF is not designed to stay within budget the PBF program may not be effective.
- ***Lack of autonomy of Health Facilities***: A lack of autonomy could reduce staff motivation and reduce the outputs. Health facilities do not have the autonomy to build or maintain their infrastructures. They have to go through bureaucratic approval in order to make even small improvements such as rehabilitation of a facility.

These killing assumptions pose a serious risk for the implementation of the pilot and need to be addressed.

7.8.8 Recommendations : Federal Ministry of Health

- Since Ethiopia as a country is not yet engaged in a full PBF strategy our first priority is to engage together with World Bank in the collective exploration of feasibility of PBF strategy in Ethiopia in relate with the three directorates to this collective exercise.
- To map and compare the current system of Ethiopia with a system informed by PBF strategy
- Try to design a brief proposal on a pilot for the future, with a target population selected from Addis Ababa (Urban) 3,433,999, Somali (Special support region) 5,748,998 and Oromia (Rural) 35,467,001 from total population 94 million. We consider that PBF budget shouldn't be below 4 USD per capita, although the needed budget for those regions was special support region USD 22.995.992, Oromia USD 141,868,004 and Addis Ababa USD 13, 735, 96.

7.8.9 Institutional Design: PBF Federal Ministry of Health

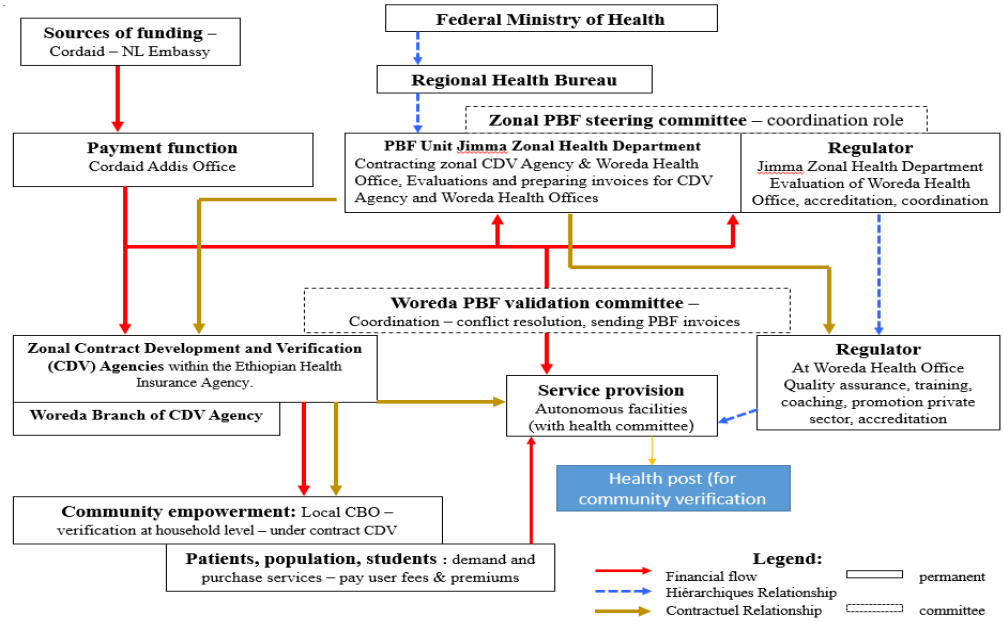


7.8.10 Recommendation : PBF Design Jimma

Internationally, an expenditure of 4 to 5 USD per capita is now widely accepted as the benchmark for a full-fledged PBF program. Even with the lower price levels there will probably be a number of initial costs such as Quality Investment Units that need to be introduced to get the pilot started which would need to be factored in. Moreover, given the increasing interest in PBF by the FMoH it is of utmost importance to implement a design ready to be integrated within the existing health structure. This will allow for greater impact and more efficient expansion of PBF across other regions and possibly even nationwide. Assuming this more full-fledged realistic design, an expected population of 1.1 million inhabitants can be reached.

7.8.11 Institutional Setup

The institutional design is based on what is expected to be possible in the longer duration of the project with a field office in Jimma which will initially have to role of the CDV agency. when the possibility is further assessed and negotiated it is the intention to integrate this into the existing health structure.



- Integrate CDV agency within the Ethiopian Health Insurance Agency if its functional
- Subcontract the health posts to perform household visits and social marketing.

7.8.12 Recommended Indicator Selection

In addition to the 22 output indicators for the health centers in Borana, 5 indicators have been added. Notably, the household visit indicator.

No	Output Indicators – Health Center
1	Positive HIV/AIDS cases (Referral Linkage to ART center)
2	Quality Improvement Bonus (QIB)
3	Number of Malaria cases tested positive by Microscope and treated
4*	TB case Detection through community TB care tested (referral to HC if tested Positive)
5*	Household visit following protocol

* performed at health post level

Additional hospital indicators

No	Output Indicators – Hospital
1	Number of patients on ART with a suppressed viral load (<1000 copies/ml) in the past 12 months
2	Impatient days for hospitalization
3	Quality Improvement Bonus (QIB)

7.8.13 Recommended Woreda Selection

The Jimma Zone constitutes of 20 districts and 1 town administration. USAID has implemented their *Transform Primary Healthcare* project throughout 11 of these districts. As in the Borana Zone, it is suggested to implement PBF in the districts where USAID is not active in order to have more accurate data regarding the measurement of PBF impact in the Jimma Zone. The Woreda choices still need to be discussed but the remaining 10 districts USAID is not active:

District proposed for PBF Jimma Zone

No	Name of Districts	Population	Number of HC
1	Agaroo	41,793	2
2	Botor Xoollay	63,201	4
3	Guumay	84,268	3
4	Manchoo	177,009	6
5	Omoo Beeyyam	127,538	4
6	Omoo Naaddaa	208,517	7
7	Qarsaa	227,959	8
8	Saxxammaa	142,635	5
9	Sh.Somboo	154,896	5
10	Xiroo Afataa	165,196	5
Total		1,393,012	49

7.8.14 Action Plan : Federal Ministry of Health

Activities	Responsible person	Time
1. Prepare the report based on PBF current situation of country context	participants	April 19, 2019
2. Submit the policy brief (best practice of PBF, comparison with Ethiopian health system) and try to link the recommendations to the exploration which is ordered by the ministry and executed in collaboration in the world bank(Mesfin from PCD)	Participants	April 25 ,2019
3. Arrange the discussion schedule to brief the policy brief to the Directors	Participants and relevant directors	April 29, 2019
4. Invite the relevant stakeholders for the discussion (focal directors from MOH, MoF, civil service commission	Participants or responsible directors	First week of May, 2019
5. Brief respective director what PBF strategy would look like in Ethiopia context?	WB and MOH	End of May, 2019
6. Make to be included on the JSC agenda to get feedback from all regions	PCD and PPMED	For the next JSC meeting

7.8.15 Action Plan : Federal Ministry of Health

Activity/Issue	Advocacy Element	Expected Output	Responsible	Time Frame
1. Discuss findings of PBF Course	1. Institutional design 2. Catchment population 3. Potential indicators	1. EHIA as CDV agency 2. Reduce catchment population 3. Include community indicators / QIB / additional equity	Jimma Stakeholders, Borana team, HQ Team, NL embassy	April 15th

2. Select draft Indicators in Jimma / Woredas / Zone	Community Indicators (HEW can perform household visits) / QIB Indicator / Additional Equity Indicators	Drafted quality & quantity indicators presented at Design Workshop	Jimma stakeholders / Cordaid	Week 16 of 2019
3. Negotiate with RHB for free market of drugs for pilot without Woreda approval	Freely buy from pharmaceuticals outside of EPSA	1 time approval to freely perform this activity for purpose of PBF pilot	Jimma stakeholders / RHB	Inception phase: until Oct 2019
4. Negotiate with Regional Finance & Economic Planning Bureau, Zonal Economic & Finance Dept., to freely build and maintain infrastructure without Woreda approval	Health facilities need to have the ability to freely build infrastructures. This is part of a health facilities right to autonomy.	1 time approval to freely perform this activity for purpose of PBF pilot	Jimma stakeholders / Regional Finance & Economic Planning Bureau / Zonal Economic Dept.	Inception phase: until Oct 2019
5. PBF Design Workshop	Finalize indicators, pricing, Woreda & Health Facility selection, etc.	Finalized Project Implementation Manual (PIM)	Multiple Stakeholders (approx.. 25) including Zone, FMoH, EHIA	July 2019
6. Negotiate with EHIA and RHB	Assess and negotiate with EHIA on the possibility to perform as the CDV and verify PBF health facilities	Contract the EHIA as the CDV agency. Integration of PBF in existing Ethiopian Health Structure	Jimma stakeholders / RHB / Cordaid	Longer term plan – 1 years

7.9 Cameroun CDV Agency North-West

Action plan for advocacy on change of quality indicator clause: "payment for coaching only done by the manager of the CDV Agency or the deputy manager."

7.9.1 Health policy in Cameroon

The Health Sector Strategic Plan 2012-2015 in Cameroon aims to sustainable universal access to quality health care and services through the improvement of health care delivery and financing of demand (use).

In this plan five strategic axes were retained: 1. Health System Strengthening ; 2. The vulgarization of the implementation of the minimum and complementary health packages in the health Districts ; 3. The development of an operational referral system ; 4. Strengthening partnership in the sector; 5. Stimulation of demand.

7.9.2 PBF in Cameroon and North-West Region

The Performance based financing (PBF) initiative in Cameroon is aimed at increasing health care provision of high quality. This initiative addresses the strategic axes of the Health Sector Strategic Plan such as in particular the quality of health care delivery at the operational levels of the health centres (minimum health package) and district hospitals (complementary health package). The PBF initiative will aim to increase the

capacity and availability of human resources. It equally aims at providing health care services for the poor, the vulnerable and the hard-to-reach.

PBF started in 2007 in the East Region by Cordaid and the Catholic Bisdom of Batouri. The next phase started in 2011 in Littoral Region and in 2012 in North-West and South West regions. The North West Region has a population of 2 million. In July 2018, there was the scale up of PBF to all 19 Districts of the North West Region and the progress is observed in the table below so that by 2019 the population is fully covered except for some areas that are affected by the socio-political instability.

Year	% Coverage	Target population
2016	28%	568.907
2017	50%	1.016.000
2018	75%	1.530.000
2019	100%	2.137.203

The Contract Development and Verification Agency (CDVA) North West operates within the North West Regional Fund for Health Promotion (NWRFHP) as the result of a contract signed *in April 2015* between the Minister of Health and the North West Regional Fund for Health Promotion. The CDV Agency North West Region is headed by the Manager who is assisted by the Deputy Manager. It has an accountant, an administrative assistant, supervisors, verifiers drivers and cleaners. The CDVA is responsible for:

1. Negotiating and signing contracts with health facilities or other structures;
2. Monthly verification of quantitative results of health facilities or other structures on PBF contract;
3. Organizing quarterly community verification coupled with the satisfaction survey of patients or users of other facilities;
4. Coaching HF/other structures on PBF tools (business plan, indices management tool);
5. Organizing training of HF/other structures staff on PBF.

In the PBF system the CDV Agency is responsible for negotiating and signing contracts with structures with the responsibility of coaching on management tools to promote transparency ensuring efficiency in the use of Health facilities' resources. This requires to coach the health facilities in the use of the indices management tool. According to the PBF manual (page 66) the coaching must be done by the manager or the deputy manager.

7.9.3 Problem analysis

- There is a high rate of non-submission of the indices tool of 35% and 22% consecutively for two quarters. There is an average low score for the quality of the use of the indices tool of 38% and 43% for two consecutive quarters. On reasons for this poor performance is that the deputy managers of the CDV Agencies in practice conduct their coaching activities at best once per year or not at all due to the security reasons and the fact that they do not reside in the district such as the verifiers. Yet, the CDV Agency verifiers (with the supervisors of the district health authorities) are the closest actors for the health facilities and the community. The verifiers visit the health facilities monthly, which provides the them the possibility for regular interactions. It also provides the possibility to coach on the indices management tool. Based on these arguments, a diagram showing the current situation and its effect has been produced below:

7.9.4 Cause-effect analysis of the coaching problem

Problem	Cause	Effect
Inadequate coaching from the CDV Agency	- Inaccessibility to many areas because of the socio-political crisis - High workload of the deputy managers	Knowledge gap by health facilities on PBF issues in general and the use of the indices tool in particular
Poor submission rate of the indices tool related to knowledge gap (49%)	- No or inadequate coaching sessions from the CDVA Personnel	Low quality score and hence reduction in subsidies leading to demotivation
Poor indices tool average score (43%)	- Coaching done by supervisor is considered of low quality and therefore not purchased. This is a demotivating factor for the supervisors and may influence quality	Poor use of finances and reporting on financial Management.
High cost of the coaching conducted by deputy managers	- Coaching done from the regional level and not decentralized. Need for night station allowances	Concerns for the sustainability of thecoaching

7.9.5 Feasibility score

Performance Based Financing is already a policy in Cameroon. A quick scan of the policy implementation is at 94%. However, the rationalization of the population is still inadequate such as in particular that some health facility catchment areas with a main contract have a population of less than 5000 persons. The second problem concerns the baseline quality reviews, which are not done in all health facilities, probably related to the socio-political crisis.

Criteria to establish in how far the program is "PBF"	Points	Score
1. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	0
2. The program includes a baseline household and quality study, which establishes priorities and allows to measure the impact of the program.	2	0
3. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	0
TOTAL	**50**	**44 = 88%**

There is no particular killing assumption but some operational issues one of which is addressed in this action plan.

7.9.6 Recommendations

- To the PBF technical unit, to amend the clause which indicates that only coaching done by the Manager or Deputy Manager is payable
- To the CDVA Manager, organize training for supervisors on the indices tool and on coaching skills. A post-test should then be administered and supervisors who scored above 80% should be selected for particular axes.
- To the supervisors, regular coaching should be done and the Manager or Deputy should be invited for risk-based coaching or coaching on pertinent issues like conflicts or adherence issues.
- The CDVA supervisors should monitor the progress in indices tool submission rate and score.

7.9.7 Action plan

What	How	Who	When	Result
Present the problem and proposed solution to the Manager of the CDVA	- Power point presentation on the challenges and proposed solutions - Present a copy of the action plan	Sama Paltiel Yeti	14/4/2019	Manager is convinced
Follow up for recommendations to be presented at the steering committee meeting / PBF course training at the central level	- Reminder of the Manager - Production of and handing of justifying documents with which to lobby for change	Sama Paltiel Yeti	25/4/19	Amendment in the clause that only the coaching done by the Manager or the Deputy shall be paid.
Organization of Training of supervisors and some DMOs on the indices tool and coaching skills. Posttest administered	- Workshop at the CDVA head office	CDVA management	14th to 18th May 2019	Training of staff on the subject matter Selection of most performing personnel for the Job
Enhanced supervision of coaching exercises done by supervisors by The Mana*	- Field visits to coaching exercises or coached Health facilities	CDVA management	June and July 2019	Corrections of errors.
Purchase of coaching from supervisors	- Verifying declared coaching sessions	CTN	September 2019	Enhanced quality of coaching, motivation of staff and improved production of Health facilities.

7.9.8 Budget

Activity	Aspect	Unit	Cost	Total
- Advocacy to Manager	- Printing Report	2	1000	2000frs
- Training of field supervisors on the indices tool and coaching	- Mission allowance and transport for training expert from Yaoundé	5	100,000	500,000frs
	- Mission allowance and transport to supervisors for training	26 x 6days=156	30,000	4,680,000
	- Feeding	31	2,500	77,500
- Supervision of supervisors on the field	- Transport and mission for Manager and Deputy	10	60,000	600,000
Total				**5,859,500**

7.9.9 Conclusion

Coaching is one of the key elements in the proper functioning of the PBF Mechanism. An unmet coaching need is disastrous to the system as many issues go wrong without being noticed. Good coaching facilitates verification, supervisions and quality reviews. It also gives information that may otherwise go without notice. Coaching is the bridge from where we are to where we are supposed to be.

7.10 Cameroun - Regional Fund for Health Promotion North-West

7.10.1 Context

The North West Regional Fund for Health Promotion (NWRFHP), or simply referred to as the "Fund" started in 1987 as a Primary Health Care Essential Medicines program in line with a national framework of re-orientation of primary health care to create a self-sustaining mechanism (revolving drug fund) to ensure a constant supply of quality essential medicines. This was recommended by African Ministers of Health in Bamako, in 1987. The structure was known then as the North West Pro-Pharmacy. In 1991, in line with the law on associations in Cameroon, it became the North West Provincial Special Fund for Health. The initial investment capital of the NWPSFH was contributed by the North West community (11%), the government of Cameroon (25%) and the German Technical Cooperation (64%). The total capital was estimated at 200 million Francs CFA. The organization and functioning of the NWRFHP consist of the General Assembly (GA), the Management Committee (MC) and the staff headed by an Administrator. The North west Regional fund for Health Promotion has as mission to assist the Ministry of Public Health in promoting access to quality health care for the population of the North West Region through the improvement of the performance of the health system.

Considering the willingness of the major partners of the Fund to ensure better health for the population by improving the performance of the health system in the regions, it was transformed into its present status to support the Ministry of Public Health in the mobilization and management of resources for health care delivery especially in the management and distribution of medicines and other pharmaceutical products; enhancing the quality of health care provision; developing financing mechanisms; and carrying out other health care promotion activities.

People are the main actors in PBF and the strengthening of the consumers' voice is an important aim. PBF advocates for the separation of functions and the consumer has a role of giving feedback on the quality of care and services rendered. Providers have the responsibility to ensure that health services are available of good quality at affordable cost to the government and consumers.

7.10.2 The "Fund" and the PBF program

The NWRFHP serves as a supervisory body for the Contract Development and Verification agency. The NWRFHP ensures that the CDVA performs their duties respecting quality and standards. With the introduction of the PBF in the NW Region, there were several positive changes such as : 1. Improvement in infrastructure and equipment through quality improvement bonuses ; 2. Enhanced quality of the services rendered to the population; 3. Improved attitude of the health personnel as the result of the performance bonuses. This reform in the implementation of the eleven best practices has brought improvements into the health sector in general and the NW Region in particular.

Yet, in 2016 a socio-political conflict emerged between an armed group and the government that gradually resulted into a war. This crisis has caused uncounted misery to the population causing trauma as many people lost their loved ones, some internally displaced including health workers, some health facilities are completely shut down, and some health facilities are unreachable. All these has rendered the provision and supervision of the quality of care offered very difficult.

The socio-political crisis plaguing the country has brought about a break down in the control quality mechanism, low quality of care due to counterfeit medicines availability in some health facilities and private sale of medicines by some health staff in some health facilities leading to lower income for the facilities and expensive and low quality services to consumers.

7.10.3 Problems analysis

- As the result of the war, the quality reviews are not conducted regularly and some health workers benefit from this situation to start buying medicines from unauthorized sources in order to increase their profits.
- There are delays in payment of the subsidies and this further contributes that staff are not adequately motivated.
- Linked to the above problem health workers tend not to report on certain sales of drugs and put money into a private pocket instead of the common basket. This leads to lower income for the facilities.
- These drugs are bought from unauthorized distributors and are usually of lower quality and are generally cheaper. The drugs are usually sold at higher prices to consumers and may not even be of good quality. The socio political crisis has grounded economic activities rendering many people poor and forcing health workers into private practice where they make extra money to take care of their basic needs.
- Low quality of care related to counterfeit medicines availability in some health facilities.

7.10.4 Can PBF solve this problem?

PBF is a reform that has succeeded in many areas. Recent experience has demonstrated that PBF can do well during crisis period such as wars, disasters or outbreak such as Ebola Viral Disease. In the Central African Republic from 2013 onwards- when war broke out it allowed to compare PBF areas with the classical emergency approach of input financing through International NGOs. The PBF approach continued to pay cash subsidies to health facilities and this turned out to more cost-effective. None of the PBF health facilities stopped to operate during the war. Qualified staff continued to work in the facilities while in the traditional emergency approach areas many qualified staff left. The study in the Central African republic also observed that during crisis periods, PBF approach should significantly increase the subsidies so that everyone affected by the crisis can be treated free of charge. Then, when the situation improves cost sharing can gradually return. Realistically speaking, PBF can solve these problem
This can be done through advocacy for change and follow up for the implementation of the recommendations

7.10.5 Feasibility scan

Although there is a feasibility score of 92%, there is need to still look very keenly at the issues addressed

Criteria to establish in how far the program is "PBF"	Points	Score
1. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	0

2. The program includes a baseline household and quality study, which establishes priorities and allows to measure the impact of the program.	2	0
TOTAL	**50**	**46 = 92%**

7.10.6 Recommendations

- Health facility managers should be guided by code of ethics. To stimulate this, the regulator should conduct regular quality reviews and provide feedback to staff from the community verification interviews.
- Ensure that the personal needs and motivation are not neglected. This can be achieved through the more regular payment of the subsidies and by the regular coaching on financial management whereby enough reserves are set aside for the rainy days.
- The Regional Delegation of Public Health should regularly update the list of accredited sources of drug procurement. They should also make surprise visits to these sources for drug quality control. Samples of their product could equally be collected for quality control.
- The District Health Authorities should make efforts to conduct their quality reviews by making use of the safer moments during the war.. They should also make surprise visits to the health facility pharmacies and sample out some drug items for quality control. They should control the drug invoices as to verify the source of the medicines and to identify the distributor in how far they are on the list of accredited distributors.
- To health facility managers to supervise the pharmacies regularly and to ensure that perpetrators of parallel sales of drugs are identified and punished. This could be done with the use of the indices tool through performance bonus where a higher mark is allocated for the non-private sale bonus. This is going to reduce the staff individual performance and consequently a lower bonus for him or her if he or she sells drugs in a parallel manner. To ensure this, health facilities should paste up signs to indicate drug prices and that all drugs should be purchased only from the facility pharmacy.
- To the consumers, to ensure that they receive receipts upon consumption of services especially drug sales.
- The government should ensure that subsidies are promptly paid in order to maintain a level of quality in Health Facilities. When the subsidies are promptly paid this will motivate workers at all levels and enhance their individual and collective performance. The timely payment of subsidies could also reduce or completely eradicate the issue of private practice and therefore enhance quality of care in all dimensions.

7.10.7 Action plan

WHAT	HOW	WHO	WHEN
- Present the issue to my Administrator.	- Discussion - Writing	me	17/04/2019
- Present concerns of quality of care in the health facilities in the regional management committee meeting with the recommendations clearly stated. This will enforce the quality reviews at various levels thereby ensuring high quality care in health facilities. - Feedback taken to the Ministry of Finance and payments made more regular.	- By presenting a paper at the Meeting	The administrator of the NWRFHP	24/04/2019
- Present recommendation on consumer's contribution to ensure quality of care - Consumers will then become more knowledgeable and get responsible for their quality of care.	- By presenting a paper at the Meeting	The Director of the NWRFHP	24/04/2019

7.11 Central African Republic Security and Justice Sector

7.11.1 Context

The recent Peace Agreements signed between the Government of Central African Republic and Armed Groups in February 2019 represents a window of opportunity for improving security sector in CAR. Furthermore, all state actors within different sectors continuously receive support from different international institutions in order to improve their duties. Different approaches / tools are applied such as "Performance Based Financing"(PBF) which has proven success within the health & education ministries.

7.11.2 Problem analysis

Providing security is one of the core functions of the state and directly linked to its legitimacy. However, security state actors such as the national police can also be considered to be a threat by their citizens based on their behavior and their way of operating.
In CAR, despite all efforts being made, state security forces are less dedicated to their job and are demotivated due to diverse reasons : low salaries, personnel not educated enough, limited facilities & equipment …etc. This leads to violation of human rights and ineffectiveness in service delivery with a high level of corruption.

7.11.3 PBF feasibility scan

I believe that, developing a pilot PBF approach can resolve some problems faced by the security forces in CAR as well as making them more professional and accountable to communities. Institutions will financially be rewarded on the basis of their performance and will have the autonomy to use the subsidies obtained through PBF, in accordance with agreed business plans. Hence, the feasibility score has been calculated at 28%.

However, there is a need of adapting criteria developed within the PBF health manual to the security sector in order to determine the adequate feasibility score.

7.11.4 Proposed performance indicators

- Number of patrols conducted by Police
- Number of community outreach visits organized by Police
- Number of files transferred to the courts within the legal delay of 48 hours
- % of prisoners transferred within the legal term from holding cells to detention center
- % of sanctioned police harassment cases noticed by the civil society
- % of transferred complaints recorded at the police level
- % of intervention received from the police after people's calls for help

7.11.5 Recommendations

- CORDAID to visit authorities from the Ministry of Interior & Public Security for proposing them a well-designed PBF approach within the Ministry.
- CORDAID to organize PBF trainings for involved staff as well as SCOs.
- CORDAID to sign performance contract with the Ministry of Interior & Public Security & with Civil Society Organizations.

7.11.6 Action plan

ACTIVITY	HOW	WHO	WHEN
Organize a briefing for colleagues from Security & Justice Program (Community of Experts/S&J)	- Skype discussion - PowerPoint presentation on feasibility study & proposed performance indicators - Exchange with colleagues from health program	Flora	May 2019
Mapping of different departments (security forces) composing the Ministry of interior & Public Security	- Organize an informal visit to the Ministry - Identify people to facilitate our introduction (known police staff, UNPOL personnel)	CORDAID-CAR	June 2019
Identify key departments to be targeted for PBF	- Refer to information received from the Ministry	CORDAID-CAR	June 2019
Visit to all stakeholders / advocacy	- Prepare a lobby paper with key added values of applying PBF	CORDAID-CAR	July 2019
Set up a pre- PBF Committee	- Ask the Ministry to nominate people to be part of the pre PBF committee	CORDAID-CAR	August 2019
Mapping of stakeholders + their functions (regulator, provider, CDV, Community voice strengthening, payment agency) within the Ministry of interior & Public Security	- Organize a workshop	CORDAID-CAR & the pre PBF committee members	August 2019
Map / institutional set up	- Organize a workshop	CORDAID-CAR & the pre PBF committee members	August 2019
Share, discuss & adapt the designed PBF program with colleagues (Community of Experts-Security & Justice)	- Participate in a planned workshop for members of the Community of Experts	CORDAID CAR	September 2019
PBF training/teams from the Ministry of Interior & Public Security	- Organize trainings for staff from identified departments	CORDAID-CAR	November 2019

Launch of the design PBF program	- Organize a launch event with participation of all stakeholders (presentation of the PBF program within the Ministry of Interior & Public Security	CORDAID-CAR & the Ministry	1st quarter 2020

7.12 The Netherlands – General Practitioner

7.12.1 Context

The Netherlands is one of the richest countries in the world. Health care is well organized. Expenditure per capita is close to €4.000. Primary care is performed by a variety of health workers, e.g. General practitioners, pharmacists, physiotherapists, midwives etc. In the whole country there is a sufficient coverage of general practitioners. Health care depends heavily on primary care. It makes the system affordable and sustainable. Without primary care patients would have to go straight to the hospitals. With huge costs as a result. With people already spending 15% of their net income on health, the system would get too expensive with no room for other expenditures.

7.12.2 Problem description

This situation of full coverage is now under threat because of the retirement of a large number of GP's in remote areas. Young doctors tend not to be willing to work in those areas. Therefore there is a need to stimulate starting GPs to work in those areas. An extra problem is the giving situation that mostly male GPs, who have full working weeks of 50-60 hours are retiring. This retiring population will majorly be succeeded by young female doctors who tend to work part time, e.g. 25-30 hours a week. With the current situation, to replace one leaving doctor you will then need 2 or 3 doctors to fill the practices. For example, in the south-west region of Holland, Zeeland there will be 58 doctors retiring in the coming 5 years. We estimate that more than 120 doctors are needed to replace them. A smaller problem exist in some of the bigger cities where cost of housing is so expensive that young doctors cannot afford to settle in those areas. To maintain full coverage of primary care doctors in the whole country we need to take action.

Can PBF be a solution?
In PBF there are tools that can be used. E.g. the geographically equity and investment bonus to better motivate younger doctors to move to remote areas.

7.12.3 Feasibility Scan.

The feasibility scan assesses the health system in Holland and even though PBF is not applied, a lot of the PBF principles are put in place in the system.

Criteria to establish in how far the programme is "PBF"	Points	Score
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	4
2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	2	2
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	2
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	0

5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	2
6. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	2
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	2
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	2
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	2
10. Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the FOSA are the signatories.	2	2
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	4
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	2
13. The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2	2
14. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2	2
15. Provider managers are allowed to influence cost sharing tariffs	2	0
16. Provider managers have the right to hire and to fire	2	2
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	2
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	2
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	2
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	2
21. Public religious and private providers have an equal chance of obtaining a contract	2	2
22. There are geographic and/or facility specific equity bonuses	2	2
23. The project provides equity bonuses for vulnerable people	2	2
TOTAL	**50**	**46/92 %**

7.12.4 Killing Assumptions

From the feasibility scan above, the health system in Holland resembles a PBF system, with a score of 46 (92%).

The main issues were:

There are no performance contracts within the ministry and the directorates. However checks and balances are provided by the parliament which has controlling power over the ministry; the minister is answerable to the parliament. Parliament can force the minister to adjust policies and activities in the ministry.
Provider managers are not allowed to influence cost sharing tariffs. Tariffs for consultation and the quarterly payments are set by the central government. They are so calculated that the total sum of primary care in a given year dos not exceed the macro budget. Like this there is no incentive to distinguish your practice from another facilitation in your area.

7.12.5 Recommendations

The following recommendations are proposed to improve the situation as described above in the problem analysis :

- Awaken all actors, by mobilizing the public and sensitizing GP's to take their responsibility and aim to cover the whole country. These actors include the general practitioners, hospitals, council, provincial authorities, health insurance companies, ministry of health and the public.
- Use the geographically equity bonus and investment bonus to stimulate GP's to start their practice in named areas. There is already a system whereby the regular, quarterly payments are increased in so called poor, city areas. This has caused a positive movement towards this areas by young starting doctors. The amount extra is sufficient to employ more workers in the health facilities to deal with the higher demand of services in those areas. On top of that we can use other incentives. E.g. recently provincial authorities in Zeeland have provided so called summer houses to attract doctors to work in summertime in Zeeland. This has resulted in a number of doctors who are going to work there. The idea is that if they experienced this environment they might subsequently settle in that area.
- Pass a motion in the national assembly of general practitioners to extend the already system to more areas.
- Work out the height of the extra payment by the union and representatives from the designated areas; GP's, council members, representative of the dominant health insurance company in that area, and negotiate this with the MoH
- Seek approval from the Ministry of Finance, for a raise in the macro budget spent on primary care.
- Seek corporation with the local health insurance company. The insurance company is having a duty by law to insure sufficient health care in their respective areas. If there are not sufficient primary care health patients have to go to the more expensive secondary facilities.
- Make adjustments to the existing system of postal code pricing. An additional investment bonus can be paid by the local health insurance company and sometimes local authorities such as counsels and provincial administration.

7.12.6 Action plan

What	How	Who	When
Make the equity bonus available for more areas where is more need for influx of general practitioners	Make the public aware of imminent shortage of doctors.	General practitioners in involved areas. Council spokesman. Provincial authorities. Union of GP's. Health Insurance Companies involved	In April.
Make the Union of GP.s adopt this plan. And fight for it.	First propose a motion for this plan in the regional assembly. Then let the regional representative bring this motion to be adopted in the national assembly.	Myself, representative of regional assembly.	Motion to be prepared for the next regional assembly meeting and to be put on the agenda two weeks in advance.
Negations with MoH	After motion is adopted start negotiations with MoH. Macro budget of primary care will be	Representatives of Union and MoH.	After the motion is passed in regional assembly to bring this

	exceeded so political will is essential.		motion on agenda of national assembly meeting.
Define how high the subsidy for underserves areas has to be.	Discuss with representatives union, local GP's and Health insurance companies responsible for those areas to set the tariffs.	See table left.	Discussions can start after motion has been accepted in the national assembly. However preliminary discussions can start on how to implement the incentive.
Implementation of equity bonus in underserves areas.	After agreement by involved parties to make a ruling by National Health Authority to implement the new tariffs.	National Health Authority.	As soon as possible after agreement of proposal.
To introduce an investment bonus for underserved areas.	To influence local councils, provincial authorities and Health regional Health Ins. Comp. to provide these bonuses	See table left and representatives GP's union and MoH	Can start after motion in national assembly has been accepted.