



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

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1. SUMMARY

Le résumé en français du rapport est présenté au chapitre 2 – page 20

1.1 Who attended and village authorities

The 78th international PBF course, organized 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 the 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 the Ministries of Health in Adamawa, Borno, Kebbi, Kwara, Nasarawa, Ondo, and Yobe States.

The Ethiopia team consisted of three participants from the federal Ministry of Health and four from a PBF pilot in Borana Zone, Oromia Region, supported by Cordaid.

The two participants from Cameroon were from the Northwest region; both were already involved in PBF implementation. We welcomed one participant from CAR, who works with CORDAID on security and justice. Two participants from the Netherlands attended: one works at CORDAID's head office in The Hague and is involved in the PBF pilot in Ethiopia, and the other is a senior general practitioner in Holland.

We were honored 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 a 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, a Kenyan psychologist from Mombasa, who assisted the team with daily organization and participant support. And Caroline Atieno, technical assistant.
5. Mr. Tom Njieri, who assisted with logistics, transportation, staff recruitment, and events.

The “Village 78” authorities consisted of the Village Chief, Dr. Omar IBRAHIM; the Deputy Village Chief, Flora KWIZERA; the timekeeper, 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 helped maintain a congenial atmosphere while keeping “order” in the village.

1.2 Evaluation of the course venue and the course

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

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

The daily evaluations yielded scores that were 1.6% above the previous 24 English courses and 6% above the previous French-spoken courses. **Methods and facilitation** scored 87,5%. **Participation** scored 87.2% (the same as the previous courses). **Organization** scored 86.6% (0,3% *above* the previous-course average). **Timekeeping** scored 78,8% (6,2% *above* the previous-course average).

The final evaluation indicated that 88% of participants felt the course content related well to their regular professional activities. Yet only 52% said they were well informed in advance about the course, and some indicated that the course book should have been distributed 1-2 weeks before the course. The fact that some participants' names were only known a week before the course began contributed to this score. Participants were satisfied with the methodology and the organization. In October 2018, 43% of participants thought the course was too short, and no one thought it was too long. For this course, we added one day (Saturday), which reduced time pressure to finalize the action plans and complete the course modules. The extra day was appreciated, and the course duration was appropriate.

1.3 Central African Republic Security and Justice Sector

- Providing security is one of the state's core functions and is directly linked to its legitimacy. However, security state actors such as the national police can also threaten their citizens through their behavior and operating practices.
- In CAR, despite these efforts, state security forces remain demotivated for various reasons, including low salaries, insufficiently trained personnel, and limited facilities & equipment, and are therefore less dedicated to their jobs. This can lead to human rights violations, ineffective service delivery, and corruption.

Recommendations

- CORDAID should meet with authorities from the Ministry of Interior & Public Security to present PBF solutions to some of these problems. A PBF pilot could follow 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.

1.4 Cameroon RFHP North-West Region - problems and recommendations

- Because of the war, quality reviews are not conducted regularly, and some health workers exploit this by buying medicines from unauthorized sources to increase their profits. The socio-political crisis has halted economic activity, leaving many people poor and forcing health workers into private practice, where they try to earn extra money to meet basic needs.
- Delays in subsidy payments further reduce staff motivation.
- Related to this problem, health workers often fail to report certain drug sales and pocket the money privately instead of putting the funds into a common basket. This reduces income for health facilities and creates tensions among staff.
- Low-quality care is linked to counterfeit medicines being available in some health facilities.

Recommendations: Regional Fund for Health Promotion North-West

- Health facility managers should follow the professional code of ethics. To support this, the regulator should conduct regular quality reviews and provide staff with feedback from community verification interviews.
- Ensure that personal needs and motivation are not neglected. This can be achieved through more regular subsidy payments and regular coaching on financial management, so staff can set aside enough reserves for rainy days.
- The Regional Delegation of Public Health should regularly update the list of accredited drug procurement sources. They and the district health authorities should also make surprise visits to these sources to ensure drug quality. They could also collect product samples for quality control.
- District Health Authorities should conduct quality reviews during safer moments in the war. They should review drug invoices to verify medicine sources and confirm whether distributors are on the list of accredited distributors.
- Health-facility managers should regularly supervise pharmacies and ensure they identify and punish perpetrators of parallel drug sales. This can be done by using the indices tool through performance bonuses, with a higher weight given to the non-private sale bonus. This will reduce the staff member's individual performance and, consequently, lower the bonus if he or she sells drugs in parallel. To ensure this, health facilities should post signs indicating drug prices and that all drugs should be purchased only from the facility pharmacy.
- To protect consumers, ensure they receive receipts when they use services, especially for drug purchases.
- The government should ensure subsidies are paid promptly to maintain consistent quality in Health Facilities. Prompt subsidy payments will motivate workers at all levels and improve their individual and collective performance. Timely subsidy payments could also reduce or eliminate private practice and, therefore, enhance quality of care in all dimensions.

1.5 Cameroon CDV Agency North-West - problems and recommendations

The non-submission rate of the indices tool is high, at 35% and 22% for two consecutive quarters. The average score for the quality of use of the indices tool is low, at 38% and 43% for two consecutive quarters. One reason for this poor performance is that, in practice, deputy managers of CDV Agencies conduct coaching activities at best once a year, or not at all, due to security concerns and because they do not reside in the district, unlike the verifiers. Yet CDV Agency verifiers (along with supervisors of district health authorities) are the closest actors to health facilities and the community. Verifiers visit health facilities monthly, allowing regular interaction. It also allows coaching on the indices management tool.

Recommendations CDVA Cameroon

- To the national PBF technical unit, amend the clause that 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. Administer a post-test and select officers who score above 80% for coaching.
- For CDV verification officers, provide regular coaching, and invite the Manager or Deputy for risk-based coaching or coaching on pertinent issues such as conflicts or adherence issues.
- CDVA verification officers should monitor progress on the indices tool submission rate and score.

1.6 Ethiopia - problems and recommendations

Ethiopia is Africa's second most populous country, 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 the fact that 1 in 3 children are chronically malnourished and that the MMR is high, at 412 per 100,000 live births.

Under the Health Sector Transformation Plan, the Federal Ministry of Health identifies Universal Health Coverage (UHC) as a key component, aiming to provide all essential health services to 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 has run a showcase PBF project since 2015 in Borena Zone, Oromia Region, serving 186,000 people with encouraging results, and now aims to expand the PBF program to 1-2 million people in Jimma Health Zone. However, Ethiopia has not yet adopted a full PBF strategy, and the priority is to engage, together with the World Bank, in collectively exploring the feasibility of results-based strategies in Ethiopia, in relation to the three directorates for this exercise.

Main problems

- The PBF feasibility score detailed on pages 78 and 79 of this report is 32-36%, far below the recommended standard of 80%. This means several design improvements are needed to better use PBF's opportunities.
- Provider managers cannot influence cost-sharing tariffs; in our country context, the government has sole authority to set them.
- No freedom to buy drugs. Health facilities must submit priorities to the EPSA, but only when items are out of stock; the EPSA mandates facilities to buy inputs from private accredited distributors.
- Lack of autonomy: health facilities are not autonomous because the Health Care Financing strategy is not yet approved.

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 a total population of 94 million.
- The PBF budget should not fall below USD 4 per capita per year. The required budget for those regions would be USD 22,995,992 for the Special Support region, USD 141,868,004 for Oromia, and USD 13,735,966 for Addis Ababa.
- 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.

1.7 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 become too expensive, leaving no room for other spending. This full-coverage situation is now under threat because many GPs in remote areas are retiring. Young doctors are often unwilling to work in those areas. Therefore, GPs need encouragement to work there. Another problem is that mostly male GPs, who work full weeks of 50-60 hours, are retiring. This retiring population will mainly be succeeded by young female doctors who tend to work part-time, e.g. 25-30 hours a week. Under the current situation, replacing one leaving doctor will require 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 cannot influence cost-sharing tariffs. Tariffs for consultation and the quarterly payments are set by the central government. They are calculated so the total primary care spending each year does not exceed the macro budget. As

a result, there is no incentive to distinguish your practice from another health facility in your area.

Recommendations

- Mobilize all actors by engaging the public and sensitizing GPs to take responsibility and aim to cover the whole country.
- Use the geographical equity bonus and investment bonus to encourage GPs to start practice in named areas. There is already a system in which regular quarterly payments are increased in so-called poor, city areas. On top of that, we can use other incentives. For example, provincial authorities in Zeeland recently provided houses to attract doctors to work in Zeeland in the summer.
- 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 with the union and representatives from the designated areas; GP's, council members, and a representative of the dominant health insurance company in that area, and negotiate this with the MoH
- Seek approval from the Ministry of Finance to increase the macro budget spent on primary care.
- Seek cooperation with the local health insurance company. The insurance company has a legal duty to ensure sufficient health care in its respective areas.
- Adjust the existing postal code pricing system. The local health insurance company can pay an additional investment bonus, and sometimes local authorities such as councils and provincial administrations.

1.8 Nigeria

1.8.1 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. Multiple monopolistic distribution systems run by government and partners; 3. Poor coordination with the private sector; 4. Lack of autonomy of health facilities; 5. Highly centralized human resource policy.
- Several vertical health programs run by the government and partners aim at similar objectives *but lack coordination*. As a result, resources are wasted, and facility-level health workers receive mixed guidance.
- The World Bank currently finances three large, but *conceptually opposing and 'verticalized' projects*: 1. Save One Million Lives; 2. The NSHIP PBF program; and 3. The newly introduced nutrition program ANRiN. Course participants felt these programs should be better coordinated through a unified conceptual framework for implementation to achieve positive reforms in Nigeria.

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

- Change the current input financing towards performance contracting;
- Break the monopolies of the drug management agencies and allow facilities to buy their inputs from accredited distributors operating in competition;

- Inject more funds directly into the health facilities and allow them more decision-making power on the use of public funds instead of leaving the decision-making power 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, of which they are also signatories, and stop transferring revenues to a single treasury account.
- Rethink the single-treasury-account practice, whereby health facilities must deposit their revenues with the treasury, to which they have little access. This runs counter to providing more (financial) autonomy to health facilities.

1.8.3 Change some features of the PBF design in Nigeria

- Domicile the *PBF unit in the Federal and State Ministries of Health* rather than in National and State Primary Health Care Agencies/Boards for better coordination, inclusion of the hospital level, and regulatory oversight 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.

1.8.4 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;

1.8.5 Political update

After the February 2019 presidential elections, Nigeria is currently establishing its federal and state governments for the coming years. The Nigerian government has embraced the Universal Health Coverage agenda, and the current challenge at the state and federal levels is to develop a sustainable proposition for health systems strengthening and health financing that leads to UHC. The federal and state governments are exploring various financing modalities. They are looking at how, for instance, a Basic Health Care Provision Fund, as a percentage of consolidated oil revenues, could contribute to domestic health financing, i.e., primary health care. Other large schemes, based on loans and grants from external partners such as the Saving One

Million Lives program, also factor into the equation. The new state and federal governments, which will take office by the end of May 2019, will need to further integrate and domestically manage the health system, making the next 18 months a crucial policy period in Nigerian health politics. Various Nigerian states represented at the April 2019 course sent senior SOML staff to explore PBF for this debate on integration and UHC. Several of the States present were also implementing the NSHIP and RBF programs in Nigeria and expressed interest in adding further RBF/PBF elements to their policies.

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

1.8.6 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 one, or in Adamawa sometimes 2, PHC centre of excellence that operate 24 hours

Recommendations Adamawa

Advocate and discuss with the Hon. Commissioner of Health the future architecture and financing of the PBF program. Issues to be discussed are:

- Rearrange the State architecture by establishing a Technical Coordination Unit in the MOH for basket funding.
- Coordinate state activities that currently run in parallel but could be integrated into the PBF program, such as SOML and other partners.
- Advocate and lobby the State Government to increase and release budgetary allocations for health funding.

1.8.7 Borno State, Nigeria - problems and recommendations

- Human resource gaps exist across all levels of health facilities.
- Most things are still 'centrally controlled' rather than left to local autonomous management: e.g., recruitment and redeployment are centrally controlled; infrastructural development in the health sector is centralized, including for PBF-contracted facilities; and the supply of drugs and equipment across all health facilities remains centralized.
- NSHIP PBF interventions operate in only 8 of the 27 LGAs in the state. Contracted health facilities include both private and public, primary and secondary health facilities.
- Most stakeholders, healthcare service providers, and the general population have inadequate knowledge of PBF.

- There is a standing committee of traditional leaders on PHC supporting demand creation and social mobilization across the state
- There is a free maternal, newborn, and child health service. However, this does not cover all 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
- Advocate to policymakers on PBF, and sensitize traditional institutions, faith-based organizations, community-based organizations, civil society organizations, and professional bodies.
- Scaling up PBF in other currently non-contracted health facilities across the state
- Make free MNCH services into high-quality, subsidized, user-fee-paid services

1.8.8 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). Services are inefficient, lack quality, and remain difficult to access. Financial accessibility also plays a role due to the dominance of “out-of-pocket expenditure”. Most programs use input-based, vertical, and uncoordinated strategies, leading to duplicated efforts and wasted resources. Facilities depend on the central distribution of inputs such as essential drugs due to the lack of confidence of the Government in other drug sources, especially those from open drug markets.
- Partner contributions in the State are uncoordinated and not aligned with the State's needs and priorities; they introduce different indicator sets and propose different strategies.
- Laws establish Hospital Management Boards, SACA (State Action Committee on AIDS), Primary Health Care Development Agencies, and KECHES (Kebbi Contributory Healthcare Scheme) in the States. Therefore, these organizations may view the introduction of PBF as an attempt to override their functions, and most will struggle to maintain their stance.
- Lack of knowledge of PBF among key stakeholders. As a result, some State policymakers may view the PBF setup as complex because it requires creating new structures, such as CDV agencies, and procedures such as paying for performance instead of inputs, and breaking pharmaceutical suppliers' monopolies. Policymakers may also tend to want to control the supply of inputs.
- Facility managers may not be allowed to spend cash because the 2018 introduction of the Single Treasury Account requires all revenues, including those generated from services rendered by hospitals, to be remitted to the Government, which receives only 70% of the total output.

Recommendations Kebbi

- Advocate with policymakers to adopt the PBF program as a reform strategy and explain how it differs from previous reform approaches that did not achieve 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 a 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 to achieve \$4-\$6 per capita for the catchment population of the State
- Integrate all vertical programs, such as KECHES, which is on the verge of implementation, with the PBF program to achieve individual program goals and ensure sustainability. The two programs can go hand in hand with support from Government, SOML, and donors
- SOML may shoulder responsibility for conducting study tours to some states that are already implementing the PBF program.
- Since some State policymakers may consider the PBF setup complex, the system should innovate by designating KECHES as the CDV agency; backed by law, it can initiate performance payments instead of input payments and break monopolies held by 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 health care facilities in 5 pilot LGAs under the PBF approach from remitting their cost recovery revenues into the treasury single account and instead remit them to the health facility bank account on which the facility operators are signatories.

1.8.9 Kwara State, Nigeria - problems and recommendations

- Weak partner coordination in the State, with partners operating in parallel without government oversight.
- A skills gap exists because Kwara State has too few health professionals.
- Physical facilities are dilapidated, and equipment is insufficient. Yet the SMOH rehabilitates facilities and purchases inputs through centralized procurement.
- The health system remains overstretched by the quickly growing population.
- The data generation system is inadequate, leading to weak evidence-based planning, policy formulation, and health systems management.

- Kwara State originally adopted a Community Health Insurance Scheme (CHIS), but it covered less than 5% of poor rural dwellers and included several input-financing elements. The scheme was voluntary. Compared with similar schemes elsewhere, these schemes have performed poorly. The scheme stopped in 2014 due to low uptake and bankruptcy. It prompted the government to enact a law on a mandatory health insurance scheme, which is still in its pre-implementation phase. This institutional setup for an obligatory insurance scheme could work, but it should be strengthened by introducing PBF within the scheme to ensure service quality, build strong verification mechanisms, and control costs by paying subsidies within the available budget.
- Skilled staff per 1000 inhabitants is 1:2070 (the standard is 1:1000), with over 60% in urban areas.

Recommendations Kwara

- Better coordination of all partners' activities
- Per-capita annual expenditure, based on state health expenditure, has consistently been below \$3. Therefore, the State must make funds available in its budget to fund 20% of the project. User fees will also be introduced for cost recovery purposes and to allow managers to handle cash.
- The SOML unit can be given responsibility for functioning as the PBF unit; hence, it 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 a pilot will be conducted in 3 LGAs.

1.8.10 Nasarawa State - problems and recommendations

- There is a considerable human resources gap in terms of quantity, skills, and attitude.
- Service providers and the community have inadequate knowledge of PBF.
- Non-PBF-accredited health facilities have poor infrastructure.
- Both NSHIP and SOML are externally funded, but this funding will probably stop by 2020. So far, the State government has not contributed to the PBF budget. Therefore, the PBF program faces a serious sustainability problem.
- The National PBF Unit is *not* sufficiently integrated into the State Ministry of Health to coordinate all health system activities in the State, including the Directorates and the Health Programs. Moreover, the current PBF setup leads to sustainability problems because only a setup through SMOH could make PBF nationally financed.

- Existing government funds mainly finance inputs rather than purchasing performance from different health actors. Government fund 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. Only contracted staff in PBF health facilities have autonomy.

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.
- Sustainable PBF financing should be planned for the 361 PBF health facilities that lost 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, 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 the population.

1.8.11 Ondo State - problems and recommendations

Conflict between the ministry and the agencies.

Conflict exists between the Ministry of Health and its agencies, including the Ondo State Primary Health Care Development Agency and the Hospitals Management Board. This results from overlapping roles and responsibilities.

Human resources gaps in quantity, skills, and attitude.

Non-PBF-accredited health facilities have an inadequate number of skilled health personnel. Health personnel attitudes are also unsatisfactory, leading to poor-quality services.

Some stakeholders have inadequate knowledge of PBF.

There is inadequate knowledge of PBF among some stakeholders in the health sector. Although PBF is operational in the State, knowledge remains inadequate in areas the program does not cover. PBF operates in 9 of the 18 Local Government Areas in the State and in 289 of the 302 Primary Health Care facilities. 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.

All PBF-accredited health facilities have undergone structural upgrades, whereas non-PBF-accredited facilities have poor infrastructure.

Inadequate budgetary allocation and budget release to health.

Budget allocation for health is usually inadequate in the State, and budget release is poor. For instance, the State Health Budget was 12% of the Total State Budget in 2018. Although this was below the recommended 15%, the State released less than 40%. Moreover, more than 70% of the State health budget is on personnel. Some players in other sectors believe Health is not the only sector in the economy and that other sectors also need funds; they also argue that the health sector has many partners supporting its programs and therefore does not need extra funds, and that it does not generate revenue. They have not considered 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.

Sustainability of the PBF program in the State.

The NSHIP that funds the PBF program in the State is an external fund and has a limited lifespan. A sustainability problem will arise when the PBF scheme ends as a 'project'. PBF Unit is in the State Primary Healthcare Development Agency, a parastatal of the Ministry. This has created many regulatory issues. For any health program to be sustainable, it must be instituted at the highest level of the health system hierarchy.

Inadequate coordination of partners.

Partners still run input systems and fund similar programs, leading to duplicated efforts and significant waste of resources.

Recommendations Ondo

- Institution of PBF in the Ministry of Health.
- Scale up PBF to all health facilities.
- Definition of roles and responsibilities
- 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 the populace about PBF.

1.8.12 Yobe State - problems and recommendations

- Human Resources for Health has gaps across all levels of health facilities.
- Centrally controlled recruitment and redeployment is an issue
- Centralized infrastructural development in the health sector, including for the PBF contracted facilities
- Centralized supply of drugs and equipment across all health facilities is
- Inadequate knowledge of PBF among most stakeholders, healthcare service providers, and the general population.

Recommendations for Yobe State

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

2. RÉSUMÉ EN FRANÇAIS

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 78^e cours international PBF, organisé par SINA Health à Mombasa, au Kenya, a accueilli 26 participants de cinq pays : quatre africains (Nigeria, Éthiopie, Cameroun, RCA) et un 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 animateurs d'énergie, Baba Laminu, Abubakar Abana et Mekdelawit Mengesha.

Ils ont activement soutenu le processus de facilitation et ont contribué à instaurer 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 Hôtel, qui offrait une ambiance à la fois professionnelle et agréable. Cela justifiait des frais de scolarité plus élevés pour la 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 de visas sans faille. Les contributions du Kenya au cours se sont approfondies grâce aux relations chaleureuses avec les autorités sanitaires du « County » de Kilifi et à la visite spéciale de la première dame de Kilifi. Et par le biais de plusieurs tâches supplémentaires pour le partenaire local, Tomasi, ainsi que pour 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 la méthodologie ont obtenu un score de 87,5 % (identique à celui des cours précédents). La participation a atteint 87,2 % (identique à celle des 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 en lien avec leurs activités professionnelles habituelles. Pourtant, seulement 52 % ont déclaré être bien informés à l'avance du cours, et certains ont indiqué que le livre

du 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. Lors du cours précédent d'octobre 2018, 43 % des participants estimaient que le cours était trop court, et personne ne pensait qu'il était trop long. Ce cours a ajouté un jour (le samedi) à sa durée, ce qui a mieux fonctionné pour réduire la contrainte de temps liée à la finalisation des plans d'action ainsi qu'à la réalisation des modules du cours.

2.3 Résumé des plans d'action des groupes du coût

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 est directement liée à sa légitimité. Toutefois, les acteurs de l'État de sécurité, tels que la police nationale, peuvent également être perçus 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 formé, infrastructures et équipements limités, etc., et sont donc moins dévouées à leur travail. Cela conduit, dans certains cas, à la violation des droits de l'homme et à une prestation de services inefficace, avec un niveau élevé de corruption.

Recommandations

- CORDAID doit se présenter 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 (d'output, de qualité et d'équité géographique). Des enseignements peuvent être tirés d'une approche PBF similaire, également mise en œuvre par Cordaid en République démocratique du Congo.

2.3.2 Cameroun RFHM Nord-Ouest - problèmes et recommandations

- En raison de la guerre, les revues de la qualité ne sont pas effectuées régulièrement, et certains agents de santé en profitent pour acheter des médicaments auprès de sources non autorisées afin d'accroître leurs profits. La crise sociopolitique a freiné les activités économiques, rendant de nombreuses personnes pauvres et obligeant les agents de santé à exercer dans des cabinets privés, où ils tentent 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 faible motivation du personnel.

Recommandations du 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 régulation devraient

procéder à des revues régulières de la qualité et fournir au personnel un retour d'information issu des entretiens de vérification menés auprès de la communauté.

- Assurez-vous que les besoins personnels et la motivation ne soient pas négligés. Cet objectif peut être atteint par des versements plus réguliers des subventions gouvernementales et par un suivi régulier de la gestion financière, qui prévoit des réserves suffisantes pour les jours de pluie.
- La délégation régionale de la santé publique devrait mettre à jour régulièrement la liste des sources d'accréditation pour les achats de médicaments. Elles et les autorités sanitaires du district devraient également effectuer des visites in situ de ces sources afin de contrôler la qualité des médicaments. Des échantillons de leurs produits pourraient également être prélevés pour des contrôles de qualité en laboratoire.
- Les responsables des établissements de santé doivent superviser régulièrement les pharmacies et s'assurer que les auteurs de ventes parallèles de médicaments sont identifiés et sanctionnés. Pour ce faire, l'outil des indices utilise des bonus de performance qui accordent une importance accrue au bonus de vente non privée. Cela va réduire les performances individuelles du personnel et, par conséquent, lui accorder une prime plus faible s'il vend des médicaments en parallèle. Pour ce faire, les établissements de santé doivent afficher des pancartes indiquant le prix des médicaments et précisant 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 prestation de services, notamment lors de l'achat 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 versés 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, par conséquent, 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 % puis de 22 % consécutivement pendant deux trimestres. L'une des raisons de cette faible performance est que les directeurs adjoints des ACV mènent leurs activités de coaching au mieux une fois par an, voire pas du tout, pour des raisons de sécurité et parce qu'ils ne résident pas dans le district, contrairement aux 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 avec elles. Cela permet également d'accompagner l'outil de gestion des indices.

Recommandations pour les ACV du Cameroun

- À la Cellule Technique Nationale PBF, pour modifier la clause stipulant que seul le coaching dispensé par le coordinateur ou son adjoint est payable.
- Aux responsables des ACV : Organisez une formation pour les agents de vérification ACV sur l'outil des indices et les techniques de coaching. Un post-test 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 assurer un coaching régulier sur l'outil d'indices et le plan d'affaires, et le coordinateur ou son adjoint de l'ACV devrait effectuer une contre-vérification fondée sur le risque ou sur des questions pertinentes, telles que les conflits d'intérêts 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 de santé en Éthiopie se sont améliorés au cours des 25 dernières années. Il subsiste cependant des problèmes importants : un enfant sur trois souffre de malnutrition chronique et 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, sans distinction de situation financière. Dans le cadre de cette stratégie globale, le financement basé sur la performance (FBP) est mentionné dans le document relatif à la politique nationale de financement de la santé. Cordaid mène un projet pilote PBF depuis 2015 dans la zone de Borena, dans la région d'Oromia, auprès d'une population de 186 000 habitants, avec des résultats encourageants. Il vise, en 2019, à étendre le programme PBF à une population plus importante, estimée 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 priorité est de s'engager avec la Banque mondiale pour explorer collectivement la faisabilité de stratégies axées sur les résultats en Éthiopie, en lien avec les trois axes de cet exercice collectif.

Problèmes

- Le score de faisabilité du PBF, détaillé aux pages 78 et 79 du présent rapport, se situe entre 32 et 36 %, soit bien en deçà de la norme recommandée de 80 %. Cela signifie que plusieurs améliorations de conception sont nécessaires pour tirer au mieux parti des opportunités offertes par le PBF.
- Les responsables des établissements de soins ne peuvent pas influencer les tarifs de partage des coûts ; dans notre pays, seul le gouvernement est habilité à les fixer.

- Absence de liberté d'achat des médicaments. Les établissements de santé doivent soumettre leurs priorités à l'EPSA, mais uniquement en cas de rupture de stock ; l'EPSA impose aux établissements de s'approvisionner auprès de distributeurs privés agréés.
- Manque d'autonomie : les établissements de santé ne sont pas autonomes, car la stratégie de financement des soins de santé n'a pas encore été approuvée.

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 portant sur un pilote potentiel, avec une population cible sélectionnée parmi 3,4 millions d'habitants d'Addis-Abeba (zones urbaines), 5,7 millions d'habitants en Somalie et 35,5 millions d'habitants en 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, à 142 millions USD pour Oromia et à 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 fédéral de la Santé, avec le soutien du gouvernement néerlandais et de Cordaid: réviser 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 problèmes : 1. Planification et financement centralisés des intrants ; 2. L'existence de multiples systèmes de distribution monopolistiques du gouvernement et de ses partenaires ; 3. mauvaise coordination avec le secteur privé ; 4. Manque d'autonomie des établissements de santé ; 5. Politique des ressources humaines hautement centralisée.
- Plusieurs programmes de santé verticaux du gouvernement et de ses partenaires visent des objectifs similaires, mais manquent de coordination. Ainsi, les ressources sont gaspillées et orientent différemment les agents de santé au sein des établissements.
- La Banque mondiale finance actuellement trois grands projets, mais qui sont conceptuellement opposés et « verticalisés » : 1. Safe One Million Lives ; 2. Le program NSHIP PBF ; 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 leur mise en œuvre, afin 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 publiques ;
- Permettre aux structures de santé d'ouvrir leurs propres comptes bancaires, dont elles sont également signataires, et mettre fin à la pratique consistant à transférer les revenus vers un compte de trésorerie unique.
- Repenser la pratique du compte unique du Trésor, selon laquelle les établissements de santé doivent déposer leurs recettes auprès du Trésor auquel ils ont peu accès. C'est l'inverse, qui consiste à accorder davantage d'autonomie financière aux établissements de santé.

2.4.3 Modifier certaines caractéristiques du montage PBF au Nigéria

- Domicilier une Cellule Technique PBF auprès des ministères de la Santé fédéraux et des États, plutôt que dans les « National and State Primary Health Care Agencies / Boards », afin d'améliorer la coordination, d'inclure le niveau hospitalier et d'impliquer les acteurs de la réglementation, et 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 n'importe quel 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 du Gombe, qui n'a commencé qu'en 2017 mais montre des signes prometteurs d'amélioration, afin de les mobiliser pour le plaidoyer.
- Présenter ces résultats au Conseil national de la santé, à la Commission de planification nationale.
- Encourager les autorités des États à faire de l'approche PBF la réforme privilégiée pour atteindre la couverture sanitaire universelle ;
- Intégrer les différents programmes verticaux dans une stratégie de santé harmonisée, conformément aux meilleures pratiques du PBF.

2.4.5 Mise à jour politique du 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 du financement de la santé afin d'atteindre 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, exprimé 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, financés par 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 prendront fonction d'ici la fin du mois de mai 2019, devront tous se tourner vers une intégration et une gestion nationale du système de santé plus poussées, ce qui transformera les 18 prochains mois en une période décisive pour la politique de la santé au Nigéria. Plusieurs États nigériens, représentés en avril 2019, avaient envoyé des cadres supérieurs de la SOML pour 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 des programmes NSHIP et 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 de première intention, les patients seraient contraints de se rendre directement à l'hôpital. Avec des coûts énormes à la clé. 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 désormais 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 de travail complète de 50 à 60 heures, prennent leur retraite. Les jeunes femmes médecins ont tendance à travailler à temps partiel. 25-30 heures par semaine. Compte tenu de la situation actuelle, pour remplacer un médecin sortant, vous aurez besoin de 2 ou 3 médecins pour assurer le service dans 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 exercer dans des zones défavorisées. Il existe déjà un système par lequel les paiements trimestriels réguliers sont augmentés dans les zones urbaines dites pauvres. De plus, nous pouvons recourir à 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 dans la province pendant l'été.
- 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 acteurs concernés ;
- Demander l'approbation du ministère des Finances pour une augmentation du budget global alloué aux soins primaires.
- Rechercher des collaborations avec les compagnies d'assurance maladie locales. La loi impose à la compagnie d'assurance de fournir un nombre suffisant de soins de santé dans ses régions respectives.
- Adapter le système de tarification existant en fonction du 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 municipaux et l'administration provinciale.

3. INTRODUCTION

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

Performance-based financing has steadily replaced input-based, centrally planned health systems that underpinned the PHC and Bamako Initiative paradigms. Since the late 1990s, PBF initiatives and pilots, formerly known as the contractual approach, have been gradually introduced in around 40 countries worldwide. A few of them, such as Rwanda, Burundi, Cameroon, and Zimbabwe, have adopted PBF as national policy. Other countries are in the process of making PBF their national strategy. As part of a focus on universal health coverage, 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 Afghanistan, Tajikistan, the Kyrgyz Republic, and Laos.

There is little controversy around the main theories and concepts of 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 ensure more sustainable systems. Its effects on transparency, good governance, and ownership are comparable to the top-down and hierarchical styles of many existing (health) systems.

PBF has proven effective in improving care quality by using a mix of revenues, such as public subsidies and cost sharing. PBF also developed standards for the revenues and staff per capita required to deliver a full package of good-quality health and education services. This implies that health facilities (or entities in other 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 of 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. In most circumstances, increasing provider revenues will also require maintaining direct fee-paying by patients and parents. This will inevitably constitute financial access problems for the very poor. Hence, we need to include demand-side support for the vulnerable in the design of new PBF interventions, such as 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 improve the population's health status and educational level by providing accessible, equitable, high-quality services while respecting the free choice of public & private providers and making rational, 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 want to be change agents, are looking for improvement tools, and who, once they understand their roles, can serve as implementers, advocates, and guides in executing performance-based financing.
- To help participants understand the relationships between health and national economic policies, the potential for economic multiplier effects, and how performance-based financing influences them.
- To help participants 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 the 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 to participants before the program started, upon confirmation of participation. The course materials (a hard copy of the course book, a PDF of the latest version of the course manual, PowerPoint presentations and country presentations, course photos, and articles) were distributed during the course, along 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 score 53% or more receive a Certificate of Participation. The exam for this course was held on Saturday, April 13th, and consisted of 30 multiple-choice questions tailored to the main subjects covered during the course.

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

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

Three participants deserved a “merit-mention” with scores of 80% or 83%, while six participants scored below 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 Ethiopia, 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 the Dutch Parliament and Director of Cordaid. Currently working as a senior health systems and governance consultant for WHO and the 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, Logistics Coordinator from Kenya
5. Mrs Caroline Atieno, Logistics Assistant from Kenya
6. Mr. Tom Njieri, General Logistics, Transportation and Events.

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. Timekeeping.

The overall average score for the four criteria combined was 85,0%. This is 1.6% *above* the previous 24 English-taught courses and 6.0% *above* the previous 44 French-taught courses.

Daily evaluation topics as scored for 10 days	French speaking courses (44x)	English speaking courses (24x)	Mombasa April 2019	Comparison Mombasa April 2019 / Previous 24 English courses	Comparison Mombasa April 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 averaged 87.5%, the same as the previous 24 English courses (87.5%) and 2.5% above the average for the French-taught courses (85.0%). Satisfaction with the methods and facilitation remained around 90%, except for D1 and D6.

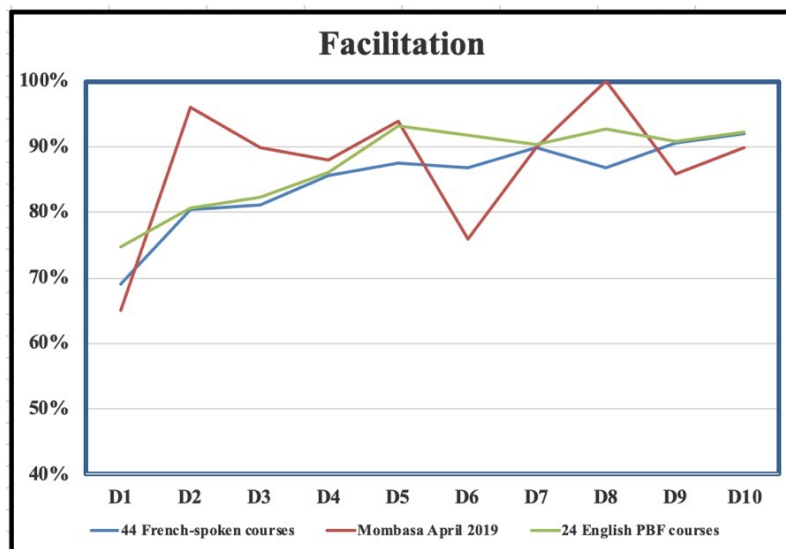


Figure 1: Evolution of the daily evaluations: *methods and facilitation*.

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%).

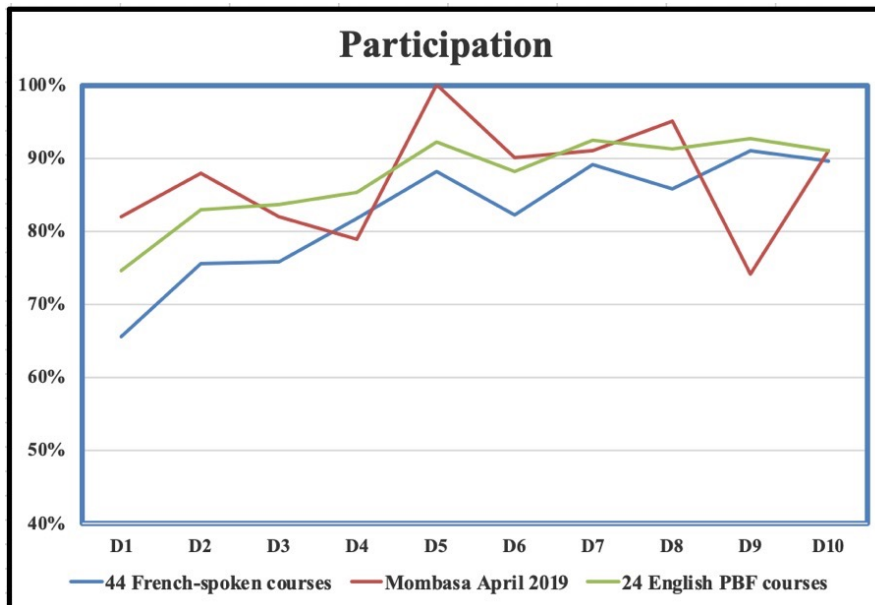


Figure 2: Evolution of the daily evaluation: *participation*.

4.4 Organization

The **organization** of the course in Mombasa had an average score of ‘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 in the second week to a low of 76%. This was due to the power failure that took a couple of hours to solve. The hotel was generally rated excellent, and the cooks even prepared *very hot Nigerian* food.

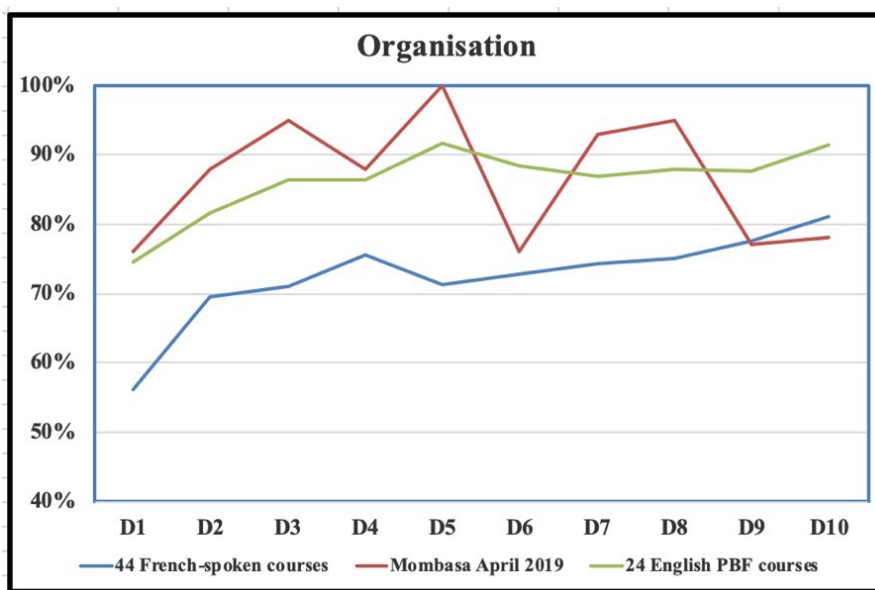


Figure 3: Evolution of the daily evaluation: *organization*.

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.

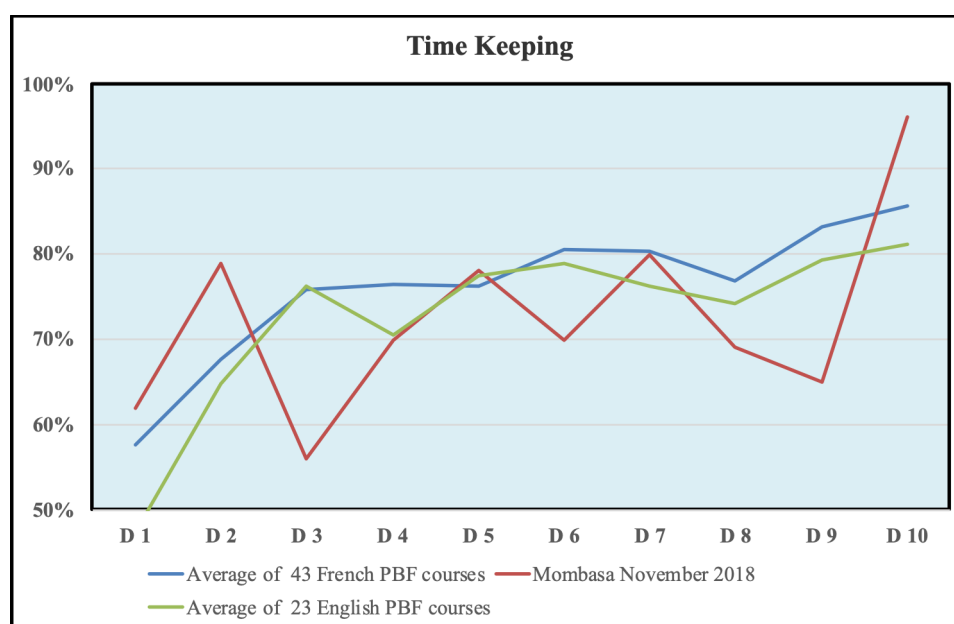


Figure 4: Evolution of the daily evaluation: *time keeping*.

5. DESCRIPTION of the COURSE

Arrival day: Sunday, March 31st, 2019

Daily Recaps

During this course, facilitators created daily recaps through structured question-and-answer sessions in PowerPoint, highlighting the previous day's key messages. This gave participants more evening time to study and work on the course's main output: their action plans.

This methodology proved effective, especially in emphasizing the key messages of the modules.

Daily Evaluation and Feedback from Participants

At the end of each day, participants were encouraged to provide written feedback during the daily evaluation to help facilitators and the hotel improve course quality and address any problems they faced.

Every morning, participants received feedback on how far the issues they raised had been resolved (“feedback on their feedback”).

Facilitators’ Meeting

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

Evening Sessions

Evening sessions with country groups were organized, allowing one-on-one dialogue with facilitators to understand country specifics, including challenges and the way forward on action plans. During the first week, facilitators met with 2 or 3 country groups each evening to get to know the participants better, understand their work, gather their impressions of the course so far, and discuss developing their action plans. During the second week of the course, the group exercises within the modules were organized to be 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 enough time 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, organized by SINA Health in Mombasa, Kenya, welcomed 26 participants from 5 countries, including 4 African countries (Nigeria, Ethiopia, Cameroon, CAR) and one European country, the Netherlands. All participants arrived on Sunday, 31 March, and were warmly welcomed by the facilitators and the hotel.

Most participants came from the health sector, but the facilitation team was also pleased to welcome one participant from CAR's security and justice sector.

Other participants came from various ministries of health at national and sub-national levels; government parastatal agencies; Cordaid (Ethiopia and the Netherlands), which implements PBF in parts of Ethiopia; and a private-sector general practitioner from 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 completed a pre-course questionnaire so facilitators could tailor the course content to their needs. The course book was also distributed, so participants began studying immediately.

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

Monday April 1st

All participants arrived by 9:00 am, and the program began with registration and distribution of the course agenda. Dr. Godelieve Van Heteren then welcomed the participants, after which she presented the course outline and training methodology so participants would have a feel for 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 got to know each other.

The pre-test, comprising 15 multiple-choice questions, was then conducted to test participants' existing knowledge of PBF. The country groups were then established, after which participants broke out to conduct a brief diagnosis of their health systems in terms of cost-effectiveness and whether they thought PBF could address challenges they face in carrying out their respective duties. In total, 11 country groups were established, with the possibility of splitting some groups further if they were not homogeneous.

During the course's first exercise, most participants rated their health systems as moderately inefficient, meaning health indices in most countries remain poor despite

increasing investment in the sector. Some participants were optimistic that PBF could address some of the challenges they face; others were eager to learn more about PBF before drawing such conclusions.

After the feedback exercise, the Mombasa village was established, and the village officials elected to help 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 / Timekeeper:	Mijana
Finance Minister:	Margret and Kees
Energizers:	Baba Laminu, Abubakar Abana and Mekdelawit

Next, Module 1 PBF in the context of the era of UHC, a comparison between Alma-Ata and the Bamako Initiative, and evidence for PBF were presented. Unlike in previous years, this topic generated little discussion. Participants were already convinced that new strategies are necessary to achieve UHC.

The day ended at 17:00 with the daily course evaluation and the selection of the day's best debater. In the evening, from 17:30 onwards, the facilitators met with participants from Kwara State, then Ondo and Nasarawa States, to better understand their specific objectives for being in the course and support them in developing a concrete action plan. Discussions with the Kwara State team focused on health system challenges, as the state has not implemented PBF. The group was, 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 teams already implementing PBF in 50% of their states through the Nigeria State Health Investment Project, discussions focused on integrating health programs and ensuring PBF sustainability, as the current PBF project will wrap up in slightly over a year.

Tuesday April 2nd

The day started at 8:30 am with feedback on the issues raised by participants during Anne's day-one evaluation. Dr Robert provided the daily recap of the main messages from the previous day. Participants reviewed the key messages delivered the previous day, followed by discussion.

After the recap, the pre-questionnaire results were presented. The analysis showed that most participants came from various ministries of health and held regulatory roles. Most members expected to understand PBF better, including its theories, best practices, tools, and applicability in conflict or war situations. This exercise helped facilitators tailor the course to the group's specific needs.

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 discussion, as expected, as participants related to the challenges some of these change issues may pose. Participants agreed that, in principle, the changes are necessary, but implementation may be challenging.

As part of Module 3, the topic of " Equity " was also 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.

In the evening, from 17:30 onwards, facilitators met with participants from Yobe, Borno, and Kebbi States (Nigeria). Discussions focused on integrating vertical health programs and better coordinating partner support for health.

Wednesday April 3rd

The day started at 8:30, with Anne presenting feedback on the issues participants raised during the evaluation. Robert then facilitated the daily recap, highlighting the key messages from the previous days' interactions.

Godelieve then presented Module 4 on PBF theories (systems analysis, public choice, contracting, decentralization, and governance), which took up most of the morning. Module 5A on microeconomics followed. The session presented basic economic principles as a foundation for understanding how markets operate and for relating some concepts to the health care market. Afterward, Module 5B on health economics began shortly before the day ended.

The session closed at 16:30 with the daily evaluation and selection of the day's best debater.

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

Thursday April 4th

Fanen Verinumbe presented the daily recap, after which the health economics module was completed. The module covered opportunity costs, economies of scale and scope, efficiency, various failures in the health market, and how sound economic instruments (taxes and subsidies) can correct some of these market failures in health.

The course received a special visit from the First Lady of Kilifi County, Mrs. Elizabeth Kingi, who welcomed all participants and officially opened the course.

Later in the day, participants were introduced to the module on the roles of various actors/stakeholders in the PBF system, starting with the regulator's role at various levels of the system and how it is organized within PBF institutional arrangements.

The session closed at 16:30 with the daily course evaluation and the selection of the best debater of the day.

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

Friday April 5th

The day started early at 8:15 am with a daily recap of the modules covered the previous day. This was followed immediately by a brief introduction to the terms of reference for field visits by Godelieve and Robert.

The groups then went into the field to visit five Kilifi County facilities for tours 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 group member as facilitator. Facilities varied in size (from dispensaries/health posts to a county hospital), so groups produced different but complementary findings on staffing, financing sources, 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 like feedback received by other groups during previous courses and is summarised below:

- All health facilities received their inputs and equipment from KEMSA, but support from other partners and donors varied. Some facilities could purchase inputs from accredited distributors only if they used internally generated resources and up to a certain amount.
- The procedure of receiving drugs and other inputs from 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 did not meet the required standard of USD 7, with most facilities generating less than USD 4.
- No health facility had the autonomy to set user fees, manage its financial resources, or hire and fire staff.
- Generally, functions were not properly separated.
- 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 was assessed using a suggestion box, direct patient interviews, and feedback through community committees, which was found to be ineffective.

- Most health facilities did not meet the recommended staffing levels of 1 technical staff per 1000 population

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

Saturday April 6th

The morning started at 8:30 with a recap of the previous day's activities.

Module 6B on quality assurance of health facilities was then presented, after which Module 7 on the role of the CDV Agency commenced.

At midday, Module 9 on "PBF project development and feasibility scan" was then presented. As part of this module, participants in their country working groups scored the PBF feasibility matrix, identified killing assumptions, and developed an 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 the best debater of the day. Participants then took a bus ride to Mombasa, including a market to shop for souvenirs and a visit to the historic Fort Jesus, a UNESCO World Heritage Site.

Sunday April 7th

On Sunday, the team traveled through history with Jumba La Mtwana, which told the story of how Swahili sailors lived and traded in Mombasa over 700 years ago. They followed this with exciting beach exercises and games, including beach volleyball and tug-of-war. The day ended with a visit to Haller Park in Mombasa, a reclaimed quarry site with a remarkable history. The park is home to tortoises, hippopotamuses, antelopes, a variety of snakes, buffaloes, and more. Highlights of the visit included feeding 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 team completed Module 7 on the role of the CDV Agency. Afterward, groups were given additional time to complete the feasibility scans and prepare the role plays.

During the role plays, each group identified its most difficult area of change and presented an advocacy for this change. Some groups advocated for changing central procurement of inputs, increasing providers' autonomy to influence cost-sharing tariffs, hire and fire staff, and use revenues at the point of collection. The organizers gave each group feedback on how well they presented the topic, managed their time (5 minutes!), proposed follow-up strategies, and demonstrated strong 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, the group discussed Module 8 on the community's role as a stakeholder in PBF. Facilitators presented two ways the community can be involved in the PBF logic: through social marketing activities and by collecting feedback during client satisfaction surveys. Participants agreed that traditional community involvement methods 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 group work, where participants in their country groups identified the 'last mile' for PBF implementation. In this exercise, participants worked in groups to design 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 improving their action plans.

Wednesday April 10th

After the daily recap, participants completed the conflict resolution module.

This was followed by a presentation of module 12 on the output indicators. The session presented the various quantitative indicators in PBF, including the selection criteria and how targets for each are being established.

Participants were given time to work on their action plans, while facilitators circulated around the groups to provide support.

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

Thursday April 11th

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

Friday April 12th

As the last day of class work, the day started at 8:30 am and was confined to the morning to allow participants to study for the exam. The day focused on presenting the PBF instruments: Module 14 on the "business plan" and Module 15 on the "indices management tool". After the morning coffee break, participants presented the key messages of their individual or group action plans in a poster session. The group then

presented their posters in plenary, with facilitators supporting each group in developing SMART recommendations.

This was a highly interactive session that most participants and facilitators valued.

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, we did not cover Module 11 on baseline and evaluation studies for PBF programs, Module 13 on costing, Module 16 on PBF in emergency, or Module 17 on PBF in Education in class. Participants were encouraged to study these on their own. The overall course evaluation was carried out before the class broke up at 12:45 to work on finalizing their country action plans, and for general revision in the afternoon to prepare for the exam.

Saturday April 13th

The exam day started at 8:00. 26 participants took the final exam.

From 9:30 onward, we reviewed the exam. At 12:00, a ceremony handed out the certificates, giving the 3 participants who needed to travel home time to get to the airport.

In the evening from 20:00, a dinner was organized 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 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 “the 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.

Participants’ appreciation of the methodology and content scored 93%, 5% above the average for previous English courses and 10% above the average for previous French courses. The criterion “content helped me to attain my objectives” scored 93%, “methodology” scored 90%, and 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 of general impressions of participants in different PBF courses.

6.2 Appreciating the duration of the course

In October 2018, 43% of participants thought the course was too short, and no one thought it was too long. For this course, we added one day (Saturday) to the course duration, which helped reduce time pressure to finalize the action plans and complete the course modules. This time, 92% of the participants thought that the course duration was about right. We conclude that adding 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 (77%) and 25% *above* the 43 previous French courses. The conference center (96%) and the food (96%) scored 21% and 34% higher, respectively, than the previous courses. The lecture room scored 100%, and the friendliness of the hotel staff and the facilitation team scored 96%. Transportation scored 92%. The educational material quality 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 of how open-minded facilitators were scored 88%, 4% *above* the average of previous English-speaking courses. Satisfaction with the time allocated for group work was 100%, 23% *above* the previous courses, confirming that the extra day added to the course duration was appreciated (in October 2018 this score was only 67%). Participants rated time for discussions at 90%, 13% above the average for previous English courses, confirming that adding 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

Mombasa participants rated overall satisfaction with the course modules highly, at 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 scored 100%, including the first-day modules: “What is PBF?”, “negotiation techniques & conflict resolution”, “community voice empowerment & social marketing,” and the “PBF feasibility scan” module. Economics scored relatively lower this time, at 79%, as did the module “business plan and the individual action plan” at 84%. We did not evaluate the “baseline studies” and “costing” modules because they were not presented during the course.

Appreciation 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 should be supplied in advance (2-4 weeks). This will give more time for the theories to sink in and for 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 organized for specific areas like education and administration

Course book, modules and other course materials

- The principles for applying PBF are general; however, most examples and exercises focus only on the health sector. 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
- A 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, a projected population of 4.9 million, and 31 health facilities across 225 political wards. The facilities are 29 General Hospitals and 2 specialized centers. Twenty-seven years after Kebbi State's creation in 1991, successive State governments have made tremendous efforts to improve hospital infrastructure across the State. To improve healthcare at the local government level, the State Primary Healthcare Development Agency was created to implement Primary Healthcare Under One Roof (PHCUOR).

7.1.2 Organization of health system

Health care in Nigeria is administered through three tiers: primary, secondary, and tertiary levels. Local governments manage the primary level, states manage the secondary level, and the federal government manages the tertiary level. State Ministries of Health, State Hospital Management Boards, and Local Government Areas (LGAs) share responsibility for managing health facilities and programs.

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 training health professionals.
- Managing teaching, psychiatric, and orthopaedic hospitals, and running some medical centers.

The States are responsible for:

- Operating secondary health facilities (general hospitals) and, in some cases, tertiary hospitals, as well as some primary health care facilities.
- Training nurses, midwives, and health technicians;
- Provide 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 capacity assessment (human resources, infrastructure, and funding potential) to reach every ward-level facility, training key and relevant staff at the state, LGA, and facility levels, and developing an implementation plan to roll out to all Primary health care facilities.

This will improve access to quality health services for urban and rural communities and build confidence in health facilities for other services, such as routine immunization, IMCI, CORPs, and VCM support.

7.1.4 Financing

The Nigerian health system has several World Bank-financed programs, including SOML (with six indicators and performance contracts with the States), ANRiN (a nutrition program mainly for supplementary feeding), and NSHIP (a PBF program). Other financing comes from the Basic Health Care Provision Fund (BHC PF), which consists of 1% of the Nigerian government revenues.

7.1.5 Problem analysis

- Kebbi State continues to record poor health indices despite considerable contributions from partners (UNICEF, USAID, and the Global Fund). Services are often inefficient, low-quality, and difficult to access. Financial barriers also play a role because of the dominance of “out-of-pocket expenditure”. Partner contributions in the State are uncoordinated and not aligned with the State’s needs and priorities.
- Patients receive poor-quality care in the hands of quasi-spiritual healers and dubious non-orthodox healthcare attendants.
- Most programs use input-based, vertical, and uncoordinated strategies, leading to duplicated efforts and wasted resources.
- Several programs are donor-driven, and partners introduce different indicator sets and propose different strategies.
- Laws establish Hospital Management Boards, SACA (State Action Committee on AIDS), Primary Health Care Development Agencies, and KECHES (Kebbi Contributory Healthcare Scheme) in states. As a result, these organizations may view the introduction of PBF as an attempt to override their functions, and most will struggle to maintain their stance.
- Lack of knowledge on PBF among key stakeholders;
- Some State policymakers may view the PBF setup as complex because it requires new structures, such as CDV agencies, and new procedures, such as payment for performance instead of inputs, as well as breaking monopolies held by pharmaceutical suppliers. Policymakers may also tend to want 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 program must go hand in hand with other programs still being implemented, 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 lack of confidence of the Government in other drug sources, especially those from open drug markets.
- Facility managers may not be allowed to spend cash because, in 2018, the Government introduced the Single Treasury Account for all revenues, including those generated from services rendered by hospitals, of which the Government remits only 70% of the total output.

Yet despite these problems, the question of 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 principles to redirect funding for various health interventions using the PBF approach to address most of the problems

and inefficiencies recorded in the various health programs. Because of its flexibility, the SOML can support a feasibility study on the PBF program. The results can convince stakeholders to start a PBF program in Kebbi State.

The SOML program is flexible, is directly managed by the Ministry of Health, and can implement the PBF approach. However, current SOML funding is unstable because once a target is achieved, no further progress unlocks new funding. For example, Borno State earned USD 3 million, while Kebbi State earned only USD 160,000. Moreover, the latter amount has not yet been received. In PBF, health facilities and other stakeholders receive performance-based payments for high-quality activities; 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 for introducing the PBF approach is to pair it with Kebbi State's KECHES program. This Kebbi Contributory Healthcare Scheme (KECHES) is another name for what, in other states, is the State Social Insurance Scheme. Yet, from an Islamic perspective, citizens cannot insure themselves; they can only 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

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 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 protocol" to be applied by all primary level principal contract holders.	2	0	2	The PBF program will contain the community indicator "visit to household 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 assures 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 allows to measure the impact of the program.	2	0	0	This might only be possible when the programme picks 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 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 to policymakers for acceptance of the PBF program as a reform strategy and explain how it differs from previous reform approaches that did not achieve the desired objectives, such as 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 to achieve \$4-\$6 per capita for the catchment population of the State
- Integrate all vertical programs, such as KECHES, which is on the verge of implementation, with the PBF program to achieve individual program goals and ensure sustainability. The two programs can go hand in hand with support from Government, SOML, and donors
- SOML may shoulder responsibility for conducting study tours to some states that are already implementing the PBF program.
- Since some State policymakers may consider the PBF setup complex, the system should be innovated by designating KECHES as the CDV agency; backed by law, it can initiate performance payments instead of input payments and break monopolies held by 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 health care facilities in 5 pilot LGAs under the PBF approach from remitting their cost recovery revenues into the treasury single account and instead remit them to the health facility bank account on which facility operators are signatories.
- Prepare a Memo to the National Council on Health to advocate for a National Policy on PBF which all states are obliged to implement

7.1.9 Action plan

This action plan focuses on addressing coordination issues with government agencies, policymakers, and partner organizations, and on providing, through the PBF program, an efficient, quality-oriented implementation framework.

How	Who	When
<ul style="list-style-type: none"> - 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 (e.g. UNICEF, USAID/GHSC-PSM) 	Advocacy team (those that attended the PBF course)	3 rd week April
<ul style="list-style-type: none"> - A draft information memo will be drafted for HCH to present at the SEC. This includes the copy of the course content with an attached Executive summary. 	PM	4 th Week April

Also, the requirement in term of funding to make a budgetary provision for a quick off the pilot PBF Programme in some selected health facilities (both Secondary and Primary Health facilities).		
- 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	2 nd 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)	4 th Week June
- Engage PBF consultants, if necessary, to work with Ministry appointee for the PBF and support its implementation	TCG	3 rd quarter 2019
- Orientation training of stakeholders to adapt the PBF institutional set up in the State	TCG	3 rd quarter 2019
- Orientation training for relevant Stakeholders (at facility level)	TCG	3 rd 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	4 th 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	4 th 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 in the North-Eastern part of Nigeria with an estimated population of 3.8 million. It has 17 LGAs and 178 political wards. The state has 556 PHC facilities, 13 secondary Health facilities, and 3 tertiary Health facilities. The state allocates 15% of its annual budget to the health sector, in line with the Abuja Declaration. The Budget performance is usually appreciable, with 50%-60% being released on an input-financing basis. The state health sector is also being funded by the Saving One Million Lives Program (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 formulating policies and supervising the following parastatal institutions:

1. Hospitals Management Board (HMB) overseeing the secondary health facilities
2. State Primary Healthcare Management Board (SPHCMB) overseeing 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

The ministry and the parastatals have a good working relationship and mutual understanding, with strong leadership and coordination.

The state government shows strong political will and commitment to investing in the health sector.

The state and partners have a good working relationship and coordination.

Maternal, newborn, and child health services are free, though they do not cover all facilities and are still insufficient even for the facilities covered.

There is a 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 are 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 Q2-Q3 of 2019.
- Most stakeholders, healthcare service providers, and the general population have inadequate knowledge of PBF.

7.2.4 Problem Analysis

- Human Resources for Health gaps do exist across all levels of the health facilities.
- Centrally controlled recruitment and redeployment.
- Centralized infrastructural development in the health sector, including for the PBF contracted facilities
- Centralized supply of drugs and equipment across all health facilities is
- Inadequate knowledge of PBF among most stakeholders, healthcare service providers, and the 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 allows 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 made 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 HF's 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 policymakers on PBF
- Sensitization of traditional institutions, faith-based organizations, community-based organizations, civil society organizations, and professional bodies
- Scaling up PBF in other non-contracted health facilities across the state
- Make Free MNCH services into high-quality, subsidized, user-fee-paid services

7.2.7 Sources of financing and Sustainability of the program

Sources of funding

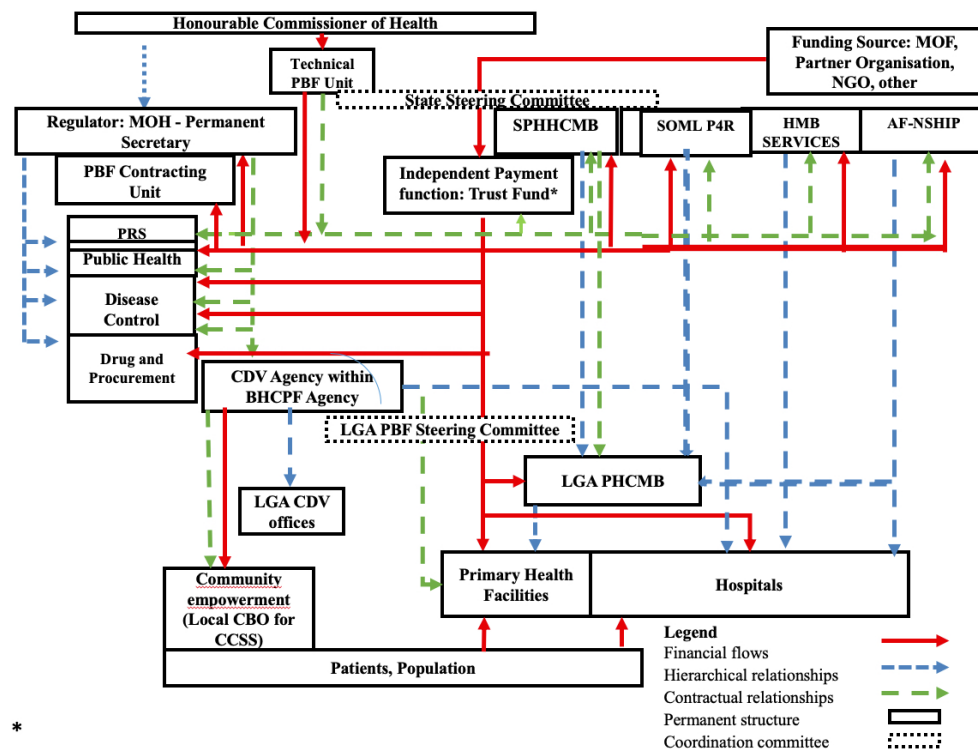
- State Government
- Basic Healthcare Provision Fund
- Nigerian State Health Investment Project (NSHIP)
- Saving One Million Lives Program (SOML)
- Tripartite fund
- Development Partners

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		December 2019	HCH

	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	January, 2020	MOBEP
	III. Development of guidelines on activities of development partners	January, 2020	MOBEP
	IV. Engagement of stakeholders and development partners on PBF central account		
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 in South-West Nigeria, with a population of 3.5 million. The State Health System is headed by the Ministry of Health, which formulates policies and supervises the parastatals: the Hospitals Management Board (HMB) (in charge of secondary health facilities), the State Primary Healthcare Development Agency (SPHCDA), and the State Emergency Medical Service Agency (ODEMSA).

The state has 591 PHCs, 20 Secondary Health Facilities, two Tertiary Health facilities (one owned by the Federal Government), and 256 Private Health facilities. Less than 30% of the private health facilities meet minimum accreditation standards. Health facilities have some autonomy. They can buy some inputs, such as drugs and laboratory reagents, recruit contract staff, and retain revenue.

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

NSHIP is operating PBF in 9 out of the 18 LGAs, covering 289 PHCs, and DFF in 302 PHCs. It has not yet been extended to Private Health Facilities. SOML PforR is in place. The State Health budget is 12% of the State's total budget, but releases are usually low. Budget per capita per annum is more than \$4.

7.3.2 Problem analysis

Conflict between the ministry and the agencies.

The Ministry of Health and its agencies, including the Ondo State Primary Health Care Development Agency and the Hospitals Management Board, are in conflict. This results from overlapping roles and responsibilities.

Human resources gaps in quantity, skills, and attitude.

Non-PBF-accredited health facilities lack adequate skilled health personnel. Health personnel attitudes are also unsatisfactory, leading to poor-quality services.

Some stakeholders have inadequate knowledge of PBF.

There is inadequate knowledge of PBF among some stakeholders in the health sector. Although PBF is operational in the State, knowledge remains inadequate in areas the program does not cover. PBF operates in 9 of the 18 Local Government Areas in the State and in 289 of the 302 Primary Health Care facilities. 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.

All PBF-accredited health facilities have undergone structural upgrades, whereas non-PBF-accredited health facilities have poor infrastructure.

Inadequate budgetary allocation and budget release to health.

The State usually allocates an inadequate budget to health, and budget release is poor. For instance, the State Health Budget was 12% of the Total State Budget in 2018. Although this was below the recommended 15%, the State released less than 40%. Moreover, more than 70% of the State health budget is on personnel. Some players in other sectors believe Health is not the only sector in the economy and that other sectors also need funds; they also say the health sector has many partners supporting its programs, so it does not need extra funds; and that the health sector does not generate revenue. They have not considered 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.

Sustainability of the PBF program in the state.

The NSHIP that funds the PBF program in the State is an external fund with a limited lifespan. A sustainability problem will arise 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 level of the health system hierarchy.

Inadequate coordination of partners.

Partners still run input systems and fund similar programs, leading to duplicated efforts and wasted 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 PBF to all health facilities.
- Definition of roles and responsibilities
- 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 the 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 based on the number of enrollees.

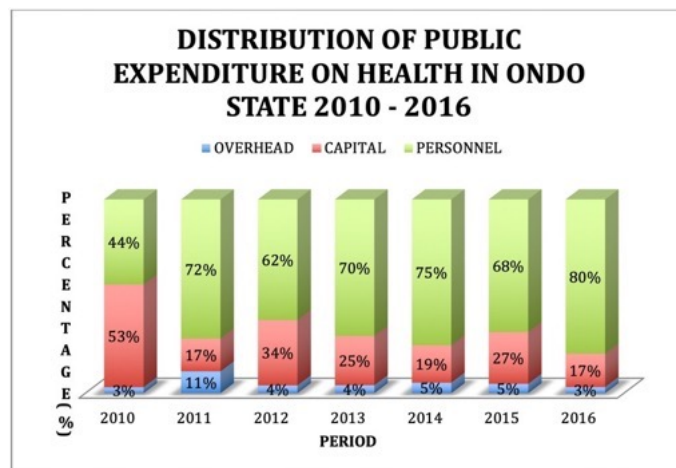
State health budget = ₦7,972,744,768.53 (\$22,146,513.25)
 Total Personnel Recurrent = ₦485,235,6897.00
 Nigerian State Health Investment Project NSHIP = ₦2,327,730,667.46 (\$6,465,918.52) this is already being used to fund PBF in 9 LGAs of the State.

These are available for the PBF Program

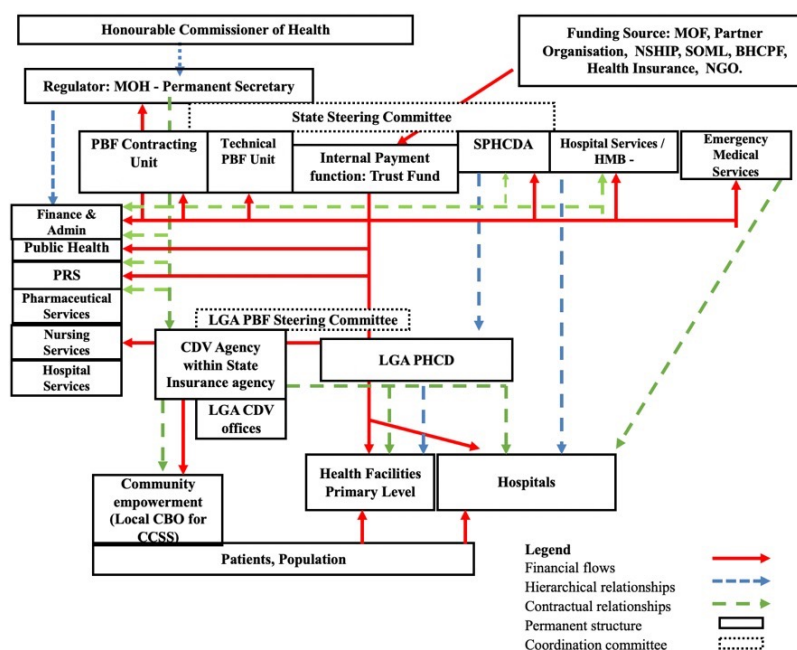
Total State Capital Budget for Health = ₦3,268,000,000.00
 Non-personnel Recurrent = ₦339,235,687.00
 Basic Health Care Provision Fund = ₦1,400,000,000.00 (\$3,888,888.89)
 Direct Payment to Health facilities (user fees) = ₦1,500,000,000.00
 Contributory Health Scheme = ₦500,000,000.00
 SOML PforR = ₦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	3 rd week April 2019	Director Planning, Research and Statistics.
	Dialogue meetings between the MDAs	3 rd week April 2019	Commissioner for Health, Permanent Secretaries MoH, HMB, ES, SPHCDA, ODEMSA, ODCHSC
	Definition of roles and responsibilities	4 th 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.	1 st & 2 nd weeks of May 2019	Commissioner for Health, Permanent Secretaries MoH, HMB, ES, SPHCDA, Heads of ODEMSA, ODCHSC
	Organize conferences and seminars	3 rd & 4 th 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.	1 st – 2 nd 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	2 nd week June 2019	Hon Commissioner and GM, CHSC
	Scale-up PBF to all the health facilities in Phases	1 st 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 appropriate release.	3 rd 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.	1 st - 2 nd 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	1 st - 2 nd week June 2019	Ministry of Health, by the Commissioner
	Put in place an enabling law for the Trust Fund.	1 st - 3 rd 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	3 rd 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 Nigeria's 12 federating units. It is in Nigeria's North Central geopolitical zone. 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 people in the State live in rural areas. The State has 16 Local Government Areas (LGAs), 872 health facilities, and 193 political wards. The State has more than 15 ethnic groups.

Kwara State serves as a gateway between Northern and Southern Nigeria, and many commercial activities take place in the State. Many junction towns and villages in the State serve as stops where long-distance and truck drivers service and refuel their vehicles. This has implications for communicable disease transmission. Major occupations include farming, trading, and public service.

Demographic and geographic features include a scattered, sparse population, especially in rural areas. Several LGAs have nomadic populations. Major ethnic groups include Yoruba, Hausa, Fulani, Nupe, Baruba, Bokobaru, and others, such as Igbo, who settle in the State for economic activities.

Kwara State is mainly a civil-service state, with a few private industries and traders, while the rural population mainly engages in subsistence agriculture. Other sources are from small- and medium-scale enterprises and civil servants. The State has ten institutions of higher learning. Poverty levels have remained high despite significant national economic growth that spanned decades. This reflects the development paradox, where a small proportion of the population lives in great wealth while the vast majority live in great poverty. The poverty, unemployment, and underemployment situation is likely to worsen with the current economic challenges, which will also impact the disease burden, health-seeking behavior, and health service utilization.

Kwara State, tagged as the State of Harmony, has enjoyed a relatively 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 the activities of the Boko Haram Sect.



7.4.2 Kwara State key indicators

In Kwara State, as of 2016, 63% of the population were in rural areas compared with 37% in urban areas. Social determinants of health in the state show that women's literacy in Kwara was 73.5%, above the national average of 59.3%. Similarly, it was 81.0% for men, compared with the 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		
Total population	3,482,024	Projected from 2006 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%	

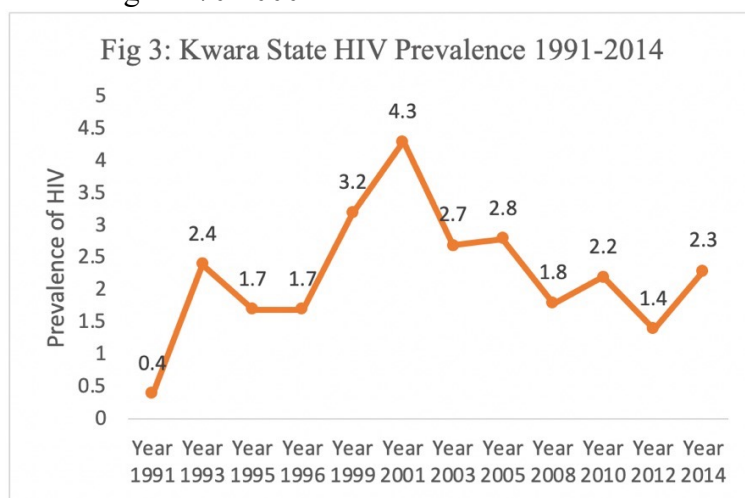
7.4.3 Health status of the population

Women of childbearing age and children less than five years are the most vulnerable in the State, and they constitute 22% and 20 % respectively. The infant mortality rate was 40/1000, while the national rate was 70; similarly, the U5 MR was 45 compared with 120% nationally.

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

Mortality/ morbidity parameter	Achieved	Source
Neonatal Mortality Rate	27/1000	MICS 2016-17
Post-Neonatal Mortality Rate	12/1000	
Infant Mortality Rate	40/1000	
Child Mortality Rate	6/1000	
U5MR	45/1000	
Low birth weight infants		MICS 2016-17
Very small	5.1%	
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 2016-17
Under weight	22.3%	
Stunted	31.5%	
Wasted	9.4%	
Overweight	2.6%	
Infant and young child feeding practices for 6-23 months		MICS 2016-17
% who received minimum dietary diversity	47.5%	
% who received minimum meal frequency	20.8%	
% who received minimum acceptable diet	13.2%	

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



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

The prevalence of underweight decreased 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		MICS 2016-17
An episode of diarrhoea	5.7%	
Symptom of acute respiratory infection	1.1%	
Episode of fever	7.3%	

% 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	30.0%	MICS 2016-17
Becomes sicker	48.8%	
Develops fever	62.0%	
Has fast breathing	32.9%	
Has difficulty breathing	41.8%	
Has blood in stool	26.6%	
Is drinking poorly	20.0%	
Mothers/ caretakers who recognize at least one of the two danger signs of pneumonia (fast/difficult breathing)	62.2%	MICS 2016-17
Immunization coverage		MICS 2016-17
Penta3	49.1%	
Measles	67.0%	
Fully vaccinated	34.0%	
Card seen	20.0%	
% of women who received at least 2 doses of Tetanus toxoid during last pregnancy	50.4%	

7.4.4 Overview of the State health system

The State Ministry of Health (SMOH) coordinates health services, with the Honorable Commissioner for Health as the Chief Executive Officer. Kwara State operates a pluralistic health care delivery system, with orthodox and traditional health care operating alongside each other, though with little collaboration. Both the private and public sectors provide orthodox health care services in the State. Kwara State has 845 health facilities, including private and public facilities. Private health facilities constitute 35% of health facilities and provide 60% of health care services. The State presently has 8,017 bed spaces, with 1 bed per 410 population. More than 60% of the health workforce 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), the bedrock of the national health system, is in a prostrate state because of poor political will, gross underfunding, and a lack of capacity at the LGA level, the main implementing body. SPHCDA coordinates PHC, and each LGA has a PHC Coordinator to provide technical and administrative direction for primary health care activities. Health workers at the LGA level provide primary health care services, available in each of the 193 political wards in the State.

The Hospital Management Bureau (HMB), under the SMOH's coordination, supervises activities of State Government-owned health facilities. This level provides secondary health care and specialized services in the State. The State has one Federal Government-owned tertiary health facility. This provides specialized care, research, training, and community service. This facility has substantial human and material resources and serves as a referral center for many neighbouring states. Research activities in health programs are not supported in the State except those commissioned by partners. This created a vacuum in evidence-based decision-making for health care services.

Development partners support health care delivery services in the State. The World Health Organization (WHO) supports immunization, disease surveillance, epidemic response, and polio eradication. UNICEF supports the State in immunization, maternal and child health, among others. HIV/AIDS program in the State is supported by the World Bank, MSH, FGH, and in collaboration with NACA. Mario Stopes supports the State in family planning programs. 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. Community members and other stakeholders, including NGOs and CSOs, were involved in health care services at various levels in the State.

Community involvement in health care was active at the time, but their involvement has withered over time for obvious extrinsic reasons. During their active period, traditional and religious institutions played an active role in program planning and implementation. Community members also volunteered in various capacities during health intervention programs. The Ward Development Committee and existing Village Health Committee played key roles in immunization programs for polio, measles, and yellow fever, among others. In addition, they helped implement the LLIN distribution program.

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 personnel distribution 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, due to recent macroeconomic management challenges related to weakening oil revenue and volatile short-term capital flows, gross foreign and fiscal reserves declined steadily. The government provides most health financing through recurrent and capital expenditures.

The budgetary allocation to the health sector in the State as a proportion of the total State budget declined from 9.3% in 2012 to 2.6% in 2016. The economic recession and competing needs explain this reduction in available funds, but they do not explain the proportional allocation to health. It implies 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.** Private out-of-pocket expenditure (OOPE) in Kwara State accounts for a very high percentage of estimated per capita health expenditure, 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, where partners operate in parallel without government oversight.
- A skill gap exists due to the inadequate number of health professionals in Kwara State.
- Physical facilities are dilapidated, and equipment is insufficient. Yet the SMOH rehabilitates facilities and purchases inputs through centralized procurement.
- The health system remains overstretched by the quickly growing population.
- The data generation system is inadequate, leading to weak evidence-based planning, policy formulation, and health systems management.
- Kwara State adopted the Community Health Insurance Scheme (CHIS), but it covered less than 5% of poor rural dwellers; it was poorly designed and included several input-financing elements. *This scheme was voluntary and had very poor feasibility, as seen in similar schemes inside and outside Nigeria. The scheme ended in 2014 due to low uptake and bankruptcy; this prompted the government to enact a law establishing a mandatory health insurance scheme, which is still in the pre-implementation phase. This institutional setup could still be used, but introducing PBF into the scheme could strengthen it. This would ensure service quality, strengthen verification mechanisms, and contain costs by paying subsidies within the available budget.*
- Skilled staff per 1000 inhabitants is 1:2070, with over 60% in the urban area.

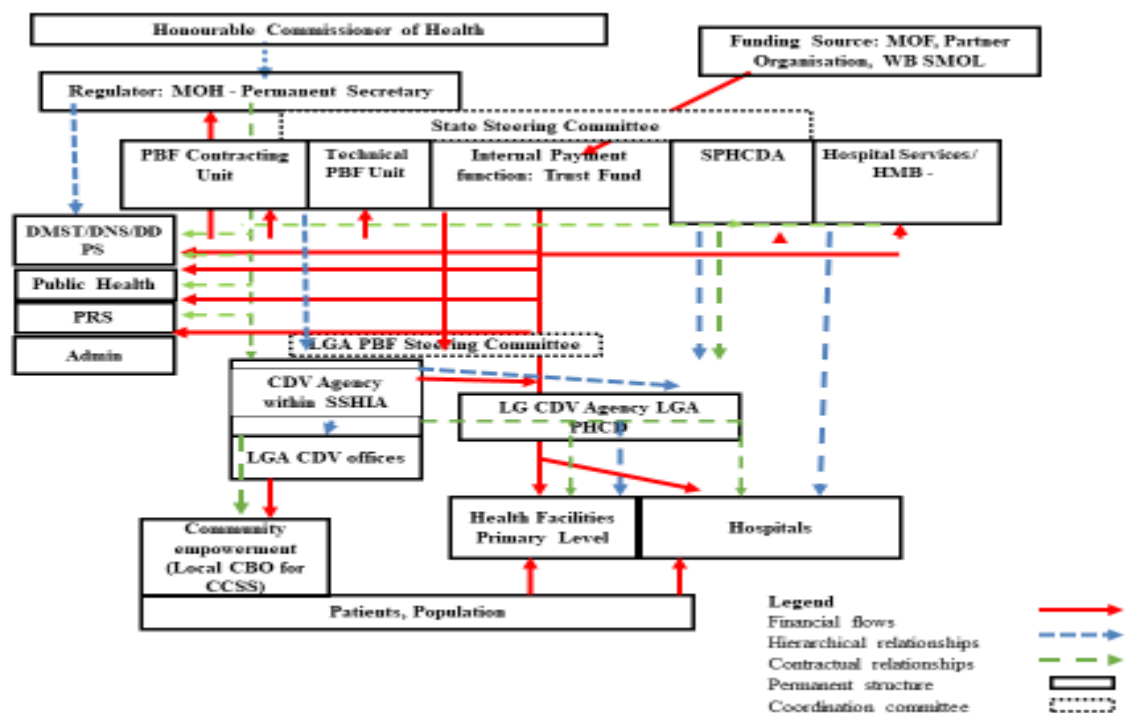
7.4.7 Can PBF solve the problems?

Yes, because PBF ensures effective health budgeting and incentivizes health care workers based on the quantity and quality of service delivery. This reform can extend to various departments and agencies in the Ministry of Health, helping ensure effective budget implementation and performance at that level.

PBF restructures institutional arrangements within the health sector by separating functions to increase transparency. It also promotes a more efficient health system through competition and improves allocative efficiency by directing more funds to the health sector's periphery.

Institutionalizing private-sector management in public health facilities and including private health facilities will allow competition among providers, promoting quality service delivery within these 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 how far the program 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 capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	0	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	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 allows 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 for Kwara State is 20% (10e. This indicates PBF may not be operable unless improvements are made along the set criteria. Proposed improvements are mainly through institutional reorganization; the score may then improve to 68%.

7.4.9 Recommendations

- Better coordination of partners activities
- Per capita annual state health expenditure has been consistently below \$3. Therefore, the State budget will allocate funds for PBF to cover 20% of the project. User fees will also be introduced for cost recovery purposes and to allow managers to handle cash.
- The SOML unit can be given responsibility for functioning as the PBF unit; hence, it will be domiciled within the Permanent Secretary's office. 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
- The Contract Development and Verification Agency will be established within the State Supported Health Insurance Agency.
- The payment unit may be established within the SMOH.
- The State will set aside laws impeding implementation and conduct a pilot in 3 LGAs.

7.4.10 Action plan

What to do	How to do	Timeline	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 LGAs	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

Implementing PBF in Kwara State will likely face difficulties due to factors such as personal interests, lack of understanding, and fear of losing roles and responsibilities, resulting in resistance and, in some quarters, outright rejection.

Different strategic approaches will be executed as a last-mile strategy to make PBF acceptable in the state.

The hardest issues that are likely to impede acceptance and implementation are as follows:

- Issues around health facility autonomy, mainly 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 counterarguments

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 cited.	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 an interest in carrying out community verification and satisfaction surveys during implementation of PBF

7.5 Nasarawa

7.5.1 General context

Nasarawa State is in Nigeria's North Central zone, with 13 LGAs, 147 wards, and 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 consist 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), and 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 in each of three states: Adamawa, Ondo, and Nasarawa. It scaled up within the three States in 2014, and in 2017 the PBF approach expanded to five additional States in the country's fragile and unstable Northeast. Several States now consider starting PBF-type interventions based on their own findings.

The PBF-NSHIP project intervention in Nasarawa State operates in 7 of the 13 LGAs and contracts 261 health facilities (235 public, 14 private, and 12 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	2	2	

annual mapping of health facilities 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	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	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 (inadequate 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, the State government has not contributed to the PBF budget. Therefore, the PBF program faces a serious sustainability problem.
- The National PBF Unit is *not* sufficiently integrated into the State Ministry of Health to coordinate all health system activities in the State, such as the Directorates and the Health Programs. Moreover, this has created sustainability problems because PBF can be nationally financed through SMOH.
- Existing government funds mainly finance inputs instead of purchasing performance from different health actors. Moreover, government fund disbursements are often delayed and 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 centrally posts, manages, and pays staff. Only contracted staff in PBF health facilities have autonomy.

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

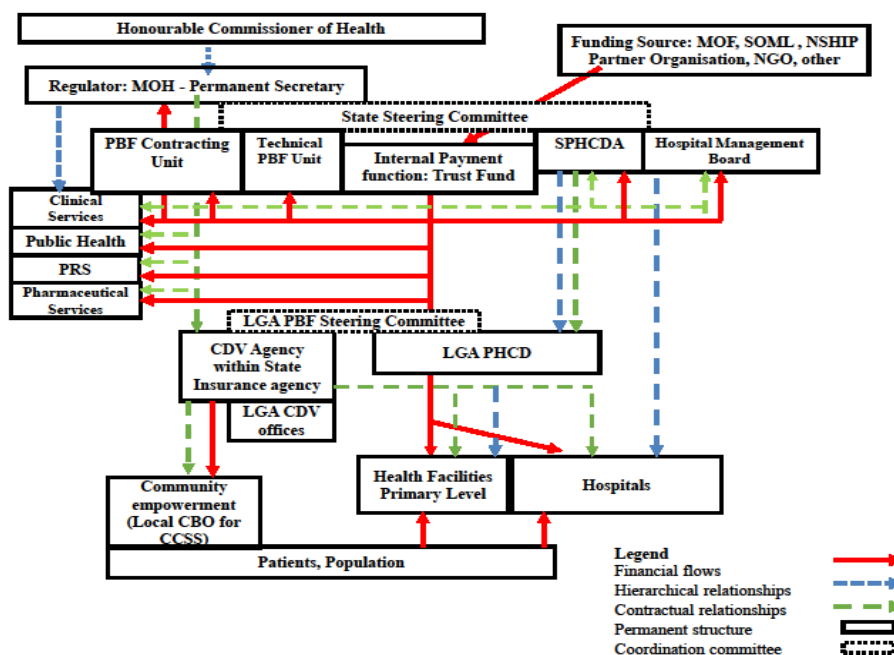
7.5.6 Recommendations

- 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, 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 the 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	17 th June 2019	SMoH

7.6 Adamawa State

7.6.1 Background

Adamawa State is in northeastern Nigeria, with a growth rate of 2.9% and a projected population of 4.6 million. The State borders Borno State to the North, the Republic of Cameroon to the East, Taraba State to the South, and, to the west, parts of Taraba State and Gombe State. Adamawa has 21 Local Government Areas, 226 political wards, and operates a 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 covers 403 primary health care facilities across the state's wards. With World Bank support through NSHIP, 11 LGAs benefit from Performance-Based Financing (PBF), while the remaining 10 benefit from decentralized facility financing (DFF).

The PBF program in Adamawa achieved encouraging results in improving quality and the effective use of scarce resources, contributing to the revitalization of the health system. However, the program has also faced financial challenges that disrupted its operations, even though it was originally designed to end in 2020.

7.6.2 Problem analysis

- The failure to define a sustainable mechanism to create State ownership and local financing
- Challenges in coordinating the partners
- Failure to move away from the input system used by the government and partners.
- Each ward has one, or in Adamawa sometimes 2, PHC centre of excellence that operate 24 hours

7.6.3 Feasibility scan:

A feasibility scan for Adamawa State scored 32 points (=64%) out of 50. The recommended minimum score is 80%. The table below highlights the problem areas in red. The issues that need 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 government release for health are below the recommended 20%, making the PBF program 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 standard output and quality indicators.	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
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

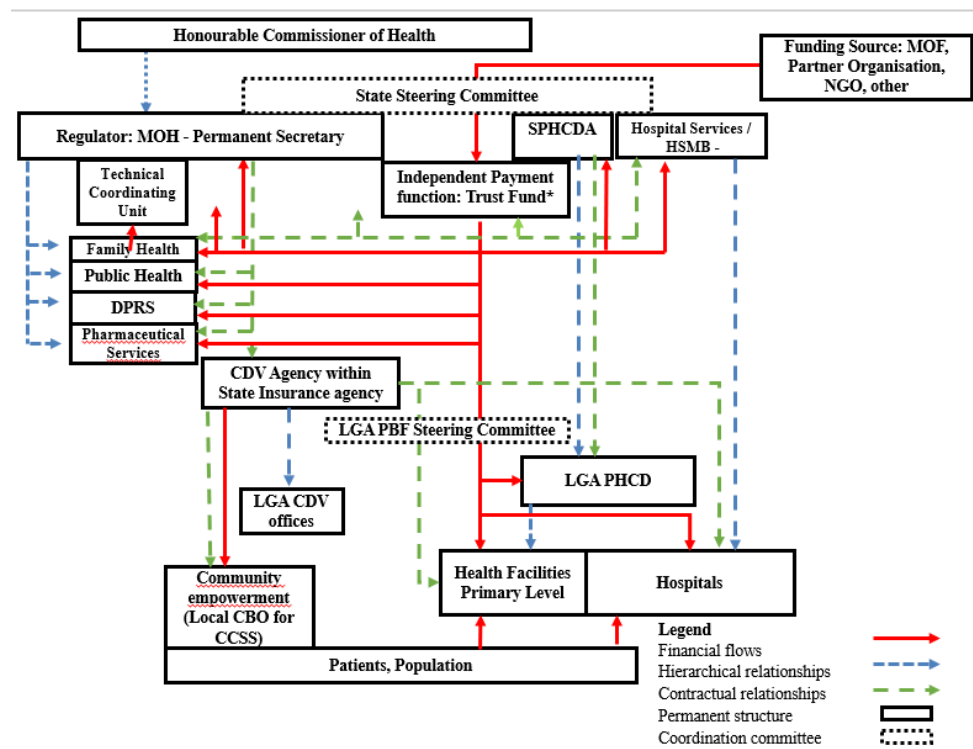
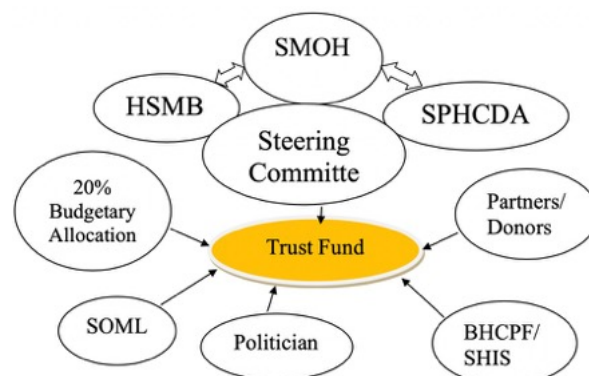
- The PBF program is not integrated into the SMOH (separation of functions).
- Inadequate budgetary allocation and release for the health sector.

7.6.5 Recommendations

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

- Rearrange the State architecture by establishing a Technical Coordination Unit in the MOH for basket funding.
- Coordinate parallel state activities that can be integrated into the PBF program, such as SOML and other partners.
- Advocate and lobby with the State Government to increase and release budgetary allocation for health financing

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	<ul style="list-style-type: none"> - Hon Commissionairs of other Ministries - Legislators - State Governor 	<ul style="list-style-type: none"> - 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. 	<ul style="list-style-type: none"> - Improved health leads to economic multiplier effect which improves standard of living positively, with spillover 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). 	<ul style="list-style-type: none"> - SPHCDA - HSMB - Professional bodies in Health - Health Institutions
Non integration of the NSHIP program with the State MOH	<ul style="list-style-type: none"> - SPHCDA 	<ul style="list-style-type: none"> - Loss of power and control 	<ul style="list-style-type: none"> - 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	23 rd 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 in north-eastern Nigeria, with an estimated population of 5.6 million. It has 27 LGAs and 311 political wards. The state allocates 12% of its total annual budget to the health sector. The state health sector is also funded by the Saving One Million Lives Program (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 the violence of the Boko Haram insurgency since 2009 to date. As a result, several health facilities across the state are nonfunctional or dilapidated. Insurgents have vandalized some. This has severely disrupted healthcare service delivery, especially in the most affected and no-go areas. However, the state government is committed to renovating those facilities. Currently, more than 2 million

people have been 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, which heads the sector and is responsible for formulating policies and overall supervision; 2. Hospitals Management Board (HMB) overseeing the secondary health facilities; 3. State Primary Healthcare Management Board (SPHCMB) overseeing 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

- The ministry and the parastatals have a good working relationship and mutual understanding, supported by strong leadership and coordination.
- The state government shows strong political will and commitment to investing in the health sector.
- The state and partners have a good working relationship and coordination.

7.7.5 Problem analysis

- Human resources gaps do exist across all levels of the health facilities.
- Recruitment and redeployment are centrally controlled.
- Infrastructural development in the health sector is centralized, including PBF-contracted facilities.
- Drug and equipment supply across all health facilities is centralized.
- PBF Interventions in the state under NSHIP operate in only 8 of the 27 LGAs. Contracted health facilities include both private and public primary and secondary Health facilities.
- Most stakeholders, healthcare service providers, and the general population have inadequate knowledge of PBF.
- There is a standing committee of traditional leaders on PHC supporting demand creation and social mobilization across the state
- Maternal, newborn, and child health services are free, though they do not cover all facilities and are still insufficient even for the facilities covered.

7.7.6 Feasibility Scan

Are there possibilities of solving 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 assessed the feasibility of a locally owned, statewide PBF program.

We came to a feasibility score of 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 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 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 allows 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 made 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 HF's 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
- Advocate to policymakers and sensitize traditional institutions, faith-based organizations, community-based organizations, civil society organizations, and professional bodies on PBF.
- Scaling up PBF in other non-contracted health facilities across the state
- Make free MNCH services into high-quality, subsidized, user-fee-paid services
- Financing and sustainability of the program

Sources of funding

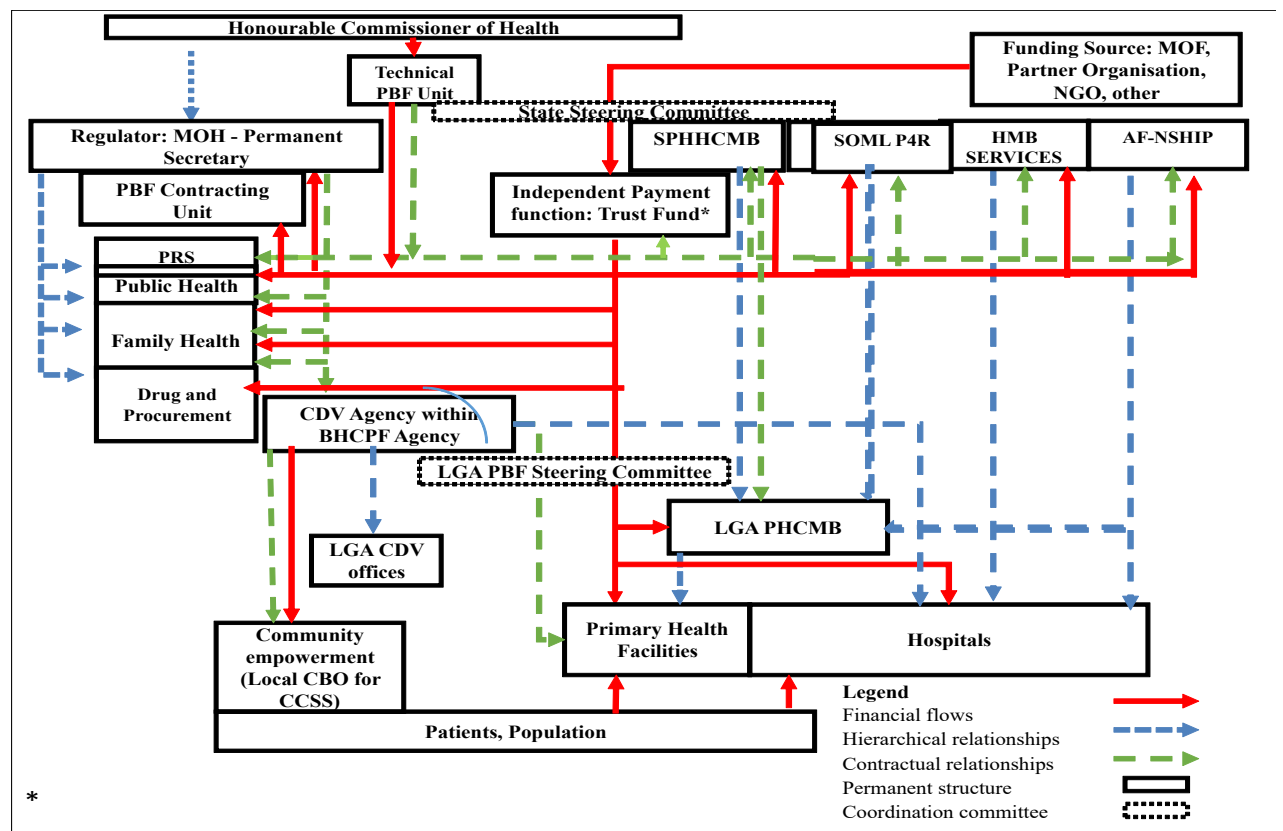
- State Government
- Basic Healthcare Provision Fund
- Nigerian State Health Investment Project (NSHIP)
- Saving One Million Lives Program (SOML)
- Tripartite fund (Govt, Dangote Foundation and BMGF)
- Development Partners

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 into 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	<p>Short to medium term: The government's health allocations Funds from state programs (SOML, NSHIP, BHC PF)</p> <p>Long term: Amendment of the Health law binding the PBF</p>	MOF Legislatures	continues

7.7.9 PBF institutional setup



7.8 **Ethiopia**

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

7.8.1 **Health context**

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

Disparities also exist in uptake and coverage of high-impact interventions across regions and woredas. The quality of health care, in terms of patient safety, effectiveness, and patient-centeredness, is often inconsistent and unreliable in both public and private facilities. 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 guide our investment toward 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 include transforming health care quality and equity, transforming woredas, moving toward compassionate, respectful, and caring health professionals, and an information revolution. Key features include quality and equity, universal health coverage, and transformation. To achieve the health sector mission and vision, the HSTP has four pillars: excellence in health service delivery, quality improvement and assurance, leadership and governance, and health system capacity.

The HSTP's performance has been critically reviewed through annual performance reviews and related reports, including the Health Management Information System (HMIS/DHIS2), the Mid-Term Reviews (MTR), and various population- and facility-based surveys.

Ethiopia has made steady progress toward its main health goals by implementing high-impact interventions, including its flagship community-focused program, 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 have declined from 97 deaths per 100,000 live births in 2000 to 59 deaths 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 undernourished.

More than one-third (36%) of married women aged 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 aged 15-49 receive a postnatal check within two days of delivery, while 81% do not receive one within 41 days. Merely 13% of newborns 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 the Demographic and Health Survey.

One current challenge is the Ethiopian Pharmaceutical Supply Agency's (EPSA) monopoly on drug supply. They have monopolized the drug market, and health facilities generally cannot buy pharmaceuticals from other suppliers unless the EPSA issues an official letter stating there is a drug stockout.

The Health Sector Transformation Plan (HSTP) is the current five-year national health sector strategic plan, covering 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 part of the country's second Growth and Transformation Plan (GTP-II).

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 PBF pilot look like? A current World Bank exploration for the government of Ethiopia will assess how to start a PBF strategy, which may involve a future pilot. The PBF pilot in the Ethiopian context will need to span more than one region. In this course, we present a preliminary assessment
3. Sustainability: Any PBF strategy should include a sustainability strategy, which means avoiding too much grant or donor dependency. Sustainability mechanisms must be designed.

Can the PBF approach solve problems? The answer is “yes”.

7.8.3 Focus: Pre-piloting PBF in Oromia Region

Start in Borana

In May 2015, Cordaid began implementing Phase I of a PBF pre-pilot project in the Borana Zone of Ethiopia's Oromia Region. The project covered 8 Health Centers and 1 Primary Hospital across 4 Woredas, reaching a catchment population of 125,918. Following positive results, Phase II of the pre-pilot continued in July 2018, expanding to 8 Woredas and a catchment population of 488,556.

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

- Engagement by the Oromia Regional Health Bureau and the Federal Ministry of Health, particularly in planning, implementation, and monitoring to sustain project results and scale up to other areas, was inadequate. These bureaus should be involved from the start.
- The Zonal PBF Steering Committee was changed to a Validation Committee at the Zonal level to include more technical staff for proper review
- Note was taken that the pre-pilot was in line with government strategies of the Health Sector Transformation Plan
- There was a significant increase in quantity and quality, but still room for improvement in the quality of health facilities
- There was significant improvement in 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, participants discussed the need to scale up PBF in a non-pastoralist area. This aimed to show that PBF also works beyond the arid and pastoralist Borana Zone and to generate additional evidence of its effectiveness. It was decided to scale up to the Jimma Zone within the Oromia Region. In 2019, the Jimma Zone population was 3.4 million, with 20 districts and 1 town administration; health facilities included 3 general hospitals, 3 primary hospitals, 3 hospitals under construction, 122 health centers, and 515 health posts.

The Jimma Zone faces multiple healthcare challenges, including:

- ***Healthcare utilization:*** The community often avoids seeking healthcare services because of low-quality care.
- ***Quality of health services:*** Low quality is linked to low staff motivation, a shortage of health professionals, and high staff turnover. Additionally, the lack of drugs and equipment means basic healthcare services are not always available.
- ***Low utilization of health information for decision-making at the district level:*** This issue stems from limited knowledge among Health Center and Woreda Health Office staff about proper reporting procedures and unclear documentation. Additionally, staff often collect data manually because they lack computers and internet access.

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 4 years. This includes a 6-month inception phase and a final 3-month exit phase. The proposal targeted 2 million inhabitants, or 60% of the Zonal population. This is equivalent to 2 Euros (2.25 USD) per capita for the full project implementation. Much of the project proposal was based on the Borana pre-pilot, including the lower per-capita amount, reflecting lower costs

in Ethiopia. Like in Borana, the Jimma PBF pilot will also start with a Cordaid Field Office in Jimma acting as the CDV agency, with the intention of integrating this role into the existing Ethiopian health structure.

7.8.4 Feasibility Scan: Federal Ministry of Health

A feasibility study analyzes and evaluates a proposed project to determine whether it is technically feasible, within the estimated cost, and profitable. The teams scored feasibility at 32%, far below what is desirable.

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 Main problems identified by the Federal level team

- Provider managers cannot influence cost-sharing tariffs; in our country, the government has sole power to set them.
- No freedom to buy drugs. Health facilities must submit priorities to the EPSA, but only when items are out of stock; the EPSA mandates facilities to buy inputs from private accredited distributors.
- Lack of autonomy: health facilities are not autonomous because the Health Care Financing strategy is not yet approved.

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	0	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	0	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	0	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	0	Yes, this will be included. Verifiers will coach HF's 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 HF's.
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. 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 HF's.
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 including 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	18 = (36%)	

7.8.7 Main Challenges Jimma PBF program Cordaid

- **Central Drug Supply:** The drug monopoly in Ethiopia can have adverse effects on the PBF program, such as drug stock-outs. In Borana, drug stock-outs lead local pharmacies to significantly increase prices for 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.

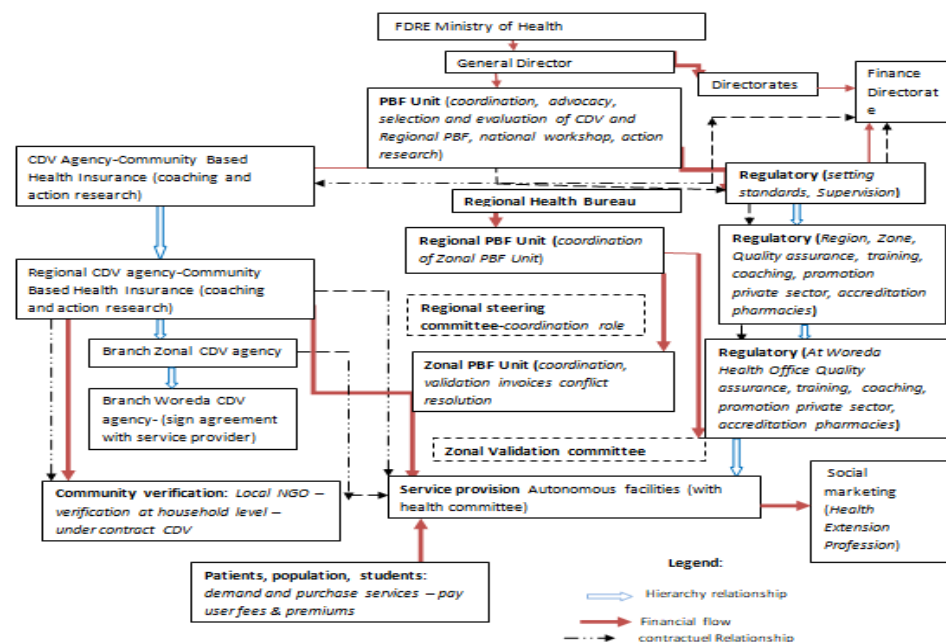
- ***Lack of autonomy of Health Facilities:*** Limited autonomy could reduce staff motivation and output. Health facilities lack the autonomy to build or maintain their infrastructure. They must obtain bureaucratic approval for even small improvements, such as facility rehabilitation.

These assumptions pose a serious risk to pilot implementation and need to be addressed.

7.8.8 Recommendations: Federal Ministry of Health

- Since Ethiopia is not yet engaged in a full PBF strategy, our priority is to engage with the World Bank to collectively explore the feasibility of a PBF strategy in Ethiopia, in relation to the three directorates, for this exercise.
- To map and compare the current system of Ethiopia with a system informed by a PBF strategy
- Design a brief proposal for a future 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 a total population of 94 million. We believe the PBF budget shouldn't fall below USD 4 per capita; however, the required budget for those regions was USD 22,995,992 for the Special Support Region, USD 141,868,004 for Oromia, and USD 13,735,96 for Addis Ababa.

7.8.9 Institutional Design: PBF Federal Ministry of Health



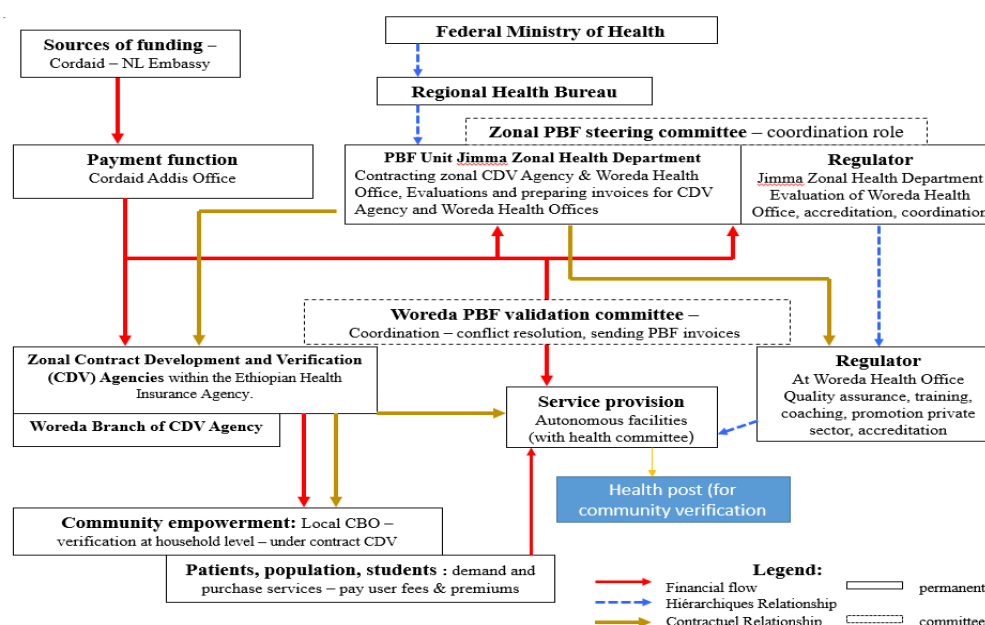
7.8.10 Recommendation: PBF Design Jimma

Internationally, an expenditure of 4 to 5 USD per capita is now widely accepted as the benchmark for a full-fledged PBF program. Even at lower price levels, initial costs, such as Quality Investment Units, will likely need to be introduced and factored in to start the pilot. 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 greater impact and more efficient expansion of PBF

across other regions, and possibly nationwide. With this more realistic, full-fledged design, the project can reach an expected population of 1.1 million inhabitants.

7.8.11 Institutional Setup

The institutional design is based on what will be possible over the project's longer duration, with a field office in Jimma that will initially serve as the CDV agency. Once the possibility is further assessed and negotiated, the intention is to integrate this into the existing health structure.



- Integrate the CDV agency within the Ethiopian Health Insurance Agency if it is 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	Inpatient days for hospitalization
3	Quality Improvement Bonus (QIB)

7.8.13 Recommended Woreda Selection

The Jimma Zone consists of 20 districts and 1 town administration. USAID has implemented its *Transform Primary Healthcare* project throughout 11 of these districts. As in the Borana Zone, it is suggested to implement PBF in districts where USAID is not active to obtain more accurate data on PBF impact in the Jimma Zone. The Woreda choices still need to be discussed, but the remaining 10 districts where 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: District and regional levels

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 achieve sustainable universal access to quality health care and services by improving health care delivery and financing demand (use).

In this plan, five strategic axes were retained: 1. Health System Strengthening; 2. The vulgarization of implementing 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 aims to increase the provision of high-quality health care. This initiative addresses the strategic axes of the Health Sector Strategic Plan, particularly the quality of health care delivery at the operational levels of 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 also aims to provide health care services to the poor, the vulnerable, and hard-to-reach populations.

PBF started in 2007 in the East Region, led by Cordaid and the Catholic Diocese of Batouri. The next phase started in 2011 in the Littoral Region and in 2012 in the North-West and South-West regions. The North-West Region has a population of 2 million. In July 2018, PBF scaled up to all 19 Districts of the Northwest Region, and the table

below shows progress; by 2019, the population was fully covered except in some areas affected by 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) Northwest operates within the Northwest Regional Fund for Health Promotion (NWRFHP) under a contract signed *in April 2015* between the Minister of Health and the NWRFHP. The CDV Agency Northwest Region is led by the Manager, 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 the 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 negotiates and signs contracts with structures and coaches on management tools to promote transparency and ensure efficient use of Health facilities' resources. This requires coaching health facilities on using the indices management tool. According to the PBF manual (page 66), the manager or deputy manager must provide the coaching.

7.9.3 Problem analysis

- The non-submission rate for the indices tool is high at 35% and 22% for two consecutive quarters. The average score for the quality of use of the indices tool is low, at 38% and 43% for two consecutive quarters. One reason for this poor performance is that, in practice, deputy managers of CDV agencies conduct coaching activities at best once a year, or not at all, due to security concerns and the fact that they do not reside in the district, unlike the verifiers. Yet CDV Agency verifiers (along with supervisors from district health authorities) are the closest actors to health facilities and the community. Verifiers visit health facilities monthly, allowing regular interactions. It also allows coaching 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 the coaching

7.9.5 Feasibility score

Performance-Based Financing is already a policy in Cameroon. A quick scan shows policy implementation at 94%. However, population rationalization remains inadequate; in particular, some health facility catchment areas with a main contract have populations of less than 5000 persons. The second problem concerns baseline quality reviews, which are not done in all health facilities, probably due 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 killing assumption, but operational issues remain, one of which this action plan addresses.

7.9.6 Recommendations

- To the PBF technical unit, amend the clause that 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. Administer a post-test and select supervisors who score above 80% for specific tasks.
- Supervisors should receive regular coaching, and the Manager or Deputy should be invited for risk-based coaching or coaching on pertinent issues such as conflicts or adherence issues.
- CDVA supervisors should monitor progress in the 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	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - 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. Post-test administered	<ul style="list-style-type: none"> - Workshop at the CDVA head office 	CDVA management	14 th to 18 th 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*	<ul style="list-style-type: none"> - Field visits to coaching exercises or coached Health facilities 	CDVA management	June and July 2019	Corrections of errors.
Purchase of coaching from supervisors	<ul style="list-style-type: none"> - 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 a key element in the proper functioning of the PBF Mechanism. Unmet coaching needs are disastrous for the system, as many issues go unnoticed. Good coaching facilitates verification, supervision, and quality reviews. It also provides information that may otherwise go unnoticed. Coaching bridges 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. African Ministers of Health recommended this in Bamako in 1987. The structure was known then as the North-West Pro-Pharmacy. In 1991, under Cameroon's association law, it became the North-West Provincial Special Fund for Health. The North-West community (11%), the Government of Cameroon (25%), and German Technical Cooperation (64%) contributed the NWPSFH's initial investment capital. The total capital was estimated at 200 million Francs CFA. The NWRFHP's organized and functions through the General Assembly (GA), the Management Committee (MC), and staff led by an Administrator. The North-West Regional Fund for Health Promotion's mission is to assist the Ministry of Public Health in promoting access to quality health care for the population of the North-West Region by improving 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 strengthening consumers' voice is a key aim. PBF advocates separating functions, and consumers play a role in providing feedback on the quality of care and services. Providers are responsible for ensuring that health services are available, high-quality, and affordable for both 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 its 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 attitudes of health personnel because of performance bonuses. This reform in implementing the eleven best practices has improved 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 in a war. This crisis has caused untold misery to the population, causing trauma as many people lost their loved ones; some are internally displaced, including health workers; some health facilities are completely shut down, and some health facilities are unreachable. All of this has made it very difficult to provide and supervise quality care.

The socio-political crisis plaguing the country has brought about a breakdown in the quality control mechanism, low quality of care due to the availability of counterfeit

medicines 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 a result of the war, quality reviews are not conducted regularly, and some health workers benefit from this situation by buying medicines from unauthorized sources to increase their profits.
- Delays in subsidy payments further reduce staff motivation.
- Related to this problem, health workers often fail to report certain drug sales and put the money into a private pocket instead of the common basket. This reduces 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 disrupted economic activity, leaving many people poor and forcing health workers into private practice, where they earn extra income to meet basic needs.
- Low-quality care is linked to counterfeit medicines available in some health facilities.

7.10.4 Can PBF solve this problem?

PBF is a reform that has succeeded in many areas. Recent experience shows that PBF can work well during crises such as wars, disasters, or outbreaks like Ebola virus disease. In the Central African Republic from 2013 onwards, when war broke out, it allowed a comparison between PBF areas and the classical emergency approach of input financing through International NGOs. The PBF approach continued to pay cash subsidies to health facilities, which proved more cost-effective. None of the PBF health facilities stopped to operate during the war. Qualified staff continued working in the facilities, while in traditional emergency-approach areas, many left. The study in the Central African Republic also found that during crisis periods, the PBF approach should significantly increase subsidies so 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 problems

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 still a need to 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 follow a code of ethics. To support this, the regulator should conduct regular quality reviews and provide feedback to staff based on community verification interviews.
- Ensure that personal needs and motivation are not neglected. This can be achieved through more regular subsidy payments and regular coaching on financial management, so they can set aside enough reserves for rainy days.
- The Regional Delegation of Public Health should regularly update the list of accredited drug procurement sources and conduct surprise visits to these sources for drug quality control. They could also collect product samples for quality control.
- District Health Authorities should conduct quality reviews by taking advantage of safer moments during the war. They should also conduct surprise visits to health facility pharmacies and sample drug items for quality control. They should review drug invoices to verify the source of medicines, identify the distributor, and confirm whether they appear on the list of accredited distributors.
- Health facility managers should regularly supervise pharmacies and ensure they identify and punish perpetrators of parallel drug sales. This could be done using the indices tool through performance bonuses, where a higher mark is allocated for the non-private sale bonus. This will reduce the staff member's individual performance and, consequently, lower the bonus if he or she sells drugs in parallel. To ensure this, health facilities should post signs indicating drug prices and that all drugs should be purchased only from the facility pharmacy.
- For consumers, ensure they receive receipts when they use services, especially for drug purchases.
- The government should ensure subsidies are paid promptly to maintain consistent quality in Health Facilities. Prompt subsidy payments will motivate workers at all levels and improve individual and collective performance. Timely subsidy payments could also reduce or eliminate private practice and, therefore, enhance quality of care across 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 Peace Agreements signed in February 2019 between the Government of the Central African Republic and armed groups represent a window of opportunity to improve the security sector in CAR. Furthermore, state actors across sectors continue to receive support from various international institutions to improve their performance. Different approaches/tools are applied, such as “Performance-Based Financing” (PBF), which has proven successful within the health & education ministries.

7.11.2 Problem analysis

Providing security is one of the state’s core functions and is directly linked to its legitimacy. However, citizens may also view security state actors, such as the national police, as a threat because of their behavior and how they operate.

In CAR, despite all efforts, state security forces remain under-motivated for various reasons: low salaries, insufficiently trained personnel, limited facilities & equipment, etc. This leads to human rights violations, ineffective service delivery, and high levels of corruption.

7.11.3 PBF feasibility scan

I believe developing a pilot PBF approach can address some problems faced by the security forces in CAR and make them more professional and accountable to communities. Institutions will be financially rewarded based on their performance and will have the autonomy to use the subsidies obtained through PBF, in accordance with agreed business plans. Therefore, the feasibility score was calculated at 28%.

However, the criteria developed in the PBF health manual need to be adapted to the security sector to determine an appropriate 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 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 to propose a well-designed PBF approach within the Ministry.
- CORDAID to organize PBF trainings for involved staff and SCOs.
- CORDAID to sign a 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)	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - Refer to information received from the Ministry 	CORDAID-CAR	June 2019
Visit to all stakeholders / advocacy	<ul style="list-style-type: none"> - Prepare a lobby paper with key added values of applying PBF 	CORDAID-CAR	July 2019
Set up a pre- PBF Committee	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - Organize a workshop 	CORDAID-CAR & the pre PBF committee members	August 2019
Map / institutional set up	<ul style="list-style-type: none"> - 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)	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - Organize trainings for staff from identified departments 	CORDAID-CAR	November 2019
Launch of the design PBF program	<ul style="list-style-type: none"> - 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	1 st 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. A variety of health workers provide primary care, e.g., general practitioners, pharmacists, physiotherapists, midwives, etc. Across the country, general practitioners are widely available. 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 become too expensive, leaving little room for other expenditures.

7.12.2 Problem description

This full-coverage situation is now under threat because many GPs in remote areas are retiring. Young doctors are often unwilling to work in those areas. Therefore, GPs need encouragement to work there. Another problem is that mostly male GPs, who work full

weeks of 50-60 hours, are retiring. This retiring population will mainly be succeeded by young female doctors who tend to work part-time, e.g., 25-30 hours a week. Under the current situation, replacing one leaving doctor will require 2 or 3 doctors to fill the practices. For example, in the south-west region of Holland, Zeeland, 58 doctors will retire in the next 5 years. We estimate that we need more than 120 doctors to replace them. A smaller problem exists in some of the bigger cities, where housing costs are so high that young doctors cannot afford to settle there. To maintain full primary care coverage across the country, we need to act.

Can PBF be a solution?

PBF offers tools we can use. E.g., geographic equity and investment bonuses to better motivate younger doctors to move to remote areas.

7.12.3 Feasibility Scan.

The feasibility scan assesses the health system in Holland; although PBF is not applied, the system already has many PBF principles in place.

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 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	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, parliament provides checks and balances and oversees the ministry; the minister is answerable to parliament. Parliament can require the minister to adjust the ministry's policies and activities.

Provider managers cannot influence cost-sharing tariffs. The central government sets tariffs for consultation and the quarterly payments. They are calculated so that the total primary care spending each year does not exceed the macro budget. As a result, there is no incentive to distinguish your practice from another facility in your area.

7.12.5 Recommendations

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

- Mobilize all actors and sensitize GPs to take responsibility, aiming to cover the whole country. These actors include general practitioners, hospitals, councils, provincial authorities, health insurance companies, the Ministry of Health, and the public.
- Use the geographical equity bonus and investment bonus to encourage GPs to start practice in named areas. A system already increases regular, quarterly payments in so-called poor city areas. This has encouraged young, newly qualified doctors to move to these areas. The extra amount is sufficient to hire more staff in health facilities to meet higher demand in those areas. On top of that, we can use other incentives. For example, provincial authorities in Zeeland recently offered so-called summer houses to attract doctors to work there during the summer. This has resulted in several doctors working there. The idea is that if they experience this environment, they might settle in that area afterward.
- Pass a motion in the national assembly of general practitioners to extend the existing system to more areas.
- Work out the amount of the extra payment with the union and representatives from the designated areas: GPs, council members, and a representative of the dominant health insurance company in that area, and negotiate this with the MoH
- Seek approval from the Ministry of Finance to increase the macro budget allocation for primary care.
- Seek cooperation with the local health insurance company. The insurance company is legally required to ensure sufficient health care in its respective areas.

If primary care is insufficient, patients must go to more expensive secondary facilities.

- Adjust the existing postal code pricing system. The local health insurance company, and sometimes local authorities such as councils and provincial administration, can pay an additional investment bonus.

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 GPs. Health Insurance Companies involved	In April.
Make the Union of GPs 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.
Negotiations with MoH	After motion is adopted start negotiations with MoH. Macro budget of primary care will be exceeded so political will is essential.	Representatives of Union and MoH.	After the motion is passed in regional assembly to bring this 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.