Mombasa – KENYA

Report of the 80th Performance Based Financing Course

October 28 – November 8, 2019

The 37 course participants in Mombasa

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1. SUMMARY

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The next English PBF course in Mombasa will take place from Monday March 23 to Saturday April 3, 2020

1.1 Who attended and village authorities

The 80th international PBF course organised by SINA health in Mombasa-Kenya, welcomed 37 participants from four African countries: Nigeria 19x; Liberia 16x; South Sudan 1x; and CAR 1x. Thirty-five participants came from the health sector at national and sub-national levels, 1 worked in the education sector and 1 at the governor's office in Bauchi State, Nigeria. There were seven States represented from Nigeria: Bauchi, Borno, Ondo, Kaduna, Rivers, Niger and Gombe States. The Liberia team consisted of representatives from the central and county levels as well as one participant from Cordaid. The Sudan and CAR representatives are working for the Dutch NGO Cordaid.

The facilitation team consisted of Godelieve van Heteren, Robert Soeters, Fanen Verinumbe, Anne Wairimu, Caroline Atieno and Tom Njieri. The "Village 80" authorities were under the leadership of the Village Chief, Norwu Howard, Deputy Minister of Administration from Liberia supported by Habiba Saidu from Borno State; the time keeper Abel P. Bembo from Liberia, the Finance Minister Thomas Padmore from Liberia and the Energizers Peter Adamu, Prudence Sangnyuykewir and Abel P. Bembo

1.2 Evaluation of the course

Thirty-four participants conducted the final exam. The average test score result was 67%, which was a 20% improvement compared to the pre-test. There were five certificates of distinction (87% score or more) and four certificates of attendance (50% or less).

This course was evaluated by the participants as one of the best ever. The daily evaluations yielded an overall score of 90,4%, which was 7,1% above the average of the previous 26 English courses and 11,4% above the previous 46 French-spoken courses. The criteria *methods and facilitation*, *participation* and *organization* scored extremely high with avarages of respectively 95,4% 93,3%, and 93,9%. *Timekeeping* was slightly lower, but still above the average of previous courses with 78,9%.

The final evaluation indicated that for 100% of the participants the content of the course related well to their professional activities and that the methodology of the course was good. Yet, only 72% said that they were well-informed in advance about the course. This was mostly due to last-minute registration and some indicated that the course book should have been distributed 1-2 weeks in advance of the course. 50% of the course participants commented that the course was too short.

1.3 Summary of the action plans of the course groups

1.3.1 Central African Republic Education Sector

The education sector in CAR faces severe problems: the population has a low level of schooling, there is inadequate funding, there are inefficient input strategies and there is an extreme shortage of skilled teachers. The school infrastructure is mostly dilapidated and there is a shortage of text books.

Education PBF pilots have been ongoing since 2009, supported by Cordaid. They obtained convincing results and PBF in the the primary school education sector in CAR would cost the modest sum of only around USD 20-25 million per year. The Ministry of Education wishes to adopt and finance performance-based financing, but this has not yet materialized. Therefore, Cordaid continues to finance PBF in one of the districts - Nana Mambéré - as a continued pilot and advocacy tool. Moreover, since 2016, Cordaid also tested two PBF-approaches for infrastructure improvement whereby the pure PBF approach had better results than a mixed input-performance payment approach. CORDAID with its current budget of almost Euro 1 million wishes to scale up PBF to 120 schools. In this action plan we propose how to do this and how to further promote the PBF approach in CAR.

Recommendations

- Advocate with the Ministry to find more funds for PBF. The World Bank is the most likely organisation that may respond favourably. Moreover, input lines in the government budget for the education sector should be reviewed to transform them into PBF budget lines.
- Sensitize further the political and administrative authorities towards PBF and integrate PBF into the recovery and peacebuilding plan of CAR.
- Review the “general” free education policy, with advocacy for “targeted” free education with the aim to enhance quality education, more efficient use of resources and better motivated teachers.
- Reduce the number of pupils to benefit from the Cordaid PBF program or search additional funding, because the costing for 60,000 pupils of $ 20 per capita per pupil requires USD 1.2 million, while so far only USD 850.000 is available. There is a need for more funds and an exit plan in case no more funding is forthcoming.
- Apply the PBF approach also to building schools by the local communities instead of a NGO-oriented building program. This approach has already been evaluated as the more successful strategy in DRC and in CAR.
- Move towards the separation of functions (Cordaid is currently executing fundholding, verification & does the quality checks) by including local education authorities and by enhancing the role of the national PBF education unit in the MOE.
- Empower and give more responsibility to schools so that they can efficiently manage their resources (financial, human, material).
- Apply the indices management tool to enhance transparency at schools and to better monitor financial processes including the performance bonuses to motivate teachers.

1.3.2 Liberia

Liberia sent a high-level, strong delegation to engage in revisiting the current Liberian PBF/RBF efforts, and produced a detailed set of propositions.

The Liberia health system is heavily donor-dependent since the emergencies of the civil war and the outbreak of the Ebola Virus Diseases (EVD) in 2015. Yet, this donor support is phasing out. The economy has also slowed down. Deep reforms are needed to make more efficient use of the scarce public resources.

Maternal mortality is extremely high with 1072 death per 100,000 live births. The Liberia Human Development Index in 2018 was 63, the country ranks 181 out of 189. The vulnerabilities of the Counties are not factored in the allocation decisions of the existing government budget resulting in a haphazard allocation of per capita health expenditure of between USD 3.00 and USD 21.00 per county. Human resource management is compromised and the country uses inefficient input supply chains. As has been shown in the different PBF programs in Liberia, PBF can assist in addressing these inadequacies. Yet in order to tap its full potential, it requires a deeper structural reform of the current PBF designs and the harmonization by government and the Ministry of Health of the approaches of the different donors.

Recommendations

- Advocate with technicians and policy makers in the Ministry of Health and the Ministry of Finance for full-scale harmonized output-based financing (strategic purchasing);
- Ensure that the PBF approach is incorporated into the current draft health strategy;
- Harmonize Liberia's different PBF schemes into one national scheme;

The new, harmonized PBF design could contain the following elements:

- Transform the current financing system of *generalized* free health care towards *targeted* free health care system and make quality care and efficiency the main objectives;
- A revision of the institutional setup of the PBF program ;
- Moving the PBF Unit under the Office of the Minister for better coordination, and contracting of all departments;
- Introducing the geographic equity bonus system with the aim to support rural services and to promote staff retention in remote health facilities;
- Identifying a national institution to play the role of CDV Agency - possibly the Governance Commission. Establish County and sometimes District level CDV branches of the national CDV Agency;
- The CDV agency should contract health facilities based on their performance and not on their status of being public, private or religious structures;
- Conducting the mapping and rationalization of the catchment areas based on national standards;
- Establishing county validation committees consisting of the County Health representatives, the CDV Agency and service providers;
- Open bank accounts for the district and county health authorities and all health facilities at all levels to autonomously manage the finances;
- Health facilities should establish their cost-sharing tariffs together with their communities;
- Quality improvement bonuses and integrating them in the standard output indicator list;

- Introducing need-based action research with budgetary allocations in the performance contracts at central level and for the CDV agencies;
- Health facilities are authorized to negotiate postings of civil servants based on needs and to recruit contracted staff including professional staff.

FY 2020-2023: MOH to develop a sustainability plan for PBF financing including a plan for national scale-up:

- FY 2020/2021, seek temporary exemption from:
  - Current public Financial Management laws. This to transform current input budget into PBF budget starting with the grant and subsidy lines in the national budgets.
  - Grant health facilities financial autonomy to collect funds and manage them with own bank accounts;
  - Create budget lines and accounts and grant more autonomy for: a. Primary facilities budgets on a per capita basis that reflects geographic equity; b. Output-based County Health Team budget for regulation; c. Output-based District Health Team budget.
  - Civil Service Regulations to grant autonomy to health facilities to manage their own human resources starting with extra professional staff based on population or work load, non-professional staff and community health workers;
- By FY 2020/2021: Develop and implement performance contracts with selected Units within the MoH.
- FY 2022/2023: scale up PBF to 100% of facilities across the fifteen Counties.

1.3.3 The Nigerian context in general

With respect to PBF experience, the seven states present in Mombasa were mixed: some had worked with PBF before, others were new to the approach. However, the states shared similar challenges in their (non-PBF) health systems such as insufficient and poorly distributed human resources, inefficient input systems with frequent stock-outs, dilapidated infrastructure, poor quality services, and the verticalization of programmes. The use of resources is extremely inefficient and some States describe their current health system as being in a *"state of emergency"*.

It was made clear, that the World-Bank supported NSHIP program PBF pilots in the states - implemented since 2011 - have produced very good results. As a result, there is growing understanding that PBF should become the preferred reform approach to achieve Universal Health Coverage.

All seven Nigerian delegations present in the course (Bauchi, Borno, Gombe, Kaduna, Niger, Ondo, Rivers State) indicated they wish to move PBF to a sustainable systems approach. Four states (Bauchi, Borno, Gombe and Ondo) are in NSHIP, but funds will run out by 2020. Three states (Kaduna, Niger and Rivers) wish to set up a PBF systems with their own funding from the start. So the Nigerian PBF system is at a cross roads.

Different World Bank approaches (SOML, DFF, PBF, nutrition) tested different strategies, but created problems in the process.

(i) The Save One Million Lives programme is basically a DLI contract mechanism between the Federal and the State level, without applying PBF best practices at the LGA and health facility levels. It therefore became seen as an input project as states used their money in the "business as usual" manner. Its evaluation in 2019 was not favourable.

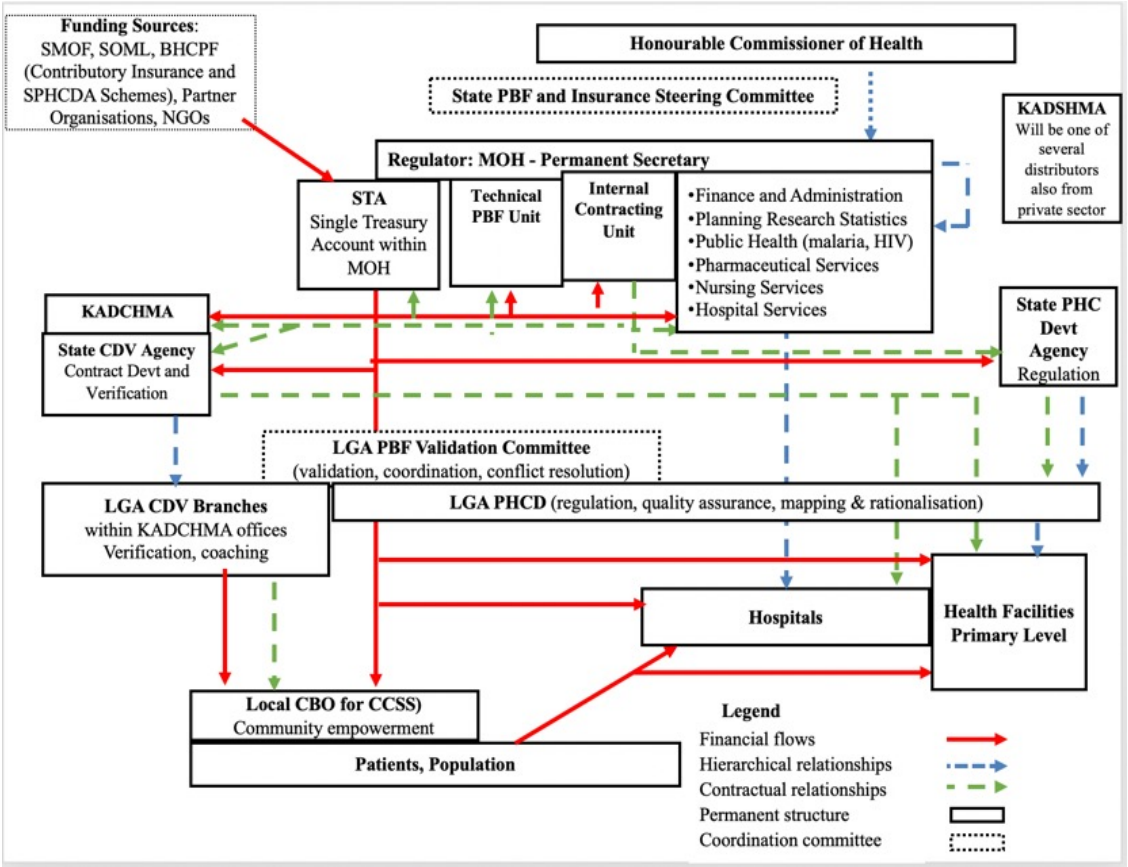
(ii) The decentralized facility financing (DFF) approach was a research idea to finance the control LGAs of the PBF LGAs but without any verification. This design aimed to test in how far it was the additional cash money to health facilities or the reform changes and tools in PBF that made the difference for better performance. Yet, this academic design was quickly compromised by contamination and cross-overs. Not surprisingly, the 'evaluation' study subsequently showed that the DFF facilities too showed encouraging results. Yet, the DFF approach basically has no checks and balances and totally lacks transparency and should never have been proposed in the first place. Since 2014, numerous groups attending the PBF courses in Mombasa proposed to change the DFF approach towards PBF, but these recommendations were ignored for many years and created contradictions in the designs and political use of terminology.

(iii) In addition, the Bank also developed a Nutrition programme (ANRIN) which has not been integrated with the PBF reforms. It would be unfortunate if this large program would not benefit from the advantages of the decentralized performance approach. It should advocate the local purchasing of supplementary feeding by the health facilities instead of centralized input financing and thereby create enormous economic multiplier effects.

1.3.4 Recommendations that apply in all States

- The World Bank is advised to harmonize its different projects such as NSHIP, SOML, DFF and ANRiN. So far, these projects ran in parallel and with some contradiction hampering the Bank to use its power to promote sustainable, efficient and quality-oriented health reforms in Nigeria.
- Analyse in each State how to move from largely input-based systems to output-based running of the health system?
- Analyse how to deal with the interests vested in the large input schemes (infrastructure, drugs, equipment) and start a constructive dialogue with the parties concerned about moving from input to output based running of the health care system.
- Embed PBF within the Ministries of Health at Federal and State levels. This to obtain access to the decision-making authorities and funding streams. For an example of the institutional set-up see below.
- Consider to embed the CDV Agencies within the Contributory Health (Insurance) Scheme (CHS). The CHS already has a legal status and federal backing and it is better positioned to generate domestic funds. Yet, CHS as a stand-alone intervention has several design problems and inefficiencies. A harmonization with PBF - if well executed - could create numerous win-win opportunities such as better quality, more efficiency and realistic targeted equity instruments.
- At State level, the State Ministries of Health should mobilize domestic resources to create new PBF budget lines including from the input-oriented capital investment, State Trust Funds, donors' resources as well as existing budget streams of PBF, insurance and SPHCDA.
- Depending on the ambitions of each State, the PBF budget should range from USD 4.00 per capita per year up till $ 7-12 if a larger number of activities (more free health care, including supplementary feeding nutrition program, including non-communicable diseases) is foreseen or when there is an urgent need for rehabilitation through the quality improvement bonuses. If a State has a large proportion of internally displaced persons or refugees this will also increase the budget requirements.

- Scale up of the PBF coverage in the States to 100% as soon as possible. This is desirable in order to create good economies of scale and to allow for the harmonization of the health system.
- In order to expand the current performance-based financing design it is recommended to develop performance contracts with all agencies and directors under the ministry of health and its agencies.
- All States stress the need for advocacy through exchanges with the decision-makers, meetings, State Health Summits, or through conducting study visits and following PBF courses.
- Several States also expressed the need to review the existing Laws in such a manner that they allow the PBF best practices to be applied and in particular autonomous health facility management, and targeted free health care with user fee payments.
- The *generalized* free health 'policy' should be replaced with sound quality-driven health-financing approach with *targeted* free health care.
- Include PBF in the medical and nursing schools' curriculum.



1.3.5 Specific Bauchi State context and recommendations

Bauchi State has 20 LGA and 7,2 million population and is part of the World Bank-supported NSHIP PBF program since 2017. Currently, approximately 60% of the population is covered with PBF. This program, during its short existence, produced exciting results and the State wishes to expand PBF and make it sustainable. Yet, so far, the State has not used its own funds for the implementation of PBF.

Specific recommendations

- Propose PBF during the forthcoming health summit as the best approach to boost the performance of the health sector.
- Mobilize various sources of funding in the state such as the State Health Budget, the Bauchi State Health Trust Fund, the Bauchi State Health Contributory Management Agency, the Nigeria State Health Investment Project, the Saving One million Lives Programme, the Basic Health Care Provision Fund and the many national and international donor partners.
- Expand the current performance-based financing design to include performance contracts with all agencies and directors under the Ministry of Health and its agencies.
- Integrate PBF operations within the Bauchi State Health Contributory Health (insurance) scheme.

1.3.6 Specific Borno State context and recommendations

Borno State in the North-East of the country has 6,3 million inhabitants with 27 LGAs. Since 2009, Borno State has been suffering from insurgencies that created huge internal population movements. There are high levels of insecurity in large parts of the state. This state of affairs has resulted in many related health challenges such as epidemics, malnutrition, WASH problems, etc.

The results of the PBF program that started in 2017, in two pilot LGAs have been very promising. Hence, after NSHIP ends in 2020, the state wishes to continue PBF in two major LGAs, which host a large part of the internally displaced people with a total of 1,7 million persons. This requires to unlock domestic finances. The cost is calculated at USD 5 per capita per year, thus requiring USD 8.5 million per annum for the target population.

Recommendations

- Conduct a costing for the PBF program with realistic assumptions of what the budget can achieve.
- Unlock input-financing from domestic and external resources by exploring with external partners the possibilities to transform input financing into output financing;
- Advocate with key stakeholders, notably in the context of the External Partners Forum
- More specifically, the Borno delegates will conduct:
  - Advocacy to the Governor through the adviser for health to mobilize USD 5 per capita in 2020 for 1.7 million people in two target LGAs.
  - Advocacy to the House of Assembly for inclusion of PBF in school curriculum college of health and technology and College of nursing and mid-wives to create cadre for PBF implementation
  - Advocacy for a targeted free health care approach to the vulnerable populations.

1.3.7 Specific Gombe State context and recommendations

Gombe state has a population of 3,6 million and 11 Local Government Areas. Only 3.5% of the 2019 state budget was allocated to health. Gombe is engaged in the World Bank-supported Nigeria State Health Investment Program (NSHIP-AF) since 2017 and has successfully implemented PBF in 6 of the 11 LGAs. The Gombe Delegation believes that the performance-based financing system approach is capable of addressing the health challenges in the State and to generate confidence that money spend on health can achieve a visible impact for the population. However, NSHIP will

end in 2020 and Gombe State wishes to sustain the P|BF program through state financing.

Recommendations

- Advocate that the state government ensures adequate funding and timely release of budgetary allocation to the health sector by using the PBF approach.
- The state Government should sustain and scale up the NSHIP program to the remaining five Local Government Areas of the state after the expiration of the NSHIP project.
- The State House of Assembly should pass a bill establishing the State Contributory Health Scheme in line with the principles of performance-based financing.
- Specifically, the Gombe delegate will:
  - Advocate the successes of PBF in the implementing LGA, through organizing meetings with members of the State Executive Council and members of the House Committee on Health of the state assembly to get their buy-in on PBF principles.
  - Advocate the establishment of the State Contributory Health Scheme in line with the principles of PBF. This requires the State House of Assembly to pass a bill on the establishment of the Contributory Health Scheme accordingly.
  - Establish a basket fund to coordinate donor funds in the state by organizing engagement meetings with Ministries of Finance, Budget and planning, Health, SPHCDA and office of the state accountant general, and representatives of donor agencies (BMGF, USAID, GAVI etc.)
  - Prepare the 2021 state health budget in line with PBF principles together with Ministries of Health and State Primary Health Care Development Agency.

1.3.8 Specific Ondo State context and recommendations

Ondo State located in the South-Western part of Nigeria has a population of 5.1 million with 18 LGAs. Ondo State was among the three initial PBF pilot states of NSHIP since 2011, scaling up to 9 LGAs in 2014 while the remaining 9 LGAs were operating under the research design of Decentralized Facility Financing (DFF). Results were good, but NSHIP financing will run out by June 2020 and the State has not prepared a sustainability plan from the outset of the project.

There are several reasons for the failure to develop sustainable PBF in Ondo State:

a) There are contradictions in the design of the World Bank approaches (PBF, SOML and DFF) as well as with other partners;
b) There is no connection as yet between the PBF approach and the current Contributory Health (Insurance) Scheme (CHS);
c) There may be reluctance among key decision makers to abandon the less transparent input-financing system over which they have a lot of decision power;
d) Key actors may lack full knowledge about PBF and its potential benefits.

Moreover, the general free health care policy in the State makes it difficult to provide quality services and prevent stock-outs of essential drugs and other inputs.

Recommendations

- Support the current governor, who is keen to improve the health services in the state.
- Participate and advance PBF during the planned high-level summit on the future of PBF with main State actors and the World Bank before the end of the year.

- Merge the PBF best practices with the health insurance CHS system and message that this can also put insurance in a more stable and successful tracking to achieve universal health coverage. In addition, there is a need towards a more aggressive State approach to generate revenues for funding the PBF /CHS interventions.
- Advocate for the continuous training involving stakeholders in the health sector as well as the Ministry of Finance, Budget & Planning. Include PBF in the medical and nursing schools' curriculum.
- Review the current law regarding the State Contributory Health Insurance (CHS) to incorporate PBF best practices within the CHS scheme. This includes the creation of a PBF Contract Development and Verification Agency within CHS.
- The new style PBF program may transfer its verification roles of the current NSHIP PIU to a CHS/PBF Unit. This to assures the sustainability of the PBF program at a level where it can more easily obtain State and Federal funds. The SPHCDA would continue to play its role as regulator for the LGAs and primary level health facilities.
- Scale up of the PBF approach to 100% of the State.
- Pool the different sources of funds towards PBF such as: a. Basic Health Care Provision Fund (SPHCDA gateway and Contributory Health Scheme gateway); b. State Government counterpart funding for BHCPF; c. State Government fund for vulnerable population through CHS; d. the SOML; e. State Health Trust Fund.
- Establish the Partners Coordination Forum in the State to Coordinate the activities of all partners and donors operating in the State.
- The free health 'policy' should be replaced with sound quality driven health financing approach with efficient financial management and equity of access.

1.3.9 Specific Kaduna State context and recommendations

Kaduna State is located in the North-West of Nigeria struggling with challenging health outcomes, severe shortages of human resources, and demotivated staff. While not yet involved with PBF, there is a strong political will at the highest levels to enhance the delivery of quality health services. The State has also expressed the interest to explore the potential of PBF.

The problems of the health systems are the same as described in the general Nigeria section above with generalized free health care without resources, which complicates the advancement of quality health services. There is an urgent need to move away from input-based system of financing health care to output method (transfer cash directly to health facilities). Yet, this may be opposed by those with interests to maintain the decision-power over the input resources.

Recommendations

- Prepare a draft information Memo for the Commissioner of Health to present at the State Council meeting.
- Advocate among the Deputy Governor and Acting Commissioner of Health for permission to develop and finance a pilot proposition for 3 LGAs.
- Analyse which funds are available in Kaduna for PBF and which can be used for a pilot in the 3 LGAs.
- Discuss the PBF institutional frame work that the Kaduna team developed in Mombasa, which establishes the PBF unit inside the Ministry of Health.
- Engage a PBF consultant for technical support in the PBF pilot.

1.3.10 Specific Niger State context and recommendations

Niger State has a highly dispersed population of 6.1 million with 25 LGAs. The health sector is critical to Niger State development, and is a priority of the present administration. Health indicators are poor and geographical access, workforce productivity and the service quality pose profound challenges.

Recommendations

- Develop a plan for a PBF pilot in three LGAs with a design that applies the PBF best practices and instruments.
- Organize a study tour to NSHIP implementing states to provide additional information for rolling out the proposed pilot.
- Undertake a detailed costing of above $ 4-6 per capita per year. Currently, the available funds for PBF could serve about 575,000 people. A full-fledged, well designed PBF" pilot in Niger would achieve convincing results visible for the population and decision makers. Such results would serve an as advocacy tools to transform the input State budget lines into PBF budget lines. This would allow the State-wide scale up of PBF.
- Encourage senior key stakeholders to attend one of the SINA PBF courses. This to learn the paradigm shifts in health care delivery systems and to develop action plans for its implementation.
- Integrate the PBF strategy in the State Contributing Health Scheme, which is still at the pre-implementation stage, so there is room to discuss.

1.3.11 Specific River State context and recommendations

Rivers State is located in the southern part of Nigeria and is embedded in the Niger delta region. Rivers State is located in the oil-rich Niger Delta region and has 23 Local Government Areas with Port Harcourt as the State capital. Rivers State is the second largest economy in Nigeria with two major refineries, two major seaports and airports and various industrial estates. While the State's economy is still largely dependent on oil, the declining oil price and ongoing security challenges has caused a steady decline.

The quality of health services is such that it is difficult to achieve UHC without major reforms and the PBF approach could provide the answers.

Recommendations

- Raise awareness and advocate to start PBF in Rivers State at the next State Steering Committee and prepare a briefing document on PBF principles and best practices;
- Encourage main decision makers such as the Deputy Governor, the Commissioner for Health, the PS MOH, PS PHCMB & DPRS MOH to attend next PBF course;
- Pilot PBF in 1 LGA covering a population of 1,000,000 residents with at least 4 USD capita per year.

1.3.12 South Sudan

Decades of war and tribal violence have rendered a large part of the population very poor. Over 60% of South Sudan's population lives below the poverty line. Health indicators and service delivery are all deeply challenged. The health system has problems at all levels such as in health service delivery, finance, supply chain management, human resources, and data management. The health system is mainly

financed by donors, but they apply the inefficient input- and "zero cash" system at health facility level that complicates the development of sustainable health facilities.

In this context, Cordaid is contemplating a PBF pilot in Torit County, for a population of 120.000 people, with one hospital (Torit State hospital) and the primary level health facilities. The conditions in Torit are favourable due to a relatively good accessibility of the health facilities, and a relatively well-developed local economy. Cordaid aims to move carefully to develop this pilot, and to build relationships and to strengthen local governance structures.

Recommendations

- Debrief the Cordaid Office to present the Mombasa action plan with the aim to start a PBF pilot program in Torit county aiming at 120.000 people. Chief points of discussion are the sources and the size of the funding needed to execute this PBF pilot, and the links with local authorities;
- Conduct meetings with the National State and Torit County Health authorities to discuss the possibility of piloting a PBF program in 50% of Torit County. The pilot should also conduct research by comparing the results in terms of quantity, quality and equity in the PBF Health facilities with the other 50% of the county applying the current Health Pool fund approach of zero cash input financing.
- Execute a feasibility study at National and Torit County level, investigating the baseline situation in both the PBF and the Pool fund health facilities.
- Solicit the support of public health- and PBF expert(s) to assist the team in identifying output indicators, mapping of the health facilities for PBF and rationalization so that each main PBF contract holder covers a catchment area of around 8,000 populations. In each catchment area, the main contract holder may also sub-contract smaller health units.

2. RESUME EN FRANCAIS

Le prochain cours d'anglais PBF à Mombasa aura lieu du lundi 23 mars au samedi 3 avril 2020.

Le 80ème cours international PBF organisé par SINA Health à Mombasa (Kenya) en novembre 2019 a accueilli 37 participants du Nigéria 19 ; Libéria 16 ; Soudan du Sud 1 ; et CAR 1. La plupart provenaient du secteur de la santé.

Le cours a été jugé par les participants comme l'un des meilleurs depuis 2007 et les critères de *méthodes, de la facilitation, de participation et d'organisation* ont été très bien notés, avec des scores moyens respectives de 95%, 93% et 94%. L'évaluation finale a révélé que pour 100% des participants, le contenu du cours était bien lié à leurs activités professionnelles et que la méthodologie du cours était excellente. Pourtant, 50% des participants au cours ont également déclaré que le cours était trop court.

2.1 Nigeria

En ce qui concerne l'expérience PBF au Nigéria, les sept États (States) présents à Mombasa étaient mélangés : quatre États - Bauchi, Borno, Gombe et Ondo - font partie du programme FBP (NSHIP), mais les fonds seront épuisés d'ici 2020. Trois États (Kaduna, Niger et Rivers) souhaitent mettre en place un système PBF avec leur propre financement dès le départ. Ainsi, le système de FBP nigérian est à la croisée des chemins.

Les États présents à Mombasa partagent tous des défis similaires dans leurs systèmes de santé (pré-PBF). Il existe des ressources humaines insuffisantes et mal réparties, des systèmes d'intrants inefficaces avec des ruptures de stock fréquentes, des infrastructures délabrées, des services de mauvaise qualité et la verticalisation des programmes. Certains représentants d'État décrivent leur système de santé actuel comme étant « en état d'urgence ».

Les participants au cours ont convenu que les projets pilotes PBF dans les États menés dans le cadre du programme NSHIP soutenu par la Banque mondiale - mis en œuvre depuis 2011 - ont produit de très bons résultats. En conséquence, il est de plus en plus compris que le FBP devrait devenir l'approche de réforme privilégiée pour atteindre la couverture sanitaire universelle. Les sept délégations nigérianes présentes au cours ont toutes indiqué qu'elles souhaitaient faire passer le FBP à une approche systémique durable.

Différentes approches de la Banque mondiale ont testé différentes stratégies, mais cela a également créé des problèmes dans le processus.

(i) Le programme Save One Million Lives (SOML) est essentiellement un mécanisme contractuel entre le gouvernement fédéral et les États, sans appliquer les meilleures pratiques en matière de FBP au niveau des collectivités locales (local government authorities - LGA) et des établissements de santé. Il a donc été considéré comme un projet « input » car les États utilisaient leur argent de la manière habituelle. Son évaluation en 2019 n'était pas favorable.

(ii) L'approche de financement décentralisé (DFF) était une idée de recherche visant à financer les LGA témoins mais sans aucune vérification. Pourtant, dans cet approche DFF il n'existe fondamentalement pas des vérification et d'équilibres, et manquait totalement de transparence et n'aurait jamais dû être proposée. Depuis 2014, de nombreux groupes participant aux cours sur le FBP à Mombasa ont proposé de modifier

l'approche du DFF à l'égard du FBP, mais ces recommandations ont été ignorées pendant de nombreuses années et ont créé des contradictions et peut-être même contribué à des systèmes moins transparents.

(iii) En outre, la Banque a également développé un programme de nutrition (ANRIN), qui n'a pas été harmonisé avec les réformes du PBF. Il est regrettable que ce vaste programme ne bénéficie pas des avantages d'une forme d'approche décentralisée axée sur les performances. Il devrait plaider en faveur de l'achat local d'aliments supplémentaires par les établissements de santé et leurs communautés plutôt que par le financement centralisé des intrants. Ce programme de nutrition, s'il applique les principes du PBF, pourrait avoir d'énormes effets multiplicateurs sur l'économie.

2.2 Recommandations generales pour le Nigeria

- Il est souhaitable d'étendre le plus tôt possible le FBP à 100% des États. Ceci afin de créer de bonnes économies d'échelle et de permettre l'harmonisation du système de santé conformément aux principes de bon sens de l'autonomie, des partenariats public-privé, de la concurrence pour les contrats et de la transparence.
- Selon les ambitions de chaque État, le budget du PBF peut aller de 4,00 USD par habitant et par an jusqu'à 7-12 USD si un plus grand nombre d'activités est prévu. Cela peut contenir davantage de soins de santé gratuits, le programme de nutrition supplémentaire, ou les maladies non transmissibles. De même, une augmentation des besoins budgétaires par habitant sera nécessaire lorsque les infrastructures sont délabrées ou si l'État compte une forte proportion de personnes déplacées ou de réfugiés.
- Cependant, pour que les réformes du FBP réussissent, il sera nécessaire de prendre en compte les intérêts dévolus aux systèmes d'intrants (infrastructures, médicaments, équipements). Cela nécessite un dialogue constructif avec les parties concernées de comment passer du fonctionnement du système de santé basé sur les inputs à celui basé sur les résultats.
- Tous les États soulignent la nécessité d'un plaidoyer par le biais d'échanges avec les décideurs, de réunions, de sommets d'État sur la santé, de visites d'étude et de suivre des cours FBP.
- Intégrez les Cellules Technique des États FBP dans les ministères de la santé aux niveaux des États. Ceci pour avoir accès aux autorités décisionnelles et aux sources de financement.
- Afin d'élargir la conception actuelle du financement basé sur la performance, il est recommandé de développer des contrats de performance avec toutes les agences et tous les directeurs relevant du ministère de la santé et de ses agences.
- Envisagez d'intégrer les agences de la contractualisation et de la vérification (ACV) dans le schéma d'assurance-maladie contributif (CHS). Le CHS dispose déjà d'un statut juridique et d'un soutien fédéral, et elle est mieux placée pour générer des fonds. Pourtant, le CHS, en tant qu'intervention autonome, présente plusieurs problèmes conceptuels et d'inefficacité.
- Au niveau de l'État, les ministères de la Santé des États devraient mobiliser des ressources nationales pour créer de nouvelles lignes budgétaires PBF, y compris des investissements en capital axés sur les intrants, des fonds d'affectation spéciale, des ressources des donateurs ainsi que les flux budgétaires existants du PBF, de l'assurance et du SPHCDA.
- Il est conseillé à la Banque mondiale d'harmoniser ses différents projets tels que NSHIP, SOML, DFF et ANRiN.

- Plusieurs États ont également exprimé le besoin de réviser les lois existantes de manière à permettre l'application des meilleures pratiques PBF, en particulier la gestion autonome des établissements de santé, et la mise en place de soins de santé gratuits « ciblés » à travers le paiement des tarifs de recouvrement des coûts.
- La politique *généralisée* de gratuité de la santé devrait être remplacée par une politique des soins de santé gratuits *ciblée,* mais qui vise d'abord la qualité de soins et l'efficience.
- Inclure le PBF dans le programme des écoles de médecine et de sciences infirmières.

2.3 Recommandations spécifiques au niveau des Etats

2.3.1 Bauchi State

L'État de Bauchi compte 7,2 millions d'habitants et fait partie du programme FBP NSHIP soutenu par la Banque mondiale depuis 2017. À l'heure actuelle, environ 60% de la population est couverte par le PBF. Ce programme, au cours de sa courte existence, a produit des bons résultats et l'État souhaite développer le FBP et le rendre durable. Pourtant, jusqu'à présent, l'État n'a pas utilisé ses propres fonds pour la mise en œuvre du FBP.

L'équipe de Bauchi propose le PBF comme la meilleure approche pour améliorer les performances du secteur de la santé. À cette fin, l'État devrait mobiliser diverses sources de financement locales. Il devrait inclure des contrats de performance avec tous les organismes et directeurs relevant du ministère de la Santé et de ses organismes. Enfin, il est souhaitable d'intégrer les opérations PBF au schéma d'assurance maladie contributif (CHS) de Bauchi State.

2.3.2 Borno State

L'État de Borno, dans le nord-est du pays, compte 6,3 millions d'habitants. Depuis 2009, l'État souffre d'insurrections qui ont créé d'énormes déplacements internes de la population. Les résultats du programme PBF lancé en 2017 dans deux LGA pilotes ont été très prometteurs. Par conséquent, après la fin du NSHIP en 2020, l'État souhaite poursuivre le FBP dans deux grandes LGA, avec 1,7 million de personnes au total et de nombreux déplacés internes. L'équipe propose de faire un costing de manière réaliste le programme FBP et de débloquer le financement « input » à partir de ressources internes et externes en financement de la production à 5 USD par habitant et par an.

2.3.3 Gombe State

L'état de Gombe a une population de 3,6 millions d'habitants. Seulement 3,5% du budget de l'État pour 2019 ont été alloués à la santé. Gombe a mis en œuvre avec succès le FBP dans 6 des 11 collectivités locales. Cependant, le programme FBP NSHIP se terminera en 2020 et l'État de Gombe souhaite maintenir le programme FBP au moyen d'un financement de l'État. Le gouvernement de l'état devrait maintenir et étendre le programme NSHIP aux cinq autres collectivités locales (LGA) de l'état. Cela nécessite la création d'un fond de panier pour coordonner les fonds des bailleurs dans l'État en organisant des réunions d'engagement avec les ministères des Finances, du Budget et de la Planification, de la Santé, du SPHCDA et du bureau du comptable général de l'État et des représentants des organismes bailleurs. La Chambre d'assemblée de l'État devrait également adopter un projet de loi établissant le schéma d'assurance maladie

contributif (CHS) de l'État, conformément aux principes du financement basé sur la performance.

2.3.4 Ondo State

L'État d'Ondo compte 5,1 millions d'habitants. L'État figurait parmi les trois États pilotes initiaux du NSHIP dans le cadre du PBF depuis 2011, passant à 9 collectivités locales (LGA) en 2014. Les résultats ont été bons, mais le financement du NSHIP sera épuisé d'ici juin 2020.

L'État n'a pas préparé de plan de durabilité depuis le début du projet et les principaux décideurs pourraient hésiter à abandonner le système de financement des inputs moins transparent sur lequel ils ont beaucoup de pouvoir décisionnel. En outre, la politique générale de gratuité des soins de santé dans l'État rend difficile la fourniture de services de qualité et produit les ruptures de stock de médicaments essentiels et d'autres intrants. Le participant d'Ondo mènera un plaidoyer auprès du gouvernement de l'État et des bailleurs afin de faire progresser le FBP lors du sommet de haut niveau sur l'avenir du FBP, qui rassemblera les principaux acteurs étatiques et la Banque mondiale. Il est également nécessaire de fusionner les meilleures pratiques PBF avec le système d'assurance maladie. Il soit souhaitable d'appliquer l'approche PBF à 100% de l'État et de mettre en commun les différentes sources de financement pour le PBF.

2.3.5 Kaduna State

L'État de Kaduna est situé au nord-ouest du Nigéria. Les problèmes des systèmes de santé sont les mêmes que ceux décrits dans la section générale ci-dessus sur le Nigéria avec la politique généralisée de gratuité des soins de santé, mais sans ressources suffisantes. Bien que n'étant pas encore impliqué dans le FBP, il existe une volonté politique forte aux plus hauts niveaux d'explorer le potentiel du FBP. Il reste à voir dans quelle mesure il y aura une opposition de ces décideurs, qui ont intérêt à conserver le pouvoir de décision sur les ressources en intrants. L'équipe Kaduna rédigera un mémo d'information que le Commissaire à la santé présentera lors de la réunion du Conseil d'État. Il est nécessaire d'analyser quels fonds sont disponibles à Kaduna pour le FBP et lesquels peuvent être utilisés pour un projet pilote dans les 3 collectivités locales (LGA). Il soit désirable d'engager un consultant PBF pour le support technique dans le projet pilote PBF.

2.3.6 Niger State

L'État du Niger a une population très dispersée de 6,1 millions d'habitants. Le secteur de la santé est essentiel au développement de l'État du Niger et constitue une priorité de l'administration actuelle. Les indicateurs de santé sont médiocres et l'accès géographique, la productivité de la main-d'œuvre et la qualité du service posent de graves problèmes.

Le participant nigérien propose un projet pilote PBF dans trois collectivités locales (LGA). En préparation, il peut être nécessaire d'organiser un voyage d'étude dans les États mettant en œuvre le NSHIP. Un costing réaliste de plus de 4 à 6 dollars par habitant et par an devrait être fait avec les ressources disponibles afin de permettre la mise en œuvre d'un projet pilote de FBP bien conçu. Cela devrait produire des résultats convaincants, visibles pour la population et les décideurs. Cela sera le meilleur outil de plaidoyer pour que l'État transforme à l'avenir les lignes budgétaires des « inputs » déjà existantes en lignes budgétaires PBF.

2.3.7 Rivers State

L'État de Rivers est situé dans la région du delta du Niger, riche en pétrole, avec Port Harcourt comme capitale. Bien que l'économie de l'État reste largement tributaire du pétrole, la baisse du prix du pétrole et les problèmes de sécurité qui se posent continuent de provoquer une baisse économique constante. La qualité des services de santé est tellement mauvaise qu'il est difficile de réaliser la CSU sans réformes majeures et l'approche PBF pourrait fournir les réponses. Le participant propose de sensibiliser et de plaider en faveur du lancement du FBP dans l'État de Rivers lors du prochain comité de pilotage et de préparer un document d'information sur les principes et les meilleures pratiques en matière de FBP.

2.4 Libéria

Le système de santé libérien est fortement dépendant des bailleurs depuis l'urgence de la guerre civile en 1989 et l'arrivée de maladies à virus Ebola en 2015. Pourtant, ce soutien des bailleurs est en train de disparaître progressivement et l'économie a également ralenti. Des réformes en profondeur sont nécessaires pour utiliser plus efficacement les maigres ressources publiques.

La mortalité maternelle est extrêmement élevée, avec 1 072 décès pour 100 000 naissances vivantes. La gestion des ressources humaines est compromise et le pays utilise des chaînes d'approvisionnement en intrants inefficaces.
Comme cela a été démontré dans les différents programmes de performance au Libéria au cours des 8 dernières années, le PBF peut aider à remédier à ces insuffisances. Cependant, pour exploiter pleinement son potentiel, cela nécessite une réforme structurelle plus profonde des meilleures pratiques actuelles du FBP et l'harmonisation par le gouvernement et le ministère de la Santé des approches des différents bailleurs.

2.5 Recommandations pour le Libéria

- Plaider auprès des décideurs des ministères de la Santé et des Finances pour un financement harmonisé FBP à grande échelle fondé sur les résultats ;
- Veiller à ce que l'approche FBP soit incorporée dans la stratégie de santé ;
- Harmoniser les différentes approches de performance du Libéria en un seul système national FBP ;
- Transformer le système actuel de financement des soins de santé gratuits *généralisés* en un système de soins de santé gratuit *ciblé* ;
- Réviser la structure institutionnelle du programme FBP ;
- Transférer la Cellule Technique Nationale FBP sous le cabinet du ministre pour une meilleure coordination ;
- Introduire le système de bonus d'équité géographique dans le but de soutenir les services ruraux et de promouvoir la rétention du personnel dans les établissements de santé éloignés ;
- Identifier une institution nationale jouant le rôle d'agence de contractualisation et de la vérification (ACV). Créer des antennes ACV au niveau des LGA ;
- Les ACV devraient sous-traiter les établissements de santé en fonction de leurs performances et non de leur statut de structures publiques, privées ou religieuses ;
- Effectuer la cartographie et la rationalisation des aires de santé basé sur des normes nationales allant de 5 000 à 14 000 habitants ;
- Les établissements de santé devraient établir leurs tarifs de partage des coûts avec leurs communautés respectives ;
- Introduire des bonus d'amélioration de la qualité ;

- Introduire une recherche action basée sur les besoins avec des allocations budgétaires dans les contrats de performance au niveau central et pour les ACV.

2.6 République Centrafricaine - Education

Le secteur de l'éducation en RCA est confronté à de graves problèmes : la population est peu scolarisée, le financement est insuffisant, les stratégies d'inputs sont inefficaces et le manque d'enseignants qualifiés est extrême. L'infrastructure scolaire est en grande partie délabrée et les manuels scolaires manquent.

Les projets FBP Éducation sont en cours depuis 2009 et bénéficient du soutien de Cordaid. Ils ont obtenu des résultats probants. Le FBP dans le secteur de l'enseignement primaire en RCA ne coûterait qu'une somme modeste d'environ 20 à 25 millions USD par an. Le ministère de l'Éducation souhaite adopter et financer un financement basé sur la performance, mais cela ne s'est pas encore concrétisé. Par conséquent, Cordaid continue de financer le FBP dans l'un des districts - Nana Mambéré - en tant qu'instrument pilote et de plaidoyer continu. Dans ce plan d'action, nous proposons des moyens d'améliorer cette initiative et de promouvoir davantage l'approche PBF.

2.7 Recommandations pour le FBP en Education

- Plaider auprès du ministère de l'Éducation pour trouver un financement pour les réformes du PBF. La Banque mondiale est l'organisation la plus susceptible de réagir favorablement. En outre, les lignes de saisie du budget de l'État pour le secteur de l'éducation devraient être revues afin de les transformer en lignes budgétaires FBP.
- Revoir la politique de la gratuité « généralisé » de l'enseignement, en plaidant en faveur d'une politique de la gratuité « ciblée » de l'enseignement dans le but d'améliorer la qualité, d'utiliser les ressources plus efficientes et de motiver les enseignants.
- Un costing FBP pour 60 000 élèves de 20 USD par habitant et par élève nécessite 1,2 million USD, alors que seulement 850 000 USD sont disponibles à ce jour. Il est donc nécessaire de réduire le nombre d'élèves bénéficiant du programme FBP de Cordaid ou de rechercher un financement supplémentaire.
- Promouvoir la séparation des fonctions (Cordaid exécute actuellement la gestion des fonds, la vérification et l'assurance qualité) en incluant les autorités éducatives locales et en renforçant le rôle de la Cellule Technique Nationale d'éducation sur le FBP au sein du Ministère d'Éducation.
- Introduire l'outil de gestion des indices pour améliorer la transparence dans les écoles et mieux contrôler les processus financiers, y compris les primes de performance, afin de motiver les enseignants.

2.8 Soudan du Sud

Des décennies de guerre et la violence tribale ont rendu très pauvre une grande partie de la population. Les indicateurs de santé et la prestation de services sont profondément contestés. Le système de santé est principalement financé par les bailleurs, mais ils appliquent le système inefficace des « inputs » et du système « zéro cash » au niveau des structures de santé, ce qui complique le développement d'institutions durables.

Dans ce contexte, Cordaid envisage un projet pilote de FBP dans le « County » de Torit, pour une population de 120 000 habitants, avec un hôpital et des établissements de santé de niveau primaire. Les conditions à Torit sont favorables en raison d'une accessibilité

relativement bonne des établissements de santé et d'une économie locale relativement bien développée par rapport aux autres « counties » du pays.

Le participant de Mombasa a l'intention de présenter le plan d'action de Mombasa au bureau Cordaid de Juba dans le but de lancer un programme pilote PBF dans Torit County. Cela pourrait être suivi de réunions avec le gouvernement national et les autorités sanitaires du Torit County pour discuter de la possibilité pour lancer un projet pilot FBP dans 50% du Torit County. Le projet pilote devrait également mener des recherches actions en comparant les résultats dans les établissements de santé FBP avec les 50% restants du County qui continuent à appliquer la méthode actuelle du fonds Health Pool consistant en un financement en input et sans apport en cash. Cela nécessite d'abord une étude de faisabilité au niveau national et au niveau du de Torit County, qui étudie la situation de base dans les établissements de santé et sollicite le soutien d'experts de la santé publique et du FBP pour aider l'équipe à développer le projet pilote FBP.

3. INTRODUCTION

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

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

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

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

The challenge of any PBF-led transformation is that it requires change that is not always easy to manage. It entails informing key stakeholders and changing their terms of reference including those of Ministries. The need to increase provider revenues will under most circumstances also require maintaining some direct fee paying for patients and parents. This will inevitably constitute financial access problems for the very poor. Hence, we include in the design of new PBF interventions demand-side support for the vulnerable in the shape of geographic and individual equity funds.

These new PBF instruments are somewhat comparable to the traditional voucher and conditional cash transfer systems but they are more efficient. In PBF, we tend to avoid inefficient blanket approaches or populist usage of generalized free health care mechanisms. Rigorous empirical research and impact evaluations on the pros and cons of various methods remain necessary and welcome.

3.2 Aims and objectives of the Mombasa PBF course

General aims of the PBF course

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

Specific Objectives

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

3.3 The November 2019 Mombasa course

The 80th 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), Liberia and South Sudan, to the Central African Republic.

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

The updated course guidebook "PBF in Action: Theory and Instruments" was distributed among the participants before the start of the program, upon confirmation of participation. The course materials (a hard copy of the course book, pdf latest version of the course manual, the PowerPoint presentations and country presentations, photos of the course and articles) were distributed during the course, together with the participants' contact details list. On Friday November 1, 2019, field excursions were organized – with great support from Kilifi County Health Office - to five health facilities: Mtwapa Health Centre, Kadzinuni Dispensary, Vipingo Health Centre, Tagaungu HC and Kilifi County Hospital. We wish to acknowledge the support the various clinics provided to the course field trips.

3.4 The pre- and post-test

SINA Health issues a Certificate of Merit to those who pass the exam at the end of the course. Those who do not score 53% or more, obtain a Certificate of Attendance. The exam for this course was conducted on Friday November 8th and consisted of 30 multiple-choice questions, tailored around the main subjects treated during the course.

The average score for pre-test was 47%, while the post-test exam was 67%. So, there was 20% progress between the pre- and the post-test. Participants obtain distinctions when the score is 87% or more.

We congratulate the following participants, who passed with distinction.

87% (= 4 mistakes)

1. Dr Hamza Abubakar — Executive Secretary SPHCDA Kaduna State, Nigeria
2. Dr Paulinus Omode — Coordinator NSHIP Ondo State, Nigeria

93% (= 2 mistakes)

3. Mr. Adamu Mohammed — SPHCDA Bauchi State, Nigeria
4. Mr. Emos Tella — SOML Manager, Kaduna State, Nigeria
5. Ramatu Abdulkadir — Executive Secretary KADHSMA, Kaduna State, Nigeria

Three participants deserved a "merit-mention" of having scores of 80% or 83%, while four participants obtained 50% or lower.

Scores	Nbr	%	Certificate
87% - 100%	5	14,7%	Distinction
80% - 83%	3	9%	Merit – mention
70% - 77%	7	21%	Merit
53% - 67%	15	44%	Merit
0% - 50%	4	12%	Participation
TOTAL	**34**	**100%**	

3.5 Who attended the October – November 2019 PBF course?

SURNAME	First name	Sex	Organisation	Country	Position
Sangnyuykew	Prudence Wongbi	f	CORDAID	CAR	Project controller Cordaid CAR
Bembo	Abel P.	m	PBF Unit / MOH	Liberia	PBF Quality Management Liaison Officer/Hea
Bondo	Michael S.	m	Ministry of Health	Liberia	PBF Primary Officer/Health Services
Dunbar	Nelson K.	m	MOH	Liberia	Director of Research
Erskine	Patricia Amie	f	CORDAID	Liberia	PBF NVA Q&Q Verification officer
Flomo	Jonathan	m	MOH / Sinoe County	Liberia	County Health Officer
Garblah	Joyce Walley	f	MOH / Rivercess County Health T	Liberia	County Health Services Administrator
Geah	Kour Elma	f	MOH/Bong County	Liberia	Medical Director, CB Dunbar Hospital
Howard	Norwu G.	f	Ministry of Health	Liberia	Deputy Minister for Administration
Jacobs	George P.	m	Ministry of Health	Liberia	Assistant Minister for Policy & Planning
Jallah	Y. Mandain P.	f	Ministry of Health	Liberia	Child Health Coordinator/Family Health Divisi
Kerwillain	Garrison J.	m	Ministry of Health	Liberia	IPC Coordinator/HQMU/Health Services
Koiblee	Wesseh	m	Ministry of Health	Liberia	Clinical Coordinator/Nursing Division/Health S
Mulbah	J. Mike	m	Ministry of Health	Liberia	Director, Monitoring & Evaluation
Padmore	Thomas N. B. Pad	m	Ministry of Health	Liberia	Accountant/OFM/Administration
Saye	Rufus Gondah	m	MOH / Nimba County HT	Liberia	Clinical Health Services Director
Tokpah	Patience D. Coope	f	MOH / CHSU	Liberia	Deputy Director for County Health Services U
Alhaji	Usman Bako	m	Office Accountant General, Bauchi	Nigeria | Bauchi	Project Accountant NSHIP
Malami	Sani	m	Governor's Office Bauchi	Nigeria | Bauchi	Special Adviser Governor Multilateral and NG
Mohammed	Adamu	m	BSPHCDA	Nigeria | Bauchi	State project coordinator NSHIP
Mohammed	Rilwanu	m	BSPHCDA	Nigeria | Bauchi	Executive Chairman
Mustapha	Yakubu Mukhtar	m	BSPHCDA	Nigeria | Bauchi	M&E Officer NSHIP PIU
Ahmed	Auwal	m	SPHCDA Borno	Nigeria | Borno	State Technical Assisstant NSHIP
Gumsuri	Abba Suleiman	m	BSPHCDA	Nigeria | Borno	Medical Officer
Muhammad	Abubakar Adam	m	BSPHCDA	Nigeria | Borno	Public Health Physician
Peter	M. Adamu	m	NPHCDA	Nigeria | Borno	PBF National focal person to Borno state
Saidu	Habiba	f	BSPHCDA	Nigeria | Borno	State Project coordinator NSHIP
Shuaibu	Abdulrahman	m	Gombe State PHCDA	Nigeria | Gombe	Executive Secretary
Abdulkadir	Ramatu	f	KADHSMA, Kaduna	Nigeria | Kaduna	Executive Secretary
Abubakar	Hamza	m	SPHCDA, Kaduna	Nigeria | Kaduna	Executive Secretary
Muhammed	Mahmud Shu'Aibu	m	SMOH, Kaduna	Nigeria | Kaduna	Permanent Secretary
Saidu	Aliyu	m	Contributory Health Man. Auth.	Nigeria | Kaduna	Director General
Tella	Emos Emmanuel	m	MOH	Nigeria | Kaduna	Program Manager Saving One Million Lives
Inuwa	Junaidu	m	Niger State PHCDA	Nigeria | Niger	Director Planning Research Statistics
Green	Pauline	f	RSMOH	Nigeria | Rivers	State program manager SOMLPforR
Omode	Paulinus Kunle	m	OSPHCDA	Nigeria | Ondo	Project coordinator NSHIP
Muia	Boniface Kiala	m	CORDAID	South Sudan	Program Manager Torit Sub Field Office

3.6 Facilitation team

The facilitation team consisted of:

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

3.7 Next English PBF course Monday March 23 to April 3, 2020

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

4. DAILY EVALUATIONS BY PARTICIPANTS

4.1 Daily evaluations by participants

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

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

The overall average score for the four criteria combined was 90,4%. This is 7,1% *above* the previous 26 English spoken courses, and 11,4% *above* the 46 previous French spoken courses.

Daily evaluation topics as scored during 10 days	French speaking courses (46x)	English speaking courses (26x)	Mombasa November 2019	Comparison Mombasa November 2019 / Previous 26 English courses	Comparison Mombasa November 2019 / Previous French courses
Methodology and facilitation	85,0%	87,3%	93,9%	6,6%	8,9%
Participation	82,2%	87,0%	93,3%	6,3%	11,1%
Organization	72,5%	86,0%	95,4%	9,4%	22,9%
Time – keeping	76,3%	73,0%	78,9%	5,9%	2,6%
Overall score	**79,0%**	**83,3%**	**90,4%**	**7,1%**	**11,4%**

Table 1: Overall daily evaluation scores of the course.

4.2 Methods and facilitation

Methods and facilitation were 6,6% superior with 93,9% compared to the previous 26 English courses (87,3%) and 8,9% above the average of the French spoken courses (85,0%). Satisfaction with the methods and facilitation remained stable at above 90% during the course.

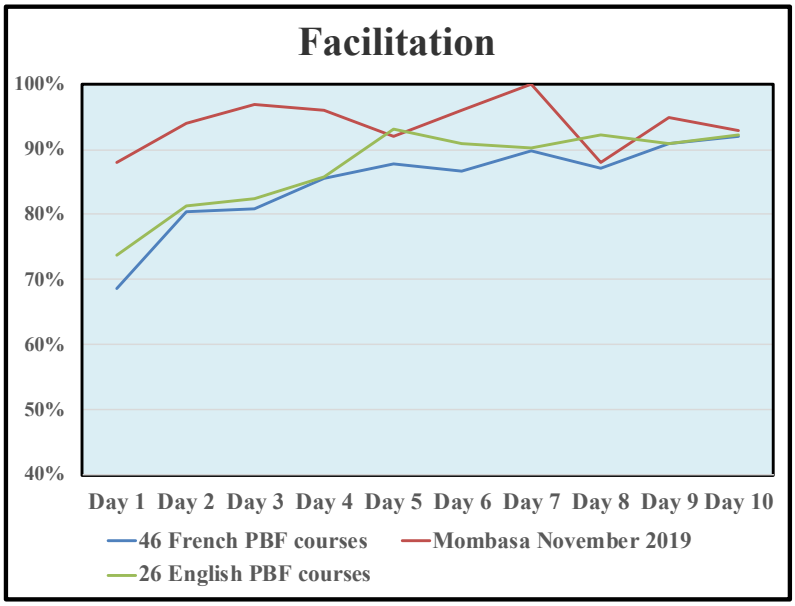


Figure 1: Evolution of the daily evaluations: *methods and facilitation.*

4.3 Participation

The satisfaction with the level of **participation** was 93,3%. This was 6,3% higher than the previous English courses (87,0%) and 11,1% above the French courses (82,2%). Satisfaction with the participation remained stable at above 90% during the course after scoring 84% the first day.

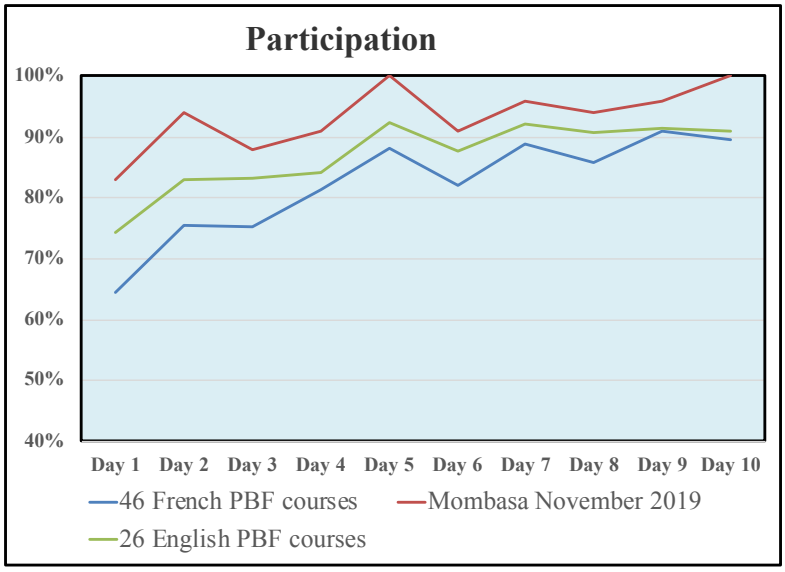


Figure 2: Evolution of the daily evaluation: *participation.*

4.4 Organization

The **organization** of the course in Mombasa had an average score 'very positive or positive' of 95,4%, which is 9,4% *above* the average of 86,0% of the previous English courses and 22,9% *above* the average of 72,5% of the previous French courses. The hotel was generally evaluated as excellent and the cooks even cooked Nigerian *very hot* food.

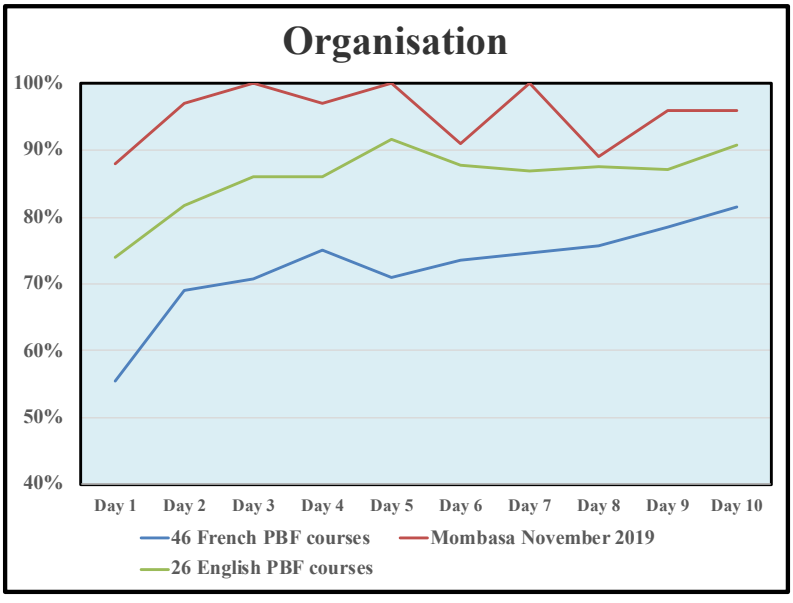


Figure 3: Evolution of the daily evaluation: *organization.*

4.5 Time keeping

Satisfaction with time keeping was 78,9%, which was 5,9% above the previous 26 English courses and 2,6% above the previous French courses. There was a dip in time keeping on Friday and Saturday of the first week to around 50% due to slightly later closure time.

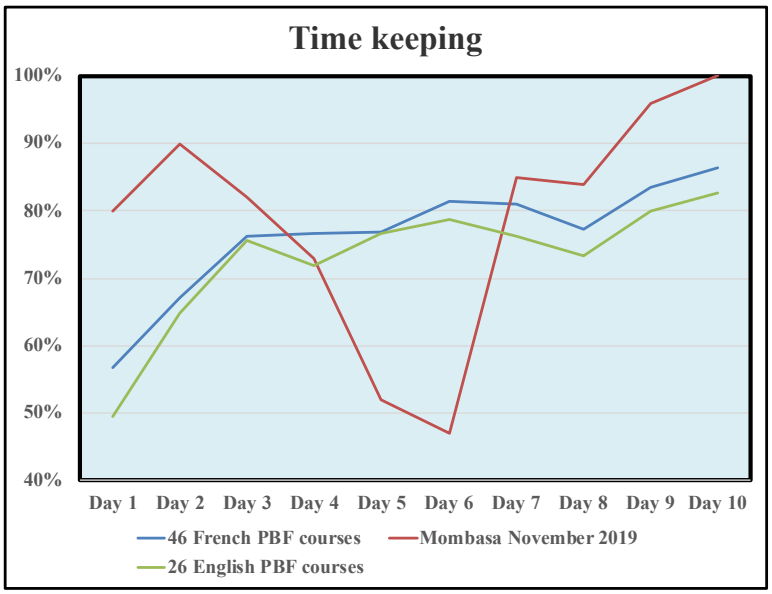


Figure 4: Evolution of the daily evaluation: *time keeping*.

5. DESCRIPTION of the COURSE

Daily Recaps. During this course, the methodology for the daily recaps was modified, where structured questions were posed as part of the modules, encouraging participants to read the chapters in the course book ahead of class. This worked well as it tested understanding of the different concepts while the sessions went on and saved time in the mornings to go straight into the activities of the day.

Daily Evaluation and Feedback from Participants. At the end of each day, during the daily evaluation, participants evaluated the day's activities in terms of the following elements: methods of facilitation, organisation of the course, their level of participation and time keeping. They also gave written feedback to help facilitators and the hotel improve on the quality of the course, as well as any problems they face with the hotel, etc. Where it was necessary, feedback was given to participants about in how far the issues they raised have been solved "a feedback on their feedback".

Evening Sessions. During the first week of the course, evening sessions with country groups were organised which allowed one-on-one dialogue between facilitators and participants to understand country/state context, including challenges and way forward on the action plans. These encounters also helped facilitators to know the participants better as well as to understand their specific needs and impressions of the course.

During the second week, participants worked on their action plans as well as on the group exercises within the modules. In the course of the groupwork, the country groups had second encounters with the facilitation team to discuss progress on their action plans.

Below is the schedule for the evening country meetings

Evening country meetings		
Tuesday October 29, 2019	17:30 – 19:00hr	Liberia
Wednesday October 30, 2019	17:00 – 18:30hr	Nigeria – Kaduna and Niger States
Wednesday October 30, 2019	18:30 – 20:00hr	Nigeria – Bauchi and Gombe States
Thursday October 31, 2019	17:30 – 19:00hr	Nigeria – Ondo and Rivers States
Friday November 1, 2019	17:30 – 19:00hr	CORDAID – CAR and South Sudan
Monday November 4, 2019	17:30 – 19:00hr	Liberia
Tuesday November 5, 2019	17:30 – 19:00hr	Nigeria – Whole Group

Arrival day: Sunday October 27th, 2019

The 80th international PBF course in Mombasa – Kenya welcomed a total of 37 participants representing four African countries - Liberia, Nigeria, South Sudan, and CAR. Most participants arrived on Sunday the 27th of October 2019 and were warmly welcomed by the hotel and the facilitators.

The facilitation team welcomed high level participants from the health sector, one from the Governor's office of Bauchi State Nigeria and one participant from the education sector. Most participants worked in the Ministries of Health or its parastatals at national and sub-national levels, while others worked with the international NGO – Cordaid. Among the participants were 2 deputy Ministers from Liberia, one Permanent Secretary of the MoH of Kaduna State, Nigeria and 5 Chief Executives of Agencies in Bauchi, Gombe, and Kaduna States, Nigeria.

About half of the participants were already involved with PBF implementation in their daily work and attended the course to improve their knowledge of PBF in terms of the theories, best practices and the application of the instruments. Those who were not

already involved with PBF implementation in their daily work were considering the set-up of a new PBF program to address the health system challenges they face.
Upon arrival, participants settled in and were asked to fill out a pre-course questionnaire to enable facilitators better understand each participant needs prior to commencement of the course so as to tailor the contents of the course to the needs of the participants. The course book was also distributed on arrival, so participants could start reading.

Monday October 28th

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

This was followed by the pre-test, which was comprised of 15 multiple-choice questions to test participants existing knowledge on PBF. This session was followed by the "getting acquainted" exercise, where participants were asked to profile themselves in terms of their key strengths in a poster. This session also served as an ice-breaker session, as participants carried out the activity and got to know each other.

The country groups were then established, after which the Mombasa Village 80, was established. In total, ten country groups were created (Liberia, Nigeria | Kaduna, Nigeria | Borno, Nigeria | Bauchi, Nigeria | Gombe, Nigeria | Niger, Nigeria | Ondo, Nigeria | Rivers, CAR and South Sudan).

The following Mombasa 80th village officials were elected to maintain "order" in the village.

Chief : Norwu Howard, Deputy Minister of Administration from Liberia
Deputy Chief : Habiba Saidu, Project Coordinator NSHIP, Borno State
Internal affairs Minister / Time keeper : Abel P. Bembo, PBF Unit, Liberia
Finance Minister: Thomas Padmore, Accountant / OFM / MOH Liberia
Energizers: Peter Adamu, Prudence Sangnyuykewir, Abel P. Bembo

The day ended at 17:00 with the daily evaluation and election of the best debater of the day. In the evening, from 17:30 onwards, participants broke out to conduct a diagnosis of their various health systems assessing in how far the system was cost-effective, and whether PBF could be a solution to some challenges that they have to confront in carrying out their respective duties.

Tuesday October 29th

The day started at 8:30am with feedback from the first exercise of the course. Most participants rated their health systems to be moderately inefficient, in the sense that the health indices in most countries are still poor, despite increasing investments in the sector. Some participants were optimistic that PBF could be a solution to some challenges they face, others were eager to learn more about PBF before making any conclusions.

Module 2 (PBF in context, Definition, history and best practices) was then presented which triggered questions and discussions from participants. From the discussions, most participants had concerns about issues related to equity in health care and how the challenges of inequities in their health systems could be addressed through PBF. In response to this, the *module on equity instruments* in PBF was presented next.

This was followed by the *module 3 on change issues*. During this module, the various changes that PBF proposes were presented in form of questions, and a number of responses presented. Participant used Turning Point technology to enter their responses and this generated a lot of discussions. This module exposed participants to the difficulties that they may encounter in moving towards a PBF reform, but also helped them understand how some of those challenges could be overcome while still maintaining the principles and best practices of PBF.

The presentation on the PBF theories started, before 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 the participants from Liberia, to understand their perception of the course so far, discuss their country specifics and agree on the theme for their action plan. For the action plan, the Liberia team agreed to design a harmonized best-practices PBF program for their country, aiming to address the limitations of their current PBF programs.

Wednesday October 30th

The day started at 8:30 and we continued with the module on the PBF theories (systems analysis, public choice, contracting, decentralization and governance). During this module, the theoretical underpinnings of PBF were presented, which helped participants understand the reasoning behind the reforms that PBF proposes.

The module *5A* on *microeconomics* then followed. Basic economic principles were presented as a foundation to understanding how markets operate as well as to relate basic concepts of economics in the health care market. Following this, the module *5B* on *health economics* was presented. In this module, the concepts of average and marginal costs, economies of scale and of scope, efficiency, the various failures that exist in the health market was presented. Also presented was how sound economic instruments (such as subsidies) could be used to appropriately correct some of the market failures that exist in health.

The session closed at 16:30 with the daily evaluation and selection of the best debater of the day. In the evening, from 17:00 onwards, facilitators met with the teams from Nigeria, Kaduna, Niger, Bauchi and Gombe States. Two of these states were already involved with PBF implementation through a World Bank funded project that is closing out next year. For these states, discussions were around the sustainability for the program - political and institutional, as well as mobilization of domestic funds for the program. For the three States not implementing any PBF program, discussions focused around an institutional design, mobilization of domestic funding and advocacy for PBF.

Thursday October 31st

On the fourth day of the course, the role of the different stakeholders was presented, starting with *module 6 the role of the regulator* at various levels of the PBF system. This presentation took the whole day. This was aimed at giving participants a deeper understanding of the PBF institutional arrangements as well as an understanding of the roles of the regulator in setting standards and quality assurance at different levels of the system. The session closed at 16:30, with the daily evaluation of the course and the selection of the best debater of the day.

In the evening from 17:00 onwards, facilitators met with 2 groups from Nigerian States; Ondo and Rivers. Similar to the other Nigerian groups, discussions focused on the design of a sustainable PBF program, using domestic resources.

Friday November 1st

The day started at 8:30am with the introduction of the terms of reference of field visits to health facilities in Kilifi, a county in Kenya.
The groups then set out in the field to visit five Kilifi County health facilities for a tour and guided interviews with the facilities' in-charges and other staff.

The facilities visited and the teams were:

Vipingo Health Centre	Kadzinuni Dispensary	Tagaungu Health Centre	Mtwapa Health Centre	Kilifi District Hospital
Sangnyuykewir Prudence Wongbi George P. Jacobs J. Mike Mulbah Rufus G. Saye Prof. Sani Abubakar Malami Dr. Pauline Green Ramatu Abdulkadir Dr. Abdulrahman Shuaibu	Garrison Kerwillain Wesseh Koiblee Joyce Garblah Mustapha Yakubu Mukhtar Dr. Abba Suleiman Gumsuri Usman Bako Alhaji	Patricia A. Erskine Dr. Paulinus A. Omode Abel Bembo Michael Bondo Dr. Abubakar Adam Muhammad Inuwa Junaidu Auwal Ahmed	Mandain Jallah Thomas Padmore Dr. Kour Geah Hamza Abubakar Adamu Mathias Peter Habiba Saidu Emos Tella Muhammed Mahmud Shu'Aibu	Norwu G. Howard Patience Tokpah Cooper Dr. Jonathan Flomo Nelson Dunbar Dr. Rilwanu Mohammed Boniface Kiala Muia Dr. Adamu Mohammed Aliyu Saidu

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

Upon return, the groups gave feedback on the interviews:

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

After the feedback session, *module 6B* on the role of the regulator in conducting *quality reviews* of health centres and hospitals was presented After which the module on the role of the CDV Agency commenced. The day ended at 16:30 with the daily evaluations and selection of the best debater of the day.

In the evening, from 17:00 onwards, the facilitators met with the teams from two Nigerian States. Discussions with this team focused on sustainability of the existing PBF project in the state.

Saturday November 2nd

In the morning, presentation on the *module 7 CDV Agency* was completed. The module 8 *Community participation and social marketing* was then presented. At about midday, the module 9 PBF *project development feasibility* was presented. As part of this module, participants were asked in their country working groups to score the PBF feasibility matrix, identify killing assumptions and develop advocacy plan, to be presented in a role play (on Monday). Participants continued to work on their action plans using the results from the feasibility scan.

The day ended at 14:00 hours, with daily evaluations and a selection of best debater of the day. Participants were then invited to enjoy a bus ride to the city of Mombasa, including the market for shopping of some souvenirs and a visit to the historic Fort Jesus – which is the main monument of Mombasa and a UNESCO world heritage site.

Sunday November 3rd

On Sunday, the team went out on a journey through history, to Jumba La Mtwana which told the story of how the sailors lived and traded in Mombasa over 700 years ago. This was followed by some exciting exercises and games on the beach, including beach volley ball and tug of war. The day was completed with a visit to Haller Park in Mombasa, which has a remarkable history of being a reclaimed quarry site. Some animals at the park include tortoise, hippopotamus, antelopes, a variety of snakes, buffalos, etc. Highlights of visit to the park include feeding of the giraffes and crocodiles. The team returned to the hotel at about 17:30.

Monday November 4th

The morning started at 8:30, with the *module 10 on conflict resolution and negotiation techniques*. This was moved earlier, in response to the needs of participants. Most participants were at a stage where advocacy for PBF was important,and found this module very useful. Following this, additional time was given to the groups to complete the work on the feasibility scans and preparation of the role plays. This was followed by feedback on the results of the feasibility scan in plenary. Unfortunately, due to time constraints, the role plays were not conducted during this course.

The day ended at 16:30 with the daily evaluations and selection of the best debater of the day. In the evening, facilitators met with the Liberia team to discuss the results of their feasibility scan as well as to support them in the development of their action plan.

Tuesday November 5th

The *module 12 on output indicators* was presented. From 16:00 onwards, the exercise on the output indicators was explained and participants were asked to work on the exercise in the evening for presentation in plenary on Wednesday morning.
The day ended at 16:30 with the daily evaluation. In the evening, participants worked on the exercise on indicators.

Wednesday November 6th

In the morning, the groups gave feedback on the exercise on output indicators, which as usual was very interesting to both facilitators and participants.
The *module 14 on business plan* was then presented, after which participants broke out into groups to work on their county action plans. The whole afternoon was dedicated to this, to enable participants make progress on the development of this plan, being the

main output of the course. Facilitators were available to provide support to the groups during this. The day ended at 16:30 with the daily evaluations, after which participants continued to work on their action plans.

Thursday November 7th

This day, being the last day of class work, started at 8:30am and was confined to the morning, to enable participants study for the exam and finalize their action plans. The module on indices management tool was presented in the morning.

After the morning coffee break, participants made a presentation of the key messages of their individual or group action plans in a poster session. A round was made, where each group presented their poster in plenary with facilitators supporting each group in coming up with smart recommendations. This was found to be a very interactive session that was found to be highly valued by most participants and facilitators.

During this course, module 11 on the *baseline and evaluation studies* for PBF programs, module 13 *on costing*, module 16 - *PBF in emergencies* and 17 – *PBF in Education* were not presented in class. Participants were encouraged to study these on their own. The overall evaluation on the course was carried out before the class broke up at 13:15 to work on finalizing their country action plans, as well as for the general revision in the afternoon in order to prepare for the exam.

Friday November 8th

The exam day started at 8:30. 34 participants took the final exam.

In the morning from 9:30 onwards the exam was reviewed. This was followed by a ceremony to hand out the certificates at 15:00 followed by a closing ceremony with cake and wine.

Saturday November 9th

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

6. FINAL COURSE EVALUATION BY PARTICIPANTS

6.1 General impression of the course

The score for 'general impression of the course' was with 87,1%, 0,6% *above* the average of the 27 previous English-spoken courses. The criterion "I was sufficiently informed" scored 72%, which is 16% *below* the average of the previous English courses. The criterion: "program answered my expectations" scored 100% (= 16% *above* the previous courses). The criterion "the course objectives related well to participant's professional activities" scored 91% (= 2% *above* the average).

Preparation	The 43 previous French-spoken PBF courses	The 27 previous English - spoken PBF courses	Mombasa Nov 2019 PBF course	Comparison Mombasa November 2019 / 43 French-spoken PBF courses	Comparison Mombasa course November 2019 / 27 previous English -spoken PBF courses
Q1. I was sufficiently informed about the objectives of the course	88%	77%	72%	-16%	-5%
Q2. The program has answered my expectations	84%	84%	100%	16%	16%
Q3. The objectives of the course relate well to my professional activities	89%	89%	91%	2%	2%
Average	87,1%	83,2%	87,7%	0,6%	4,4%

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

The participants' overall appreciation of the methodology and the contents scored very well with 98%, which was 10% *above* the average of the previous English courses and 16% above the previous French courses. The criterion "content helped me to attain my objectives" scored 100%, "methodology" scored 100%, and the "balance between lectures and working groups" scored 88%. The criterion "interaction in working groups" scored 100% and the "working methods stimulated my participation" scored 100%.

Methodology and contents of the course	The 43 previous French-spoken PBF courses	The 27 previous English - spoken PBF courses	Mombasa Nov 2019 PBF course	Comparison Mombasa November 2019 / 43 French-spoken PBF courses	Comparison Mombasa course November 2019 / 27 previous English - spoken PBF courses
The content of the PBF modules has helped me to attain my objectives	83%	91%	100%	17%	9%
The methodology of the course	84%	88%	100%	16%	12%
Balance between lectures and exercises	69%	79%	88%	19%	9%
Interaction and exchanges in working groups	89%	92%	100%	11%	8%
The working methods adopted in the course have stimulated my active participation	86%	90%	100%	14%	10%
Average	**82%**	**88%**	**98%**	**16%**	**10%**

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

6.2 Appreciating the duration of the course

In October 2018 a large proportion of 43% of participants thought the course to be too short and nobody thought that the course was too long. During the April 2019 course we added one day (the last Saturday) to the course duration and this worked better to reduce the time pressure to finalize the action plans as well as the course modules. In April 2019, 92% of the participants thought that the course duration was about right. We concluded that the addition of one day to the course duration was successful.

Yet, for different reasons, during the November 2019 course, we skipped the extra Saturday and 50% of the participants again thought that the course was too short. After due deliberation, the facilitation team decided to go with the same timeframe in March 2020 and see if further time efficiency can be introduced to take off some of the pressures, and will assess then what the duration of future courses should be.

Duration of the course	The 43 previous French-spoken PBF courses	The 27 previous English - spoken PBF courses	Mombasa Nov 2019 PBF course	Comparison Mombasa November 2019 / 43 French-spoken PBF courses	Comparison Mombasa course November 2019 / 27 previous English -spoken PBF courses
Too Short	32%	24%	**50%**	18%	26%
Fine	61%	65%	41%	-20%	-24%
Too Long	6%	11%	9%	3%	-2%

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 92% was 14% *higher* than the previous 27 English courses with 78% and 22% *above* the 43 previous French courses. The conference centre (97%) and the food (100%) scored respectively 21% and 37% higher than the previous courses. The lecture room was appreciated by 94% and the friendliness of the hotel staff as well as the facilitation team was appreciated by 97%. The score for the quality of the educational material was 94% and for transportation 70%. Some participants felt that some buses were too old or lacked air-conditioning.

How do you value the organization of the training?	The 43 previous French-spoken PBF courses	The 27 previous English - spoken PBF courses	Mombasa Nov 2019 PBF course	Comparison Mombasa November 2019 / 43 French-spoken PBF courses	Comparison Mombasa course November 2019 / 27 previous English -spoken PBF courses
Quality and distribution of educational material	80%	87%	94%	14%	7%
The lecture room	67%	70%	94%	27%	24%
Travelers Hotel in general	57%	76%	97%	40%	21%
How were you received and friendliness	88%	92%	97%	9%	5%
Food and drinks, including tea/coffee breaks	61%	63%	100%	39%	37%
Transportation	66%	78%	70%	4%	-8%
Average	**70%**	**78%**	**92%**	**22%**	**14%**

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 92%, which was 13% above the average of the previous 27 English courses. The question in how far facilitators were open minded was evaluated at 82%, which was 7% *above* the average of the previous English spoken courses. The satisfaction with the time allocated for group work was 97%, which was 19% *above* the scores of the previous courses. Time for discussions was evaluated at 97%, which was 14% *above* the average of the previous English courses.

Aspects related to the execution of the program and the facilitation	The 43 previous French-spoken PBF courses	The 27 previous English - spoken PBF courses	Mombasa Nov 2019 PBF course	Comparison Mombasa November 2019 / 43 French-spoken PBF courses	Comparison Mombasa course November 2019 / 27 previous English -spoken PBF courses
The facilitators had an open mind towards contributions and criticism	80%	75%	82%	2%	7%
Time allocated to group work was adequate	63%	78%	97%	34%	19%
Time for discussions was adequate	76%	83%	97%	21%	14%
Average	**73%**	**79%**	**92%**	**19%**	**13%**

Table 6: How was the facilitation?

6.5 Evaluation per module

The overall satisfaction of the course modules by the Mombasa participants was high with 94,7%. This was 6.2% above the average (= 86%) of the previous 27 English courses and 11,7% above the 46 previous French courses. Four modules obtained 100% including the module 1 "What is PBF?", module 4 "Theories", module 7 "CDV Agency" and module 6 the "Regulator". Module 5 "Economics" this time scored relatively high with 94%. Module 14 "business plan and the individual action plan" also scored 94%. We did not evaluate the module 10 "baseline studies" and module 13 "costing" as they were not presented during the course. The lowest score was module 14 "indices management tool" with 76%. This slightly lower score can be understood because the presentation of the module was shortened and the exercise was skipped this time.

Appreciation of Course Modules	The 46 previous French-spoken PBF courses	The 27 previous English -spoken PBF courses	Mombasa Nov 2019 PBF course	Comparison Mombasa November 2019 / 46 French-spoken PBF courses	Comparison Mombasa course November 2019 / 27 previous English -spoken PBF courses
Why PBF & What is PBF?	93%	93%	100%	7%	7%
Notions of micro-economics and health economy	63%	81%	94%	31%	13%
PBF Theories, best practices, good governance and decentralization	85%	92%	100%	15%	8%
Baseline research – household survey launching process	76%	77%	NA	NA	NA
Output indicators in PBF interventions	87%	88%	97%	10%	9%
CDV agency, data collection, audit	85%	88%	100%	15%	12%
Regulator – quality assurance	81%	92%	100%	19%	8%
Negotiation techniques and conflict resolution	88%	91%	97%	9%	6%
Black box Business Plan	85%	89%	94%	9%	5%
Black box Indices tool: revenues – expenditure – performance bonuses	78%	80%	76%	-2%	-4%
Community voice empowerment and social marketing	80%	88%	87%	7%	-1%
PBF feasibility, killing assumptions & advocacy	87%	90%	97%	10%	7%
Elaboration of a PBF project – costing	65%	66%	NA	NA	NA
Average for all modules	**82,4%**	**86,0%**	**94,7%**	**11,7%**	**6,2%**

Table 7: Evaluation per module.

6.6 Written comments during final evaluation by participants

Course Preparations

- I did not get the course information on time.
- The course material should have been given out ahead of arrival.
- I was asked to apply the course, due to the nature of my work, but not much detail was provided

About the course methodology, content and modules

- *Fifteen participants* commented that the 14 days training period was too short to fully understand all content of the course. Fifty percent of these suggested that three weeks course would be better, while others suggested to add 1 or 2 days.
- *One* person thought that the course was too long
- One person commented that the content of the book is broad. Yet, some course modules are either skipped or only superficial explanations are given. This participant felt that this impacts participants negatively because all topics are relevant.
- Another commented that the course duration was not really too long. However, working throughout the weekend – and working on Saturday should be avoided!
- One participant felt there were too many lectures in comparison to group work. More exercises are needed.

- One participant commented that one facilitator was considered not too open minded to concerns of participants, and a bit too unaccommodating of people's context. All other facilitators were brilliant.
- The last module was not significantly covered. 1x
- One person found that Sunday should not be a day of optional activities, but of complete rest.
- Module 4 "theories" needs more time for better understanding 1x
- Module 14 "business plan" was not fully covered, which was regrettable 1x
- We couldn't rest well because we even had to be working after sessions and even throughout the night 1x
- The daily sessions should have closed earlier than 4pm so that participants will have adequate time to go through what has been discussed in class 1x
- The training went very well but we skipped/rushed some modules due to time constraints. I feel we lost a lot of time in week one, discussing Nigerian problems. Next time we should concentrate on course content, not more on country / state issues or problems 1x

Hotel

- One commented that the lighting in the conference venue was poor and needed more light.
- One commented the hotel accommodation was ok.
- Quality food and drinks is nice, however there were sometimes flies in the restaurant.

Transportation

- The buses were hot.
- The tours were very adventurous.
- Air-conditioned buses should be provided.
- Newer buses with AC suggested.
- Very hot and humid environment. ACs needed in the cars/buses.
- The vehicles at times did no have AC and were hot.
- One of the busses taking us on the field trip was uncomfortable, i.e. the bus used for Vipingo.

7. COUNTRY & STATE PRESENTATIONS

7.1 Gombe State

7.1.1 Context

Gombe state is located in the North-East region of Nigeria. The state has 11 Local Government Areas with 114 political wards. The present administration is four months old. The projected population of the state according to the 2006 census is 3,6 million. The state has one tertiary hospital, 22 secondary health care facilities and 518 primary health centres. Gombe state has a maternal and infant mortality rate of 1549 deaths per 100,000 live births and 35/1,000 live births respectively. Only 3.5% of the state budget was allocated to health in the 2019 budget.

Figure 1: Map of Nigeria showing all the 36 states of the federation (Gombe highlighted).

7.1.2 Problem analysis

Inadequate Funding: The health sector financing is insufficient and there is poor budget performance from the previous administration. The state does not have a State Contributory Health (Insurance) Scheme; over 70% of the health expenditure is out of pocket. The state health funding is complimented by donor agencies such as Bill and Melinda Gates Foundation, UNICEF and WHO. There is a lack of accountability and transparency in the health system because of a weak financial management system.

Insufficient human resources for health: Gombe state is one of the states with the lowest health worker to population ratios in Nigeria. There are no doctors deployed to any PHC facility in Gombe state. The distribution of HRH in Gombe state varies across LGAs irrespective of the LGA population. The state HRH suffers from low number of available staffs, uneven distribution of the available workforce, gaps in skilled workers, out of date HRH data base and lack of a task shifting policy.

Service Delivery: Access and utilization of immunization services have declined in the state, leading to increase in Penta 3 drop out. Only the PBF facilities open for 24 hours and there are frequent stock outs of essential commodities across health care facilities. There is a poor attitude of health care workers resulting from motivation problems. The demand for health services is weak as the result of the poor-quality health system, financial- and sociocultural barriers.

The Gombe state participant believe that the performance-based financing system approach is capable of addressing the health care challenges of the state.

7.1.3 PBF in Gombe State

The Nigeria State Health Investment Project (NSHIP) is currently operating in five North-Eastern States of Bauchi, Borno, Gombe, Taraba and Yobe in addition to the 3 original pilot states. The States were chosen as a result of the humanitarian crises caused by the Boko Haram insurgency. The NSHIP in Gombe State is a World Bank assisted project, which commenced on the 1st of October 2017 and expected to end in June 2020. Total funding for the project is 11 million USD ($1.4 per capita per year). The project has been successfully implemented in six out of 11 Local Government Areas of the state. The project was initially piloted in Gombe Local Government Area in October 2017. It was then scaled up to three additional Local Government Areas in July 2018 (Balanga, Dukku, Yamaltu-Deba). Akko and Billiri Local Governments were added in July 2019. So far, eighty-six Primary Health Care facilities and nine secondary health care facilities have benefitted from the project in the state.

7.1.4 Objective of the Action Plan

The chief objective of this action plan is to sustain the gains of Nigeria State Health Investment Program in Gombe state through state financing in order to improve the quality and efficiency of health service delivery among the indigenes of the state.

7.1.5 Feasibility scan of the existing and/or designed PBF program

Criteria to establish in how far the programme is "PBF"	Points	Score (NSHIP)	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	The PBF program budget is presently $1.4 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	All the PBF budget comes from the World Bank
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	The National PBF Unit is domiciled in the NPHCDA
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	0	No performance contracts
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	2	
6. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	2	
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	2	
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	2	
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	2	
10. Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the FOSA are the signatories.	2	2	
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	4	

12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	2	
13. The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2	2	
14. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2	2	
15. Provider managers are allowed to influence cost sharing tariffs	2	2	
16. Provider managers have the right to hire and to fire	2	2	
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	2	
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	2	
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	2	
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	2	
21. Public religious and private providers have an equal chance of obtaining a contract	2	2	
22. There are geographic and/or facility specific equity bonuses	2	2	
23. The project provides equity bonuses for vulnerable people	2	2	
TOTAL	**50**	**40**	**80%**

The main problems are the following:

- The PBF program is a unit under the SPHCDA. This places the PBF program at a parallel position to the Ministry of Health and thereby makes it difficult to coordinate the activities and to make the program sustainable.
- The PBF project is completely funded by the World Bank without taken into consideration the sustainability of project by the state government.
- The PBF budget is less than $4 per capita per year; this may not be enough to provide the minimum service package of health, including to the vulnerable groups in the state.

7.1.6 Recommendations

- The state government should ensure adequate funding and timely release of budgetary allocation to the health sector. The state health sector budget should be financed through the PBF approach.
- The state Government should sustain and scale up the NSHIP program to the remaining five Local Government Areas of the state after the expiration of the NSHIP project.
- The state house of assembly should pass a bill establishing the State Contributory Health Scheme in line with the principles of performance-based financing in order to ensure improved quality and efficiency in health service delivery.
- The state Government should contribute at least 1% of the state consolidated revenue to the health sector in order to ensure sustainability of the PBF approach.

7.1.7 Action plan

Proposed Activity	How	Who	When
Advocate to major stakeholders the successes of PBF in the implementing LGAs	Organize meetings with members of the State Executive Council and members of the House Committee on Health of the state assembly to get their buy-in on PBF principles	Commissioner for Health, Finance and Executive Secretary Gombe State Primary Health Development Agency	January 2020
Establish the State Contributory Health Scheme in line with the principles of PBF	State House of Assembly to pass the bill on establishment of the Contributory Health Scheme	Speaker of the House of Assembly and Chairman House Committee on Health	February 2020
Establish a basket fund to coordinate donor funds in the state	Engagement meetings with Ministries of Finance, Budget and planning, Health, SPHCDA and office of the state accountant general, and representatives of donor agencies (BMGF, USAID, GAVI etc.)	Senior special assistant to the Governor on budget planning and donor coordination, commissioners for Health, Finance, state accountant general and Executive secretary State Primary Health Care Development Agency	February - March 2020
Prepare the 2021 state health budget in line with PBF principles	Ministries of health and State Primary Health Care Development Agency to negotiate and defend budget lines at the State House of Assembly	Commissioner for Health and Executive Secretary Gombe State Primary Health Care Development Agency	October 2020

7.2 Bauchi State

7.2.1 Context

Bauchi State is one of the six States of the North East, created in 1976 and has a projected population of 7,222,452 million, with 20 LGAs and 323 Wards. The State has 5 tertiary Hospitals, 27 General Hospitals and over 1,100 Health Facilities. The health sector is governed under the leadership of the State Ministry of Health with 7 Health Agencies (State Hospital Management Board, Bauchi State Agency for the control of TB/Leprosy Malaria and HIV/AIDS, Drugs and Medical Consumable Management Agency, Health Trust Fund, State Health Contributory Management Agency, Specialist Hospital Management Board) and 2 State owned Health training institutions.

The State has the following health targets 2016–2020:

- Increase state immunization coverage among children aged 0–5 (U5) years by 2015
- Reduce infant mortality rate from 79/1000 to 35/1000 by 2020
- Reduce U5 mortality rate from 104/1000 to 45/1000 by 2020
- Reduce, by 30%, mother-to-child transmission of HIV by 2020
- Reduce, by 40%, the percentage of children aged 0–59 months with diarrhea by 2020
- Reduce incidence of malaria from 11,534/100,000 to 7500/100,000 by 2020
- Reduce level of maternal mortality from 1380/100,000 live births to 450/100,000 live births by 2020
- Increase by 50% the number of facilities providing basic emergency obstetric care by 2020.

One of the main strategies towards achieving the above targets is the implementation of performance-based financing which began in 2017 through the Additional Financing for Nigeria State Health Investment Project (AF NSHIP). The implementation was done in phases moving from 1 LGA to 10 LGA's -192 Primary Health Care Centres and 12

Hospitals covering 4,184,966 people. The Minimum Package of Activities has 27 indicators and the Complementary Package of Activities has 22 indicators. The total AF NSHIP budget for the State is $ 17.6 million for the duration of 3 years and this represents $ 1.4 per capita per year for the target population of 4,2 million.

So far, PBF has shown promising results in Bauchi State, which include improvements in the quality of care, the establishment of drugs revolving funds in all the 2014 Health facilities, improvements in health care waste management by provision of colour coded dust bins and incinerators. Moreover, health workers are better motivated because of the incentives given to them, the autonomy to solve problems locally and capacity building. There is active community participation through the involvement of Ward development communities and the use of community-based organizations for community client satisfaction surveys. The design of NSHIP has the adequate separation of function between the regulator (SMOH, SPHCDA, HMB, LGA PHCs) purchaser (SPHCDA), contract management and verification agency (CMVAs) and Providers (Health Facilities)

7.2.2 Problem analysis

- Inadequate human resources for health. This is compounded by the poor distribution of the available health workers in favour of urban health facilities.
- There are several hard to reach settlements.
- There are dilapidated infrastructures, including lack of health care waste management facilities, lack of toilets facilities, inadequate water supply, lack of constant electricity.
- Lack of basic equipment.
- Inadequate drugs and consumable supply.
- Lack of adherence to treatment protocol especially at primary health care facilities.
- Verticalization of programmes,
- Lack of a sustainability plan for performance-based financing. The World Bank support will end by June 2020 and, so far, the State has yet to use its domestic funds for the implementation of PBF. Another key challenge is the sustenance of the current design especially establishment of the Contract Development and Verification Agency.

7.2.3 Can PBF assist in solving these Challenges?

Yes, PBF is helping the State to address the identified challenges. This includes the recruitment of additional health staffs by the health facilities on a contract basis, renovation and expansion of infrastructure including provision of health care waste management facilities (dust bins, waste and burry pits, placenta pits, incinerators), renovation and construction of toilets, installation of solar facilities to assure regular electricity, provision of basic equipment, establishment of drug revolving funds in all the health facilities, enforcement of use of protocols and motivation of health workers through performance bonus.

7.2.4 Feasibility scan of the existing and / or designed PBF program

Because Bauchi State is already implementing PBF, 2 different feasibility scans were done.
Feasibility scan 1 is the scan of PBF Program under NSHIP, while feasibility scan 2 is the scan of the readiness of the State to implement PBF using State Budget.

Criteria to establish in how far the programme is "PBF"	Points	Actual with NSHIP	Actual after NSHIP	Proposed after NSHIP	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	0	0	0	1. Creation of Budget line for PBF in the State Health Budget 2. Ride on BHETFUND towards implementation of PBF.
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	0	2	PBF State budget to be launched
3. The State 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	0	2	Creation of PBF Unit at SMOH to coordinate contact with all agencies and Directorates under the MOH while the State PIU remains with the SPHCDA
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	0	0	2	Proposed.
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	2	2	We will continue with the already existing indicators under NSHIP
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	2	2	Already in place
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	2	Planned
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency (State Health Insurance) and one or more representatives of the providers	2	2	2	2	(State Health Insurance)
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	2	2	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	2	2	2	
11.Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	4	4	4	
12.The project introduces the business plan that includes the Quality Improvement Bonuses	2	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	2	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	2	2	State Health Insurance will perform the function of the CDV Agency in terms of verification and counter-verification while SPHCDA signs the Contract
15.Provider managers are allowed to influence cost sharing tariffs	2	2	2	2	
16.Provider managers have the right to hire and to fire	2	2	0	0	They cannot hire and fire permanent staff, but can hire

					and fire temporary staff on contract basis.
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	0	0	(State Health Insurance)
18.There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	2	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	2	2	
20.The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	2	2	2	
21.Public religious and private providers have an equal chance of obtaining a contract	2	2	2	2	
22.There are geographic and/or facility specific equity bonuses	2	2	2	2	
23.The project provides equity bonuses for vulnerable people	2	2	2	2	
TOTAL	**50**	**40 (80%)**	**36 (72%)**	**42 (84%)**	

7.2.5 Recommendations

- Bauchi State Government has declared the state of emergency in health and a health summit is proposed to take place soon. The performance-based financing reforms should therefore be considered as a cost-effective approach towards revitalizing the health sector.
- Bauchi State has the opportunity of having various sources of funding to health the sector. These include the State Health Budget, Bauchi State Health Trust Fund, Bauchi State Health Contributory Management Agency, Nigeria State Health Investment Project, Saving One million Lives Programme, Basic Health Care Provision Fund and many national and international donor partners. It is therefore recommended that all these funding sources be harmonized for synergy to revive the performance of the health sector.
- Bauchi State should create a special budget line for the implementation of performance-based financing. This fund should be made readily available so that government can hold each health manager accountable.
- The current performance-based financing design should be expanded to include performance contracts with all agencies and directors under the ministry of health and its agencies. With this PBF reform approach the health sector becomes better harmonized, and it can help the government to hold agencies and directors accountable towards the delivery of pre-agreed tasks.
- Bauchi State should integrate PBF with the State Insurance Scheme (Bauchi State Health Contributory Management Scheme) so that the role of contract development and verification can be given to the Health Insurance while PBF pays for quality.
- The New Agency created by Bauchi State Government (Bauchi State Health Trust Fund) should consider using the PBF approach to disburse funds to the Health Facilities.
- Bauchi State Primary Health Care Development Agency should rationalize and redistribute its health workers so that the urban-rural imbalance can be addressed.

PBF can serve as a veritable tool towards addressing this imbalance by allocating more money to the rural health facility through the geographic and health facility specific equity bonuses.

7.2.6 Action plan

What	How	Responsible	Time-Frame
1. Mobilization of domestic Funds towards implementation of PBF.	Creation of Budget Line for the PBF	Executive Chairman	Dec 2019
	Advocacy to BHETFUND ES for the use of other funds for the implementation of PBF (BHETFUND, BHCPF)	NSHIP PC	Nov 2019
2. Use of State Health Insurance Agency as the CDV Agency while BHETFUND perform the QCV and CCSS function	Advocacy to the ES BASHCMA	NSHIP PC	Nov 2019
	Creation of PBF Unit within the BASHCMA	ES BASHCMA	Feb 2020
	Harmonization of the existing CMVA Verifiers with the BASHCMA	ES BASHCMA	Feb 2020
	Creation of PBF Unit within BHETFUND to perform QCV and CCSS	ES BHETFUND	Feb 2020

7.3 Borno State

7.3.1 Context

Borno State in the Federal Republic of Nigeria was formed in 1976 and is located in the North-East Zone of the Country, its capital is Maiduguri. It shares a border with the Republic of Cameroon, Chad & Niger Republic. It has a total projected population of 6,3 million inhabitants in 2019, 27 LGAs with total number of 311 political Wards. There are 2 pilot implementing PBF LGAs {JERE & Maiduguri Metropolitan Council (MMC)} with the total number of 27 political Wards (12 and 15 respectively).

The state has the Ministry of health as the major regulator and policy enforcement body, with departmental heads and institutions of learning, State Primary Health Care Development Agency, a State Agency for control HIV/AIDs and malaria and a Hospital Management Board as parastatals. The State delivers health services through public and private health facilities: GHs = 38, PHCs = 640, private = 36.
Since 2009, Borno state has experienced insecurity due to insurgency. The state was largely affected by mass movement from the northern part of the state and some LGAs from the south respectively. Currently MMC and Jere LGAs harbour about 1/3 of the state's population as IDPs in publicly controlled camps and host communities. These IDPs move from one camp to another, seeking comfort and other incentives.

7.3.2 State health indices / challenges:

- The state has 800 health facilities across the state, but only 55% of its population have access to health care due to the insecurity in the state. The state has only 287 health workers. About a 1/3 of the population of Borno State cannot afford the health services fees, because Maiduguri being the capital city harbours IDPs from

more than 10 LGAs. Some LGAs with less security concerns have communities that are still accessible.
- The camps are overcrowded with weak infrastructure and services. This creates the possibility of public health threats and outbreaks.
- Health services are overstretched after the arrival of additional IDPs in the catchment areas of the health facilities where the camps are located. From high security risk areas health workers were relocated and evacuated impacting the quality and availability of essential health care services.
- Freedom of movement of health staff working in community-based outreach services especially for hard-to-reach teams is a big challenge as many areas are facing insecurity. MMC, Jere, Monguno, Guzamala and Kukawa of Borno State are high risk for cholera due to WASH challenges and congested living conditions.
- There is a need for psychosocial support services, mental health evaluation for new arrivals, documentation and response to experiences of conflict-related sexual violence and referrals for specialized services.
- Partners are reporting high number of Severe Acute Malnutrition cases with medical complications as population coming out of bush and inaccessible areas.
- Reports of lack of supplies and drugs from some camps on which the state is working to fulfil the increasing demand of medicines and medical supplies.

The Borno state NSHIP started in June 2017 with a pilot in MMC and Jere LGAs. These LGAs have 37 HFs in 26 wards. Currently the project is supporting 181 HFs in 129 wards in 15 LGAs in the state.

7.3.3 PBF proposal and recommendations

After NSHIP ends in 2020, the State wishes to continue with PBF in the 2 metropolitan LGAs due to the massive population dynamics of about 1.7m inhabitants including IDPs. This requires at least $5 per capita for the 1.7m population, which will amount to $8.5m per year. The state currently has $2 per capita in its 2019 budget which is insufficient to finance PBF.

Identifying the financial gap:
To continue with PBF in the LGAs (MMC & Jere) the state needs an additional $3 per capita to finance the project.

Unlocking the input funds:
The state has a humanitarian partners coordination forum in place with the following members: ICRC, MSF, ALIMA, RESCUE, WFP, WHO, UNICEF, Premiere International, Plan international, IOM, IMC and Dangote/BMGF among others. These partners mainly have input-based support for the health sector in the state, which could potentially be tapped to finance the PBF program. Alternatively, the partners could be approached to support any of the indicators that are of interest in the basic and additional packages.

Advocacy/Dialogue:
PBF stakeholders - champions can lead the advocacy for PBF at various levels:

- Advocacy to the Governor through the adviser for health for budgetary allocation of $5 per capita in 2020;
- Advocate for targeted support to the vulnerable population;

- Advocate to the House of Assembly for inclusion of PBF in school curriculum college of health and technology and College of nursing and mid-wives;
- Advocate to humanitarian actors for output support/common basket funding;
- Propose SMoH to institute PBF into the curricular of the colleges;
- Encourage HFs to adopt strategies to stimulate demand causing increase internally generated revenue

7.3.4 Feasibility scan of the existing and/or designed PBF program

Criteria to establish in how far the Programme is "PBF"	Points	Score AF-NSHIP	State driven PBF	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	4	0	So far, the Borno State is dependent on AF-NSHIP, Humanitarian actors and SOML input base fund, and there is no contribution from state budget
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	0	So far, no state budget for PBF but SPHCDA will lobby for funding through SSC
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	PBF coordination shall continue from the SPHCDA
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	0	2	NSHIP coordination shall remain at the SPHCDA
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	2	State will likely consider number of MPA based on available resources
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	2	Is a very important indicator, state shall continue with implementation of the indicator
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	State shall maintain this approach of quarterly quality review
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	2	State will continue with this approach
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	2	2	Yes, state shall conduct baseline assessment before contract to enable state document success
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	2	Yes, state shall encourage HFs to sustain IGR and other income generating activities
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	4	4	Yes, state shall sustain HF autonomy
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	2	0	HFs already have improved HR and infrastructure
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	2	Yes, state shall sustain best practice
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	2	No, CDV will be responsible for contract management on behalf of the SPHCDA
15. Provider managers are allowed to influence cost sharing tariffs	2	2	2	Yes, state will sustain best practices

16. Provider managers have the right to hire and to fire	2	2	2	Yes, state will sustain best practices
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	2	Yes, state will sustain best practices
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	2	2	Yes, state will sustain best practices
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	2	2	Yes, state will sustain best practices
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	2	2	Yes, state will sustain best practices
21. Public religious and private providers have an equal chance of obtaining a contract	2	2	2	Yes, state will sustain best practices
22. There are geographic and/or facility specific equity bonuses	2	2	2	Yes, state will sustain best practices
23. The project provides equity bonuses for vulnerable people	2	0	2	State will advocate for targeted free health services
TOTAL	**50**	**44 (88%)**	**40 (80%)**	

7.3.5 Action plan

Recommendation	Timeline	Responsible
Advocacy to the Governor through the adviser for health for budgetary allocation of $ 5 per capita in 2020	16th December	PBF champion
Advocacy to humanitarian actors for output support.	17th, December, 2019	PBF champion
Advocacy to house of assembly for inclusion of PBF in school curriculum college of health and technology and College of nursing and mid-wives	19th December, 2019	ED / SPHCDA & SPC
Advocate for targeted support to the vulnerable population	19th, December, 2019	ED / SPHCDA & SPC

7.4 Ondo State

7.4.1 Context

Ondo State was created in 1976 and is located in the South-Western part of Nigeria. It has a population of 5.1 million (2019 projection) and 18 LGAs with 203 wards. The State Health System consists of the Ministry of Health with as parastatals under it the Hospitals' Management Board (HMB), the State Primary Health Care Development Agency (SPHCDA) and the State Emergency Medical Services Agency (ODEMSA). There are 591 PHCs, 21 Secondary Health Facilities, 3 Tertiary Health Institutions and 256 registered Private Health Facilities in the State.

Performance-based financing (PBF) aiming at strengthening the health system commenced in the State in 2011 as a pre-pilot in Ondo East LGA, scaled up in 2014/2015 to 9 LGAs operating PBF while the remaining 9 LGAs were operating Decentralized Facility Financing (DFF). The PBF program has made tremendous impact on the health system particularly at the Primary Health Care level. The PBF program is sponsored through a loan from World Bank to the State and disbursed directly to the health facilities as output-based financing for the quantity and the quality of their services delivered.

The PBF approach introduced into the health system eleven best practices to strengthen the health system. It also aims at improving the performance of human resources as well as the delivery of qualitative health services and increased health services utilization. The principles include: Managerial autonomy and decision-making rights on resources; Separation of functions; Increase transparency and accountability; Promote efficiency and cost containment by paying performance subsidies directly to the HF accounts; social marketing and community satisfaction surveys and; stimulating economic multiplier's effects

In the process of achieving Universal Health Coverage (UHC) and to position the State for the implementation of Basic Health Care Provision Fund (BHCPF), the State established the State Contributory Health Scheme (CHS) which is backed by law in line with the FMoH guideline. The Save One Million Lives (SOML) performance for results has also been implemented by the State MoH. The Stakeholders in the State is leveraging on the CHS as the realistic way to sustain NSHIP PBF in the State.

The PBF approach has brought enormous gains to the Ondo health system, and it must therefore be made sustainable. For that, urgent steps and actions must be taken especially now that the World Bank sponsored NSHIP program is winding down. Despite that there is interest to use the PBF approach also within the insurance scheme, there is not yet a policy guideline on how to do this. Therefore, a new design is required for the combined "CHS-PBF" approach.

7.4.2 Problem analysis

Conflicts of interest among key stakeholders in the Health sector and line ministries.
Conflicts of interest among the key decision makers in the State health sector make it difficult to introduce PBF. This because PBF reduces the decision power about resources at the State centre and increases power of the health facilities on the basis of their performance. The money for the health facilities is earmarked so that it cannot be used by other stakeholders.

Parallel designs in the State (PBF and CHS)
The NSHIP PIU was not involved in the design of the State Contributory Health (Insurance) System and thus there is no integration of the insurance scheme with the PBF concepts as yet.

Lack of discussion on sustainability plan from the design stage of the NSHIP project.
Discussions on the NSHIP PBF sustainability started only in late 2017. These discussions were hampered by a regrettable misunderstanding of the initial PBF design. For the NSHIP PBF program, an academic design was developed in 2012 for the impact study that created an artificial control approach, i.e. "decentralized facility financing" (DFF). Here, the control health facilities received money without any verification. In the mind of the designers this set-up would test whether it was the *additional money* to health facilities or the reform changes and tools in PBF that made the difference for better performance. In practice, this academic design was rapidly compromised/contaminated. In fact, the control health facilities too studied what was happening in the PBF health facilities and there were many cross-overs taking place. Not surprisingly, the subsequent evaluation study showed that also in the DFF facilities there were encouraging results. As a result, the former Federal Minster of Health proposed to apply the 'cheaper' DFF approach as a standard. Yet, the DFF approach basically had no checks and balances and totally lacked transparency. This DFF design should never have been proposed in the first place. And this was clear to most of the

field implementors in the State. Since 2014, numerous groups attending the PBF courses in Mombasa proposed to change the DFF approach towards PBF. It was in fact eliminated from the NSHIP-AF design. But the damage was done, and the confusion persisted.

As said, the midterm evaluation (comparing PBF with DFF) did not take into consideration all the confounding factors (selection bias – PBF & DFF LGAs selected randomly without separating Urban & Rural LGAs leading to PBF having mostly rural LGAs and DFF mostly Urban LGAs; dilution factor as health worker were regularly transferred between PBF and DFF LGAs/HFs and the non-incentive 'positive expectational motivation' given to DFF that if they performed very well they would be moved to PBF, among others). In short: this design had many flaws in practice, and unfortunately hampered a realistic assessment of the sustainability agenda and confused further propositions.

Human resources gap in terms of quantity, skills and attitude.
Even though the PBF health facilities have increased their number of staff because the managers have the autonomy to employ contract staff, there still remains a large gap even in the PBF facilities. Howeer, the gaps in the non-PBF health facilities are larger.

Inadequate knowledge and wrong perceptions of PBF by most stakeholders.
There was a poor understanding of the PBF approach and its concepts among stakeholders in general from the outset. This has led to an inadequate buy-in. This is still the case in the implementing PBF (9 LGAs with 231 HFs), but is worse among those in the DFF LGAs and other Directorates in the health sector.

Inadequate coordination of partners and donor interventions.
There is verticalization of the donor-funded interventions with partners implementing input financing. There is multiple financing of similar programs leading to duplication of efforts and inefficient utilization of resources. Examples of such are: Save One Million Lives (SOML), GAVI, programs of the African Development Bank and UNICEF.

Free health care policy of the State government and the BHCPF program
Over the past years, successive administrations have declared free health care services for pregnant women and under-5 children in Ondo State. Yet, these declarations were not backed by financial commitments. Recently, the State government released N300million (about USD 800.000) for the CHS to cater for the vulnerable population including pregnant women and under-5. This was commendable. However, if we would translate this to a PBF costing standards of USD 5,00 per capita per year, such schemes would require about USD 25 million per year for Ondo State. So, the now available budget is grossly inadequate to achieve the ambitious State policies. There is a need to provide much better guidance on financing and costing issues.

Lack of specific policy guidelines on NSHIP PBF sustainability.
The PBF currently implemented by NSHIP is externally funded through a World Bank loan and the project is scheduled to end by June 2020. Currently, there is no specific blue-prints on how the programme will be sustained, despite the encouraging results that have been recorded. This is a big challenge for the State at this critical time. However, the establishment of the CHS in the State by the present government present an opportunity to utilize the PBF approach in driving its implementation.

7.4.3 Feasibility scan of the existing and/or designed PBF program

Criteria to establish in how far the programme is "PBF"	Points	Score	State driven PBF	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	0	<$1 per capita/year (this is a killing Assumption)
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	0	May not be up to 20% through CHS in the short term (this is a killing Assumption)
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	0	The National PIU is situated at the NPHCDA and there is little coordination of activities with the MoH
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	0	0	There are no performance contracts with the Directorates of the MoH
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	2	Currently about 27 output indicators
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	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	2	2	
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	2	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	2	2	
11.Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	4	4	
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	2	2	
14.CDV Agency signs 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	Here the OSPHCDA sign contract
15.Provider managers are allowed to influence cost sharing tariffs	2	2	2	
16.Provider managers have the right to hire and to fire	2	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	0	2	The CDV function is performed by the OSPHCDA where the State PIU is situated
18.There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	2	2	The OSPHCDA
19.CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	0	2	There is no CDV agent but the OSPHCDA is the purchaser
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	2	2	
22.There are geographic and/or facility specific equity bonuses	2	2	2	

23.The project provides equity bonuses for vulnerable people	2	2	2	
TOTAL	**50**	**34 68%**	**40 (80%)**	

Based on the above, the State feasibility score of the current PBF NSHIP program is 68%. However, if the proposed improved design were to be accepted by the policy makers, the feasibility score would mount to above 80%.

A favourable factor is that the current Governor of Ondo state is willing to implement the PBF best practices if that boosts the health care delivery in the State with affordable quality health care.

7.4.4 Recommendations

- ***Incorporation of the PBF approach into the CHS.***
  Push the right message of PBF best practices and how it can efficiently implement the contributory health (insurance) scheme to achieve universal health coverage. There will be a **State Health Summit** with the National NSHIP PIU and the World Bank to guide the State in developing a design for the combined "**CHS-PBF"** approach.

- ***Advocacy and training.*** Continuous education of key stakeholders in the health sector as well as line Ministries (Ministry of Finance, Budget &Planning etc) on the new approaches in PBF implementation and how it is can help save cost and strengthen the implementation of CHS.

- ***Review de current law.*** The current law establishes the State CHS, but it should be reviewed also to incorporate the PBF best practices within the CHS scheme, which includes the creation of a PBF Contract Development and Verification Agency.

- ***Location of the NSHIP PIU under SPHCDA***. The new style PBF program may transfer the verification roles of the current NSHIP PIU towards the CHS/PBF Unit. This to assure the sustainability of the PBF program at a level where it can more easily obtain State and Federal funds. The SPHCDA would continue to play its role as regulator for the LGAs and primary level health facilities. This transition will also provide Technical Assistants and capacity building to the CHS staff and the State Stakeholders on the implementation of CHS-PBF concept.

- ***Scale up of the PBF approach.*** The extension of the pilot PBF program within the CHS-PBF approach for at least one year, would facilitate the future sustainability of the combined approach when the results are encouraging.

- ***Pooling of funds.*** The sources for the combined CHS-PBF programme could be :
  - Basic Health Care Provision Fund (SPHCDA gateway) = N500,000,000.
  - Basic Health Care Provision Fund (Contributory Health Scheme gateway) = N500,000,000.
  - State Government counterpart funding for BHCPF = N100,000,000.
  - State Government fund for vulnerable population through CHS = N300,000,000
  - SOML PforR = N100,000,000

  Total = N1,500,000,000

Moreover, The State may establish a State Health Trust Fund where mandatory payment of at least 5% of the LGAs consolidated funds would be pooled to.

- Establishment of Partners Coordination Forum in the State to Coordinate the activities of all partners and donors operating in the State is urgently needed.
- ***Include PBF in the medical and nursing schools' curriculum***.
- The free health 'policy' should be replaced with sound quality driven health financing approach with efficient financial management and equity of access.

7.4.5 Action plan

There is the need to change from a pure health insurance approach with poorly defined PBF elements to a well-defined strategy of health insurance implemented with PBF approach otherwise called "CHS-PBF". Also, a change from reliance on insufficient BHCPF as the major financial source to run the CHS to a more aggressive State generated revenues for funding this intervention.

What	How	Who	When
1. Prepare a combined "CHS-PBF" approach and revise the policy document	▪ Urgent organization of State Health Summit on UHC	HCH, PS (MoH) ES, GM (CHS) DPRSs, PC PBF Desk Officer (MoH)	Last week in November, 2019
2. Validate the revised Policy Document for the implementation of CHS-PBF approach	▪ 5-Day Residential State Health Summit with Economist and PBF experts from NPHCDA, World Bank and other States in attendance	PS (MoH), ES PBF Desk Officer (MoH), PC HCH	Between 2nd & 3rd week of February 2020
3. Increase the knowledge of CHS staff and key decision makers in line ministries on new approaches in PBF implementation towards UCH	▪ Training of CHS staff and key officers in the State health sector on the new approaches in PBF implementation, Strategic Purchasing and health financing policy for UHC	PC ES PBF Desk Officer (MoH & HMB)	November 2019, and February 2020
4. Review of the law establishing CHS to include PBF elements	▪ Advocacy to the State House of Assembly, HCH after the development of implementation policy guidelines from the Health summit ▪ Creation of PBF Unit for the Contributory health scheme and transfer of existing staff of the NSHIP PIU into this unit.	HCH PS (MoH) PS (HMB) ES GM (CHS) PBF Desk Officer (MoH) PC	3rd week of February 2020
5. Increase the revenues for the adequate financing of CHS-PBF and make the funding sustainable	▪ Integration and pooling of funds for output-based financing from vertical programmes from partners in the State (basket funding) ▪ Establish the State Health Trust Funds with a mandatory deduction of at least 5% of consolidated revenue of all LGAs in the State as well as including 1% Health Trust Fund to taxes paid by contractors and businessmen in the State ▪ Enactment of a law for this Trust Fund	HCH/PS (MoH & HMB) ES/GM (CHS) HCF (Finance Ministry) HCB&P	First quarter 2020

6. Attitudinal Change among civil servants in the health sector and line ministries including partners	▪ Continuous reorientation of civil servants and partners on transparency and accountability in public service through Behavioural Change Communication and Reorientation Seminars	PS (MoH), ES PC, PBF Desk Officer (MoH)	Last week November 2019 through to 2020
7. Removal of the free health care components that are not backed with adequate funding	▪ Replacement of free health care 'policy' with sound and quality driven health financing policy with efficient financial management approach and equity of access when resources allow.	PS (MoH) ES HCH Governor	December 2019
8. Partner Coordination	▪ Inaugurate and strengthen the Partners Coordination Forum so that they key into the PBF program. ▪ Ensure that partners submit their workplans in conformity with the PBF approach to the Partners Coordination Committee for review	PS (MoH), ES HCH, PC, GM SOML Manager DPRSs SA to Gov. on Multilaterals	January 2020
9. Include PBF in the State training schools	▪ Institutionalization of PBF in the State by offering it as a Certificate Course in the Department of Community Medicine of the State University of Medical Sciences Ondo as well as incorporating it in the Undergraduate medical curriculum through advocacy and MoU with the health institutions in Ondo State	HCH/PS (MoH)/ES/PBF Desk Officer (MoH)/PC	Quarter 1 2020
10. Increase the political sustainability	▪ High level advocacy to the State Executive Council & House of Assembly (share policy briefs with data/financial implication to convince the governor) ▪ Sensitization meeting with the workers' union, CSOs, etc. in the state on PBF principles	HCH/PS/ES/PC	December 2019

7.4.6 NSHIP Transition / Sustainability plan

This describes NSHIP sustainability through CHS and how to co-manage NSHIP & CHS initially and then perfect the CHS-PBF approach before NSHIP closure and afterwards

	2019	2020	>2020 June
NSHIP	531 HFs currently supported (PBF & DFF)	531 HFs currently supported (PBF & DFF)	
OSCHS	70 HFs (provide funds for HFs not covered by NSHIP)	372 HFs (Start operating PBF model in DFF HFs in addition to the 70 uncovered HFs)	601 HFs + Private HFs (Implement CHS-PBF in all qualified HFs in the State using the HFs' accreditation criteria).
BHCPF	₦100,000,000 counterpart fund had been paid by the State government	50% to CHS to fund HFs 45% to PHCs	This will go into the State Contributory Health Scheme while 45% go directly to the PHC HFs
Other interventions including SOML		Supported the establishment of OSCHS. Continue to support the OSCHS to cover funding of HFs not currently covered by NSHIP PBF	Have budgetary provision for funding HFs through CHS-PBF
Reformed CHS-PBF with all the pooled funds			Implement **"CHS-PBF"** in all accredited HFs/GHs (both Public and private) after NSHIP closure.

7.5 Kaduna State

7.5.1 Context

Kaduna state, the third most populous state located in the north-west of Nigeria has over the past years reported below par health indicators compared to bordering states despite the availability of personnel and the political will to address poor maternal and infant mortality trends. With well over 1,193 health facilities across the 255 wards of the state, there is a need to enhance delivery of health services and ensure strategic improvements in the health outcomes of Kaduna State residents.

7.5.2 Problem analysis

Verticalization of health Programs: Findings from a desk review revealed that out of 1165 health facilities implementing PHC programs in Kaduna state, only 478 of the health facilities are delivering PHC services in an integrated manner. The remaining health facilities deliver health services in a fragmented manner.

Weak social marketing: There is a lack of awareness of care givers on the benefit of immunization and other important PHC services. Social marketing strategies are also inadequate and this results in the low utilization of PHC interventions.

Poor quality of health services: The Kaduna State health services are input-based, which are inefficient in the management and utilization of resources. The distribution of inputs to public facilities is monopolized by the Kaduna State supply chain management authority. As a result, public health facilities suffer from constant stock out of essential medicines and consumables with poor quality health services and poor client satisfaction.

Inadequate number and poorly motivated health workers: Misdistribution and high attrition rate of skilled health workers in Kaduna State are the main reasons for shortage of skilled health personnel. This is the result of poor remuneration leading to poor motivation of health workers.

7.5.3 Is PBF a solution?

Yes, PBF can provide solution to our health system challenges in Kaduna State. However, there may be resistance to implement PBF for the following reasons:

- Lack of knowledge on PBF among key decision makers.
- Kaduna State declared generalized free health services and adopting PBF may need to change this into targeted free health care.
- There may be resistance to grant autonomy to health providers and in particular against hiring and firing and to spending the revenues generated by the health facilities by the managers themselves.
- Moving away from input-based system of financing health care to output method (transfer cash directly to health facilities) may be opposed by those with interests to maintain the decision power over resources.

7.5.4 Feasibility scan of the existing and/or designed PBF program

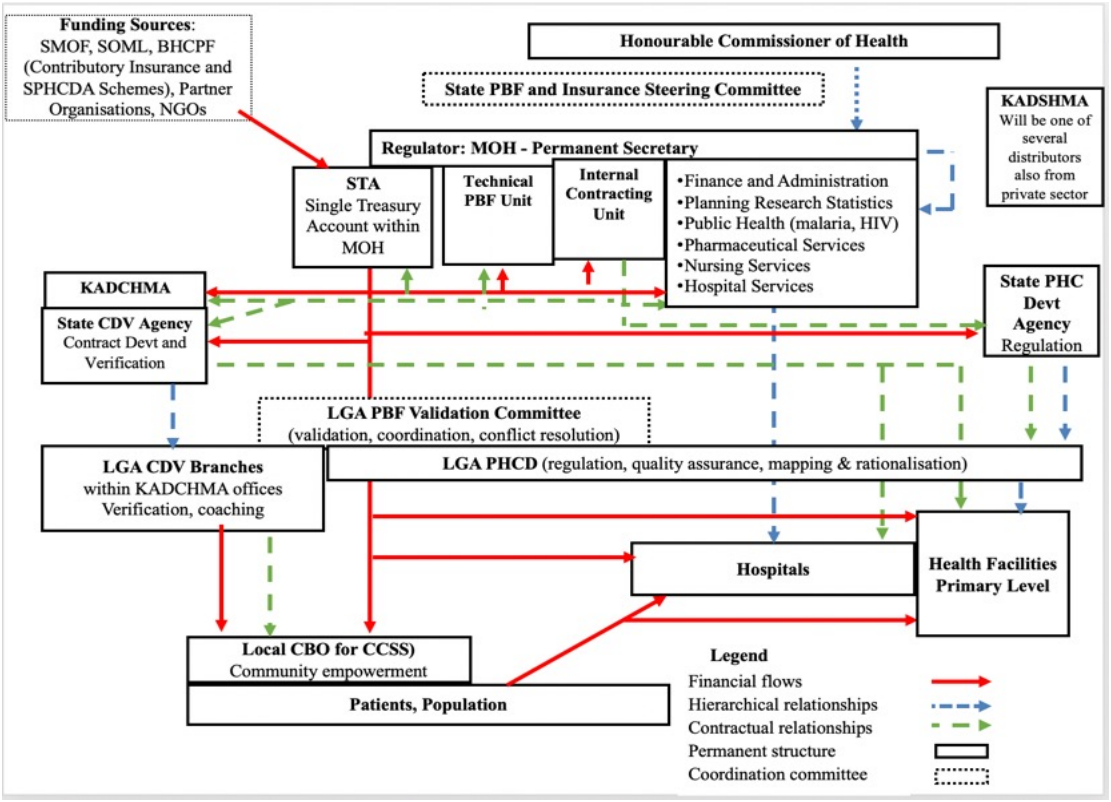
Criteria to establish in how far the programme is "PBF"	Points	Score	Recommendations	Final Score
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	0	- A pilot will be conducted in 3 LGAs (Jama,a, Igabi and Kaduna) with a population of 1.1 million - A total of 2,057,400,000 ($ 5.4 million) is needed to achieve 5 dollars per capita per year to implement PBF in 3 LGAs. - Funds from personnel and OPEX budget is N 264,000,000 ($ 733,300) going to the HFs, insurance scheme is 490,360,000 ($ 1,361,111) and basic health care provision funds through SPHCDA gateway is 66,000,000 ($ 183,333) can be mobilized to implement PBF in pilot LGAs. This amount to 820,360,000 ($ 2,278,778). - Amount needed to fill in the gap = 1,237,040,000 ($ 3,436,222). This amount to 2 dollars per capita per year.	0
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	The government can provide 33% of PBF budget in Kaduna state (3 LGAs).	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	The Kaduna State PBF Unit to be integrated in the State ministry of health reporting to Permanent Secretary	2
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	0	Against current government policy. Higher level buy in is needed	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	0	Design at least 25 output indicators during the development of the PBF program	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	Community indicators will be design for household visit following a protocol	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	LGA level regulation plan develop with quality of at least 125 composite indicators	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	A validation committee will be set up in each district with all the required composition	2
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	0	Households base line survey will be conducted	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	All Health facilities in Kaduna already have bank accounts, therefore health facilities will be allowed to spend the revenue generated from cost recovery	2
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	0	Provider managers will be allowed to procure their inputs from accredited distributors of their choice.	4
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	0	Business plan that include quality improvement bonuses will be introduced	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		Indices tools for autonomous management of revenues, planning of expenses and calculation of 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	0	CDV Agencies will be setup and allowed to sign contracts directly with the managers health facilities	2
15. Provider managers are allowed to influence cost sharing tariffs	2	0	Provider managers will have the power to influence cost sharing	2
16. Provider managers have the right to hire and to fire	2	0	Provider managers will have the right to hire and 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	0	A CDV agency will be operate independently of the local authority in 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	0	CDV will have a clear separation between contracting and verification task and the payment function of the agency	2
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	0		1
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	0	Infrastructure and equipment investment unit will be set up in the PBF program and will be paid against the bench mark agreed in the business plan	2
21. Public religious and private providers have an equal chance of obtaining a contract	2	0	Public, religious and private health facilities will have equal chances of obtaining contract in the PBF program	2
22. There are geographic and/or facility specific equity bonuses	2	0	There will be geographic and or health facility equity bonuses	2
23. The project provides equity bonuses for vulnerable people	2	0	There will be equity bonuses for the vulnerable	2
TOTAL	**50**	**0 (0%)**		**43 (86%)**

7.5.5 Recommendations

- Pilot PBF in 3 LGAs in Kaduna State, Igabi, Jama,a and Kudan LGAs.
- Debrief Deputy Governor / Acting commissioner of health asking for permission to develop a pilot proposition for 3 LGAs in the state to be submitted and discussed with her.
- Conduct advocacy to relevant stakeholders to adopt PBF.
- Prepare a draft information Memo to the commissioner of health to present at the State council meeting
- Analyse the potentially available funds to be used for the pilot in 3 LGAs
- Advocate for pulling funds from (BHCPF from SPHCDA and KACHMA), 1% state consolidated revenue for vulnerable population, salaries and OPEX of staff in the PBF pilot LGAs and funds from other budget lines to pilot PBF in 3 LGAs.
- Develop a PBF institutional frame work, this involve also the establishment of the PBF unit inside the Ministry of Health. This preferably under the permanent Secretary
- Engage a PBF consultant for technical support in the PBF pilot (see set up below).
- Integration of all vertical programs and implements them as a package of health interventions using the PBF approach.

7.5.6 PBF Institutional Set-up



7.5.7 Action plan

Design a Pilot in 3 LGAs with a population of 1.143 million inhabitants

How	Who	When
Debriefing the Deputy Governor/Acting commissioner of health asking for permission to develop a pilot proposition for 3 LGAs in the state to be submitted and discussed with her.	Team that attended PBF course	3rd week Nov 2019
Advocacy to relevant stake holders to adopt PBF.	Team that attended PBF course	4th week Nov 2019
A draft information Memo for HCH to present at the State council meeting	PM SOML	1st week Dec 2019
Develop a clear overview of the potential available funds to be used for the pilot in 3 LGAs	ES PHCDA,DG KADCHMA	2nd week Dec 2019
Advocate for Pulling of funds from (BHCPF from SPHCDA and KACHMA),1% state consolidated revenue for vulnerable population, salaries and OPEX of staff in the PBF pilot LGAs and funds from other budget lines to pilot PBF in 3 LGAs.	PS,ES SPHCDA,DG KADCHMA	1st quarter 2020
Develop a PBF institutional frame work, this involve also the establishment of the PBF unit inside the Ministry of Health. This preferably under the permanent Secretary.	TCG	1st quarter 2020
Engage a PBF consultant for technical support in the PBF pilot.	TCG	1ST quarter 2020
Integration of all vertical programs and implements them as a package of health interventions using the PBF approach.	Honourable commissioner of Health, PS	1st quarter Dec 2020

7.6 Niger State

7.6.1 Context

The State has the largest landmass of 76,481km^2 in Nigeria which constitutes 9.3% of the country. Niger State has a highly dispersed population of 6,100,866 of which 47% are under the age of 15 and approximately 40% are women of reproductive age and children under 5. The average life expectancy is 52 years. Based on the large agrarian economy, Niger's GDP per capita is $1,518 with 34% of the residents living below the poverty line (Niger PHC Diagnostic, 2016). The state is made up of 25 Local Government Areas, 274 political wards spread across the 3 senatorial districts and 6 health zone. It has 1,348 functional Primary Health Care Centre (PHCCs), 23 Secondary Health Facilities and one tertiary health institution. Prioritization of the health sector will be critical to Niger's development, and this is a priority of the present administration.

7.6.2 Problem analysis

Findings of the national surveys shows that Niger's performance on health and key service delivery indicators ranked among the lowest among its regional peers. The maternal mortality ratio stood at 452 per 100,000 live birth, which is higher than the nation's average (DHIS 2016), the neonatal and under five mortality rates for the state are 59 and 149 per 1,000 live birth, which is worse compared to the states in the same region (NDHS 2018). Further analysis of the health service coverage in the 2016 Niger PHC Diagnostic assessment shows that childhood malnutrition and malaria prevalence is higher (21% and 9% respectively) than that of States in the North central region. 11% of children 12-23 months did not receive vaccination, and only 4% of the new-borns attend post-natal check-ups within the first two days after birth.

The latest report of NDHS 2018 shows that only 7.6% of women of reproductive age have access to any modern method of contraception despite the high fertility rate of 6.1%. The coverage for deliveries by skilled providers was 30.6%, and the coverage in a health facility was 25.8%. Only 41.5% of the women receive ANC from skilled service provider, 33% had four ANC visit and the penta3 coverage is 38.8%.
Although, the percentage of budget allocated to health has improved during the last 3 years from 8.3% in 2015 to 11.7% in 2017, this has not translated into significant improvements in the key health indicators.

Three further key challenges are;

- *Poor geographic access* to health services due to state's large land mass and dispersed population. The average travel time to a referral facility is 60-80 mins making it extremely difficult to access basic health care services especially in time of emergency.
- *Inadequate workforce productivity* – PHC workers are unevenly distributed across the State and limited availability of health workers is compounded by limited clinical competence and capacity; gaps in personnel management such as high level of absenteeism, contributing factors to low staff morale, such as delays in salary payments. Approximately 23% of HCWs in the surveyed facilities were absent from the post with third of these workers absent for unapproved reasons. Only 34.1% of the clinical conditions were accurately diagnosed by the HCWs and only 33.3% of HCWs adhered to clinical diagnosis for Integrated Maternal and Childhood Illnesses (IMCI) (NHFS 2016).

- Inadequate Supply of Quality services coupled with high out-of-pocket (OOP) spending on health care. On average, 43% of the UN lifesaving commodities are available in the State while OOP constitute 80% of the total health expenditure in the state on health, which contributes to the low demand for services.

7.6.3 Is PBF a solution?

Considering the three challenges above, improving the supply of quality services and reducing out-of-pocket health expenditure, especially for the poor is important. This can be achieved with the establishment of a mechanism for financing the health sector. Performance-based financing (PBF) through a Strategic Purchasing Agency (SPA) can address these challenges. More so, the PBF approach improves the quality of the services, improves the access to quality manpower at the health facilities.

Funds available for the implementation of PBF in the state

Available Funds for PBF Program	
BHCPF (NSPHCDA Gateway)	₦429,000,000.00
PHC Renovation	₦200,000,000.00
BHCPF (NSCHA Gateway)	₦505,000,000.00
1% CRF from the State Govt (NSCHA)	₦420,000,000.00
Total funds available	**₦1,554,000,000.00**
Population of the State (2006 Projection)	6,100,866
Per head per year: Available Funds / Total Population	**₦254.72 ($1:00)**

The funds available for the PBF reform strategy for the 6.1 million population is $ 1 per capita per year, which is far below the PBF standard of $ 4-6 per capita per year. Therefore, it is proposed that the reform should be implemented in only three pilot LGAs with a population of 575,725. At ₦1,400 ($ 4) per capita per year, the State requires a total amount of ₦806,015,000 ($2,302,900) to implement the PBF approach for improving the quality of health care services in the State.

Required funds for Pilot in three LGAs	
Agaie	205,265
Paikoro	244,152
Wushishi	126,308
Total Population in the 3 Proposed LGAs	**575,725**
We Require ₦1,400 ($4) per capital per year	₦806,015,000.00
Converted to USD ($1=350)	**$2,302,900.00**

7.6.4 Feasibility scan of the existing and/or new PBF program

In the following table we present the current score without PBF with the proposed score if the PBF design is accepted by the authorities. This would produce a score of 80%, which is sufficient to launch a successful PBF pilot.

Criteria to establish in how far the programme is "PBF"	**Max Points**	**Actual score**	**Proposed 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	4	Budget at $ 1 per capita for population of 6 million. Reduce the target population to 3 LGAs in order to increase the amount per capita. This should lead to successful implementation and thereby generate evidence for further financing and scale up

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	We could get almost 100% of the budget from the state. However, the take-off of SCHA will generate sufficient funds to implements PBF.
3. The State 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	Activities within the ministry of health are well coordinated and that PBF unit can be integrated
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	0	2	The unit saddled with this responsibility will be at the Ministry of health and would be required to performance contracts with standard outputs and quality indicators. The PBF technical unit at the NPHCDA will provide the TA
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	Minimum of 25 output indicators would be generated for subsidies receipt
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 State PBF Pilot program will develop a protocol that will have community indicators for household visit. This will be applied by all primary level principal contract holder
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 state continuously and on annual basis review the mapping of Health facilities. A step further would be taken to rationalize the catchment areas in units of between 6,000-14,000 inhabitants. The LGA regulators will conduct quality reviews of at least 125 composite indicators at public and private health facilities
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	The pilot PBF program will develop the LGA Validation Committee that will bring together the District regulators, the CDV Agency and a representative of the providers.
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	0	2	The pilot program will establish priorities based on the baseline household and quality study. This will help in measuring the impact of the pilot
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	0	2	All the focal facilities have functional bank account and HF manager is one of the signatories. Cost recovery revenues will be spent at the facility level (i.e. point of collection)
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	0	0	Inputs such as the drugs, only DMA are authorized supply to all the HFs in the State. The law establishing DMA must be reviewed to address it.
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	0	2	Business plan will be introduced in the PBF program and inclusive of Quality Improvement Bonuses
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	One key challenge is that the State do not have confidence in the PHC handling all the financial issues
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	In line with the structure design of the PBF, CDV Agency will sign contract directly with the daily manager of the provider
15. Provider managers are allowed to influence cost sharing tariffs	2	0	2	Under the principle of autonomy design by the strategy, Provider

				manager will be allowed to influence cost sharing tariffs
16. Provider managers have the right to hire and to fire	2	0	0	Only the state Government hire and fire by law. The law must be reviewed to accommodate autonomy of the HF Manager
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	The CDV Agency will established as an independent entity, domiciled in the SCHA with sufficient and qualified 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	0	The SMOH might want all the entities embedded with the Ministry and might be subject to abuses and frauds
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	0	2	The existing system already accepts the promotion of the full government determined package and would be incorporated into the PBF reform
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	0	2	The pilot PBF reform will introduce infrastructure & equipment investment units, which will be 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 PBF reform in the State will create equal chance opportunity for public, religious and private provide to obtain a contract
22. There are geographic and/or facility specific equity bonuses	2	0	2	The current distribution of staff is skewed to the urban areas. Therefore, the geographic and/or facility specific equity bonuses will correct the anomaly
23. The project provides equity bonuses for vulnerable people	2	0	2	Equity bonuses for vulnerable people will be provided by the reform
TOTAL	**50**	**0**	**40 (80%)**	

7.6.5 Potential killing assumptions

- The available funds can only cater for 6 million populations at $1 per capita income which is grossly inadequate as its far below the benchmark of $4-$6 per capita per year.
- The SMOH might want all the entities embedded within the Ministry and might be subject to abuses and frauds
- Input policies such as for drugs, only Niger State Drug Hospital Consumable Management Agency (NSDHCMA) are authorised to supply to all the HFs in the State. The law establishing NSDHCMA should be reviewed to address the monopoly of drug supplies.
- One key challenge is that the State does not have confidence in the PHC handling all the financial issues
- Only the state Government can hire and fire by law. The law must be reviewed to accommodate autonomy of the HF Manager to be autonomous to hire and fire.

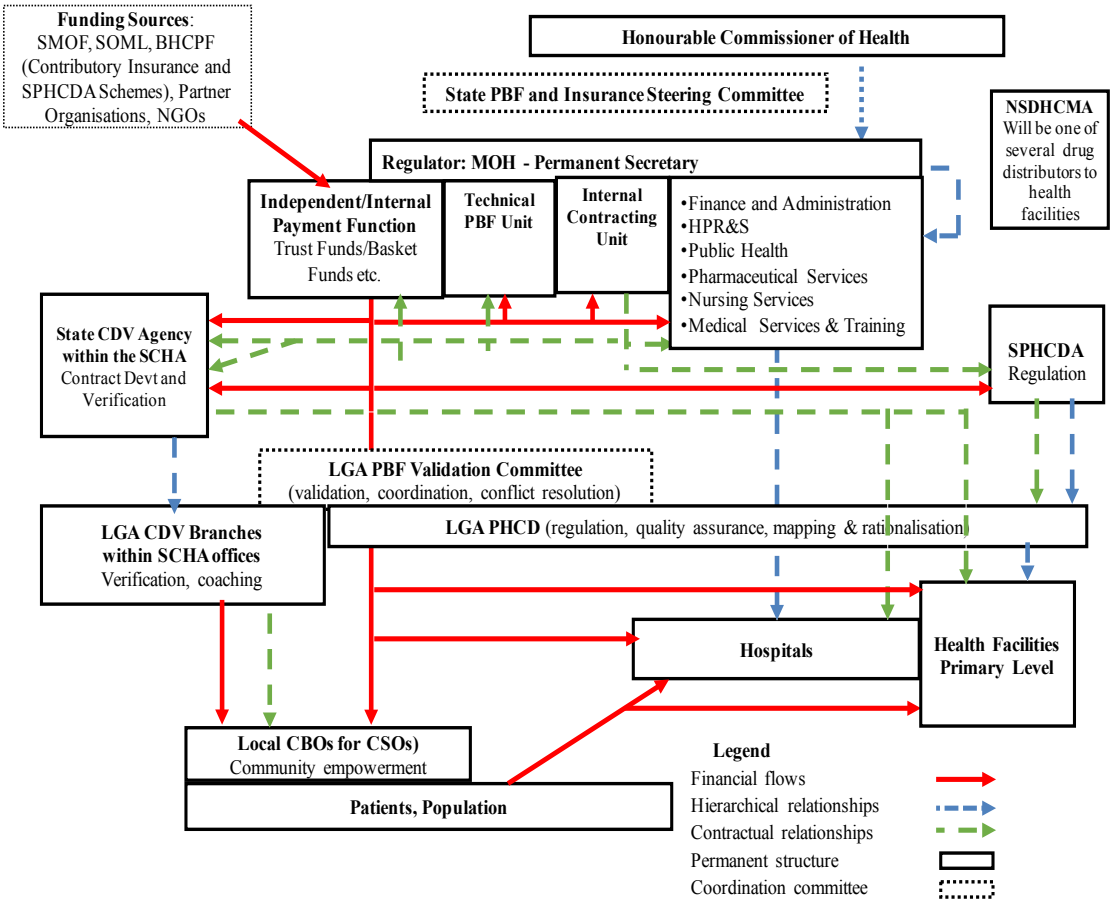
7.6.6 Recommendations

- The per capita budget per year for 6 million people is about $1, which is too low and will not achieve its intended objectives. Therefore, we propose that the State pilots the PBF programme in a few LGAs with a budget of $4 per capita per year by using the same budget. This will convince the decision makers at a later stage

to seek more revenues once convincing results and impact are being achieved. This will be used as advocacy tools to advocate for more input State budget lines to be transformed into PBF to cover the complete state.

- Encourage the participation of Honourable Commissioner of Health, Permanent Secretary, Heads of Agencies (Executive Medical Director –Hospital Management Board, Executive Director – Primary Health Care Development Agency, Executive Director – State Drug and Hospital Consumable Management Agency, Executive Secretary – State Contributory Health Agency and Chairman House Committee on health into the SINA PBF course to get an update information on the paradigm shift in health care delivery system using the PBF reform strategy.
- Propose a plan for the pilot of PBF in three LGAs, harness best practices and key lessons learnt for dissemination to the relevant stakeholders. Also, study tour to NSHIP implementing states is strongly encouraged for cross learning and peer review of the PFB model implementation. This will provide additional information for rolling out the proposed pilot.
- The State Contributing Health Scheme is still at the pre-implementation stage and would be a great opportunity for the state to harness the benefit of PBF strategy by can be incorporating it into scheme.
- The signed MoU with BMGF to strengthen the PHC system and with many other MoUs being planned, all offer a good opportunity to factor the PBF approach by earmarking funds to support the pilot implementation in the State.

7.6.7 PBF Institutional Set-up



7.6.8 Action plan

Action Points	Responsible Person	Timeline
Brief the Honourable Commissioner of Health and the Permanent Secretary on PBF, how the strategy can improve the quality of health care in the State and agree on the next steps	Dr Inuwa J	3rd week of November
Design a proposal for a PBF pilot in three LGAs (Agaie, Paikoro and Wushishi) of the State.	Dr Inuwa J. / PBF Technical Unit Staff	4th Week of December, 2019
Sensitize the State Ministry of Health's Top Management Team (HCH, permanent Secretary, Head of the Agencies and their Directors). The TMT meets every quarter to deliberate on the health issues.	Dr Inuwa J.	4th quarter TMT 1st week December, 2019
Conduct consultative meeting with SCHA, DMA, SPHCDA, Partners forum on PBF. Monthly meeting of the MDAs and Partners forum quarterly meeting will provide a good forum	Dr Inuwa J.	2019 December Monthly meetings for all MDAs, 4th quarter partners forum
To work with the NPHCDA PBF Technical Unit to review the existing advocacy kits for PBF and adapt to suit the state's context	Dr Inuwa J./PBF Technical Unit Staff	4th Week of November, 2019
Conduct the advocacy visit to health of Agencies, Ministry for Local Government and Chieftaincy Affairs (ML&CA), State Planning Commission (SPC), Niger State House Committee on Health on the need for the state to adopt the PBF reform strategy for financing health care services	Dr Inuwa J and other Staff of Niger State Primary Health Care Development Agency	2th Week of January, 2020

7.7 Rivers State

7.7.1 Context

Rivers State, is located in the southern part of the country and is embedded in the Niger delta region. It was created on May 27, 1967 and, on 1st October 1996, Bayelsa State was carved out of Rivers State.

Rivers State is located in the oil-rich Niger Delta region in the South-South geopolitical zone and is made up of 23 Local Government Areas and 319 political wards, with Port Harcourt as the State capital. Rivers State vegetation is characterized by mangrove forest and thick rain forest with arable land. Over one third of the State is occupied by water. Port Harcourt still has communities/settlements that can only be accessed by the use of canoes and small motorized boats. This terrain makes service delivery difficult for the health workforce in the State. There are 408 Public health facilities (385 Primary, 18 secondary and 5 tertiary facilities) spread across the State.

The inhabitants of the State are of different ethnic groups with cultural diversity expressed in language, beliefs, dress codes and music. They are mainly Christians, though a few Muslims and traditional worshipers exist. Rivers State has a population of 7,24 million, adults and adolescents aged 15 to 64 years account for 61%, children below the age of 15 account for 36% of the population and those aged 65 years and above, another 3%.

Rivers State is the second largest economy in Nigeria after Lagos State with two major refineries, two major seaports and airports and various industrial estates. While the State's economy is still largely dependent on oil, the declining oil price, ongoing

security challenges in the Niger Delta and the subsequent recession has caused a steady decline.

There is a relationship between female literacy levels and rate of change in maternal mortality ratios. The female literacy rate is about 98.1% in Rivers State, which is high despite the poor health indices. Literate women care for the health of their family especially their children and are more likely to complete the immunization schedule than others.

7.7.2 Problem analysis

Rivers State health status indicators are low. There is a HIV/AIDS prevalence rate of 5.8%. The maternal mortality ratio of 338.1 per 100,000 live births (DHIS 2) is low as against the national maternal mortality ratio of 576/100,000. The other health status indicators: are under-five mortality rate 58/1000, infant mortality rate 41/1000 and child mortality rate 18/1000. The life expectancies for male, 52.6 years and female, 53.8 years are low compared to 54 and 57 years (2008) respectively, and the national 54.5 years and global average of 71.4 years.

Health services in Rivers State is provided from three levels: primary, secondary and tertiary- through private and public providers. There is maldistribution of facilities in the private sector, whereby most are in the urban areas while very few are located in the rural areas. The health work force in the public sector is not only maldistributed but also inadequate.

7.7.3 Is PBF a solution?

Yes, the expansion of access to quality health care services is necessary if Rivers State wishes to attain the Social Development Goal 3 target of universal access of all to health care services. This access to quality health care and prevention is also vital for poverty reduction and economic growth, which is key to the attainment of her Vision 2020.

This action plan focuses primarily on the necessary awareness raising and advocacy to start PBF in Rivers State.

7.7.4 Feasibility scan of the existing or new PBF program

Criteria to establish in how far the programme is "PBF"	Points	Score	Proposed final score	Assessment of potential for change
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	PBF does not exist in the State. This may be difficult to achieve but with evidence from other States and good advocacy to government and stakeholders this may be possible
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	The State currently has very few donors / partners. PBF is therefore an opportunity for State to be self-driven by making more efficient use of the available money
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	State MOH is coordinating body so State PBF unit can be integrated at a sufficiently higher level under the Commissioner or permanent secretary and coordinate when established
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	0	2	This can be put in place when PBF is established

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	Is possible
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	Can be done
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	Can be done
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	Can be done
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	0	2	Can be done. This will be useful for the State
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	2	Health facilities have accounts but no full autonomy to spend, so might be very difficult but possible BHCPF already stimulated more HFs to open bank accounts
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	4	4	Possible
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	0	2	Possible
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	Possible
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	Considerable work will have to be done to change the current practice which are currently based in the in the MOH
15. Provider managers are allowed to influence cost sharing tariffs	2	0	2	possible but may be difficult because of currently existing central control
16. Provider managers have the right to hire and to fire	2	0	0	May be impossible
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	Possible but comes with challenges. (see challenges above)
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	0	2	Possible
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	0	2	Possible
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	0	2	Possible
21. Public religious and private providers have an equal chance of obtaining a contract	2	0	2	Possible given the fact that the government is already promoting private sector involvement
22. There are geographic and/or facility specific equity bonuses	2	0	2	possible
23. The project provides equity bonuses for vulnerable people	2	0	2	Possible. State has just commenced free treatment program for HIV patients, but work would need to be done on targeted equity bonuses
TOTAL	**50**	**6 (12%)**	**48 (96%)**	

7.7.5 Recommendations

- To pilot PBF in 1 LGA (PHALGA) covering a population of 1,000,000 residents at 4 USD/ capita at 1.2 Billion Naira per year.

7.7.6 Action plan

WHAT	HOW	WHO	WHEN
Advocate to principals on the importance of PBF implementation in Rivers State	Write a report and Brief the PS MOH	State program manager	13th November 2019
Create awareness of PBF at the next State Steering Committee meeting	Prepare a presentation on key PBF principles	State Program manager	End Nov. - 2nd week Dec.
Encourage principals (Deputy Governor, Commissioner for Health, PS MOH, PS PHCMB & DPRS MOH) to attend next PBF course	Provide enabling resource through SOML PforR	State Program Manager	March -April 2020

7.8 Central African Republic (CAR)

7.8.1 Introduction

CAR's education system has been paralyzed over the last couple of decades due to recurrent political and military crises. Primary education indicators are poor with a primary enrolment rate of only 55 per cent for girls and 71 per cent for boys. Cordaid has introduced PBF into the education sector since 2008, and it has shown good results.

The government has declared PBF a national policy. Despite this political will, funding of about $ 20 million a year to cover the entire country has not yet been mobilized.

Since 2016, Cordaid has tested two FBP approaches: 1. An approach for a stable zone (Nana Mambéré) where a "pure" PBF is applied and; 2. Another approach for an unstable zone (Ouham Pendé) where a mixed approach is applied of the PBF approach with input approach elements. The construction in the unstable zone was dedicated to an external builder who build the schools. Yet, this external approach did not work well. Six schools are built by external builders, but the quality was not good. On the other hand, the two schools that were built by the community in the pure PBF approach in Nana Mambéré were of better quality. Due to lack of funding, the south-east and south-central zones have been abandoned since 2018. To date, PBF/RBF is being implemented in Nana-Mambéré in 85 schools with a contract with Cordaid.

7.8.2 Context

The Central African Republic (CAR) is a fragile country in Central Africa with a population of 4.9 million. It is landlocked with an area of 623,000 square kilometres (8 inhabitants per square kilometre) divided into 16 prefectures and 71 sub-prefectures. Sango is the national language. 60% of the population lives in rural areas. Bangui, the capital, has an estimated population of 800,000.

Since independence from France in 1960, the CAR has experienced a series of political crises and irregular transition of power. The last major conflict took place in early 2013, when a coalition of Seleka armed groups took control of much of the territory and power in Bangui. In 2014, a transitional government was appointed drafting a new constitution and holding elections. With a legitimate government in power there was progress, but the security situation remains fragile. Only about 40% of the territory is under the control of the government. In the absence of a strong government, women and girls are the most affected in the last five years.

In 2019, the Central African government and the international community organized a conference in Khartoum with the representatives of 14 armed groups, among which the most influential, which resulted in an agreement called "Khartoum Agreement" which includes armed groups in the civil administration and the military.

7.8.3 Problem analysis

- ***Weak schooling indicators.*** Access to education was weakened by the destruction, closure or occupation of schools and the displacement of the population. The country has more than 70,000 children (ages 3-17), who are displaced and have no access to education. 20% of schools remain closed throughout the country and teachers are still struggling to return to their duty stations, especially as few have official status. The governance of the education sector has been profoundly affected by the withdrawal or absence of the deconcentrated structures of the ministry as well as by the disorganization of the social status which has rendered inactive the associations of parents of pupils in certain regions.
- ***Under funding of the education sector.*** OCHA estimates that there is underfunding of 94% (USD 2 million instead of 27 million). If we take the $ 4 per person per year requirement (or $ 20 per high of primary schools for PBF this is a budget of $ 18 million per year.
- ***Lack of direct funding for schools.*** Primary schools do not have bank accounts and do not receive credits, subsidies or another budget support. Only high schools and colleges, academic inspectorates and school districts had budget support from the state in operating funds but this is in kind. These last budgets were also cancelled during the last ten years following the crisis. The financing system is not efficient because resource management is input-oriented.
- ***"Inputs" strategies.*** Also, before the socio-political crisis, schools did not have autonomous management with direct financial support of the State. Management was based on the receipt of inputs such as books, tables, benches, toilets etc...
- ***Shortage of qualified teachers.*** The government currently recruited 2000 teachers as civil servants. Only 5% of then remained at their duty post outside Bangui during the crisis due to insecurity and the failure of the civil service finance/banking system. The need for primary school teachers is 24,000 (960,000 primary school students in CAR divided by 40 pupils per class). There are 4000 parent teachers, but who are not qualified. It is estimated that the private sector recruits around 3,000 qualified teachers. Thus, it can be estimated that the need for qualified teachers is around 24,000 - 2000 - 3000 = 19,000. Across the country, 61% of schools operate thanks to the support of unqualified teachers. This leads to a poor level of teaching quality.
- ***Infrastructure, equipment and textbooks are inadequate***. This is caused by the underfunding of schools as well as the lack of household means to pay school fees.
- ***Lack of incentives and motivation for teachers*** to work in the interior of the country. This is related to the problems of the banking system for teachers to have access to their salary, lack of housing and the dilapidated state of schools.
- ***Household poverty.*** This causes problems such as child labour, lack of resources to help children go to school.
- ***Problems with minority groups.*** Including pygmies and Fulahs.

7.8.4 Can Cordaid increase their financial support to assist 85 to 120 schools?

CORDAID with its current budget wants to scale up to 120 schools. This could be achieved in the following ways:

- Increase the financial contribution of the State by operationalizing PBF as the national policy;
- Empower and give responsibility to schools so that they can efficiently manage their resources (financial, human, material).
- Increase budget transparency for better management of resources made available to schools and for greater efficiency with the indices management tool.
- Give tools (revalorization of the school council, preparation of the business plan, action plan, simplified budget) and improve attendance of students and teachers. Students responds to the problem central learning time.
- Improve material learning conditions: through 3 key factors (possession of the teacher's guides, possession by the students of the minimum equipment, seating).
- Improve educational monitoring by the administration: pay particular attention to the educational monitoring provided by the director and reinforced by the inspectors.

7.8.5 Feasibility score of the existing or designed PBF program

In order to effectively implement the education PBF program in the Central African Republic, the PBF experts will need to focus on the following to clarify the objectives of the intervention and determine the feasibility of the program.

Criteria to establish in how far the programme is "PBF"	Points	Comments and appreciations for the launch of the PBF Education - CAR Case Program	Score	Recommendations
1. The PBF program budget is not less than $ 20/pupil. Assume that primary school pupil constitutes 20% of their surrounding population. The target population is 5 times the	4	- Current Budget is 1 million Euros admin 200.000 Euros, 850,000 / 20$ per pupil this is 42.500 pupils x 5 = target population of 212,500. Assuming the target population is 300000 we will need to cover 60,000 pupils.	0	
2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	2	- The Cordaid FBP program has a guarantee of 100% financing with a grant from a private donor. Since the state has already made PBF its national education policy, the program also has the resources to advocate with the government to refocus future funding on the PBF approach.	0	The government needs to be involved. There are private funds, but an advocacy plan needs to be set up.
3. The National PBF Unit is integrated into the Ministry of Education at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	- The National Technical Unit FBP Education exists and is integrated at the level of the Ministry of National Education. Its level of integration is acceptable but, the implementation of the new program will have to reinforce the legitimacy of PBF on the agenda of the Minister of National Education. This Technical units is purely funded by external funds.	2	In the context of a sustainability plan the discussion should be about to have a home owned PBF Unit
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	- As the Program is not yet national, only the inspections concerned at the program implementation level are under performance contracts but not based/linked to PBF. The contracting of the departments will be at the pace of development of the program on the national territory.	2	
5. The PBF project has at least 15 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	- CORDAID has 11 education indicators are set according to sector requirements subsidies are paid accordingly.	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.	N/A	- This doesn't seem quite feasible for the Education sector.	N/A	
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.	N/A	- This doesn't seem quite feasible for the Education sector.	N/A	
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 Schools	2	- YES.	2	
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	- Yes- A baseline study was conducted at the launch of the program	2	
10. Cost recovery revenues are spent at the point of collection (school level) and the school level have bank accounts on which the daily managers of the school are the signatories.	2	- Well, this is not possible in certain areas as not all schools have bank accounts. But this is done where it is possible.	2	Currently remote schools do not have bank account, but mobile banking is growing thus this should be considered
11. School managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	- Yes. For PBF funds exclusively. For the rest it is still inputs. The government is very much input driven.	0	To extend the PBF way of dealing with funds at the school. To be discussed with government and other PBF promoters too. Try to find out if there is RBF communication between ministries
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	- Yes. Even though this aspect needs to be improved.	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	- No	0	This aspect needs to follow up and improved.
14. CDV agencies sign contracts directly with the daily managers of the Schools/schools – not with the indirect owners such as a religious leader or private person.	2	- Yes	2	
15. School managers are allowed to influence cost sharing tariffs	2	- Yes. Individual teachers are asking individual fees from parents, but this is not centralized at school level.	0	
16. School managers have the right to hire and to fire	2	- No	0	This is still centralized by the government

17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and community verification.	2	- Yes. But, this mainly for quality and satisfaction	2	
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	- NO. Cordaid is the donor / donor representative - plays the role of CDV and endorses the payment function.	0	It is quite possible to change once the government appropriates funding.
19. CDV agents accept the promotion of the full government determined packages	2	- Yes. The government indicator set are the standard set. Is what CORDAID use for output payments and not inputs like other agencies.	2	
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	- Yes	2	
21. Public religious and private Schools have an equal chance of obtaining a contract	2	- No. it is not a principled decision against religious schools but currently the contracts are given to schools that require stronger quality stimulus.	0	
22. There are geographic and/or facility specific equity bonuses	2	- Yes. This is equity- based on the degree of displacement.	2	
23. The project provides equity bonuses for vulnerable people	2	- No, as it is more focused on displaced children. The people who are displaced are not necessarily financially destitute such as cow farmers, huge commercial dealers.	0	
TOTAL	**46**		**24 = 52 %**	

7.8.6 Recommendations

- Separation of functions (fund holding, verification & quality checks). Explore to see if we could build a proper relationship with the local government.
- For the 60,000 pupils we will need USD 1,200,000. This means reducing the number of pupils, but we can't cover the 60,000. Or search for additional funding.
- The government needs to be involved as 20% of the budget is not involved.
- There are private funds, but an advocacy plan needs to be set up. As an exit plan
- Review the PBF/FBR education system in CAR, if possible, by involving the World Bank.
- Evaluate the budget lines FBR in the Finance Law for the education sector and propose accompanying measures to transform the input lines into FBR
- Establish transparent management using the indices management tool for teacher mobilization and motivation.
- Give the community much more autonomy to carry out construction activities at the local level.
- Increase the number of student teachers in training institutes.
- Open PBF lines in the government budget for schools and increase the amount.

7.8.7 Action plan

What	How	Who	When
Produce and disseminate tools to implement RBF/PBF	Identify and contract an external consultant (FBR expert) to support the process.	CORDAID - Education Sector	Febr-20
	Evaluate the National FBR Education Technical Unit and the existing FBR Strategy	CORDAID	05/12/19
	Develop a PBF Education manual and all other necessary tools	Consultant / NTC / Cordaid	Dec-19
	Organize a validation workshop with the education authorities	Cordaid / Consultant / CTN / IA / Partners	Jan-20
	Disseminate the manual and PBF tools at the level of the different actors of the system	Cordaid / Ministry of Education	Jan-20
Sensitize the political and administrative authorities for a better appropriation of the PBF approach	Training of departmental managers (CTN, IA, and other actors on the tools PBF Organize a workshop on PBF with other national and international actors in Education.	Cordaid / Ministry of Education	Jan-20
Integrate PBF into the recovery and peacebuilding plan of CAR	Advocate for the integration of RBF/PBF into the strategic plan of the Ministry of National Education	Cordaid/CTN	Jan-20
Kill "free education" notion and advocate for quality education	Advocate for the removal of free education	Cabinet members of the Ministry, members of the National Federation of Student Parent Office and the Unions	Jan-20

7.9 South Sudan

7.9.1 Context

At independence in 2011, South Sudan was one of the most fragile countries in the world. In late 2013, the political settlement brokered within the ruling Sudan People's Liberation Movement (SPLM) fell apart. An armed conflict ensued, primarily between the Sudan People's Liberation Army (SPLA) government forces and Sudan People's Liberation Army in Opposition (SPLA-IO). While there was a period of optimism brought about by the signing of the Agreement on the Resolution of the Conflict in the Republic of South Sudan in August 2015, open conflict escalated again in Juba in July 2016 and rapidly spread throughout the country. The renewed conflicts from December 2013 through July 2016 have undermined the development investments and gains achieved since the Comprehensive Peace Agreement (CPA) and independence, worsening the humanitarian situation.

The majority of South Sudanese have lived in poverty most of their lives. In 2016, it was estimated that 66 percent of the population lived below the poverty line (US$1.90 per day). This is a considerable increase in poverty from an already high level of 52 percent in 2009. Poverty incidence varies across the country, with the highest rate of 81 percent in Eastern Equatorial and the lowest rate of 40 percent in Central Equatorial. Poverty in urban areas of South Sudan increased from 49 percent in 2015 to 70 percent in 2016. Inequality amongst the poor also worsened, and the poverty severity index doubled from 0.10 in 2015 to 0.20 in 2016. Poverty manifests itself in all dimensions:

lack of access to clean water, access to health and education and a non-existent safety net to cushion the most vulnerable.

7.9.2 Health outcomes

South Sudan has some of the worst health outcomes in the world. Child mortality and morbidity rates are high: under-five mortality is 91 per 1,000 live births while neonatal mortality is 39 per 1,000 births; child malnutrition is severe, with underweight prevalence at 23 percent of children (UNICEF, 2016). Maternal mortality is among the highest in the world, estimated at 789 per 100,000 births. Endemic diseases pose a heavy burden, particularly malaria, which accounts for 20–40 percent of all health facility visits. The health care system is extremely stretched: only about 40 percent of the population can access health care within a 5-kilometer radius. Life expectancy of 56 years is low.

Health outcomes in South Sudan 2016	South Sudan 2016	East/Southern Africa (2010-2015)
Maternal Mortality Ratio per 100,000 live births	789	417
U5 mortality Rate per 1,000 live births	91	67
Contraceptive prevalence rate	4%	40%
Percent (%) of children under 5 wasted	23%	6%
Immunization coverage of DTP3	26%	80%
Mothers receiving at least 4 antenatal care visits	17%	45%
Percentage (%) of births attended by a trained health professional	19%	49%

The organization of the health system in South Sudan follows a three-tier order:

- Tertiary level (National Teaching Hospitals)
- Secondary level (State and County Hospitals)
- Primary level (Primary Health Care Centres, Primary Health Care Units and Boma Health Initiative).

7.9.3 Problem analysis

Inadequate financing of the health sector

The Public Expenditure Review for South Sudan's health sector, conducted in 2016, shows that public financing for health has been a low priority for the government. Since the comprehensive peace agreement, the share of health in overall government expenditure decreased from 3.8 percent in 2006 to 2 percent in 2015. The commonly-cited government expenditure figure of 4 percent is based on the approved budget, not on actual expenditure. Social budget allocations remain low while aid as a percentage of the government budget has risen significantly over the last few years. This low level of health expenditure is the result of prioritizing the security sector (47 percent of total expenditure) over human development needs. The role that humanitarian and development actors play in financing and delivering health services also allows the Government to prioritize other sectors when allocating public resources.

Inadequate number of health workers

At independence, the country had extremely low ratios of qualified health workers to population, with services mostly provided by humanitarian and other non-state actors. This continues to be the case, both due to ongoing conflict, as well as overall limited government capacity. It is estimated that there is only one doctor per 65,000 patients and one obstetrician/gynaecologist per 200,000 people. There are no paediatricians in South Sudan (WHO, 2016). There are, however, some positive trends, with the number of midwives increasing significantly since 2010, from only 8 in 2011 to over 600

trained with essential professional midwifery competencies (United Nations Population Fund, 2018).

Health Service Delivery

Only 44% of population of South Sudan have access to services. This is attributed to the fact that more than 80% of population is rural and to issues of equity in distribution with urban bias. Currently 70% of health facilities are functioning. Health services at the protection of civilian sites (POCs) are provided through implementing partners. This is evidenced by the fact that the number of outpatients per capita was only 0.6. Four visits for ANC services is only achieved in 17% of cases; the proportion of deliveries in health facilities is at a mere 14%, and Penta3 coverage is 33%

Supply Chain Management

Procurement and supply chain management continue to be extremely challenging in South Sudan. MOH is responsible for pharmaceutical supply to all primary healthcare facilities and it has implemented an input based "push" system (i.e., dependent on forecasting rather than demand) which is unresponsive to needs. In addition, due to poor storage, tracking and utilization of medicines, the vertical forecasting mechanism that administers the "push" system to lowest levels incurs high losses.

The availability of medicines and health supplies to the population has been hampered by insufficient domestic allocation of financial resources for medicines, and poor coordination of available resources with partners resulted in the implementation of parallel supply chain mechanisms. This is exacerbated by inadequate quantification and projections of national need to guide procurement of medicines, inadequate storage space and distribution logistical challenges to health facilities and irrational prescription. The resultant frequent stock-outs of medicines mean people have to pay out-of-pocket expenses for medicines or don't get treated at all.

Health Information system

Over the last 10 years the paper-based Health Management Information System (HMIS) has been improved to DHIS1.4 and now has transitioned to DHIS2 for monitoring health service delivery. The performance of the nascent Health Management Information System is about 50% for timeliness and completeness. Despite the operationalization of DHIS2, the HMIS remains fragmented, with vertical programs collecting information that is often not shared with and used by the information repository in the Ministry of Health. It mainly collects data from Primary Health Care facilities, thus leaving hospitals and private sector data unreported. Surveys and facility assessments have been used to fill the resulting gaps in information, however these proved to be too expensive and irregular.

7.9.4 Is it possible to solve the problems with PBF?

Yes. PBF can play a critical role in solving the health challenges in South Sudan. Motivating health staff will ensure increased quality and quantity of health care services and improve the low health indicators in the country. PBF will ensure availability of funds at health facility level and develop the capacity of health management teams (HMT) to plan their own actions to provide quality health care services. This will include procuring of relevant drugs and other medical supplies on time which are not provided by central medical stores.

7.9.5 Feasibility scan of the existing and/or new PBF program

The following emerges from the feasibility scan in South Sudan:

- The existence of a 'Zero cash policy', which only allows subsidies and inputs in kind to health facilities. This has created a pure inefficient input policy.
- Free health care with not enough public money at hand to pay for the health services. This leads to informal practices in an unregulated private sector (the result of pricing below equilibrium through the FHC).
- Many vertical programs are run in parallel, leading to inefficiencies.

Criteria to establish in how far the project is "PBF"	Points	Current Situation	Score	Proposed designed PBF program.	Possible Score
1. The PBF program budget is not less than $ 4 per capita per year of which at least 70% is used for health facility subsidies, local NGO contracts and infrastructure input units.	5	Most of the budget is input-based without positive incentives	0	Negotiate with donors on the need for output-based programs. Cordaid to pilot PBF in Torit county applying PBF to one hospital and 6 primary health care centres (PHCC). This approach will increase the budget to at least 4 USD per capita.	5
2. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives.	3	The programs are vertical and do not meet the minimum package of activities for both primary and secondary care	0	Start with at least 25 SMART selected output indicators covering main activities of the health facilities. Quality checklist maybe based on international used standard indicators.	3
3. The PBF program finances the full health centre and hospital health packages and is not restricted to a limited number of vertical program indicators	2	The programs are vertical, do not meet the minimum Package of activities for both primary and secondary care	0	Ok	2
4. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	No community interventions in current incentive schemes, only used in campaigns.	0	Introducing community indicators to reachable (secure) populations	2
5. The project includes (or is part of) baseline and evaluation household and quality studies that establish priorities and allow measuring progress	3	Baseline assessment done, but priorities were determined by the donor	0	Baseline to be done by PBF experts working with CORDAID team, to establish the baseline, develop indicator list and design the program.	3
6. Cost recovery revenues are spent at the point of collection (facility level)	2	Yes	2	Collected revenue spent at the health facilities	2
7. Health facility managers have the right to decide where to buy their inputs	4	Yes	4	Health facility managers have the right to decide where to buy their inputs	4
8. The project introduces business plans	3	No business plans in based budgets available	0	Introduce business plans for facilities	3
9. The project introduces the indices tool for autonomous management	3	Available tools are not for autonomous management	0	Avail indices tools for autonomous management	3
10. CDV agencies sign contracts directly with the daily managers of the health facilities – not with the indirect owners such as a religious leader.	2	No contracts sign with facility managers (MOUs signed between implementing partners and (S)/MOH)	0	Cordaid Juba office will act as CDV paying agent while CORDAID Torit office will act as CDV agency. County Health department (CHD) will be the regulator. Cordaid will sign contracts with HF Managers and CHD .	2

11. Health facility managers are allowed to influence cost sharing tariffs	2	HMT proposes fees structures which is seconded by Board of governors	2	Health facility managers are allowed to influence cost sharing tariffs	2
12. Health facility managers have the right to hire and to fire	2	No, Hiring of staff is done by the (S)/MOH	0	Health facilities are allowed to recruit contractual staff and use cost-sharing and PBF revenue subsidy revenues	0
13. There is a CDV Agency that is independent of the local health authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	No independent CDV Agencies	0	Cordaid Juba office will act as CDV paying agent while CORDAID Torit office will act as CDV agency. County Health department (CHD) will be the regulator. Cordaid will sign contracts with HF Managers and CHD .	2
14. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	No there is no separation of functions	0	Cordaid Juba – payment agent and Cordaid Torit is the CDV agency.	0
15. CDV agents accept the promotion of the full government determined health packages (this in Africa mostly concerns discussions about family planning)	2	No, packages are donor driven	0	No problem for provision of the whole package at primary and hospital level.	0
16. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	No, infrastructure and investments are input based	0	Infrastructure and investment units in place.	2
17. Public religious and private facilities have an equal chance of obtaining a contract	3	No, private facilities are excluded from the input-based system	0	Equal treatment for all facilities	0
18. There are geographic and/or facility specific equity bonuses	3	No equity considerations in positive incentives distribution	0	Equity considerations be basis for bonuses.	3
19. The project provides equity bonuses for vulnerable people	3	In places where there is cost sharing, there are exemptions to cost sharing. However, projects do not have cash recovery for free services provided by the facility	0	Project should provide reimbursement for vulnerable people to provide services free of charge.	3
TOTAL	**50**		**10 (20%)**		**41 (82%)**

7.9.6 Recommendations

PBF is a health systems reform that is applicable to South Sudan despite the challenging operating environment. Therefore, the following action recommendations are made:

- **Debrief with Cordaid office**. Present the proposal to start a PBF pilot program in Torit county. The points of discussion would also be in how far in this pilot money of Health Pool Fund of around 12 USD per capita can be used or whether this pilot should be financed by MEMISA money. A financing mix could also be proposed with financing from the Health pool fund for the payment of the contracts, while the preparation, action research and evaluation could be financed by MEMISA. The

conditions of starting a PBF pilot in Torit County are favourable due to relatively good accessibility of the health facilities and the relatively well-developed local economy and proximity to Uganda.

- **Meetings with the National and Torit State Health authorities**. If the Cordaid response is favourable, then we should meet with representatives of the National Ministry of Health and the Torit State Ministry of Health to discuss the possibility of piloting a PBF program in 50% of the County. This pilot would compare the results in terms of quantity, quality and equity in the PBF Health facilities with the other 50% of the county applying the traditional Health pool fund approach. The main differences of the two approaches are the shift from input-financing towards performance financing and the more autonomous management of health facilities, including the demand driven purchasing of inputs.
  The *study hypothesis* is that PBF approach would be around *4 times more efficient* than the traditional input approach of the Health pool fund.
- **Feasibility study**. In order to start this pilot, there is a need to conduct a feasibility study at National and Torit level. This study should investigate the baseline situation in both the PBF and the Pool fund health facilities concerning the number of staffs per 1,000 habitants, the number of health facilities, the comprehensiveness of the health services provided, the revenues per capita generated by health facilities, the quality scores, the motivation of health staff and security situation.
- **Technical assistance support**. The feasibility study may require the support of public health- and PBF expert. The PBF expert will assist the team in identifying output indicators, mapping of the health facilities for PBF and rationalization.
- **Mapping and rationalization**. This pilot would cover one hospital (Torit State hospital) and 3 PHCCs. This also requires the mapping and rationalization of the intervention area to ensure geographical coverage and good economics of scale, each main PBF contract holder should cover a catchment area of around 8,000 populations. In each catchment area, the main contract holder may also sub - contract smaller health units.
- **PBF design elements**. Torit is the proposed PBF hospital and Nimule Hospital will be the control hospital under this comparative study. The remaining 3 PHCCs in Torit and the PHCCs under them will be considered control Health facilities.

7.9.7 Action plan

Activity	*Who*	*How*	*When*
Debrief with Cordaid office: Present the proposal to start a PBF pilot program in Torit county.	Boniface	Feedback report	Quarter 4, 2019
Meetings with National and Torit state Health authorities: Discuss the possibility of piloting a PBF program in 50 % of the county.	Boniface/Andrew	Meetings.	Quarter 4 , 2019.
Feasibility study: In order to start this pilot, there is a need to conduct a feasibility study at National and Torit level.	Andrew/Boniface	MEMISA grant	Quarter 1 , 2020.
Technical assistance support: The feasibility study may require the support of public health and PBF experts.	Cordaid PBF expert/ Boniface	Assessment tools	Quarter 1, 2020.
Mapping and rationalization: This pilot will require mapping and rationalization of the intervention	PBF expert / Boniface/Juliet	Assessment tools.	Quarter 1 , 2020.

area to ensure geographical coverage and good economics of scale.			
PBF design elements. Torit is the proposed PBF hospital and Nimule Hospital will be the control hospital under this comparative study. The remaining 3 PHCCs in Torit county and the PHCUs under them will be considered control Health facilities.	PBF expert / Boniface/Juliet	Proposal development.	Quarter 2 , 2020.

7.10 Liberia

7.10.1 Context

The population of Liberia is 4.7 million. Its population is growing and predominantly young. The population density is 51 persons per square kilometer, with 52% of the population residing in urban settings. A quarter of the population lacks easy access to health facilities. Liberia has 1.9 health facilities per 10,000 population, and thereby almost achieved the WHO recommended minimum health facilities of two health facilities per 10,000 population. Yet, the distribution of public health facilities remains skewed towards urban areas.

The 2013 Demographic Health Survey (DHS) report improvements in Liberia's health indicators such as those related to infant or under five mortality. Yet, maternal mortality increased from 994 to 1072 death per 10,000 live birth. Overall life expectancy at birth increased by 2.3% from 62.5 in 2015 to 63.9 in 2019. The Liberia Human Development Index in 2018 was 63 and ranks 181 out of 189 countries.

Performance-based financing is being implemented since 2009 at primary level and in 8 hospitals to enhance the quality and efficiency of the services. Additionally, the MOH has operationalized the logistic management information system, which makes the supply chain management system more effective. Stock balances of commodities for most health facilities that have entered their data are being tracked in real time. Furthermore, an automatic web-based financial management system has been installed at central level and is being rolled out to the counties. This system has facilitated real time monitoring of financial resources and transactions at central and county levels making financial reports generation easy and financial data for decision making handy.

Despite these improvements, there are weaknesses such as no defined resource allocation formula to facilitate equitable distribution of resources to the counties and health facilities. Hospitals receive more resources compared to primary facilities where the poor and vulnerable population mainly seek care. The vulnerabilities of the counties are not factored in the allocation decisions resulting and there is a haphazard allocation of per capita health expenditure of between USD 3.00 and USD 21.00 per county.

7.10.2 Problem analysis

The Liberian health sector is faced with the following challenges.

1. Inefficient human resource management.
Liberia stands at 11.8 per 10,000 health workers to population ratio. This falls far short of WHO's recommendation by more than half. Despite this low number, many health workers are yet to be placed on government payroll. Health workers are not equitably distributed across the counties and are mostly in the urban settings and counties closer to Monrovia. There is high level of demotivation among health worker mainly paramedics due to low salaries, poor working conditions and lack of access to basic social services especially for those in rural and hard to reach places. This has made it difficult to curb the high maternal and neonatal mortalities and improve the quality of the services.

2. Inefficient and ineffective supply chain management
There is huge gap in the ministry of health budget for the procurement of medicines. Government allocated USD 4 million against the 20 million projected by the supply chain technical working group. Stock outs are regular and in 2018, only 35 percent of health facilities had at least one of the essential medicines.

Logistics management for drugs distribution is poor. The use of information to inform quantification and monitoring of medical commodities is limited. The Logistics management information System is a new system and so has very limited staff with the requisite capacities to run the system.

3. Health financing is not sustainable and dependent on donors and OOPHE
Liberian health financing is characterized by high (informal) out-of-pocket payments, limited risk pulling and unsustainable free care health policy. Informal household out-of-pocket expenditures have increased leading to the increase in catastrophic health expenditures. This, despite the government free health care policy. The Liberia health system is heavily donor-dependent since the emergencies of its civil war and the subsequent outbreak of the Ebola virus Diseases (EVD) in 2015. Yet, this donor support has a downward trend year-on-year and the economy has also slowed down.

To mitigate these resource constraints that faces the MOH, work is being done around operationalizing the Liberia Health Equity Fund (LHEF) in its efforts to achieve UHC. This calls for ending the universal free health care policy, reintroducing affordable fees for services, revolving drugs funds, and health insurance.

The inadequacies in the Liberian PBF system as outlined above necessitates a structural reform of the PBF design and needs to harmonize the different approaches from the different donors.

7.10.3 Assessment / Scan of Liberia's PBF Design

A feasibility scan of Liberia's PBF design was done in November 2019, using twenty-three criteria. The criteria are based on PBF best practices. The feasibility score was evaluated at an average of 35% overall, whereby we considered also the differences in the WB and FARA approaches. These findings placed Liberia far below the ideal PBF implementation compliance score of 80% and suggests design inadequacies that must be addressed in order to optimize the potential of PBF as a strategic approach to assure quality, efficiency and equity to achieve universal health coverage.

Prominent among the shortcomings in Liberia's current PBF design are:

1. The existence of many elements of input-based financing
2. Limited autonomy of providers
3. Lack of equity considerations in the allocation of geographic and individual bonuses for the vulnerable counties and patients and in the enlistment of all public and private participating facilities
4. No provision for quality improvement bonuses
5. The need to improve the regulatory framework and to assure the clear separation of roles and responsibilities of stakeholders to avoid conflicts of interest and so that it can command a level of influence anticipated.

7.10.4 Is PBF a solution?

PBF has a large potential and advocates for strategies geared towards achieving sustainable health financing for the attainment of UHC. PBF implementation in Liberia dates as far back as mid 2009 when the MOH introduced the USAID flagship project-Rebuilding Basic Health Services (RBHS). Performance-based contracting scheme was piloted in selected health facilities across six counties. This performance-based contracting approach included awarding management contracts to external players including international and local non-governmental organizations. In spite of some encouraging outcomes, the scheme was not designed according to current best practices. Facility- and key implementing agents, did not have enough autonomy, the separation of roles and responsibilities were not clear, and the PBF equity instruments were not used. The Liberia design did not have performance contracts with the County Health teams and instead of giving contracts to health facilities they were given to the Key Implementing Agents (KIA) – mostly NGOs.

About three years later, the Ministry of Health, piloted a mixed model version of PBF involving a purely contracting-in approach (MOH contracting its county health team) funded by the Health Sector Pool Fund on one hand, and a contracting-out approach (contracting NGOs) funded by the MoH USAID FARA project. Yet, these two approaches share the same limitations of being partially input-based financing.

The shift away from contracting NGOs to contracting County Health Teams became imperative given the economic realities and associated financial limitations that compelled decision makers to shift towards the contracting-in approach. A contracting-in guideline was developed based on lessons learned from the evaluation of the contracting-in scheme piloted in one of the counties which showed laudable results.

7.10.5 Action Plan/ activities

1. Begin advocacy starting with technicians and policy makers in the MOH and then to other key government agencies including Ministry of Finance for a full-scale harmonized output-based financing (strategic purchasing) approach towards health reforms and ensure that this is incorporated into the current draft health strategy.
2. Harmonize Liberia different PBF schemes into one common national scheme to be scaled up nationwide as a national health reforms and financing strategy;
3. **FY 2020-2023: MOH to develop a sustainability plan for PBF financing including plan for national scale-up;**

4. FY 2020/2021, seek temporary exemption from:
   a) Current public Financial Management laws to transform current input budget into PBF budget starting with the grant and subsidy lines in the national budgets, grant health facilities financial autonomy to collect funds and manage them with their own bank accounts;
   b) Create budget lines and accounts for district health teams and grant them more autonomy:
      i. primary facilities budgets on a per capita basis that reflects geographic equity
      ii. an output-based County Health Team budget for regulation
      iii. an output-based District Health Team budget
   c) Civil Service Regulations to grant autonomy to health facilities to manage their own human resources starting with extra profession staff based on population or work load, non-professional staff and community health workers;
5. Open bank accounts for DHTs and all health facilities at all levels to manage their own finances;
6. FY 2022/2023: scale up PBF to 100% of facilities across fifteen counties
7. Move the PBF Unit directly under the Office of the Minister for better coordination, contracting of all departments and the national scale-up of the PBF reform
8. Revise the institutional setup of the PBF program at all levels (see scheme attached)
9. By FY 2020/2021: Develop and implement performance contract with selected Units within MoH
10. Introduce mapping and rationalization of catchment areas according to national standard
11. Establish a county data validation committee consisting of County Health representatives, CDV and service providers
12. Introduce budgetary allocation at central level and for the CDV agencies in their performance contracts to finance need-based action research;
13. Introduce formal cost recovery as part of the PBF scale up plan in Hospitals
14. Introduce quality improvement bonuses in the standard output indicator list
15. Identify a national institution to play the role of CDV Agency ; possibly the Governance Commission;
16. Establish county level CDV branches as sub-managers of national CDV placed at county and district levels.
17. Health facilities establish their tariff together with their communities after the introduction of cost sharing,
18. Health facilities have the liberty to negotiate assignment of civil servants based on needs;
19. Health facilities are authorized to recruit contracted staff including professional staff
20. CDV agency new style contract health facilities based on performance irrespective of their status (public, private or religious affiliation)
21. Introduce geographic equity bonus system as an intervention to attract rural service and promote staff retention
22. Transform financing system from generalized free health care to targeted free health care system

7.10.6 Annex I. Assessment / scan of PBF Liberia approaches

Criteria to establish in how far the program is "PBF"	Av Score	Issues	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	0%	- Current per capita budget is approximately $ 3.00; - Free health care design with the intention to start a cost recovery; - Full free health care is very expensive; ~ ($12 - $15 / capita) - The actual PBF budget is totally externally financed; creating sustainability problem. - World Bank and FARA Budget is still a mix of Input and Performance components which is not recommended according to PBF best practice	- Introducing a cost recovery scheme could reduce the budget to $7 - Use the existing budget of $3.00 - Transform the input Bank and FARA project components of their budget into output PBF financing - Transform the national budget into PBF financing starting with the lines "grants" and "subsidies" to the counties - A detailed costing of output, quality and equity indicators must be done
2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	0%	1. Commitment of Liberian Government is not yet assured giving that there is no budget allocation for PBF.	- FY 2020 - 2023: GoL to propose a strategic sustainability plan for PBF financing including proposal for national scale-up - FY 2020/2021: identify component of the "Grant" and "subsidy" budget lines that can be transformed to PBF budget lines in PBF counties and transform all existing Gol grants and subsidies to PBF budget beginning with facilities with direct budget transfer - FY 2021/2022: a. Increase Gol share of contribution to PBF financing overtime b. PBF scale-up to 75% of the counties - FY 2021/2022: transform the integrated existing county budget into: a. Primary Health facilities budget on a per capita basis that it reflects geographic equity b. An output-based County Health Team budget for regulation c. An output-based District Health Team budget - FY 2022/2023: scale up PBF to 100% of facilities across fifteen counties
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.	100%	Now, the PBF Unit is operating from one of the three Departments of the MOH; thus, making difficult: a. Coordination b. Contracting of other	- Move the PBF Unit directly under the Office of the Minister for better coordination, contracting of all departments and the national scale-up of the PBF reform - Revise the institutional setup of the PBF program at all levels

		department and c. national scale up PBF	
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	0%	The Units have no performance contract	FY 2020/2021: Develop and implement performance contract with selected Units within MoH
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	100%	OK	
6. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	100%	There are no community indicators related to social marketing	Introduce the following incentivized indicators - "Visit to households following protocols by qualified staff" - "Follow-up on drop-outs" for TB, nutrition, HIV, family planning, immunization, etc. - "Identification of new cases" (….)
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.	0%	- Mapping and rationalization not done; - Contracts are facility-based, instead of population-based	- Introduce mapping and rationalization of catchment areas according to national standard
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	0%	- County validation committee has not been established	- Establish a county data validation committee consisting of County Health representatives, CDV and service providers
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	67%	- Currently, there is no plan budgetary provision for Action Research	- Introduce budgetary allocation at council level or CDV performance contract for need based action research
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 Health facilities are the signatories.	33%	- No formal cost recovery.	- Introduce formal cost recovery as part of the PBF scale up plan - Open bank accounts for DHTs and all health facilities at all levels
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	33%	- At Primary level, there is an input-based; "push" system	- Transform from input-based system to demand based; "pull" system whereby health facilities buy from accredited distributors.
12. The project introduces the business plan that includes the Quality Improvement Bonuses	100%	- Business plans in place; no Quality Improvement Bonus system in place	- Introduce Quality improvement bonus in the standard output indicator list
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	33%	- OK	
14. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect	0%	- CDV agencies (NVA) does not sign contract with the daily managers of health facilities	- Identify national organization to play the role of CDV Agency

owners such as a religious leader or private person.			- Transform the national CDV agency into a national CDV agency for the signing of performance contract - Establish county level CDV branches as sub-managers of national CDV placed at county and district levels.
15. Provider managers are allowed to influence cost sharing tariffs	33%	- There is no cost sharing at primary levels	- After introduction of cost sharing, health facilities the right to establish their tariff together with their communities
16. Provider managers have the right to hire and to fire	0%	- Civil servants' recruitment is centrally based	- Health facility may propose or refuse appointed civil servants - Health facilities are authorized to recruit staffs including professionals
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	33%	- Current NVA is only doing verification; no contracting or coaching	- New CDV institutional setup with local organization would also contract and coach
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	0%	- OK	
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	100%	- OK	
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	100%	- No QIB in place	Introduce QIB
21. Public religious and private providers have an equal chance of obtaining a contract	0%	- No equal chance of obtaining contract	CDV agency new style contract health facilities based on performance irrespective of their status (public, private or religious affiliation)
22. There are geographic and/or facility specific equity bonuses	0%	- No geographic equity bonus system in place	Introduce geographic equity bonus
23. The project provides equity bonuses for vulnerable people	0%	- Free health care system in place;	Transform financing system from generalize free health care to targeted free health care system
TOTAL	**35%**		

7.10.7 Annex II. Action plan

Main Problem	Issues identified	Proposed Intervention	Timeline	Responsible person
Inefficient Health Financing mechanism	Generalized free health care services is marred by inefficiencies and frequent stock outs, and compromises quality	- Begin advocacy for the use of a full-scale harmonized output-based financing as a strategic purchasing approach to efficient health financing; - Ensure that output financing is endorsed in the draft health financing policy	10-Dec-19	Health Services / Planning
		- Introduce a cost recovery scheme as a strategy to reduce the per capita PBF budget for the primary level	01-Jan-20	Planning
		- Find input budget lines in the national budget and transform them into PBF financing	Jan-June 2020	Administration / Planning / MFDP
	Full free health care is very expensive; ~ ($12 - $15 / capita)	- Transform the input Bank and FARA-project components of their budgets into PBF output financing	Jan-June 2020	Administration / Planning / MFDP
	The actual PBF budget is totally externally financed creating sustainability problems.	- Use the existing budget of $3.00 to transform from input-based system to demand based "pull" system whereby health facilities buy from accredited distributors.	Jan-June 2020	Administration / Planning / MFDP
	World Bank and FARA Budget is still a mix of input- and performance components. This is not advised in PBF best practice	- Open bank accounts for DHTs and all health facilities at all levels	Jan-March 2020	Administration / Planning
There is absolute dependency on donors for PBF financing, which puts at long-term risk the sustainability of PBF financing	Commitment of Liberian Government is not yet assured given that there is no budget allocation for PBF.	- FY 2020 - 2023: GoL to propose a strategic sustainability plan for PBF financing including proposal for national financing and scale-up	Jan 2020-Dec 2023	Administration / Planning
		- FY 2020/2021: Identify components of the "grant" and "subsidy" national budget lines that can be transformed to PBF budget lines in the PBF counties and transform all existing GoI “grants” and “subsidies” into PBF budget beginning with the HF with direct budget transfers	Jan 2020-Dec 2021	Administration / Planning
		- Increase GoI share of contribution to PBF financing overtime	Jan-June 2020	Administration / Planning
		- PBF scale-up to 75% of the counties	Jan-Mar 20	Health Service / Planning
		- Introduce Primary Health facilities budgets on a per capita basis that reflects geographic equity	Jan-June 2020	Administration / Planning
		- Introduce an output-based County Health Team budget for regulation	Jan-June 2020	Administration / Planning
		- FY 2022/2023: scale up PBF to 100% of facilities across fifteen counties	Jan 22-Dec 23	Administration / Planning

PBF Unit is not fully integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	PBF Unit is now operating from one of the three Departments of the Ministry of Health. This is difficult for: a. Coordination; b. Contracting of other departments and c. National scale up of PBF	- Move the PBF Unit directly under the Office of the Minister for better coordination, contracting of all departments and the national scale-up of the PBF reforms	Jan-March 2020	Health Services
		- Revise the institutional setup of the PBF program at all levels	July-Dec 2020	Health Services / Admin / Planning
Lack of extrinsic motivation among central level actors could lead to inefficiencies among regulatory stakeholders within the scheme	The Units have no performance contract	- By FY 2020/2021: Develop and implement performance contracts with selected Units within MoH	Jan 2020-Dec 2021	Administration / Health Services
Service providers have no direct contract for PBF implementation	Mapping and rationalization not done;	- Introduce mapping and rationalization of catchment areas according to national standards	Jan-June 2020	Planning / Health Services
Lack of a forum for validating invoices poses a risk to transparency and accountability	County validation committee has not been established	- Establish a county data validation committee consisting of County Health representatives, CDV and service providers	Jan-June 2020	Planning / Health Services
Lack of forum and mechanism for bi-directional accountability poses risk to transparency	No budgetary provision for action research	- Introduce budgetary allocation at council level or CDV performance contract for need-based action research	Jan-June 2020	Planning / Health Services
	No cost recovery	- Introduce formal cost recovery as part of the PBF scale up plan in Hospitals	Jan-March 2020	Planning / Health Services
		- Open bank accounts for DHTs and all health facilities at all levels	Jan-March 2020	Administration
	No Quality Improvement Bonus system in place	- Introduce Quality improvement bonus in the standard output indicator list	Jan-March 2020	Administration / Health Services
	CDV agencies (NVA) does not sign contract with the daily managers of health facilities	- Identify national organization to play the role of CDV Agency	Jan-June 2020	Planning / Health Services
		- Transform the national CDV agency into a national CDV agency for the signing of performance contract	Jan-June 2020	Administration / Health Services
		- Establish county level CDV branches as sub-managers of national CDV placed at county and district levels.	Jan 2020-Dec 2021	Administration / Health Services
Provider managers are not allowed to influence cost sharing tariffs	There is no cost sharing at primary levels	- Health facilities establish their tariff together with their communities after introduction of cost sharing,	Jan-June 2020	Planning / Health Services

Lack of HR autonomy at facility undermines productivity	Provider managers have no right to hire and to fire	- Health facility have the liberty to propose or to refuse appointed civil servants	July-Dec 2020	Planning / Health Services
		- Health facilities are authorized to recruit contracted staffs including professional staffs	July-Dec 2020	Planning / Health Services
Poor health infrastructures and lack of essential equipment compromises quality of service delivery	The PBF system does not have infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	- Introduce the PBF system of Quality Improvement Bonuses as a means of stimulating infrastructure development and the quality of service delivery	Jan-March 2020	Administration / Health Services / MFDP
Lack of competition among service providers creates monopolies and endangers efficiency	Public religious and private providers must have equal chance of obtaining a contract	- CDV agency new style contract health facilities based on performance, irrespective of their status (public, private or religious affiliation)	July-Dec 2020	Planning / Health Services
Staff attrition due to limited motivation for rural postings	No geographic equity bonus system in place	- Introduce geographic equity bonus system as an intervention to attract staff in rural HF and promote staff retention	Jan-June 2020	Planning / Health Services
Generalized free health care policy without sufficient external support endangers quality and is inefficient	Poor quality of services due to limited revenues to finance the services	- Transform the financing system from generalize free health care to targeted free health care system. This implies fee paying for those who can afford	Jan-June 2020	Planning / Health Services