Mombasa – KENYA

Report of the 74th Performance Based Financing Course

October 29 – November 9, 2018

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

Final version 19th of November, 2018

Mombasa, Kenya

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1. SUMMARY

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The next English PBF course is in Mombasa Monday April 1 to Saturday 13, 2019

The 74th performance-based financing (PBF) course took place from Monday, October 29th to Friday, November 9th, 2018, in Mombasa, Kenya. Thirty-six participants attended the course: 34 from Nigeria, 1 from Liberia, and 1 from Cameroon.

Most participants came from Nigeria so that we could concentrate during this course on the specific issues of Nigeria. PBF in Nigeria started in 2011 with a small pilot covering one LGAs in the three States of Adamawa, Ondo, and Nasarawa. It was scaled up within the three States in 2014 and in 2017 the PBF approach expanded towards five additional States in the fragile and unstable North East of the country.

1.1 Main health problems in Nigeria

- The maternal mortality rate is 821 deaths per 100.000 live births on average in the country, but reaches the extremely high 1549 deaths per 100.000 live births in the North Eastern States. These are also the States where PBF reforms have been proposed in response to the health problems and instability. The main causes of maternal death are haemorrhage, sepsis and unsafe abortions.
- In 2017, malnutrition in Nigeria increased to 31,5% of children underweight, 43,6% stunted and 10,8% wasted.
- Under-five mortality is 120 / 1000 live births. Vaccination DTP3 coverage in 2017 was between 30% and 40% - far below the Africa average.
- The unmet demand for modern family planning methods is high with a couple protection rate in 2013 of 10%, while the total demand is estimated at 36%.

1.2 Main structural challenges of the health system in Nigeria

- A range of causes lies at the root of the *poor quality* health services and inefficient use of public and private resources in Nigeria: 1. Central planning and financing of inputs; 2. The existence of multiple monopolistic distribution systems of government and partners; 3. Poor coordination with the private sector ; 4. Lack of autonomy of health facilities and ; 5. Highly centralized human resource policy.
- Several vertical health programs of government and partners aim at similar objectives *but which lack coordination*. Thus resources are wasted and they give different orientations to health workers at the facility level.
- The World Bank currently finances three large but *conceptually opposing and 'verticalized' projects*: 1. Safe One Millions Lives; 2. The NSHIP PBF program and; 3. The newly introduced nutrition program ANRiN. The course participants felt these programs should be better coordinated through a unified conceptual framework for implementation to attain positive reforms in Nigeria.
- The current *"carrot x stick"* approach used in the NSHIP program as quality factoring is problematic, and from an international comparative perspective increasingly dis-advised. The main disadvantage of the 'carrot x stick' is that the revenues become unpredictable for the health facilities, demotivating staff when the cost of certain activities that must be fully reimbursed such as for persons living with HIV, tuberculosis and for immunization are not fully covered due to the punitive "stick". Yet, certain quality problems are intrinsic to already existing

baseline problems and despite sometimes good efforts to improve the services the punitive stick may push the health facilities even deeper into problems. Supporting the vulnerable implies that there must be the full reimbursement of the cost. The carrot x stick approach has already led to the refusal of several health facilities to continue the PBF approach such as, prominently, in Borno state, a state which faces already enough challenges as it is. So in short, while we all agree that quality is of prime importance, the current incentive structure may not achieve the desired results.

1.3 Encourage reforms – based on the PBF best practices and paradigms

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

1.4 Change some features of the PBF design in Nigeria

- Domicile the *PBF unit at the Federal and State Ministries of Health* rather than in National and State Primary Health Care Agencies/Boards for better coordination, the inclusion of the hospital level and for the regulatory stakeholders to ensure sustainability.
- Introduce the *carrot + carrot* approach instead of the current *carrot x stick* approach in terms of the incentive payments, but at the same time promote quality by applying sticks such as delaying signing contract for those health facilities that do not make progress ;
- Encourage all wards, LGAs and States to conduct the *complete mapping and rationalization* of health facilities so that on average one principal contract holder covers around 10.000 inhabitants at primary level and around 100-200.000 people at the hospital level ;
- *Increase* the per capita direct PBF subsidies and investment units from the current *$ 1 per person per year to $ 2,50 - $3,00* ;
- *Introduce LGA validation committees* in which the LGA health authorities together with the LGA CDV staff discuss the invoices based on the verified data, solve problems, discuss the patient satisfaction surveys and the consequences of these data for the renewal of contracts ;
- *Review the roles of the Contract Management and Verification Agencies* (CMVA) and the *Independent Verification Agencies* (IVA) ;
- *Modify existing laws* so that: 1. Health facilities retain and use their cost recovery revenues in PBF dedicated accounts ; 2. The managers of the facilities are the signatories of these accounts ; 3. Facility managers can choose their supplies from any accredited supplier.

1.5 Recommendations concerning advocacy for Nigeria

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

1.6 Problem analysis Borno State

Borno is the epicenter of the conflict in NE Nigeria with the Boko Haram insurgency. Due to displacements, the population is highly mobile and there is insecurity across vast areas in the state with vandalized health structures. 15% of the population is not accessible at all for health workers. The PBF program so far only signed 108 or 27% of the contracts on a total of 399 desired contracts (this ratio excludes the inaccessible areas).

Due to concerns about gaming, whereby false data were produced, the PBF program decided to switch from the carrot + carrot approach towards the carrot x stick approach. This lead to frustrations among health facility staff and several health facilities have since refused to sign contracts. The highly dynamic population and the insecurity in the state make patients reluctant to give their true addresses, which makes verification an even larger challenge and applying punitive sticks under such circumstances may be counterproductive. Another demotivating factor is that the PBF program suffers from long payment cycles, which is particularly damaging in the unstable environment of Borno State.

1.7 Recommendations for Borno State

- Review the “sanction system” so as to make it more realistic under the difficult circumstances in Borno State and rendering it more attractive for health providers (in particular from the private sector) to sign contracts ;
- Change the payment cycle to monthly reimbursements instead of three monthly ;
- Integrate all vertical programs at the state primary health care development agency and the state ministry of health into one basket of results-based payments.
- The specific circumstances in Borno State make it important to conduct intense action research of the best approach towards the emergency PBF approach. Any action researcher with a promising study protocol should be encouraged with PBF performance financing to conduct studies.

1.8 Recommendations for Gombe State

- Adopt the PBF approach as health system strengthening strategy in Gombe State ;
- Create a PBF unit at the highest level possible within the State MoH so that the hospitals and the regulators can also be included in the PBF reforms ;

- Create a State budget line in 2019 for PBF and use already existing external partner resources. For example, 40% of the SOML funds should be channelled towards a pure PBF approach ;
- Request the State to finance PBF in two additional LGA's from 2019 onwards ;
- Advocate for the integration of the vertical programs into one single program using the PBF approach to maximise the opportunities and improve efficiency.

1.9 Recommendations for Liberia

- Advocate with the government on the need to expand PBF implementation to all health facilities and consider addressing the problems identified in the PBF feasibility scan (see the detailed report)
- Support the Ministry of Health to commence full implementation of primary PBF in 3 counties ;
- Continue to be a PBF advocate within and outside the World Bank.

1.10 Recommendations for Cameroon

- Accelerate the scale-up of the PBF health reforms from the current 65% to 100% of the population.
- Transform the input financing strategies of several (partner) programs into the PBF output and quality-based payment approach ;
- Expand the national PBF unit at the level of Ministry of Public Health so that they can better play their coordinating role in Cameroon ;
- Start human resource policy reforms that allow for more autonomy for health service providers ;
- Increase the capacity of central Ministry of Health members by sending them to PBF courses.

1.11 Who attended and village authorities

The Nigeria team consisted of nine participants from the Federal level (4 from the NPHCDA and 5 from the FMOH) and 25 persons from nine States (Bauchi 5x, Borno 3x Gombe 4x, Kaduno 3x, Kano 1x, Kebbi 1x, Ondo 2x, Sokoto 3x, and Taraba 3x.

We were honoured to welcome the Commissioners of Health from Ondo, Gombe and Taraba States. There were three participants from the private sector, carrying out CDV roles in Borno State. There was one Senior Health Expert from the World Bank, based in Liberia. There was one high-level Cameroon Inspector from the Ministry of Health.

The facilitation team consisted of:

1. M. Christian Habineza, who is an independent consultant from Rwanda and who has worked in PBF for more than 15 years.
2. Dr .Godelieve van Heteren, senior health, governance and PBF expert, once a member of the Dutch parliament and Director of Cordaid, now working as senior health systems consultant for various agencies (WHO, World Bank).
3. Dr. Robert Soeters, the director of SINA Health and overall course coordinator.
4. Dr. Jean Claude Taptue, Senior Health Expert of the World Bank.
5. Dr. Fanen Verinumbe, PBF consultant of the National PHCDA in Nigeria.
6. Mrs. Ann Waimiru, who is a psychologist, from Kenya assisted us with the daily organisation and support of the participants.
7. Mr. Tomasi, who assisted with the logistics, recruitment of staff and the events.

The "Village 74" authorities consisted of the Village Chief, Mrs. Munirat OGUNLAYI ; the Deputy Village Chief Cyprian Akwo CHUO ; the Internal Affairs Minister and Time keeper Samira Abdullahi Mohammed; the Finance Minister Comfort Dave-Diamond and ; the Minister of Energy Oluwatosin Kolade.
They actively supported the facilitation process and contributed to a congenial atmosphere while maintaining "order" in the village.

1.12 Evaluation of the course venue and the course

Thirty-two participants conducted the final exam. The average test score result was 70% with four certificates of distinction and three certificates of attendance.

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

The daily evaluations yielded scores which were slightly above the previous 23 English courses. **Methods and facilitation** scored 90,7% (3,3% above the previous courses. **Participation** scored 85.2% (2% below the previous courses). **Organization** scored 88.5% (2,3% *above* the average of the previous courses). The subject of **timekeeping** scored 72,5% (comparable with the average of the previous courses).

The final evaluation indicated that the participants felt the content of the course to relate well to their regular professional activities. The participants were also satisfied with the methodology and the organization. The contents of the course modules were appreciated with higher scores compared to the previous courses with the exception of the indices management tool, which scored with 63% slightly lower. This was due to the fact that we did not finish the full module.

Yet, 41% of the participants felt that they were not sufficiently informed about the course in advance and some would have wished to receive the course book earlier. 43% of the participants felt the course was too short. The French spoken courses have one more day and this reduces the time pressure. We will also add one day to the Mombasa course of April 2019.

There was an improvement in the approach of the facilitation team during debates in this course by more actively involving those participants who were in favor of certain paradigm shifts to explain these to their colleagues instead of this being done by the facilitators. This lead to a score of 97% of the participants, who felt that the facilitation team was open for debate and criticisms compared to 74% during the previous English spoken courses.

Some participants commented that they would prefer more adult learning methodologies. With the next course extending by a day, the facilitation team will also consider the further deepening of adult learning, group work, exercises, etc.

2. RESUME EN FRANCAIS

Le prochain cours d'anglais PBF aura lieu à Mombasa du lundi 1er avril au samedi 13ème avril, 2019

Le 74ème cours du financement basé sur la performance (FBP) s'est déroulé du lundi 29 octobre au vendredi 9 novembre 2018 à Mombasa, au Kenya. Trente-six participants ont assisté au cours: 34 du Nigéria, 1 du Libéria et 1 du Cameroun.

La plupart des participants sont venus du Nigéria afin que nous puissions nous concentrer pendant ce cours sur les problèmes spécifiques du Nigéria. Le FBP au Nigéria a débuté en 2011 avec un projet pilote couvrant un district dans les trois États d'Adamawa, d'Ondo et de Nasarawa. Il a été mise à l'échelle dans les trois États en 2014. En 2017, l'approche FBP s'est étendue à cinq États supplémentaires dans le Nord-Est du pays.

2.1 Principaux problèmes de santé au Nigéria

- Le taux de mortalité maternelle est de 821 décès pour 100 000 naissances vivantes en moyenne dans le pays, mais atteint les 1549 décès extrêmement élevés dans les États du Nord-Est. Ce sont également les États où des réformes du FBP ont été proposées pour répondre aux problèmes de santé et à l'instabilité. Les principales causes de décès maternel sont les hémorragies, les sepsis et les avortements exécutés sous de très mauvaises conditions de qualité.
- En 2017, la malnutrition au Nigeria a augmenté pour atteindre 31,5% des enfants en insuffisance pondérale, 43,6% en retard de croissance et 10,8% en perte de poids.
- La mortalité des moins de cinq ans est de 120 / 1.000 naissances vivantes. La couverture vaccinale du DTC3 en 2017 était comprise entre 30% et 40%, ce qui est bien en dessous de la moyenne africaine.
- La demande non-satisfaite en méthodes de planification familiale moderne est élevée, avec en 2013 un taux de protection du couple de seulement 10%, tandis que la demande totale est estimée à 36%.

2.2 Principaux défis structurels du système de santé au Nigéria

- La *mauvaise qualité* des services de santé et l'utilisation *inefficiente* des ressources publiques et privées au Nigéria sont à l'origine de plusieurs causes :
  1. La planification et financement centralisés des intrants; 2. Existence de multiples systèmes de distribution monopolistiques du gouvernement et des partenaires; 3. La mauvaise coordination avec le secteur privé; 4. Le manque d'autonomie des structures de santé et; 5. La politique de ressources humaines hautement centralisée.
- Plusieurs *programmes de santé verticaux* du gouvernement et des partenaires visent des objectifs similaires mais *manquent de la coordination.* Ainsi, les ressources sont gaspillées et les programmes donnent souvent des orientations contradictoire aux agents de santé.
- La Banque mondiale finance actuellement *trois projets de grande envergure, mais qui sont conceptuellement opposés* et « verticalisés »: 1. Safe One Millions Lives; 2. Le programme PBF NSHIP et; 3. Le programme de nutrition nouvellement introduit, ANRiN. Les participants au cours ont estimé que ces programmes

devraient être mieux coordonnés grâce à un cadre conceptuel unifié pour la mise en œuvre en vue de réaliser des réformes positives au Nigéria.

- L'approche actuelle *« carotte x bâton »* utilisée dans le programme NSHIP pour améliorer la qualité est problématique. Le principal inconvénient du *« carotte x bâton »* est que les revenus deviennent imprévisibles pour les formations sanitaires, démotivant le personnel lorsque le coût de certaines activités devant être intégralement remboursées, comme pour les vulnérables, les personnes vivant avec le VIH, la tuberculose et la vaccination, n'est pas entièrement couvert en raison du « bâton » punitif. Cependant, certains problèmes de qualité sont intrinsèques aux problèmes de base déjà existants et, malgré parfois des efforts encourageants pour améliorer les services, le bâton punitif peut pousser la structure de santé encore plus profondément dans les problèmes. L'approche carotte x bâton a déjà entraîné le refus de quelques structures de santé de poursuivre l'approche PBF, comme par exemple dans l'État de Borno, qui fait déjà face à suffisamment de défis. En bref, bien que nous sommes d'accord que la qualité est d'une importance primordiale, les incitations actuelles risquent de ne pas donner les résultats souhaités.

2.3 Encourager les réformes FBP - basées sur les meilleures pratiques

- Changer le financement « inputs » actuel en faveur des contrats de performance ;
- Casser les monopoles des distributeurs des médicaments et permettre aux structures de santé d'acheter leurs intrants auprès des distributeurs accrédités opérant en concurrence ;
- Injecter des fonds directement dans les structures de santé et donner plus de pouvoir de décision sur l'utilisation de ces fonds au lieu de laisser les pouvoirs de décision aux administrateurs centraux ;
- Donner plus d'autonomie aux établissements de santé pour la gestion des ressources humaines et la fixation des tarifs du recouvrement des coûts ;
- Collaborer plus étroitement avec le secteur privé et leur proposer des contrats sur un pied d'égalité avec les structures de santé publics ;
- Permettre aux structures de santé d'ouvrir leurs comptes bancaires sur lesquels ils sont également signataires et mettre fin à la pratique selon laquelle les revenus doivent être transférés sur un compte de trésorerie unique.

2.4 Changer certaines caractéristiques du montage FBP au Nigéria

- Loger les Cellules Techniques FBP auprès des ministères de la Santé fédéraux et des États plutôt que dans les NPHCDA et SPHCDA pour une meilleure coordination, l'inclusion du niveau hospitalier et les acteurs de la régulation et afin d'assurer la durabilité à travers des fonds locaux ;
- Introduire en termes de paiements incitatifs l'approche *carotte + carotte* au lieu de l'approche actuelle *carotte x bâton*. Appliquer autres bâtons tels que retarder la signature du contrat pour les établissements de santé qui ne progressent pas ;
- Encourager tous les communes (wards), les districts (LGA) et les États (States) à procéder à la cartographie complète et à la rationalisation des structures de santé afin qu'un titulaire principal du contrat couvre en moyenne environ 10 000 habitants au niveau primaire et environ 100 à 200 000 dans les hôpitaux ;
- Augmenter les subsides directes et les unités d'investissement du FBP aux prestataires de 1 USD par personne et par an à 2,50 USD - 3,00 USD ;

- Introduire des comités de validation des districts (LGA) dans lesquels les autorités de santé des district et le personnel des ACV discutent des factures sur la base des données vérifiées, résolvent les problèmes, discutent des enquêtes de satisfaction des patients et les conséquences de ces données pour le renouvellement des contrats des structures ;
- Examiner les rôles des agences de gestion des contrats et de vérification (CMVA) et des agences de vérification indépendantes (IVA) ;
- Modifier les lois existantes afin que: 1. Les structures de santé conservent et utilisent leurs revenus de recouvrement des coûts dans des comptes bancaires dédiés ; 2. Les gestionnaires des structures sont les signataires de ces comptes; 3. Les responsables des structures peuvent choisir leurs intrants auprès de tout distributeurs (de médicaments) agréés.

2.5 Recommandations concernant le plaidoyer pour le Nigeria

- Mieux documenter les résultats encourageants du FBP dans les États performants tels que l'Adamawa - où le FBP existe depuis 2011 - et l'État de Gombe qui n'a commencé qu'en 2017, mais montre des résultats prometteurs d'amélioration, de sorte qu'ils puissent être utilisés pour le plaidoyer ;
- Présenter ces résultats lors du Conseil National de la Santé (NHC) et pour la Commission Nationale de Planification (NPC) ;
- Encourager les autorités Fédéraux et des États à faire que l'approche FBP devient la réforme privilégiée pour atteindre la couverture sanitaire universelle ;
- Intégrer les différents programmes verticaux dans une stratégie de santé harmonisée suivant l'approche des meilleures pratiques FBP.

2.6 Analyse du problème État de Borno

- Borno est l'épicentre du conflit dans le Nord-Est du Nigéria avec l'insurrection de Boko Haram. En raison des déplacements, la population est très mobile et l'insécurité règne dans de vastes régions de l'État avec des structures de santé vandalisées. 15% de la population n'est pas du tout accessible aux agents de santé. À ce jour, le programme FBP n'a signé que 108, soit 27% des contrats, sur un total de 399 contrats souhaités (ce ratio exclut les zones inaccessibles).
- En raison d'inquiétudes concernant la fraude, qui ont généré de fausses données, le programme FBP a décidé de passer de l'approche carotte + carotte à l'approche carotte x bâton. Cela a provoqué des frustrations chez le personnel des structures de santé et plusieurs structures de santé ont depuis refusé de signer des contrats. La population vivant en insécurité rendent les patients réticents à donner leurs véritables adresses, ce qui fait que la vérification communautaire devient encore plus complexe. Appliquer le bâton punitif dans de telles circonstances peut être contre-productif. Un autre facteur démotivant est que le programme PBF souffre de longs cycles de paiement, ce qui est particulièrement dommageable dans l'environnement instable de l'État de Borno.

2.7 Recommandations pour l'État de Borno

- Revoir le système de sanctions afin de le rendre plus réaliste dans les circonstances difficiles de l'État de Borno et de le rendre plus attrayant à signer des contrats pour les prestataires de santé (en particulier du secteur privé);
- Modifier le cycle de paiement en remboursements mensuels au lieu de trois mois ;

- Intégrer tous les programmes verticaux de l'agence de développement des soins de santé primaires de l'État (SPHCDA) et du ministère de la Santé de l'État (State MOH) dans un panier de paiements axés sur les résultats.
- En raison des circonstances particulières dans l'État de Borno, il est important de mener une recherche-action sur la meilleure approche à adopter pour l'approche FBP d'urgence. Tout chercheur spécialisé en recherche action avec un protocole prometteur devrait être encouragé avec le financement de performance FBP.

2.8 Recommandations pour l'État de Gombe

- Adopter l'approche FBP en tant que stratégie de renforcement du système de santé dans l'État de Gombe ;
- Créer une cellule technique FBP au plus haut niveau possible au sein du ministère de la santé de l'État de sorte que les hôpitaux et les régulateurs puissent également être inclus dans les réformes FBP ;
- Créer une ligne budgétaire de l'État en 2019 pour le FBP et utiliser les ressources des partenaires externes déjà existantes. Par exemple, 40% des fonds du SOML devraient être orientés vers une financement purement FBP ;
- Demander à l'État de financer le FBP dans au moins deux autres districts (LGA) à partir de 2019 ;
- Plaider pour l'intégration des programmes verticaux dans un seul programme en utilisant l'approche FBP pour maximiser les opportunités et améliorer l'efficience.

2.9 Recommandations pour le Libéria

- Plaider auprès du gouvernement sur la nécessité d'étendre la mise en œuvre du FBP à tous les structures de santé et envisager de résoudre les problèmes identifiés dans l'analyse de faisabilité du FBP (voir le rapport détaillé de chapitre 7) ;
- Aider le ministère de la Santé à entamer la mise en œuvre complète du FBP primaire dans trois comtés (Counties)
- Continuer à être un avocat du FBP à l'intérieur et à l'extérieur de la Banque mondiale.

2.10 Recommandations pour le Cameroun

- Accélérer la mise à échelle du FBP des 65% de la population actuels à 100%.
- Transformer les stratégies des « inputs » de plusieurs programmes (inclusivement des partenaires) en une approche FBP de paiement basée sur les résultats ;
- Élargir la Cellule Technique Nationale FBP au niveau du ministère de la Santé afin qu'ils puissent mieux jouer leur rôle de coordination au Cameroun ;
- Commencer les réformes de la politique des ressources humaines qui permettent plus d'autonomie aux prestataires de services de santé ;
- Augmenter les capacités des membres centraux du ministère de la Santé en les envoyant suivre des cours sur le FBP.

2.11 Qui ont assisté au cours, les autorités du village, et facilitateurs

L'équipe nigériane comprenait neuf participants du niveau fédéral (quatre du NPHCDA et cinq du FMOH) et 25 personnes de neuf États (Bauchi 5x, Borno 3x Gombe 4x, Kaduno 3x, Kano 1x, Kebbi 1x, Ondo 2x, Sokoto 3x et Taraba 3x). Nous avons eu l'honneur de souhaiter la bienvenue aux Ministres de la Santé des États d'Ondo, de Gombe et de Taraba. En plus, il y avait trois participants du secteur privé

en exerçant des fonctions des ACV dans l'État de Borno, un expert en santé de la Banque mondiale basé au Libéria, et un inspecteur camerounais de haut niveau du ministère de la Santé.

L'équipe de facilitation était composée de:

1. M. Christian Habineza, consultant indépendant rwandais, qui travaille dans la reforme FBP depuis plus de 15 ans.
2. Dr. Godelieve van Heteren, experte dans les domaines de la santé, de la gouvernance et du FBP, autrefois membre du Parlement néerlandais et directrice de Cordaid. Elle travaille pour diverses agences comme l'OMS, et la Banque mondiale.
3. Dr. Robert Soeters, directeur de SINA Health et coordinateur général du cours.
4. Dr. Jean Claude Taptue, expert principal en santé de la Banque mondiale.
5. Dr Fanen Verinumbe, consultant FBP de la PHCDA nationale au Nigéria.
6. Mme. Ann Waimiru, psychologue du Kenya, nous a assistés dans l'organisation et le soutien quotidiens des participants.
7. M. Tomasi, qui a participé à la logistique, au recrutement du personnel et aux événements.

Les autorités du « village 74 » étaient composées du chef de village, Mme. Munirat OGUNLAYI ; Le chef adjoint du village, Dr. Cyprian Akwo CHUO; La ministre des Affaires intérieures et berger Dr. Samira Abdullahi Mohammed; La ministre des Finances, Dr. Comfort Dave-Diamond, et le ministre de l'Énergie, Dr. Oluwatosin Kolade. Ils ont activement soutenu le processus de facilitation et ont contribué à créer une atmosphère agréable tout en maintenant « l'ordre » dans le village.

2.12 Évaluation du cours

Trente-deux participants ont passé l'examen final. Le résultat moyen du test était de 70% avec quatre certificats de distinction et trois certificats de présence.

Il s'agissait du deuxième cours du Traveler's Hôtel 4 étoiles, qui offrait l'atmosphère professionnelle et agréable nécessaire à un processus d'apprentissage favorable. Les contributions du Kenya au cours se sont approfondies.

Les évaluations quotidiennes ont donné des notes légèrement supérieures aux 23 cours d'anglais précédents. Les méthodes et la facilitation ont marqué 90,7% (3,3% de plus que les cours précédents. La participation a marqué 85,2% (2% de moins que les cours précédents). L'organisation a obtenu 88,5% (2,3% de plus que la moyenne des cours précédents). Le respect du temps a marqué 72,5% (comparable à la moyenne des cours précédents).

L'évaluation finale a révélé que les participants estimaient que le contenu du cours correspondait bien à leurs activités professionnelles. Les participants étaient satisfaits de la méthodologie et de l'organisation. Le contenu des modules de cours a été apprécié avec des scores plus élevés par rapport aux cours précédents

Cependant, 41% des participants ont estimé qu'ils n'étaient pas suffisamment informés à l'avance du cours et que certains auraient souhaité recevoir le livre de cours plus tôt. 43% des participants ont trouvé le cours trop court. Les cours francophones ont une journée de plus, ce qui réduit la pression de temps. Nous ajouterons également un jour au cours d'avril 2019 à Mombasa.

Au cours des débats de ce cours, l'approche de l'équipe de facilitation a été améliorée en impliquant plus activement les participants favorables à certains changements de paradigme pour les expliquer à leurs collègues au lieu que cela soit fait par les facilitateurs. Cela a conduit à un score de 97% des participants, qui ont estimé que l'équipe de facilitation était ouverte au débat et aux critiques, contre 74% lors des précédents cours d'anglais.

Certains participants ont indiqué qu'ils préféreraient davantage de méthodologies d'apprentissage pour les adultes. Le prochain cours étant prolongé d'une journée, l'équipe de facilitation envisagera également d'approfondir l'apprentissage des adultes, le travail de groupe, les exercices, etc.

3. INTRODUCTION

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

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

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

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

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

3.2 Aims and objectives of the Mombasa PBF course

General aims of the PBF course

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

Specific Objectives

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

3.3 The November 2018 Mombasa course

The 74th group consisted of a mix of people with a variety of implementation experience in PBF in three different countries across Africa (Nigeria various states and federal, Liberia and Cameroon).

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 2, 2018, field excursions were organized to four health facilities: Mtwapa Health Center, Kadzinuni Dispensary, Vipingo Health Center, Tagaungu HC and Kilifi County Hospital.

3.4 The pre- and posttest

SINA Health issues a Certificate of Merit to those who pass the exam at the end of the course. Those who do not score 53% or more, obtain a Certificate of Participation. This exam was conducted on Friday November 9th from 8.00 am and consisted of 30 multiple-choice questions, tailored around the main subjects treated during the course.

The average score for the exam was 70%. Participants obtain distinctions when the score is 87% or more. We congratulate the following participants, who received certificates with distinction.

With 97% - 1 mistake
Mrs Abdullah SAMIRA MOHAMMED, public health officer from PHCDA in Bauchi State

With 93% - 2 mistakes
Mrs Paul Iyaji CHINDIMA, economist from the NPHCDA in Abuja

With 87% - 4 mistakes
Dr Adefunke Oyinkansola ADESOPE, Public Health Administrator from the Federal MOH in Abuja
Dr. Wudiri William ZARA from the CDV Agency in Borno working for the private company CASELS.

Another 5 participants deserved a "merit-mention" of having scores of 80% or 83%, while three participants obtained less than 53%, meaning a certificate of participation.

Scores	Nbr	%	Certificate
87% - 100%	4	13%	Distinction
80% - 83%	5	16%	Merit - mention
70% - 77%	8	25%	Merit
53% - 67%	12	38%	Merit
0% - 50%	3	9%	Participation
TOTAL	**32**	100%	

3.5 Who attended the October - November 2018 PBF course?

34 from Nigeria; 1 from Liberia and 1 from Cameroon

The list of participants to the 74th PBF course

Surname	Name	Sex	Organisation	Country	State / Region	Position
CHIDINMA	Paul Iyaji	f	NPHCDA	Nigeria	Abuja	Economist
ADESOPE	Adefunke Oyinkansol	f	NPHCDA - South West	Nigeria	Abuja	Public Health Administrator
ABDULRAHMAN	Ibrahim Gafai	m	Federal MOH	Nigeria	Abuja	Health Administrator
IYANDA	Hafsat	f	Federal MOH	Nigeria	Abuja	Medical Officer
URUA	Uzibeabasi E.	m	NPHCDA - South South	Nigeria	Abuja	Medical Doctor
DAVE-DIAMOND	Comfort Msurshima	f	NPHCDA	Nigeria	Abuja	Community Health Officer
LABARAN	Shehu	m	Federal MOH	Nigeria	Abuja	Medical Doctor
UGBAH	Josephine Isioma	f	Federal MOH	Nigeria	Abuja	Program Officer
ALEX CHINWEIKPE	Ekwuruke	m	Federal MOH	Nigeria	Abuja	Health Administrator
SAMIRA MOHAMMED	Abdullah	f	PHCDA Bauchi State	Nigeria	Bauchi State	Public Health Officer
MANGA	Abdulaziz M	m	Bauchi State HMB	Nigeria	Bauchi State	Medical Doctor
MOHAMMED	Sadiq	m	PHCDA Bauchi State	Nigeria	Bauchi State	Public Health Officer
SANI	Ibrahim	m	Bauchi State MOH	Nigeria	Bauchi State	Pharmacst
BELLO MUSTAPHA	Mohammed	m	PHCDA Bauchi State	Nigeria	Bauchi State	Director PHCDA
ZARA	Wudiri William	f	CDV CASELS	Nigeria	Borno state	Medical Doctor
AUDU LUCKY	Emmanuel	m	CDV Bell Dome Consult Ltd	Nigeria	Borno state	Medical Doctor
KOLADE	Oluwatosin	m	CDV Health Systems Consult Lt	Nigeria	Borno state	Medical Doctor
CHUO	Cyprian Akwo	m	Ministry of Health	Cameroun	Cameroon	Health Inspector
ABUBAKAR	Musa	m	PHCDA Gombe State	Nigeria	Gombe State	Medical Doctor
EMMANUEL MADI	James	m	Gombe State MOH	Nigeria	Gombe State	Medical Doctor
KENNEDY	Ishaya	m	Gombe State MOH	Nigeria	Gombe State	Hon. Commissioner
MUSA DIRRI	Umar	m	PHCDA Gombe State	Nigeria	Gombe State	Administrator
USMAN MUHAMMAD	Shehu	m	Kaduna State MOH	Nigeria	Kaduna State	Perm Secr (PhD)
DUTSE	Musa Gimba	m	Kaduna State MOH	Nigeria	Kaduna State	Medical Doctor
BALARABE	Hadiza Sabuwe	f	PHCDA Kaduna State	Nigeria	Kaduna State	Medical Doctor
KAMAL	Adamu Ibrahim	m	Kano State MOH	Nigeria	Kano State	Medical Doctor
ISAH KAMBA	Bala	m	Kebbi State MOH	Nigeria	Kebbi State	Statistician
OGUNLAYI	Munirat	f	World Bank	Liberia	Liberia	Senior Health Specialist
OGUNENIKA	Abiola Olubumni	f	Ondo State MOH	Nigeria	Ondo State	Medical Doctor
ADEGBENRO	Wahab	m	Ondo State MOH	Nigeria	Ondo State	Hon. Commissioner
ABDULRAHMAN	Adamu Ahmed	m	Sokoto State MOH	Nigeria	Sokoto State	Medical Doctor
ABDULLAHI ROMO	Adamu	m	PHCDA Sokoto State	Nigeria	Sokoto State	Nurse
OTHMAN ALI	Pharm Almusthapha	m	Sokoto State MOH	Nigeria	Sokoto State	Permanent Secretary
MADAKI	Micah Musa	m	NSHIP - Taraba HMB	Nigeria	Taraba State	Medical Doctor
APAKE	Ebenezer Koku	m	NSHIP Taraba MOH	Nigeria	Taraba State	Medical Doctor (MPH)
VAKKAI	Innocent	m	NSHIP Taraba MOH	Nigeria	Taraba State	Hon. Commissioner

3.6 Facilitation team

The facilitation team consisted of:

1. M. Christain Habineza, Independent Consultant and PBF expert from Rwanda
2. Dr. Godelieve van Heteren, MD, Public Health Specialist, previous Member of Dutch Parliament and Director of Cordaid. Currently working as senior health systems and governance consultant for a.o. WHO and World Bank.
3. Dr. Robert Soeters, MD, PhD, Director SINA Health - chief course facilitator
4. Dr Jean Claude Taptue, Senior Health Expert of the World Bank
5. Dr. Fanen Verinumbe, A medical doctor and PBF consultant at the National PBF Unit in Nigeria
6. Mrs Anne Wairimo, Logistic Coordinator from Kenya
7. Mrs Caroline Atieno, Logistic Assistant from Kenya

3.7 Next English PBF course Monday April 1-13, 2019

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

4. DAILY EVALUATIONS BY PARTICIPANTS

4.1 Daily evaluations by participants

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

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

The overall average score for the four criteria combined was 84,2%. This is 0,8% *above* the previous 23 English spoken courses, and 5,3% *above* the 43 previous French spoken courses.

Daily evaluation topics as scored during 10 days	French speaking courses (43x)	English speaking courses (23x)	Mombasa November 2018	Comparison Mombasa November 2018 / Previous English courses	Comparison Mombasa November 2018 / Previous French courses
Methodology and facilitation	84,9%	87,4%	90,7%	3,3%	5,8%
Participation	82,4%	87,5%	85,2%	-2,3%	2,8%
Organization	72,4%	86,2%	88,5%	2,3%	16,1%
Time – keeping	76,1%	72,6%	72,5%	-0,1%	-3,6%
Overall score	**79,0%**	**83,4%**	**84,2%**	**0,8%**	**5,3%**

Table 1: Overall daily evaluation scores of the course.

4.2 Methods and facilitation

Methods and facilitation scored 3,3 percent higher with 90,7% than the previous 23 English courses (87,4%) and 5,8% above the average of the French spoken courses (84,9%). Satisfaction with the methods and facilitation remained always above 83%.

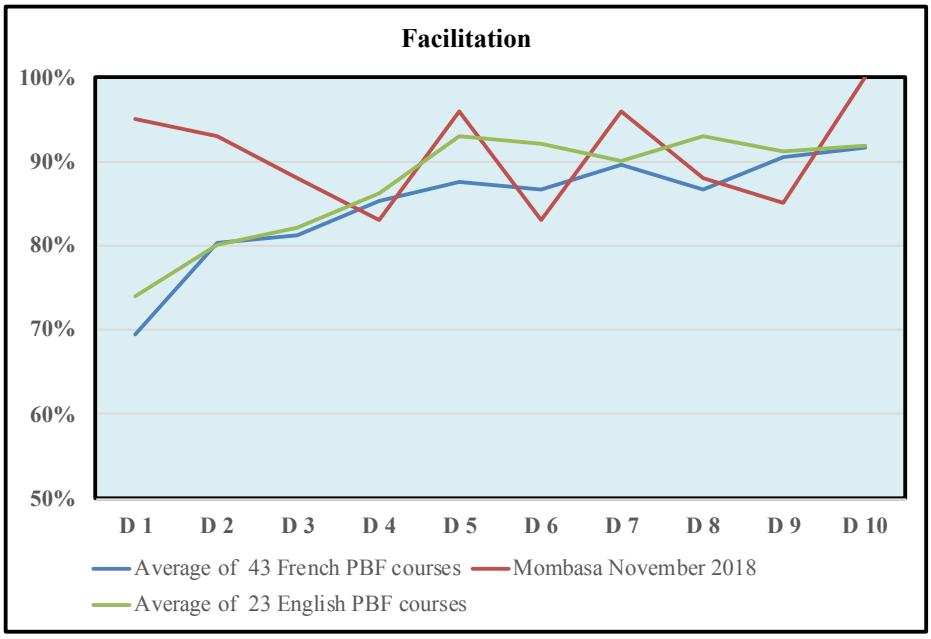


Figure 1: Evolution of the daily evaluations: *methods and facilitation.*

4.3 Participation

The satisfaction with the level of **participation** was 85,2%. This was 2,3% lower than the previous English courses (87,5%) and 2,8% above the French courses (82,4%). Satisfaction with the participation gradually improved during the course.

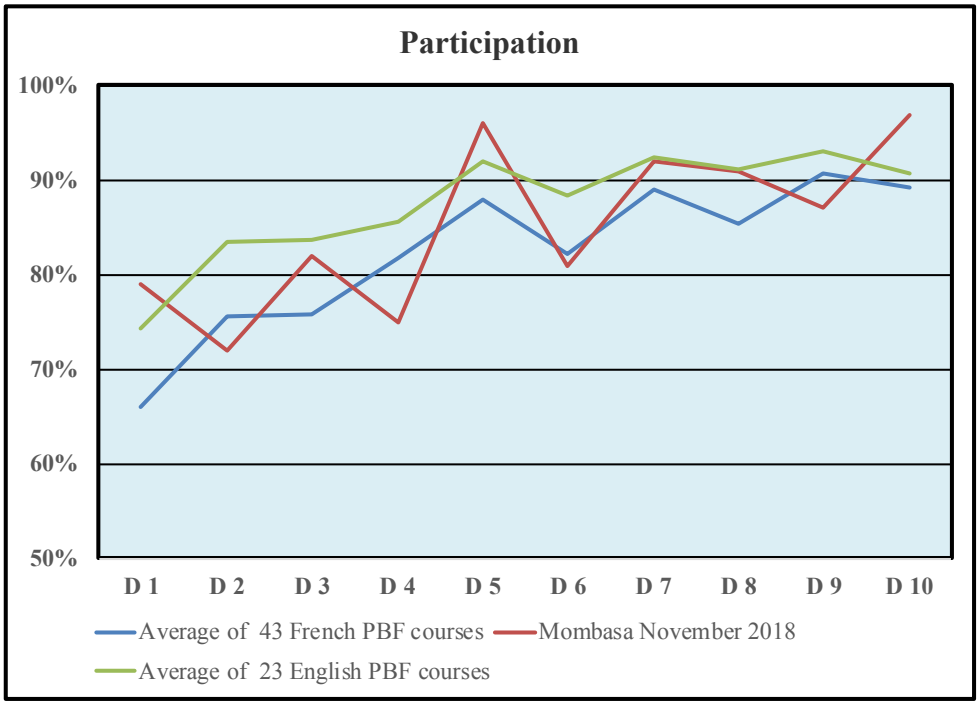


Figure 2: Evolution of the daily evaluation: *participation.*

4.4 Organization

The **organization** of the course in Mombasa had an average score 'very positive or positive' of 88,5%, which is 2,3% *above* the average of 86,2% of the previous English courses and 16,1% *above* the average of 72,4% of the previous French courses. Organization dipped slightly during the second week to the lowest point of 73%. This was probably the result of time pressures on the participants to finish the program. The hotel was generally evaluated as excellent and the cooks even cooked Nigerian *very hot* food.

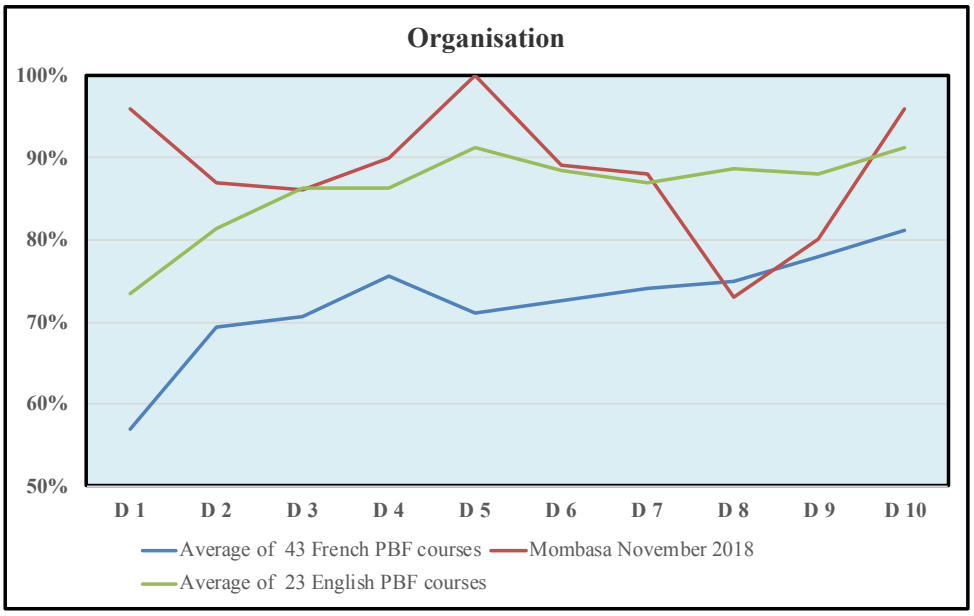


Figure 3: Evolution of the daily evaluation: *organization.*

4.5 Time keeping

Satisfaction with time keeping was 72,5%, which is comparable with the previous 23 English courses and 3,6% below the French courses.

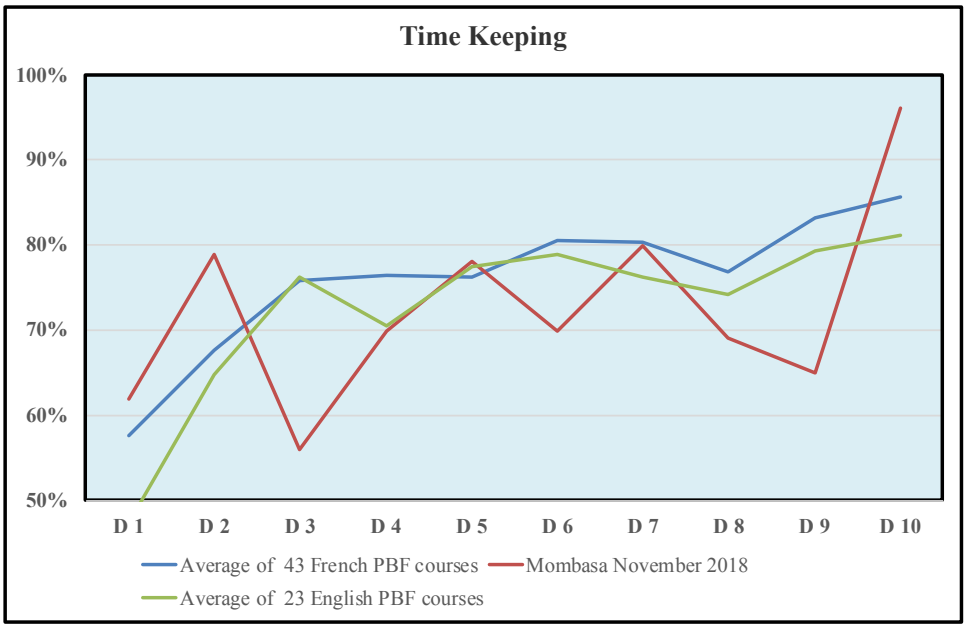


Figure 4: Evolution of the daily evaluation: *time keeping.*

5. DESCRIPTION of the COURSE

Arrival day: Sunday November 28th 2018

A total of 36 participants from 3 African countries (Nigeria, Liberia and Cameroon) arrived and were welcomed to the SINA Health 74th International PBF course held in Mombasa –Kenya. Most of the participants came from Nigeria. Nine from the federal level, and 25 from nine Nigerian states; one participant came from the World Bank group in Liberia, one from Cameroon. Three Nigerian participants were from the private sector, carrying out the CDV role in one of the Nigerian States (Borno). We welcomed a delegation of high-level participants including 3 commissioners of health, permanent secretaries and directors of State PHCDAs.

About 25% of participants were already fully involved with PBF implementation, while 75% of participants came to the course simply to learn about PBF, and how PBF principles can be incorporated in their health systems. Most participants arrived on Sunday and were welcomed by the course facilitators and hotel staff. On arrival, the course book was distributed, and participants were asked to fill out a pre-questionnaire, to enable the facilitators understand the specific needs of each individual participant prior to commencement.

Contrary to previous course, during this course, the daily recaps were done by the facilitators. This methodology worked well and enabled facilitators to save time by keeping to the key messages of the previous day. Evening sessions with country groups were organised to allow one-on-one dialogue with the facilitators. This to better know the participants and to understand specific work issues and challenges and to guide on the way forward in the action plans. One contact was made with each group in the evenings and a second contact with all the groups during a poster session.

Below was the schedule for evening country meetings

Evening country meetings		
Monday October 29, 2018	18:30 – 19:30hr	Liberia
Monday October 29, 2018	19:30 – 20:30hr	Cameroon
Tuesday October 30, 2018	17:30 – 20:00hr	Nigeria – Bauchi State
Wednesday October 31, 2018	17:15 – 18:15hr	Nigeria – Kebbi State
Wednesday October 31, 2018	18:15 – 19:15hr	Nigeria – Taraba State
Wednesday October 31, 2018	19:15 – 20:30hr	Nigeria – NPHCDA
Thursday November 1, 2018	17:00 – 18:30hr	Nigeria – FMoH + NPHCDA
Thursday November 1, 2018	18:30 – 19:30hr	Nigeria – Kaduna + Kano + Ondo States
Friday November 2, 2018	17:00 – 18:30hr	Nigeria – Borno State
Friday November 2, 2018	18:30 – 19:30hr	Nigeria – Gombe State
Saturday November 3, 2018	18:00 – 19:00hr	Nigeria – Sokoto State
Tuesday November 6, 2018	17:00 – 18:30hr	Nigeria – Gombe State

Monday October 29th

The course started at 9:00am, with the welcoming of participants. The course outline as well as the training methodology were presented. This session was followed by the "getting acquainted" exercise, where participants were asked to profile themselves in terms of their key strengths and weaknesses in a poster. This session served as an ice-breaker session, as participants enthusiastically carried out the activity and go to know each other.

The pre-test, comprising of 15 multiple-choice questions was then conducted to test participants existing knowledge on PBF. Following the pre-test, 13 country working groups were established, after which participants set off to carry out the first activity of the course, where they discussed the problems of their respective health system. They highlighted the various in-efficiencies that exist in the system, in terms of distribution of human resources, service delivery, health financing, etc. Already on day one, most participants agreed that PBF could have a role in improving the health system and in making it more cost-effective.

The next module 1, "PBF in context": in the era of UHC presented a comparison between Alma Ata and Bamako Initiative and PBF health reforms, followed by the evidence for PBF. This generated some intense discussions, which could be expected because most participants are policy makers. Therefore sufficient time was allocated.

At the end of the day, the ground rules of the village were established and the 'village officials elected to assist facilitators maintain the rules during the course.

The following persons were elected by the participants to become the Mombasa 74th village officials :

Chief: Munirat Ogunlayi from Liberia ;
Deputy Chief: Chuo Cyprian Akwo from Cameroon ;
Internal affairs Minister / Time keeper: Comfort Dave-Diamond from NPHCDA in Abuja ;
Finance Minister: Samira Abdullahi Mohammed from Bauchi State Primary Health Care Development Agency ;
Minister of Energy / Energizer: Oluwatosin Kolade from Borno private sector.

The day ended at 17:00 with the 'official' installation of the village officials, the daily evaluation of the course and the selection of the best debater of the day
In the evening, from 18:30 onwards, the facilitators met with the participants from Liberia and then Cameroon.

Tuesday October 30th
The day started at 8:30am with the daily recap of the main messages of the previous day. This was in an interactive session with the participants stating the key messages which was delivered the previous day followed by discussions around these. The key outcomes of the evening meetings with individual working groups was also presented. The course on this day received a special visit by the first lady of Kilifi County, Mrs. Elizabeth Kingi, to welcome all participants and to officially declare the course open. Group pictures were made that can be seen on the cover of the report.

Module 2, "a simple example of PBF", definition, institutional set-up and module 3 "change topics" were presented by Jean Claude. The Turning Point Questions (TPQs) stimulated very interesting discussions. Adequate time was given to these discussions which allowed participants to understand the basic principles of PBF and express areas where they perceived the change to be "difficult".
Next was Module 4 on PBF theories (systems analysis, public choice, contracting, decentralization and governance). The day ended at 16:30 with the daily evaluations and selection of the best debater of the day.

During the evening meeting with facilitators the team from Bauchi State (Nigeria) discussed issues around PBF implementation in their state. Discussions cantered

around the proper mapping and rationalization of health facilities within LGAs covered on the PBF program.

Wednesday October 31st

The day started at 8:30 with a recap and summary of important points from day 2, including outcome of the evening discussions.

Module 4 on PBF theories (systems analysis, public choice, contracting, decentralization and governance) was completed, and this took most part of the morning. We continued with the module on microeconomics (module 5A). Basic economic principles were presented as the foundation to understand how markets operate as well as to relate some of the concepts also in the health care market. The session closed at 16:30 with the daily evaluation and selection of the best debater of the day.

In the evening, facilitators met with 3 Nigerian groups (Kebbi State, Taraba State, and the NPHCDA). The key outcome of those discussions cantered around the sustainability of PBF in Taraba state, and at the Federal – NPHCDA level. These included discussions around the institutional set-up of PBF as a health reform policy, as well as on advocacy for the move towards PBF as a health reform policy.

Thursday November 1st

The daily recap was done. The module on health economics was then presented. These included presentations on the concepts of economies of scale and of scope, efficiency, the various failures that exist in the health market and how sound economic instruments (taxes and subsidies) could be used to correct some of the failures in the health market.

Later during the day, participants were introduced to the module on roles of various actors / stakeholders in the PBF system, starting with module 6 “the role of the regulator” at various levels of the system and how this is organised in the PBF institutional arrangements. The session closed at 16:30, with the daily evaluation of the course and the selection of the best debater of the day.

In the evening, facilitators met with 2 groups, one from the federal level, and the other from the SOML states of Ondo, Kaduna and Kano. Discussions focused on harmonization of various existing vertical programs, applying the PBF best practices to improve efficiency within the system. At federal level, discussions were around setting up the institutional arrangements to adequately support states who might be willing to start up PBF programs.

Friday November 2nd

Daily recap of previous day included information on the outcome of the previous days meeting with the individual country groups. With a brief introduction of the terms of reference of field visits. The groups then set out on the field to visit four Kilifi County facilities for a tour and guided interviews with the facilities’ in-charges and other staff.

The facilities visited were:

Health Facility	Team Members
Kadzinuni Dispensary	- Dr. Zara Wudiri - Chidinma Oluchi Agu - Umar Musa Dirri - Dr. Dutse Musa Gimba

	- Mohammed Bello Mustapha
Vipingo Health Centre	- Munirat Ogunlayi - Dr. Urua Utibe-Abasi Essien - Dr. Iyanda Hafsat Iyabode - Abdulrahman Ibrahim Gafai - Adamu Abdullahi Romo - Dr. James Emmanuel Madi - Dr. Mdaki Micah Musa
Kilifi District Hospital	- Dr. Adefunke Oyinkansola Adesope - Mr. Chuo Cyprian Akwo - Mohammed Shehu Usman - Dr. Ebenezer Koku Apake - Dr. Kamal Adamu Ibrahim - Almustapha Othman Ali - Sadiq Mohammed - Dr. Abubakar Musa
Tagaungu Health Center	- Dr. Abdulaziz Manga - Alex Chinweikpe Ekwuruku - Dr. Audu Lucky Emmanuel - Samira Mohammed Abdullahi - Ibrahim Sani
Mtwapa Health Center	- Dave-Diamond Comfort - Dr. Labaran Shehu - Ugbah Josephine Isioma - Dr. Oluwatosin Kolade - Dr. Abdulrahman Adamu Ahmed - Bala Isah Kamba

Each team was led by one member of the group as facilitator. The facilities were of different sizes (from dispensary/health posts to a county hospital), so groups got different, but complementary findings regarding the sources of financing, supply and expenditures. Upon return, the groups gave feedback on the questionnaire, which helped to assess the vitality and PBF readiness of the facilities.

The following feedback was received from the participants:

- All health facilities received their inputs and equipment from KEMSA and 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 but with a lot of limitations.
- The procedure of receiving drugs and other inputs from the KEMSA is tedious, takes a long time and health facilities frequently experienced stock-outs.
- Free health care policy is being implemented in all primary health facilities, hence health facilities did not generate any revenues from cost recovery
- User fee tariffs for the hospital are fixed at County level.
- Revenue per capita did not meet the required standards of 7 USD per capita for the primary level health facilities, with most facilities generating less than USD 4 per capita.
- There was no health facility with the autonomy to set user fees, manage their financial resources or to hire and fire their staff.
- There was no proper separation of functions.
- Some form of PBF implementation was reported to have started in some health facilities, but the payments of the subsidies was irregular.

- The facilities reported that client satisfaction information is collected by using the suggestion box, by directly interviewing patients and through the feedback of community committees. Yet, these methods were found to be ineffective.
- Most health facilities did not meet the recommended staffing levels of 1 qualified staff per 1000 population

The day ended at 16:30 with the daily evaluations.

In the evening, the facilitators met with the teams from Borno and Gombe States. Discussions centred around reviewing the existing PBF design in terms of the CDV role, as well as reviewing the impact of some of the negative incentives implemented in the program. Discussions with the Gombe group focused on the sustainability of PBF as well as advocacy for PBF as health reform in the state.

Saturday November 3rd

The morning started at 8:30 with a recap of previous day activities. The module on the role of the regulator as well as quality assurance of health facilities was then completed.

The module 9 on PBF project development feasibility was presented. As part of this module, participants were asked in their country working groups to score the PBF feasibility scan matrix and to identify the main problems or "killing assumptions". Based on these, the groups developed advocacy plans, which were presented in the form of role plays the next Monday morning.

The day ended at 12:45 hours, with the daily evaluation and the selection of the best debater of the day. Participants were then invited to enjoy a bus ride to the city of Mombasa, including the market for some shopping and the historic Fort Jesus.
In the evening, from 18:00 onwards, facilitators met with the team from Sokoto state.

Sunday November 4th

On Sunday, the team went out on a journey to the ruins of Mtwapa. These ruins tell the story of the old Swahili culture and how the Oman Arabs lived and traded in Mombasa. This was followed by some exciting exercises and games on the beach, including beach volley ball and tug of war. The day continued with a visit to Haller Park in Mombasa, which has a remarkable history of being a reclaimed quarry site. Highlights of visit to the park included the feeding of the giraffes, the snakes and the crocodiles.

Monday November 5th

The morning started at 9:00 with the presentation of the feasibility scores of the groups and discussions about the main problems or killing assumptions. The role plays from the outcome of the feasibility scans were then carried out by some groups. The module 8 on the role of the community in PBF and social marketing was presented by Christian Habineza. This included community-provider interactions, aspects and ways of community involvement in PBF. This was followed by a presentation of module 7 "the role of the CDV Agency", in verification and coaching of health providers. The day ended at 17:00, with the daily evaluations and selection of the best debater of the day. In the evening, participants continued working on their action plans.

Tuesday November 6th

After the daily recap, participants started preparing a poster presentation of their action plans. A round was made, whereby each group presented their poster in plenary

with facilitators supporting each group in coming up with smart recommendations. This interactive session was valued by most participants and facilitators. The following module presented was the "Business plan" followed by the module on the "baseline and evaluation studies".

The final session of the day was module 12 on the output indicators. Here the various quantitative indicators in PBF were presented, including the criteria for selection as well as how the targets for each are calculated Participants worked on the exercise of the output indicators in the evening for presentation in plenary on Wednesday morning. The day ended at 16:30 with the daily evaluations and selection of best debater of the day.

In the evening, facilitators had another meeting with the group form Gombe – Nigeria, being that the Honourable Commissioner of health joined in the second week of the course.

Wednesday November 7th

The recap of the previous day centred around highlighting the main recommendations developed during the poster session. The recommendations are presented in the summary of this report. The module on output indicators was then completed, and followed by the solution to the exercise in plenary. The module on indices management tools was then presented. Participants were asked to work on the exercise in the evening for restitution on Thursday morning.

Thursday November 8th

The day was confined to the morning, to enable participants study for the exam. The exercise on indices tools was solved in plenary, followed by the module on conflict resolution and negotiation techniques. The overall evaluation on the course was carried out before the class broke up 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.

Module 15 – costing was presented as an optional session for participants who showed interest at 17:00 of the same day. About 16 participants attended the sessions that ended by 19:00. During this course, the modules 16 (PBF in emergency) and 17 (PBF in Education) were not presented in class.

Friday November 9th

The exam day started at 08:00 and 32 participants took the final exam, as 5 had left earlier due to official commitments. In the morning from 10:30 onwards the exam was marked by the facilitation team. Five participants left by 13:00 after having received their certificates of merit or distinction. From 15:00 onwards the exam questions were reviewed in class, followed by a ceremony to hand out the certificates at 15:00. This event was graced by Christina Mutasa, the chief nursing officer of Kilifi county, where the health facility visits took place.
In the evening from 20:00, a dinner was organised at the restaurant to give all participants and facilitators an opportunity to say their goodbyes. A few participants and some of the facilitation team went to the club in Mtwapa by 22:00 and returned safely by 01:30 at Saturday morning.

Saturday November 10th

Most participants left on Saturday on different flights and the Soeters family left Mombasa on the first flight of Sunday morning.

6. FINAL COURSE EVALUATION BY PARTICIPANTS

6.1 General impression of the course

The score for 'general impression of the course' was with 74.7%, 9,4% *below* the average of the 24 previous English-spoken courses. The criterion "I was sufficiently informed" scored 59%, which is 19% below the average of the previous English courses. The criterion: "program answered my expectations" scored 79% (= 6% *below* the previous courses). The criterion "the course objectives related well to participants" professional activities" scored 86% (= 3% *below* the average).

Preparation	**The 40 previous French spoken PBF courses**	**The 24 previous English spoken PBF courses**	**Mombasa November 2018**	**Comparison Mombasa Nov 2018 / 40 previous French spoken PBF courses**	**Comparison Mombasa Nov 2018 / 24 previous English spoken PBF courses**
Q1. I was sufficiently informed about the objectives of the course	88%	78%	59%	-29%	-19%
Q2. The program has answered my expectations	84%	85%	79%	-5%	-6%
Q3. The objectives of the course relate well to my professional activities	89%	89%	86%	-3%	-3%
Average	**87,1%**	**84,1%**	**74,7%**	**-12,4%**	**-9,4%**

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

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

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

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

6.2 Appreciating the duration of the course

For 57% of the participants, the course duration was right, while the large proportion of 43% thought the course to be too short. Nobody thought that the course was too long. In the French spoken courses we added one day (the Saturday) to the course duration and this worked better to reduce the time pressure to finalize the action plans as well as the course modules. We will add one day to the Mombasa course starting in April 2019.

Duration of the course	The 40 previous French spoken PBF courses	The 24 previous English spoken PBF courses	Mombasa November 2018	Comparison Mombasa Nov 2018 / 40 previous French spoken PBF courses	Comparison Mombasa Nov 2018 / 24 previous English spoken PBF courses
Too Short	33%	23%	43%	10%	20%
Fine	61%	64%	57%	-4%	-7%
Too Long	6%	12%	0%	-6%	-12%

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 16% *higher* than the previous 24 English courses with 77% and 22% *above* the 42 previous French courses. The conference center (96%) and the food (96%) scored respectively 22% and 36% higher than the previous courses. The conference hall scored 96% and the friendliness of the staff as well as the facilitation team scored 100%. Transportation scored 72%. The quality of the educational material scored 93%.

How do you value the organization of the training ?	The 42 previous French spoken PBF courses	The 24 previous English spoken PBF courses	Mombasa November 2018	Comparison Mombasa Nov 2018 / 42 previous French spoken PBF courses	Comparison Mombasa Nov 2018 / 24 previous English spoken PBF courses
Quality and distribution educational material	80%	88%	93%	13%	5%
The lecture room	66%	67%	96%	30%	29%
Conference center in general	58%	74%	96%	38%	22%
How were you received and friendliness	88%	91%	100%	12%	9%
Food and drinks, including tea/coffee breaks	61%	60%	96%	35%	36%
Transportation	66%	80%	72%	6%	-8%
Average	**70%**	**77%**	**92%**	**22%**	**16%**

Table 5: Evaluation of the organization of the course.

6.4 Comments on the execution of the course and the facilitators

The execution of the program scored 85%, which was 8% above the average of the previous 24 English courses. The question in how far facilitators were open minded was evaluated at 97%, which was 23% *above* the average of the previous English spoken courses. Time allocated for group work was 69%, which was 8% *below* the scores of the previous courses and which reconfirmed that time was too short during this course. Time for discussion was evaluated at 90%, which was 8% above the average of the previous English courses.

Aspects related to the execution of the program and the facilitation	The 42 previous French spoken PBF courses	The 24 previous English spoken PBF courses	Mombasa November 2018	Comparison Mombasa Nov 2018 / 42 previous French spoken PBF courses	Comparison Mombasa Nov 2018 / 24 previous English spoken PBF courses
The facilitators had an open mind towards contributions and criticism	81%	74%	97%	16%	23%
Time allocated to group work was adequate	63%	77%	69%	6%	-8%
Time for discussions was adequate	76%	82%	90%	14%	8%
Average	**73%**	**77%**	**85%**	**12%**	**8%**

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 92,4%. This was 4% above the average (= 88%) of the previous 24 English courses and 10% above the 43 previous French courses. The participants appreciated the completeness and the illustration given by the facilitation team of the modules. Two modules obtained 100% including the black box business plan / personal action plans and the PBF feasibility scan module. Economics this time scored good with 93%. We did not evaluate the module costing. The module indices management tool scored relatively low with 63%, while all the other modules scored above 90%.

Appreciation of course modules	The 43 previous French spoken PBF courses	The 24 previous English spoken PBF courses	Mombasa November 2018	Comparison Mombasa Nov 2018 / 43 previous French spoken PBF courses	Comparison Mombasa Nov 2018 / 24 previous English spoken PBF courses
Why PBF & What is PBF?	93%	93%	97%	4%	4%
Notions of micro-economics and health economy	64%	83%	93%	29%	10%
PBF Theories, best practices, good governance and decentralization	85%	92%	97%	12%	5%
Baseline research – household survey launching process	77%	79%	93%	16%	14%
Output indicators in PBF interventions	87%	89%	90%	3%	1%
CDV agency, data collection, audit	86%	89%	93%	7%	4%
Regulator – quality assurance	82%	93%	93%	11%	0%
Negotiation techniques and conflict resolution	88%	90%	97%	9%	7%
Black box Business Plan	85%	89%	100%	15%	11%
Black box Indices tool: revenues – expenditure – performance bonuses	79%	81%	63%	-16%	-18%
Community voice empowerment and social marketing	80%	88%	93%	13%	5%
PBF feasibility, killing assumptions & advocacy	87%	90%	100%	13%	10%
Elaboration PBF project - costing	NA				
Average for all modules	**82,8%**	**88,0%**	**92,4%**	**10%**	**4%**

Table 7: Evaluation per module.

6.6 Written comments during the final evaluation by the participants

Pre-Course Preparations

- The course book should be shared well in advance.
- Besides the goals, the main messages of PBF should also be given to participants beforehand.

About Course methodology

- There was not enough time for key modules such as the costing and the indices management tools.
- Course duration was too short because not all of the modules were covered
- Time allocated to output indicators and population targets was too short
- Time allocated to CDVA and payment agency was too short.
- The facilitators tried their best, but more of participatory adult methodology would have been helpful. I guess this is due to time factor but should be considered.
- Different modes of lecturing should be considered. More group work, use of gallery, and discussions.
- More mixed methods of adult learning should be incorporated into the course.
- Increase group work and other participatory methods especially the indices tool.
- The exercises are good but there is not enough time to do them. The course should better balance the plenary and the group work sessions.
- Group works and role plays help adults to interact and learn than more of lectures.
- The excel presentations should already been shown before that the participants worked on it in group work. This would overcome the phobia for those who are not excel friendly.
- The time allocated to group work was not adequate because I am new to PBF and need to learn and understand all concepts discussed during the course.
- The field visit would have been better undertaken to an ideal PBF settings where we can learn and ask questions about their implementation of PBF.
- Overall, thanks a lot for the efforts. I have learned tremendously from the course and the resources would serve as good reference in my work on PBF. Thanks for making me learn the theoretical components of PBF

Course Book, Modules and other course materials

- Course material was adequate ;
- Module 4 on theories should be given more time and be simplified ;
- Indices management tool should be simplified ;
- The prints of the PBF course book were rather small and not attractive to read ;
- SINA health should kindly consider covering the expenses of one group photograph to each participant as part of course fee ;
- The visit to the historical site should have also been entirely covered by SINA health, since participants did not have previous knowledge of this, otherwise the entrance fee to the museum should be communicated to participants ahead of the course.

Hotel

- Lecture room was sometimes too cold, but otherwise very satisfactory.
- Fruit juices were served with too much sugar.

Transportation

- Better vehicles to convey participants from the airport.

7. COUNTRY & TOPIC PRESENTATIONS

7.1 Liberia

Munirat Ogunlayi PhD Senior Health Specialist, The World Bank

7.1.1 Background

Liberia is a post conflict and post Ebola country with a population of about 4.2 million. Sixty-three percent of the population is below 25 years, maternal mortality is 1072/100,000 and infant mortality is 54/1000 live births, with 31 percent unmet family planning need. To address the above, Liberia developed Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) Investment Case (IC) in 2016 with the aim of improving the overall health and social welfare of the Liberian population and reducing the impact of social determinants on health and overall wellbeing. The focus of the IC includes; Emergency Obstetric and Neonatal Care (EmONC), Adolescent Health, Community Engagement, Diseases surveillance and response, Civil Registration and Vital Statistics (CRVS), and Child Health and Nutrition.

7.1.2 Key Problem Definition and Analysis

Access to service delivery in Liberia is a challenge. For example, shortage of human resource with 1.5 of skilled birth attendants per 1000 population, commodities stockout, less than 30 percent of births being registered, 29 percent of the population live outside 5 km radius with 69% in Gbarpolu, out of pocket expenditure is estimated at 51%, 74% of health workers lack skills in manual uterine compression with 4% health facilities having functional blood banks. In addition, Liberia is faced with gendered decision making at household level, poor infrastructure and inadequate adolescent focused programming. Donor funds in most cases go into vertical programs with high proportion of inputs and not maximally coordinated with and by government.

7.1.3 Feasibility Scan

A feasibility scan of 26.5/50 (53%) was identified for Liberia (see table 1 below for details and justification for the scoring). This is significant progress as compared to the score of 6/50 (12%) recorded by the Liberia PBF training team in December 2017. The 53% score reflects consideration for the on-going hospital PBF in six hospitals and primary PBF in three counties of hard to reach areas of Gbarpolu, Sinoe and Rivercess counties which are about to commence full implementation. The problems identified include: complete donor driven of PBF implementation, PBF implementation limited to 6 counties out of 15 counties in the country, autonomy to health facilities still limited and did not cover hiring and firing of staff, the government operates free health care policy which makes cost recovery revenue challenging.

Table 1: Feasibility Scan for Liberia PBF Program

Criteria to establish in how far the program is "PBF"	Points
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units - Not sure of budget per capita but major part of PBF resources go into provider subsidies, infrastructure inputs and local NGOs contract.	4 - 2

2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency. No government contribution.	2 - 0
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2 - 2
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2 - 0
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives – quantity indicators are not yet up to at least 25.	2 - 0
6. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders. – Community Health Assistant doing most of these already but not under the PBF program for now even though they are incentivized.	2 - 1
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. – County Health Team conduct supervision of public health facilities and in the process takes action as required. **The best practice is to have peer reviews conducted at the hospital level.**	2 - 1
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 - 1
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program. – Baseline for quality studies done but not for household	2 - 1
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. – No cost recovery revenue for now due to free health care policy of government. But the hospitals have bank accounts with the managers serving as signatories.	2 - 1
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition. – Discussion held with the MoH and Liberia Medical and Health Regulatory Agency and list of accredited pharmacies provided where they can procure drugs in cases of stock out. Meanwhile, supplies are still mainly from National Drug Store.	4 - 2
12. The project introduces the business plan that includes the Quality Improvement Bonuses – Yes, fully implemented at the hospital level, while the primary level implementation is yet to commence but all preparatory activities completed.	2 – 1.5
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. – CDV do not sign contracts but the County Health Services in the MoH. Need to consider CDVA doing the contracting especially if insurance would fully take on this role in the future.	2 - 1
15. Provider managers are allowed to influence cost sharing tariffs – Government still operates free health care policy.	2 - 0
16. Provider managers have the right to hire and to fire – Autonomous yet to get to this level.	2 - 0
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2 - 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 - 1
21. Public religious and private providers have an equal chance of obtaining a contract – Not excluded and have the chance should they bid	2 - 2
22. There are geographic and/or facility specific equity bonuses	2 - 2
23. The project provides equity bonuses for vulnerable people	2 - 0
TOTAL	**50 – 26.5**

7.1.4 Recommendations

1. Advocacy to government on the need to expand PBF implementation to all health facilities and consider addressing the problems identified in the feasibility scan.
2. Encourage stakeholders at various levels as required to utilize and action findings and recommendations from the hospital verification reports to ensure improvement and provision of quality services.
3. Support Ministry of Health to commence full implementation of primary PBF in 3 counties.
4. Continue to be PBF advocate within and outside the World Bank.

Action	By Who	When
Discuss feasibility scan score with the PBF unit and the PIU unit on return; and discuss on actions required to enhance the feasibility scan scores for the country.	Munirat, PIU and PBF units	November 2018
Advocacy to government on the need to expand PBF implementation to all health facilities and consider addressing the problems identified in the feasibility scan.	Munirat	November 2018 onwards
Encourage stakeholders at various levels as required to utilize and action the findings and recommendations from the hospital verification reports to ensure improvement and provision of quality services.	Munirat working with the MoH Curative Health Services Director, Project Implementation Unit and the PBF unit	At Project Technical Committee, Health Sector Steering Committee Meetings, and any other opportunity as required.
Support Ministry of Health to commence full implementation of primary PBF in 3 counties.	Munirat working with Project Implementation Unit and the PBF unit	November 2018 onwards
Continue to be PBF advocate within and outside the World Bank.	Munirat	November 2018 onwards.

7.2 Cameroon

Dr. Chuo Cyprian Akwo, Inspector of Health

7.2.1 Key Problem analysis

- The PBF program is currently implemented in about 65% of the country and has produced a positive impact on the health status of the assisted communities. The scale up at national level should be completed by the end of 2019.
- Historically, there is a weak governance structure in the Ministry of Public Health (MoPH) with a large number of uncoordinated initiatives and projects – often supported by different partner organisations. This is characterized by a poor communication and the duplication of interventions.
- The government has shown the willingness since a few years to invest through the current budget towards PBF and PBF budget lines were opened but the degree of budget implementation has often been disappointing. Moreover, the bulk of the government budget still continue to be traditional input budget lines, but which are inefficient and ineffective with limited impact on Universal Health Coverage.

- There is a large proportion of unemployed qualified health workers in Cameroon. The implementation of PBF strategy across the country is expected to create more jobs for these unemployed health professionals and thereby reduce social tensions among communities.
- There is still a shortage of PBF practitioners at the level of the central administration and not all staff appointed in the central MoPH have been trained in PBF.

7.2.2 Recommendations to the Ministry of Public Health of Cameroon

- The Ministry of Health should accelerate the scale up of the PBF health reforms to 100% of the population.
- The Ministry should transform the input financing strategies of several (partner) programs into the PBF health financing policy.
- A PBF unit at the level of Ministry of Public Health should be expanded so that they can play their coordinating role in Cameroon.
- The Ministry should conduct stakeholders and development partners mapping
- The Ministry should change the earmarked input budget lines into PBF output budget lines
- Start human resource policy reforms that allows more autonomy to the health service providers.
- Government should increase the capacity of MoPH members by sending them to PBF courses.

7.2.3 Action Plan

What	How	Who	When
1. Organize a working session to present the PBF course report and recommendations	Through the weekly coordination meeting in the MoPH	Cyprian	Nov 2018
2. Develop an advocacy plan aiming at the extension and funding of the PBF reform	The inception of a draft plan will be initiated soon after the presentation of the course report	Cyprian	Dec 2018
3. Validation of the advocacy plan	Internal review and feedback from MoPH members will be gathered and integrated	Inspector General in charge of Administrative affairs	February 2019
4. Dissemination of the validated advocacy plan	Through the weekly coordination meeting in MoPH	Inspector General in charge of Administrative affairs	February 2019
5. Regular follow up of the recommendations of the present action plan.	Through the weekly coordination meeting in MoPH	Cyprian	Nov 2018-June 2019
6. Organization of a debriefing of the team in the department on the main PBF features and principles	The debriefing will be done during the weekly team meeting (3 times)	Cyprian	Dec 2018
7. Initiate the review of human resource management policy and make updates based on the PBF best practices	A draft proposal with relevant changes in line with positive and negative incentives for HR will be produced and presented to the decision makers	Cyprian	March 2019
8. Conduct a PBF experts mapping in the country	Preparation of a Memo to the Minister proposing the mapping exercise	Cyprian	April 2019

9. Prepare a PBF course within the country for the central administration staff members including MoPH	Preparation of a Memo to the Minister proposing the mapping exercise	Cyprian	May 2019
10. Analyze the current organogram of the MoPH and propose potential changes supported by the decentralization act and PBF principles	A concept note with a proposal of a new organogram of MoPH which includes the PBF unit will be submitted to the Minister's cabinet	Cyprian	June 2019

7.3 Federal level MOH and NPHCDA

7.3.1 Background

The government of Nigeria in collaboration with the World Bank has strengthened primary health care through the Nigeria State Health Investment Project (NSHIP) using the PBF approach. This approach aims to improve the quantity and quality of health services, to decentralize health facility financing, to address structural problems, and to motivate health workers. The PBF approach was piloted in one LGA in Adamawa, Nasarawa and Ondo States each since December 2011 (Fufore, Wamba and Ondo East). On the basis of lessons learnt from the pre-pilot, the project was then scaled-up to the remaining LGAs in the three states throughout 2014.

By the end of 2014, 25 LGAs were implementing Performance-based Financing (PBF), and the other 25 LGAs Decentralized Facility Financing (DFF) – another financing approach not based on performance, but solely as grants for fiscal decentralization and institutional strengthening. Based on the documented achievements of the current NSHIP and lessons learnt from its implementation in Adamawa, Nasarawa and Ondo states, an additional Financing was requested and granted to the government of Nigeria for rehabilitating the insurgency ravaged healthcare infrastructure in the Northeast States of Bauchi, Borno, Gombe, Taraba and Yobe.

The Additional Financing has been adapted to the specific conditions in the NE by reinforcing healthcare service delivery under Performance-Based Financing (PBF), promoting contracting of non-public sector actors, especially indigenous organizations; application of special strategies like mobile clinics, temporary structures for health service delivery, community nutritional rehabilitation etc. Currently, the AF-NSHIP is operating in 3 LGAs in Bauchi and Taraba States, 1 LGA in Gombe, 2 LGAs in Borno and Yobe; with plans to scale up rapidly by July 1st 2018. As of this time, a further 1 LGA in Gombe will be part of the project, as well as 8 additional LGAs in Yobe and 6 in Borno State.

The main objective of the project is to increase the delivery and use of high impact maternal and child health interventions, and to improve the quality of care at selected health facilities in the participating states. In addition to improving service delivery at health facility level, the project also aims to strengthen institutional performance at the Federal, State and LGA levels.

7.3.2 Key problems

There is a lack of a coherent National Policy on PBF and there is need of institutionalizing the PBF best practices nationwide at primary, secondary and tertiary levels.

7.3.3 Feasibility scan

The table below illustrates the design of the NSHIP and the AF-sNSHIP PBF design with identified key problems

Criteria to establish in how far the programme is "PBF"	Total Points	Scored
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
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
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	2
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	0
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	2
6. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	2
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	2
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	2
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	2
10. Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the HF 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	0
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**
PERCENTAGE		**= 80%**

7.3.4 Recommendations

- Develop a new institutional set up under the direct umbrella of the FMOH and the State Ministries of Health ;
- Revise the PBF incentive structure in Nigeria towards the carrot + carrot approach instead of the carrot x stick approach ;
- Develop an advocacy plan with as the main message to change from input financing towards output financing. There will be a need for informing and lobbying of the National Council of Health (NCH) to adopt PBF at all levels and in all States. A source for advocacy will be the findings of the impact evaluation report and the finding from the different States such as Gombe which report excellent results in their pilots.
- Develop a national PBF Policy.
- Integrate all government and partners financed vertical program into one overall health reform program using the definition and best practices of PBF ;
- Assure a regulatory framework to make the market for essential drugs, consumables, equipment and other inputs more competitive ;
- Promote an human resource decentralisation of funds with the aim to distribute equitably qualified health workers over the different States, LGAs and health facilities
- Map out all private and public health facilities for PBF and assure that rationalisation of principal contract holders into catchment areas of on average 10.000 inhabitants for the primary level and 100-200.000 for the primary referral hospitals.

What	How	Who	When
Develop a new institutional set up	**Develop a PBF reform organogram :** - There is need to carefully identify all the relevant stakeholders that will be integral to the institutionalization of PBF as a health sector reform and National Policy.	FMOH / NPHCDA, National PBF Steering Committees	6 months
Advocacy Plan	**Develop advocacy briefs** - There will be need for informing the National Council on Health (NCH) on the introduction of PBF at all levels in all States. While developing the National Policy - Materials for advocacy will be the Impact evaluation report and other convincing materials buttressing the efficacy of PBF - The implementing states will be used as key advocates for showcasing PBF at the NCH. - Strong advocacy needs to be done at the National Economic Council (NEC), Nigerian Governors' Forum (NGF), etc. - Advocacy from Development Partners who are proponent of PBF.	FMOH/NPHCDA, National PBF steering Committee.	1 year
Develop a National PBF Policy (to be coordinated by the FMOH and anchored by the DHPRS)	- All relevant stakeholders (FMOH/Agencies, States, CSOs, etc) will come together to develop / formulate a National PBF Policy. - Policy will be approved at the NCH and moved further up for institutionalization in places like FEC, SECs, NASS, State Houses of Assembly etc.	All stakeholders (relevant departments in the FMOH / Agencies / states	1-2 years

7.4 Borno State

7.4.1 Background

Borno is the epicenter of the conflict in NE Nigeria. Due to displacements the population is highly mobile and there is insecurity across vast areas in the state with vandalized health structures. Table 1 shows that 15% of the population is not accessible for health workers at all, while for 45% they are partially accessible and 39% of the population is totally accessible. The PBF program so far only signed 108 contracts (27%) on a total of 399 contracts desired if we consider the accessible and the partially accessible areas.

Table 1- Distribution of population across LGA in Borno State.

LGA	Number	Population	%	Ideal, if one principal contract holder per 10.000	Contracted	Gap
Accessible	10	2.354.080	39%	236	108	128
Partially accessible	12	2.710.296	45%	271	Nil	271
Inaccessible	5	911.748	15%	91	Nil	
TOTAL	**27**	**5.976.124**	**100%**	**598**	**108 = 27%**	**399**
IDP Population		2.193.769	37%			

7.4.2 Context

The health indicators of the State are poor with an immunization coverage of 32%, and a maternal mortality rate at 1518/100,000. There are too few qualified health staff, which are distributed unequitable. The State has seen an influx of INGO, which are plethoric. Most of these international NGOs have their own strategies and policies resulting in uncoordinated health services in the State.

Due to concerns about gaming and false data produced, the PBF program decided to switch from the carrot + carrot approach towards the carrot x stick approach. This led to frustrations among health facility staff and several health facilities even refused to signing contracts. This PBF "sanction system" in Borno State also implies that health facilities lose money when the data verified are not within the 10% margin of the declared data presented by the health facilities.

7.4.3 Key problems

- The highly dynamic population and the insecurity in the state that makes patients reluctant to give their true addresses, make it difficult to trace patients during the community verification surveys.
- PBF payments suffer from long payment cycles resulting in paucity of funds at the health facility, which is particularly problematic when the system wishes to reimburse funds for non-fee-paying patients.
- The State proposed free health care services for patients, but without a convincing reimbursement plan for the PBF health facilities
- Inadequate human resource for health and poor infrastructure at the level of the health facilities.

7.4.4 Recommendations

- Review the "sanction system" so that it becomes more attractive for health providers (in particular from the private sector) to sign contracts : Return to the carrot + carrot design and apply other "sticks" for health facilities submitting false invoices such as cancelling the contract and stimulating competition for contracts ;
- Change the payment cycle to monthly reimbursements instead of three monthly ;
- Integrate all vertical programs at the state primary health care development agency and the state ministry of health into one basket of results-based payments.
- Move the State PBF Project Implementation Unit towards a new PBF Unit within the State Ministry of Health so that PBF will become inclusive towards the hospital level and regulatory agencies instead of only focusing on the primary level ;
- Stimulate the use of mobile health units (MHU) for underserved population – to be implemented by the principal health facility contract holders.

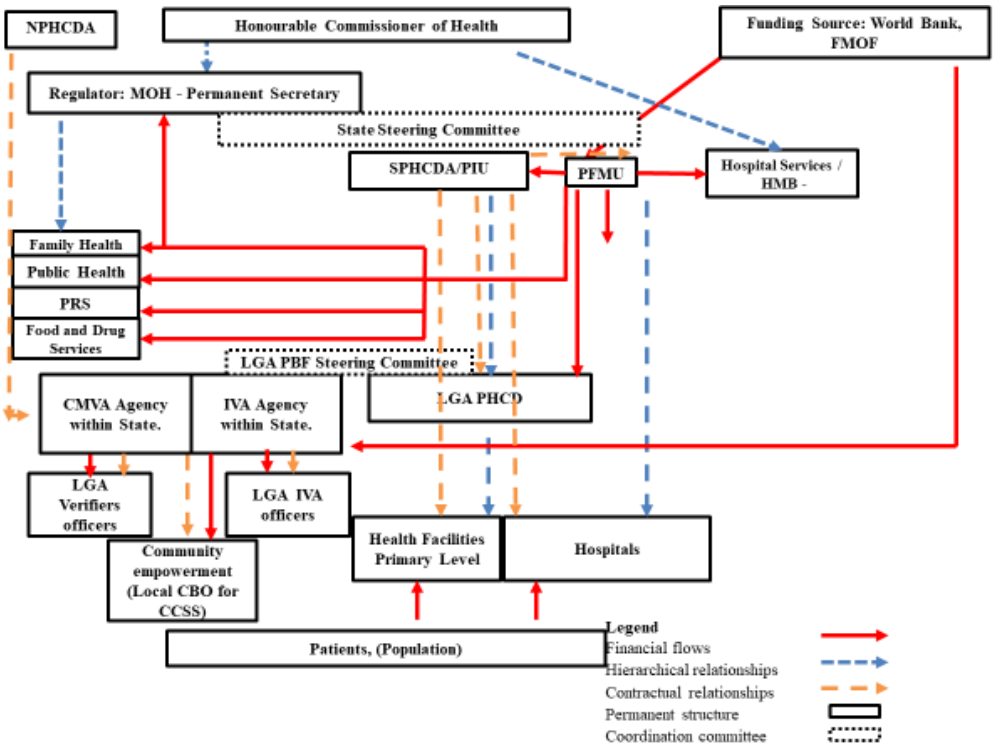
Criteria to establish in how far the program is "PBF"	Points
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure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

Criteria to establish in how far the program is "PBF"	Points
21. Public religious and private providers have an equal chance of obtaining a contract	2
22. There are geographic and/or facility specific equity bonuses	2
23. The project provides equity bonuses for vulnerable people	2
TOTAL	**40 = 80%**

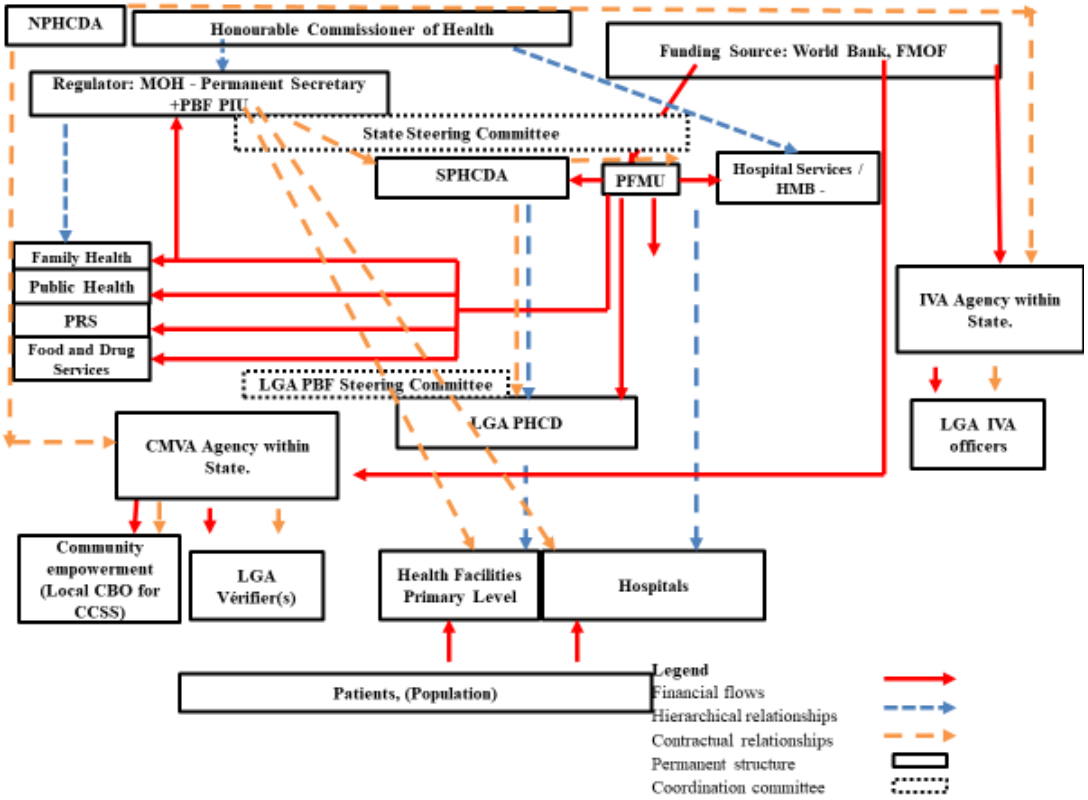
7.4.5 Action Plan Borno

What	How	Who	When
Return the PBF design to carrot + carrot	Advocacy by CMVA & SINA HEALTH.	NPHCDA	Q1 2019
A phased approach to the introduction of sanctions.	Advocacy by CMVA & SINA HEALTH.	NPHCDA	Q4 2019
Integration of all vertical programs in the state (INGOs +++)	Advocacy to Governor through the HCH and ED SPHCDA.	SPHCDA/SMOH	Q4 2018
Review of payment cycle into monthly plan.	Advocacy by CMVA & SINA HEALTH.	NPHCDA/FMoF	Q1 2019
Move PIU to SMOH as proposed in the PBF manual.	Advocacy by SINA HEALTH to FMoH for revision of PBF institutional design with NPHCDA.	FMoH/NPHCDA	Q1 2019
Mapping of HF in inaccessible LGAs and contracting of HFs for underserved population.	LGAPHCD to conduct baseline assessment of LGAs for HFs with support from SPHCDA and Partners	SPHCDA/LGAPHCD/CMVAs	Q4 2018
Introduction of MHU to underserved population.		Health facilities	Q4 2018

7.4.6 Existing PBF institutional design



7.4.7 Proposed PBF institutional design



7.5 Kano, Kaduna, Ondo, Sokoto and Kebbi Action Plan

7.5.1 Problem analysis

The Nigerian Health System has a number of important programs financed by World Bank such as the SOML (the six indicators with performance contracts with the States), ANRiN (nutrition program, mainly for supplementary feeding), NSHIP (PBF program). Other programs concern the Basic Health Care Provision Fund (BHCPF), which is financed by 1% of the Nigerian government revenues. The implementation of these programs is mostly input based, vertical and uncoordinated leading to the duplication of efforts and, as a result, the wastage of resources. Most are donor driven and partners introduce different indicator sets and propose different strategies to achieve targets.

In addition, there are the following problems

- Lack of knowledge on PBF among key stakeholders ;
- Authorities may not accept the separation of the functions of provision, regulation and contract development & verification ;
- Facilities depend on the central distribution of inputs such as essential drugs ;
- Facility managers may not be allowed to spend cash such as in Kaduna and Sokoto States ;
- There are administrative bottlenecks in communications
- There may be resistance to change towards implementation of PBF

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

7.5.2 Recommendations

- Integration of all vertical programs using PBF for implementation to achieve individual programs goals and ensure sustainability ;
- All programs will be under one State Steering Committee and Technical Consultative Group ;
- Advocacy to the relevant stakeholders to adopt PBF ;
- Adapt the PBF institutional set up in all states ;
- Engage consultants when necessary to support the implementation of PBF
- Pilot PBF in some selected LGAs of the state ;
- Raise a Memo for the National Council on Health to advocate for National Policy to adopt PBF.

7.5.3 Action plan

This action plan is oriented towards solving the coordination partners organisations and to provide through PBF an efficient and quality oriented framework for implementation.

Where	How	Who	When
Kano, Kaduna, Ondo, Kebbi, Sokoto	- PM submit report of the course - Advocacy to the relevant stakeholders to adopt PBF	Advocacy team (those that attended the PBF course)	3rd week Nov
Kano, Kaduna, Ondo, Kebbi, Sokoto	- Draft information memo for HCH to present at the SEC	PM	4th Week Nov
Kano, Kaduna, Ondo, Kebbi, Sokoto	- Integration of all vertical programs using PBF for implementation to achieve individual programs goals and ensure sustainability	Top management meeting State Steering Committee	1st week Dec 2nd Week Dec
Kano, Kaduna, Ondo, Kebbi, Sokoto	- All programs will be under one State Steering Committee and Technical Consultative Group	Chairman (HCH and PS)	2nd Week Dec
Kano, Kaduna, Ondo, Kebbi, Sokoto	- Engage PBF consultants when necessary to support the implementation of PBF	TCG	1st quarter 2019
Kano, Kaduna, **Ondo,** Kebbi, Sokoto	- Adapt the PBF institutional set up in all states	TCG	1st quarter 2019
	- Orientation training for relevant Stakeholders (at facility level)	TCG	1st quarter 2019
Kano, Kaduna, **Ondo,** Kebbi, Sokoto	- Pilot PBF in some selected LGAs of the state	TCG	
Kano, Kaduna, Ondo, Kebbi, Sokoto	- Raise a Memo for the National Council on Health to advocate for National Policy to adopt PBF	HCH	

Key: Blue colour does not apply

7.6 Gombe State

7.6.1 Background

Gombe State is located at the Centre of the North-East sub-region. It shares boundaries with Bauchi State to the West, Borno to the East, Taraba and Adamawa to the South and Yobe State to the North.

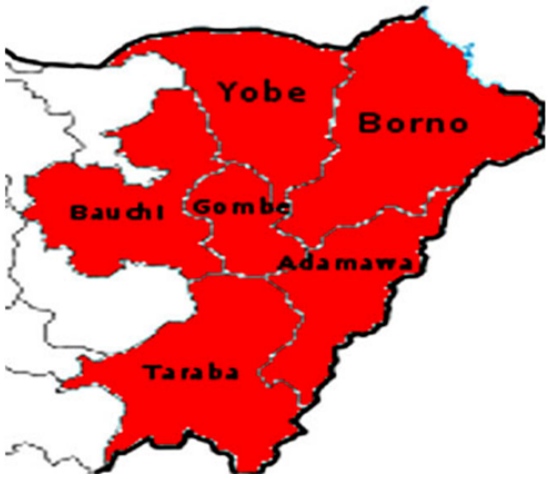


Figure 2: Map of North-East Nigeria showing the location of all the 6 states in the Zone.

It has an estimated 2018 population of about 3.2 million people (projected from 2006 census) with 11 LGAs, and 114 political wards.

7.6.2 Health Indices in Gombe State

Demographic Indicator	Indicator value	Data source
Population	3,225,382	NPC 2006 census projection
Population growth rate	3.2%	NPC 2006 census projection.
Number of LGAs	11	GSBOS
Number of Political Wards	114	GSBOS
Number of Health Facilities	518	SMOH
Under 1 Year	135,578 (4%)	NPC 2006 census projection.
Under 5 year	745,680 (20%)	NPC2006 census projection
Pregnant women	169,743 (5%)	NPC 2006 census projection
Women of Child Bearing Age	745,680 (22%)	NPC2006 census projection
Median age at first marriage	16.3	MICS Survey 2016/2017
Total Fertility Rate	6.6	MICS Survey 2016/2017

7.6.3 PBF in Gombe State

Performance Based Financing (PBF) was recently scaled up in Nigeria from three to eight additional financing states of the North East sub-region. This in response to the devastating effect of the Boko Haram insurgency and to rebuild the health system. The approach is currently being implemented as a “project” funded entirely by the World Bank through the Additional Financing Nigeria State Health Investment Project (AF-NSHIP).

In Gombe State, the urban Gombe LGA and the most populous one, with a projected 2018 population of 391,103 people was selected for the PBF pilot. The project started on the 1st of October 2017 with a total of 21 health facilities contracted across the 11 political wards. Of these 14 are public PHC’s while 6 are private hospitals with the

aim to start an urban PBF effort and one State Specialist Hospital to serve as the secondary referral facility.

So far, encouraging results have been recorded thanks to the initial investments improving the infrastructure and the quality of services. The baseline quality score of Q4 2017 was 14% and by the end of Q3 2018 it increased to 64%. Output indicators and staff motivation improved, health facilities became more autonomous, and there was better community involvement. Yet, the successes mentioned above were achieved with subsidies worth only 1.1 USD per capita per year.

In July 2018, performance-based financing was scaled up to the three additional LGA's of Balanga, Dukku and Yamaltu-Deba. Yet, only 38 health facilities were contracted in the 3 LGA's covering an additional population of 1.1 million people and all contracts were public so that there is need to contract an additional 72 health facilities with an average catchment population of 10.000 people.

7.6.4 Key fundamental Problems in the Health Care System

Poor Financing
- Only 8% of the total state budget is allocated to health, which is mostly used for inefficient input-based strategies ;
- More than 70% of total health expenditure in the State is out of pocket, while the combined expenditure on health including from government and partners amounts to not more than 30% ;
- There are huge inefficiencies in the top-down and monopolistic procurement processes ;
- There are weak financial checks and balances and accountability systems with persistent inefficiencies and low value for money.

Leadership and Governance
- Political will for change and strengthening the health systems seems to be a challenge ;
- There is a need for the review of the legal framework and policies to allow the decentralization of decision making powers of health facilities in the field of regarding human resource management, where to buy inputs, etc.

Service Delivery
- Quality of service delivery in most health facilities is poor ;
- Most HF's are not operating on a 24/7 basis ;
- There are frequent stock-outs due to centralised top-down distribution systems ;
- Client satisfaction with the services rendered are poor ;
- There are several barriers for access to quality services such as cost, distance but also socio-cultural factors.

Human Resources for Health
- There is a shortage of human resources in terms of quantity and quality (skill mix, competence and inequitable distribution) ;
- Health workers are poorly motivated and there is no performance-based reward system (the carrots) ;
- In the now-existing system it is difficult to discipline health workers and punitive measures are rarely enforced (the sticks).

The Gombe participants believe that the performance-based financing approach may solve the above described problems.

7.6.5 PBF Feasibility Scan

Criteria to establish in how far the program is "PBF"	Points	Score	Remarks
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	4	Cost at 4.2 USD/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	Solely funded from WB loan
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	PBF unit domiciled at SPHCDA
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	0	No 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	Yes
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	Yes
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	Yes
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	Yes
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	0	Baseline HH survey not done
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 are the signatories.	2	2	Yes
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	0	Not yet at the secondary HF's
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	2	Yes
13. The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2	2	Yes
14. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2	2	Yes
15. Provider managers are allowed to influence cost sharing tariffs	2	2	Yes
16. Provider managers have the right to hire and to fire	2	2	Yes
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	2	Yes
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	2	Yes
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	2	Yes
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	2	Yes
21. Public religious and private providers have an equal chance of obtaining a contract	2	2	Yes
22. There are geographic and/or facility specific equity bonuses	2	2	Yes
23. The project provides equity bonuses for vulnerable people	2	0	Bonus for the vulnerable not in the design
TOTAL	**50**	**36**	**72%**

The main problems identified by the feasibility scan are :

- PBF is still a donor driven approach instead of a national or state policy and its institutional set up under the SPHCDA means that it is difficult to expand it from the PBF level to the hospital level and towards a systematic reform of the regulatory levels ;
- There is still a mix of input and output based approaches in the PBF implementation such as the centralised distribution of drugs to the contracted secondary health facilities ;
- There is still a poor separation of functions with SPHCDA signing contracts with providers instead of the CDV agency.

7.6.6 Recommendations

- Adopt the PBF approach as health system strengthening strategy in Gombe State ;
- Request the State to finance PBF in at least two additional LGA's from 2019 onwards ;
- Create a PBF unit at the highest level possible with the State MoH so that the hospitals and the regulators can also be included ;
- Create a State budget line in 2019 for PBF and use already existing external partner resources. For example 40% of the SOML funds should be channelled towards a pure PBF approach ;
- Advocacy for the integration of the vertical programs into one single program using the PBF approach to maximise the opportunities and improve efficiency.

7.6.7 Action plan

Proposed activity	How	Who	When
Obtain evidence on impact and progress till date of the PBF program implementation in the pilot LGA	- Conduct a short term assessment and document the evidences of success in the pilot LGA - Analysis of data in the pilot LGA - Comparative evaluation of infrastructure improvement with pictorial evidences	PBF Technical Unit	30th Nov 2018
Organize a stakeholder meeting on PBF to share the findings and successes of the project so far in the state and build a critical mass of PBF champions	The potential champions within the State to engage with political leaders : - Health Commisisoner MoH - Permanent Secretary, - Directors in the MoH - Executive Secretary SPHCDA - Directors SPHCDA - PBF Unit staff - PBF LGA PHCD - PBF Health Facility Managers and selected staff - Community/Traditional Leaders involved in PBF implementation	HC	7th Dec 2018
Develop Materials to be used for advocacy in the state	Produce and Print - Handbills, - Fact sheets/leaflets	PBF Unit	10th Dec 2018
Advocate for the state to sponsor PBF in at least 2 additional LGA's	- One on One Meeting with the Governor to discuss the PBF approach and get his buy in - Create a budget line for PBF in the 2019 budget for the MoH	HC	15th Nov. – 7th Dec. 2018
Advocacy for the Integration of all the vertical programs into a single program using the PBF logic	- Sponsor a memo at the state council on Health for adopting the PBF strategy - Sponsor a bill for the adoption of PBF as a state policy in the house of assembly	HC, ES SPHCDA	20th Dec. 2018

7.7 Bauchi State

Contributors : Dr. Abdulaziz A ; Manga, Mohammed ; 2. Sadiq Mohammed ; 3. Ibrahim Sani and ; 4. Samira A. Abdullahi

7.7.1 Background

Bauchi State has a population of 7.3 million, with 20 LGAs and 323 Wards. There are 1,100 Health Facilities of which 90 are private. Bauchi is one of the states that benefitted from the Additional Financing for NSHIP in 2016. So far, PBF has been implemented in 3 LGA's -3 Hospitals, and 54 Primary Health Care Centers of which 1 is a Private Provider. The Minimum Package of Activities has 23 indicators and the Complementary Package of Activities has 27 indicators. AF NSHIP budget for the State is $ 16.8 million for the duration of 4 years, and the Program was designed to cover 7 LGAs representing 33% of the population.

7.7.2 Key problems

- The State has been restricted to select only 1 Primary Health Facilities (PHC) per ward, which has resulted in poor rationalization of health facilities especially in the urban LGAs, with some of the Primary Health Centres having a target population of more than 50,000 as against 10,000.
- Private health facilities are not in equal competition with public health facilities. In conforming with the 1 PHC per ward, there has been a greater preference for public health facilities during mapping and selection processes.
- Shortage of qualified staff and the distribution is often skewed towards the urban centres
- Use of input and output financing mechanisms. NSHIP uses output financing only, but other partners and donors still engage in input financing.
- The use of "carrot x stick" approach along with other forms of sanctions has greatly limited earnings of the health facilities, there by demotivating staff.
- Inadequate competition amongst essential drugs vendors, which has resulted in some level of monopoly.

7.7.3 Feasibility Scan

Criteria to establish in how far the program is "PBF"	Points	
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	$ 2,7 *excluding* Administrative Cost and $ 4,2 with admin costs
2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	0	The State Government gave a counterpart funding, but was not up to 20%
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	The National and State PIU are under the Primary Health Care Development Agency, which is a Parastatal of the Ministry of Health
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	0	

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

23. The project provides equity bonuses for vulnerable people	0	
TOTAL	**36 = 72%**	

7.7.4 Bauchi State action plan

Problem	Proposed activity	Who	When
Poor rationalization of health facilities especially in the urban cities	- Increase the number of health facilities with principal contracts in the urban LGAs through population rationalization (between 6000 and 14.000 inhabitants per facility catchment area)	EC BSPHCDA PC NSHIP	Jan-Mar, 2019
Inadequate qualified personnel and skewed distribution	- Encourage PBF facilities to hire qualified personnel as appropriate - Liaise with SPHCDA and HMB to ensure adequate distribution of qualified personnel	EC BSPHCDA PC NSHIP ES HMB Health Facility Managers	Jan-Mar, 2019
Mixed approach of input and output financing	- Discourage the input strategies and ensure full autonomy for health facilities	Comm. MOH EC BSPHCDA	Apr-Jun, 2019
Use of Carrot and Stick	- Return to the use of Carrot + Carrot to ensure adequate funds for Health Facilities	EC BSPHCDA PC NSHIP	Apr-Jun, 2019
Poor competition amongst Essential Drugs Vendors	- Ensure free market entry for all Essential Drug Vendors that have met certain well-established quality criteria	EC BSPHCDA PC NSHIP	Jan-Mar, 2019

7.8 Taraba state

7.8.1 Background

Taraba State is located in the North-East of Nigeria with a population of approximately 3.4 million. Administratively, it is made up of 16 local government areas (LGAs) and 168 wards. Health facilities in the State include 2 tertiary hospitals, 16 general (secondary) hospitals and about 800 PHC facilities. There are quite a number of private health facilities. Health care financing is mainly through out of pocket expenditure of the population. The public health facilities, receive inputs such as drugs from central distribution centers.

With the support of a World Bank credit, the State piloted PBF in one LGA and this has now been scaled up to two additional LGAs. The pilot program produced significant improvements in output indicators such as immunization coverages, ANC attendance, and deliveries by skilled attendants etc. compared to the other LGAs.

7.8.2 Problem Analysis

Quite a number of public health facilities, particularly PHCs and secondary health facilities are characterized by dilapidated infrastructure, poor funding and inadequate human resources. Health facility staff are poorly motivated, with a significant number of them working in hard-to-reach locations. Health care commodities are centrally distributed and stock outs are frequent.

With the evidence from the pilot program, the Taraba group believes these problems can be addressed using the PBF approach.

7.8.3 Feasibility scan of the existing PBF program

Criteria to establish in how far the program is "PBF"	Max Points	Score	Comments
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	4	Most of the funding is form the WB credit
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	Government contribution is mainly HF staff salaries
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	0	
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	0	
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	2	
6. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	2	
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	2	
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	2	
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	2	
10. Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the HF 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 providers – not with the indirect owners such as a religious leader or private person.	2	0	
15. Provider managers are allowed to influence cost sharing tariffs	2	2	
16. Provider managers have the right to hire and to fire	2	0	
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and 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	0	
23. The project provides equity bonuses for vulnerable people	2	2	
TOTAL	**50**	**38 = 76%**	

The feasibility scan of the PBF program in the State revealed a score of 38 points out of a maximum score of 50 points (= 78%).

The main problems of the Taraba State PBF program are:

- The government is not contributing towards the PBF budget and the State is dependent almost entirely on the World Bank credit for their PBF program. Government pays the salaries for the government health facilities but provides virtually no funds for running the facilities. This poses a serious sustainability challenge once the World Bank funding ends
- Facilities depend on the central distribution of their inputs (essential drugs, equipment) and they have no alternative supplier of commodities.
- The State has an Essential Drugs Program (EDP) established by law and all public health facilities are expected to procure their drugs from the Central Medical Store. Prices are set by the Central Medical Store. As the result of this input-based approach there are regular stock outs.
- The Facility managers are not allowed to directly spend their revenues.
- Cost-recovery revenues from the sales of drugs and other services are paid into the treasury account of the government. Health facility managers are not allowed to use these revenues. Facilities have monthly allocations to run their services, but in practice these budgets often are not provided.

7.8.4 Recommendations

- Government releases HF budgets to the health facilities for service delivery ;
- Existing laws should be modified so that: 1. health facilities retain and use their cost recovery revenues in PBF dedicated accounts ; 2. The managers of the facilities are the signatories of these account ; 3. Facility managers can chose of their supplies from any accredited supplier.
- Scale up PBF to all LGAs in the long term

7.8.5 Action plan

Activity	*How*	*Who*	*When*
Brief the Ministry of Health on the need to scale up PBF	- Submit report of PBF course - Advocacy to the Ministry on PBF (at Ministerial meeting)	- ES HMB, DPH - ES HMB, DPH	- 3rd week Nov 2018 - Dec 2018
Advocate to the Chairman, House Committee on Health, Taraba State House of Assembly	- Ministry of Health conducts Advocacy visit to the Chairman House Committee on Health	- Honorable Commissioner	- 2nd Q 2018