# Mombasa – KENYA

## Report of the 64th Performance-Based Financing Course

November 20 – December 1, 2017

***The 34 course participants in Mombasa enjoying happy moments together***

**Final Version, 18th December 2017**
Mombasa, Kenya

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# 1. SUMMARY

This report presents lessons learned from the nine PBF courses held in 2017 and the latest PBF developments included in the course content. The French summary is presented in Chapter 2 - page 13 - of this report.

The 64th performance-based financing (PBF) course took place from Monday, November 20 to Friday, December 1, 2017, in Mombasa, Kenya. The country groups analyzed their health systems and produced detailed action plans to advance PBF in their respective countries.

34 participants attended the course in Mombasa: 21 from Nigeria, 5 from Zimbabwe and Liberia, 2 from Lesotho, and 1 from South Sudan. Participants were high-level officials from various Ministries of Health and agencies. 32 participants took the final exam, and the average score was high at 79%. Five participants obtained distinctions. The Sai Rock Hotel is an attractive venue on Mombasa Beach, but participants raised concerns about internet reliability and room maintenance, as well as occasional interruptions to the water supply. We aim to keep the PBF courses relatively low cost, and holding them in a 5-star accommodation would increase course fees. A very luxurious environment would also send the wrong signal, as we aim to promote efficient use of public resources.

## 1.1 Overview of the nine PBF courses during 2017

The Mombasa course was the last of nine 14-day PBF courses in 2017, and we welcomed 344 participants from 18 countries. There were seven French-language courses with 285 participants and two English-language courses with 59 participants. Participants came from Cameroon (94x), Gabon (73x), the Central African Republic (47x), Nigeria (30x), Thad (19x), and the Democratic Republic of Congo (18x). Smaller groups came from Guinea 11x, Zimbabwe 8x, Senegal 7x, Burkina Faso 6x, Ivory Coast 6x, South Sudan 5x, Liberia 5x, Congo Brazzaville 4x, Lesotho 4x, Uganda 3x, Niger 3x and Ethiopia 1x.

In the following table, we observe several trends in the PBF courses since 2007:

| | 2007-2014 | 2015-2016 | 2017 | TOTAL 2007-2017 |
|---|---|---|---|---|
| **TOTAL (Engl + Fr)** | **1176 = 100%** | **468 = 100%** | **344 = 100%** | ***1988 = 100%*** |
| Female | 24% | 28% | 23% | 25% |
| Average Score | 78% | 73% | 72% | 76% |
| Distinctions | 23% | 13% | 12% | 18% |
| Failures | 3% | 11% | 12% | 7% |
| ***French courses*** | ***730 = 62%*** | ***321 = 69%*** | ***285 = 83%*** | ***1336 = 67%*** |
| Female | 21% | 29% | 20% | 23% |
| Average Score | 79% | 74% | 71% | 76% |
| Distinctions | 22% | 14% | 11% | 17% |
| Failures | 3% | 8% | 14% | 7% |
| ***English courses*** | ***446 = 38%*** | ***147 =31%*** | ***59 = 17%*** | ***652 = 33%*** |
| Female | 31% | 25% | 39% | 30% |
| Average Score | 77% | 70% | 79% | 76% |
| Distinctions | 24% | 10% | 16% | 20% |
| Failures | 4% | 15% | 4% | 7% |

1. The *proportion of female participants* in the PBF courses remains low at 25%. We do not fully understand the core reason, but it warrants attention.
2. The *final* exam has become more difficult in recent years. The average score during the 2007-2015 courses was 78% and reduced to 72% in 2017. A higher proportion of participants also failed the exam, increasing from 3% during the 2007-2014 courses to 12% in 2017. The proportion of distinctions reduced from 23% during the 2007-2014 courses to 12% in 2017.

## 1.2 New developments in course content during 2017

The course facilitation team continuously updates the course content with the latest developments that take place in the PBF reform approach. This is made possible because the facilitators also work in the field, so they can translate their experiences into the course content. Participants and their organizations seem to appreciate this hands-on experience, and demand for the PBF courses remains strong, even for 2018.

**The following PBF developments were integrated during 2017 in the course content:**

- PBF countries such as Cameroon and CAR developed and *tested better equity strategies* to target vulnerable districts, health facilities, minority groups, and individuals, as well as how to respond during a humanitarian crisis. This development makes the PBF approach more attractive and the preferred strategy for achieving Universal Health Coverage in low- and middle-income countries. It incorporates ideas such as ensuring, first, the quality and efficiency of health systems while also targeting free health care for specific activities and vulnerable groups. Equity objectives can be achieved only with sufficient and stable public financial resources. This quality- and efficiency-oriented approach is better than the generalized free health care still promoted by some, where quality suffers, health staff becomes demotivated, and transparency problems and uncontrolled informal activities arise.
- The PBF equity approach is also more efficient at achieving the objectives of *classical demand-side strategies, such as vouchers,* by targeting similar patient groups with increased subsidies to health facilities. In the PBF scenario, health facilities must develop strategies to identify the beneficiaries in their catchment area.
- *Voluntary community-based health insurance* has lost its attractiveness, but pilots are underway in Cameroon and Gabon to determine how far *obligatory health insurance* can be incorporated into the more efficient PBF contracting and verification system.
- Several PBF countries developed during 2017 strategies *to promote more sustainable PBF systems*. This is done by:
    1. Transform existing MOH input budget lines into PBF performance budget lines;
    2. Promote PBF as the national health reform approach, fully integrated into the Ministry of Health and government policies. This requires abandoning the PBF project approach, whereby partner organizations such as the World Bank set up independent Project Implementation Units. The problem with this "project" approach is that the Ministries of Health and governments do not "own" it.

3. Sign performance contracts not only with health facilities and peripheral regulatory authorities but also with the central MOH Directorates. Central regulatory authorities should also receive variable performance payments based on output and quality indicators, rather than fixed salaries and fixed input budget lines such as per diems or operational costs.

- The *PBF community approach* improved in 2017 by systematically allocating 15-20% of the total PBF budget to social marketing and strengthening community voice. One community PBF indicator that has become popular is "household visit following a protocol". The idea is that primary-level health staff visit each household in their catchment area twice a year. During these visits, staff check about 20 health-related points, such as immunization status, nutrition, family planning, use of bed nets, availability of latrines, waste disposal, and maternal or child deaths. Community PBF also incentivizes follow-up on dropouts of TB, immunization, malnutrition, HIV patients, etc. Moreover, community PBF actively identifies vulnerable patients and groups.
- Apply PBF best practices not only in the health sector but also in *broader civil service reforms*. During discussions with the governments of Gabon and Cameroon, the World Bank and IMF used some PBF best practices as a conditionality for budget support. The idea behind this is that budget support should go hand in hand with improving the efficient use of those resources.

## 1.3 Changes in training methodology

Over the last 10 years of PBF courses, the aim has been to cover all course book modules within the 12 or 13 days of the course. This has become difficult because many new developments and instruments have emerged. As a result, the course book expanded from an 80-page manual into a 260-page handbook with 17 modules.

**We therefore made the following changes in the course methodology:**

- *Reduce the course messages to the essential ideas of each module and make those messages simple to understand*. This process is ongoing because lessons learned, new developments, and opportunities in PBF change so quickly that the course materials require continuous editing.
- Reduce time spent on plenary sessions and give the facilitation team more time to help different groups and individuals develop their *specific action plans*.
- *Review participants' views and expectations of PBF* by asking each participant, upon arrival, to complete a pre-course questionnaire. Some are PBF novices who have come to learn but first need to understand and accept the PBF change issues. Others already have PBF knowledge or were recently recruited for a job in PBF. They do not need to be convinced about the change issues but wish to learn specific PBF knowledge and skills.
- Conduct a pre-test on the PBF knowledge of each participant. The outcome will determine how much the course should focus on PBF basics versus fast-tracking to the "how" of PBF, with more emphasis on instruments such as output indicators, the indices management tool, costing, and the contracting process with different stakeholders.
- Organize *national PBF courses* (about 50% of all courses) with a specific selected group of participants, for example, from the central regulatory level, hospital managers, regional or district regulators, and/or CDV Agency staff. In such courses, we usually concentrate on developing SMART action plans for each stakeholder present.

- We also better coordinate debates by using the "village" approach, where participants become part of the facilitation team and influence the content and methodology. During the PBF course in the Central African Republic, the participants facilitated the debate instead of the facilitation team.

## 1.4 Observations about the 64th Mombasa course of December 2017

The PBF course welcomed participants from five countries.

1. The Nigeria team included 8 participants from the Federal level (FMoH and NPHCDA) and 13 from various states (Katsina, Kebbi, Taraba, Kano, Nasarawa, and Adamawa), including the Commissioner of Health from Nasarawa.
2. The Zimbabwe team consisted of five people from the Ministry of Health: three central-level directors and two Provincial Medical Directors.
3. The Liberia team consisted of 5 persons from the central Ministry of Health.
4. Lesotho sent a delegation from the national MoH to support quality assessments of the RBF program in the country.
5. Cordaid sent a TB public health expert for their South Sudan program.

The facilitation team consisted of:

1. Dr Godelieve van Heteren, working as a senior health system expert for the Health Systems Governance Collaborative, hosted by WHO
2. Dr. Fanen Verinumbe, training coordinator of Adamawa State in Nigeria
3. Dr Claire Rwiyereka, independent consultant from Rwanda
4. Mr. Christian Habineza, Director of HDP, Rwanda
5. Dr Robert Soeters, Director of SINA Health and overall course coordinator.

The "village 64" chief, Dr Daniel IYA, together with his deputy, Dr Cuallau JABBEH-HOWE, the timekeeper, Dr Simon NYADUNDU, and the tax collector, Mrs. Lineo MOHLOMI, actively supported the facilitation process, contributed to a congenial atmosphere, and maintained "order" in the village.

The daily evaluations produced scores that, compared with previous courses, were above average. The **methods and facilitation** scores were 93.9%, 7% above the average of the previous 20 English courses. The **participation** score was 87.2%, comparable to previous courses. The course organization in Mombasa scored 90.7%, 5% *above* the average of previous courses. However, participants were less satisfied with Sai Rock Hotel this time, particularly with the water supply and the food, which was considered too monotonous. **Timekeeping** scored 67.9%, 5% *below* the average of previous courses.

The final evaluation showed the program met participants' expectations, but it could improve by informing participants about the course in advance. Participants rated the course methodology well, with an average score of 91%.

## 1.5 Country recommendations of the November 2017 Mombasa course

### 1.5.1 Nigeria

Nigeria's health system suffers from underfunding, inefficient input financing, poorly motivated health workers, and frequent strikes. Health indicators are worse than in other countries. Health service quality varies and does not instill client confidence, so some people seek care from unorthodox medical practitioners, go directly to tertiary health institutions (bypassing primary and secondary health facilities), or even go outside the country.

PBF schemes have been initiated so far in eight States, and more seem willing to follow. The recent impact study of the World Bank-financed PBF project in three States since 2012 shows encouraging results for the PBF districts compared to the control districts. A research experiment (DFF) that provided money without PBF verification mechanisms also showed some quality improvements. However, participants in Mombasa from the states that carried out this experiment argued that the PBF approach heavily influenced this arm of the research, so it was seriously contaminated.

**Problem analysis**

- In Nigeria, PBF remained a World Bank-led "project" for too long rather than a "national health reform strategy" that efficiently uses scarce government resources, unlike health policy in Burundi and Cameroon.
- The Nigerian health system remains predominantly input-based, offers several free healthcare elements, and would greatly improve efficiency and service quality by adopting performance-based financing.
- The private health sector in Nigeria already plays a vital "de facto" role for the population, but it is poorly integrated into the Nigerian health system and is almost unregulated.
- The Federal level is still undecided about the merits of PBF and its potential for Universal Health Coverage. Despite limited evidence of its effectiveness, the government proposes obligatory health insurance as a strategy toward UHC.
- States do not use their powers to steer their health systems toward PBF.
- The World Bank-financed Save One Million Lives (SOML) project uses each State's achievement of disbursement-linked output indicators as the main payment criterion. Yet once disbursed (the first instalment was $US 1.5 million per State), States use the money to finance inputs through traditional channels, fostering inefficiency and even corruption. Moreover, the SOML approach does not promote providers' autonomy, functional separation, or public-private partnerships.

**Recommendations:**

- States are encouraged to start PBF programs using several sources of financing. The Commissioner of Health of Nasarawa State, who is committed to launching a state-wide PBF program, proposed this in Mombasa.
- Transform SOML financing into a pure PBF approach while still targeting state-level disbursement-linked indicators.
- The World Bank may match funding on a 50%–50% basis for States willing to start a pure PBF approach using Internally Generated Revenues, SOML funding, own State resources, or resources from other partners. This would also address

fiscal space for WB-financed PBF programs (preferably at least $US 4.00 per capita per year) while ensuring buy-in from States and federal authorities.
- Review the institutional set-up of the federal-level PBF program and identify the roles and profiles of staff for the NPHCDA and the FMOH.
- Liaise with the 193 participants in Mombasa PBF courses since 2010 to build a critical mass to lobby for purer forms of PBF in more States.

### 1.5.2 Lesotho

The PBF program in Lesotho started with a pilot in two districts and scaled up in 2016 to 6 out of 10 districts. Studies showed improvements in output and service quality, and the government decided to scale up the PBF program nationwide in 2018.

**There are still the following problems:**

- Lesotho's health system is not cost-effective. It is one of the few low-income countries that nearly reaches the recommended target of 15% of the government budget spent on health. Yet despite this funding, health indicators do not improve, and some are even declining.
- The free health care policy in Lesotho leads to poor-quality services, and patients are forced to buy medicine from poorly regulated pharmacies outside the health facilities;
- Donor support is fragmented, and the MOH does not adequately coordinate the different partner interventions;
- Human resource management in government health facilities is fragmented because NGOs and other external partners post staff.
- The Lesotho PBF program design still has issues, with a feasibility scan score of 72%.

**Recommendations:**

- Review the PBF design and improve the PBF feasibility score.
- Recommend reviewing the policy on abolishing user fees.
- Advocate for competition between public and private pharmaceutical suppliers.
- Advocate for greater autonomy for health facilities, including using cost-sharing revenues and buying inputs from accredited distributors.
- Review and increase the number of indicators to at least 25. Separate quality and quantity indicators and ensure inclusion of community-based indicators.
- Address leadership problems at the central level by better describing each actor's profile, outputs, and desired service quality, including at the Ministry's top regulatory level. PBF contracts may formalize these relationships and include performance-based payments.
- The regulatory health district authorities should be capacitated and empowered with performance contracts to implement PBF-style reforms.

### 1.5.3 South Sudan

Since independence in 2011, South Sudan's political landscape has remained dominated by internal and external threats to sustainable peace and stability. In December 2013, the country descended into protracted fighting, heightening uncertainty. In August 2015, the parties signed a peace agreement, but implementation remained a major challenge.

**Problem analysis**

- The South Sudan health system is too donor-driven and ignores the vibrant private South Sudanese health sector in urban and rural trading areas.
- The health system suffers from poor leadership and governance, weak HRM, poor infrastructure, service duplication, and a very high proportion of vulnerable populations.
- Most inputs are centrally distributed by a single supplier.
- Regulatory authorities perform poorly, with inadequate health policy development and quality assurance mechanisms.

**Recommendations:**

- The South Sudan participant proposes joining hands with previous Cordaid PBF course graduates from May 2017 to build a critical mass and advocate with the government and donors for performance-based programs. An important partner may be the World Bank, which may also advocate for PBF-style reforms.
- Develop and implement a well-designed PBF pilot in areas where INGO Cordaid leads. The PBF scheme should include the full primary- and hospital-level packages and be adequately funded.

### 1.5.4 Zimbabwe

Zimbabwe's Ministry of Health and Child Care began piloting performance-based financing in 2011. A 2014 impact evaluation found encouraging results, and the Ministry adopted PBF nationwide, financed by the World Bank and the Health Transition Fund (now the Health Development Fund). Significant improvements in maternal mortality, child mortality, coverage indicators in ANC care, and access to FP have been achieved in recent years, to which PBF is likely to have contributed.

However, design problems remain, and participants scored the purity of the PBF intervention at 66% in the World Bank-financed and Cordaid-supported districts and 32% in the Health Development Fund-financed and Crown Agent-supported districts.

**Recommendations:**

- Advocate for a purer form of PBF together with previous PBF course participants.
- Advocate that the Ministry of Health change input budget lines from GOZ funding, levies, taxes, and partners towards PBF performance funding.
- Provide equal opportunity for obtaining PBF contracts to all health facilities, whether public, religious, or private; urban or rural.
- Create a more competitive environment for supplying health commodities by removing restrictions that favor monopolies.
- Allow the Directorate of Pharmacy Services to accredit public and private wholesale pharmaceutical companies, including registration requirements and scope of work, to allow entry into PBF.

### 1.5.5 Liberia

Much has changed in Liberia because of the Ebola Virus Disease (EVD) crisis, with a reduction in economic growth and a worsening of health indicators. Liberia has two PBF programs: one at the primary level, financed by USAID, and another at the hospital level, financed by the World Bank. The Liberia team present in Mombasa believes that PBF can make a big difference,

**Problem analysis**

- The current PBF programs have design problems, and the feasibility scan score is 6 out of 50 (12%), while the recommended minimum is 80%.
- Liberia implements a free health care policy for all, but implementation shows that people need not just "services," but "quality services."
- Public health facilities provide poor-quality care, with routine stock-outs of drugs and medical supplies, which has driven consumers to patronize private health facilities.
- The health sector is heavily donor-dependent, with vertical interventions that are difficult to coordinate.

**Recommendations:**

- Review the existing PBF institutional and implementation arrangements as well as the package of services to be subsidized.
- Consider introducing user fees and compensating vulnerable groups with targeted equity bonuses.
- Separate the functions through the "purchaser-providers split".
- Introduce PBF contracts not only with health facilities but also with the other actors in the health system.

These recommendations are like those previously proposed by groups in Liberia. Yet, by increasing the critical mass of PBF-trained participants from Liberia, these recommendations should become implementable.

# 2. RÉSUMÉ

Le ***64e cours de financement basé sur la performance (PBF)*** s'est tenu du lundi 20 novembre au vendredi 1er décembre 2017 à Mombasa, au Kenya. Les groupes de pays ont analysé leurs systèmes de santé et élaboré des plans d'action détaillés pour faire progresser le FBP dans leurs pays respectifs.

34 participants ont suivi le cours à Mombasa, dont 21 du Nigeria, 5 du Zimbabwe, 2 du Lesotho et 1 du Soudan du Sud. Les participants étaient de haut niveau, issus de divers ministères de la santé et d'agences. 32 participants ont passé l'examen final et le score moyen était élevé, à 79%. Cinq participants ont obtenu des distinctions. Le Sai Rock Hôtel est un lieu attrayant sur la plage de Mombasa, mais il y avait des inquiétudes quant à la disponibilité d'Internet et à l'entretien des chambres, ainsi que des interruptions occasionnelles de l'approvisionnement en eau. Nous visons à maintenir les cours PBF à un coût relativement bas, et organiser les cours dans un hébergement 5 étoiles entraînerait une augmentation des frais de cours. Un environnement trop luxueux enverrait également un mauvais signal quant à l'utilisation efficace des ressources publiques.

## 2.1 Aperçu des neuf cours PBF en 2017

Le cours de Mombasa a été le dernier des neuf cours PBF de 14 jours en 2017, au cours duquel nous avons accueilli 344 participants de 18 pays. Il y avait sept cours en français avec 285 participants et deux cours en anglais avec 59 participants. Les participants venaient du Cameroun 94x, du Gabon 73x, de la République centrafricaine 47x, du Nigéria 30x, du Tchad 19x et de la République démocratique du Congo 18x. D'autres groupes venaient de Guinée 11x, du Zimbabwe 8x, du Sénégal 7x, du Burkina Faso 6x, de la Côte d'Ivoire 6x, du Soudan du Sud 5x, du Libéria 5x, du Congo-Brazzaville 4x, du Lesotho 4x, de l'Ouganda 3x, du Niger 3x et de l'Éthiopie 1x.

Dans le tableau suivant, nous observons un certain nombre de tendances dans les cours PBF depuis 2007 :

| | **2007-2014** | **2015-2016** | **2017** | **TOTAL 2007-2017** |
|---|---|---|---|---|
| **TOTAL (Angl + Fr)** | **1176 = 100%** | **468 = 100%** | **344 = 100%** | ***1988 = 100%*** |
| Féminin | 24% | 28% | 23% | 25% |
| Score moyen | 78% | 73% | 72% | 76% |
| Distinctions | 23% | 13% | 12% | 18% |
| Échecs | 3% | 11% | 12% | 7% |
| ***Cours Françaises*** | ***730 = 62%*** | ***321 = 69%*** | ***285 = 83%*** | ***1336 = 67%*** |
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| Distinctions | 22% | 14% | 11% | 17% |
| Échecs | 3% | 8% | 14% | 7% |
| ***Cours Anglaises*** | ***446 = 38%*** | ***147 =31%*** | ***59 = 17%*** | ***652 = 33%*** |
| Féminin | 31% | 25% | 39% | 30% |
| Score moyen | 77% | 70% | 79% | 76% |
| Distinctions | 24% | 10% | 16% | 20% |
| Échecs | 4% | 15% | 4% | 7% |

1. La proportion de femmes parmi les participantes aux cours PBF, de 25%, reste faible. C'est une préoccupation que nous ne comprenons pas entièrement et qui nécessite de l'attention.

2. Le niveau de difficulté de l'examen final a augmenté au cours des dernières années. Le score moyen des cours, de 2007 à 2015, était de 78 % et a été ramené à 72 % en 2017. Il y avait aussi une proportion plus élevée de participants ayant échoué à l'examen, passant de 3% durant les cours 2007-2014 à 12% en 2017. La proportion de distinctions a diminué de 23% lors des cours 2007-2014 à 12% en 2017.

## 2.2 Nouveaux développements dans le contenu des cours en 2017

L'équipe de facilitation du cours met continuellement à jour le contenu du cours avec les derniers développements de l'approche de réforme du FBP. Ceci est facilité par le fait que les animateurs travaillent également sur le terrain, afin que leurs expériences se reflètent dans le contenu du cours. Cette expérience pratique semble être appréciée par les participants et leurs organisations, et la demande pour les cours PBF reste forte, comme en 2018.

**Les développements PBF suivants ont été intégrés en 2017 dans le contenu du cours :**

- Des pays PBF comme le Cameroun et la RCA ont développé et testé *de meilleures stratégies d'équité* pour cibler les districts vulnérables, les établissements de santé, les groupes minoritaires et les individus, ainsi que pour réagir en cas de crise humanitaire. Cette évolution rend l'approche PBF plus attrayante et en fait la stratégie privilégiée pour atteindre la couverture santé universelle dans les pays à revenu faible et intermédiaire. Il incorpore des idées visant à assurer, avant tout, la qualité et l'efficience des systèmes de santé, tout en ciblant des soins de santé gratuits pour des activités spécifiques présentant des externalités positives et pour des groupes vulnérables. Les objectifs d'équité ne peuvent être atteints que lorsque les ressources financières publiques sont suffisantes et stables. Cette approche, orientée vers la qualité et l'efficience, est meilleure que les soins de santé gratuits généralisés encore promus par certains, dont la qualité souffre, où le personnel de santé est démotivé et où se posent des problèmes de transparence et d'activités informelles incontrôlées.
- L'approche de l'équité PBF est également plus efficace pour atteindre les objectifs des *stratégies classiques axées sur la demande*, telles que les chèques santé (vouchers), en ciblant des groupes de patients similaires et en offrant des subventions élevées aux structures de santé. Dans le scénario PBF, les structures de santé doivent élaborer des stratégies pour identifier les bénéficiaires au sein de leurs aires de santé.
- L'assurance maladie communautaire volontaire ou mutuelle a perdu de son attrait, mais des projets pilotes sont en cours au Cameroun et au Gabon pour déterminer dans quelle mesure l'assurance maladie obligatoire peut être intégrée au système plus efficace du FBP.
- Plusieurs pays du PBF ont développé en 2017 des stratégies pour promouvoir des systèmes PBF plus durables. Ceci est fait par :
    1. Transformer les lignes budgétaires existantes, inputs du ministère de la Santé, en lignes budgétaires de performance PBF ;
    2. Promouvoir le FBP en tant qu'instrument national de réforme de la santé, pleinement intégré aux politiques du ministère de la Santé et du gouvernement. Cela nécessite d'abandonner « l'approche projet » PBF, dans le cadre de laquelle des organisations partenaires telles que la Banque mondiale ont mis en place des unités de mise en œuvre de projet indépendantes. Le

problème de cette approche « projet » est que les ministères de la Santé et les gouvernements ne le « possèdent » pas.

3. Signer des contrats de performance non seulement avec les établissements de santé et les autorités de régulation périphériques, mais aussi avec les directions centrales du Ministère. Les autorités de régulation centrales devraient également recevoir des paiements variables fondés sur l'atteinte d'indicateurs de résultats et de qualité, plutôt que de recevoir uniquement des salaires fixes et des fonds alloués à des lignes budgétaires fixes pour des intrants, tels que les per diem ou les coûts opérationnels.

- Des *améliorations de l'approche communautaire du PBF* ont été mises en œuvre en 2017, en allouant systématiquement 15 à 20 % du budget total du PBF au marketing social et au renforcement de la voix communautaire. Un indicateur PBF communautaire devenu attrayant est la « visite à domicile suivant un protocole ». L'idée est que le personnel des structures primaires visite chaque ménage deux fois par an dans son aire de santé. Au cours de ces visites, une vingtaine de points sont vérifiés, tels que la vaccination, la nutrition, la planification familiale, l'utilisation des moustiquaires, la disponibilité des latrines, l'élimination des déchets, la mortalité maternelle et infantile, la tuberculose, la malnutrition, la présence de personnes vivant avec le VIH, etc. De plus, le PBF communautaire identifie activement les patients et les groupes vulnérables.
- Appliquer les meilleures pratiques de PBF non seulement dans le secteur de la santé, mais aussi dans le cadre de réformes plus larges de la fonction publique. Lors des discussions avec les gouvernements du Gabon et du Cameroun, la Banque mondiale et le FMI ont utilisé certaines des meilleures pratiques du PBF comme conditionnalité à l'appui budgétaire. L'idée sous-jacente est que l'aide budgétaire devrait aller de pair avec une utilisation efficace de ces ressources.

## 2.3 Changements dans la méthodologie des cours

Au cours des 10 dernières années de cours PBF, l'objectif a toujours été de couvrir tous les modules en 12 ou 13 jours. Cela est devenu difficile en raison des nombreux nouveaux développements et instruments apparus. En conséquence, le livre de cours est passé d'un manuel de 80 pages à un manuel de 260 pages comprenant 17 modules.

**Nous avons donc apporté les modifications suivantes à la méthodologie du cours.**

- Réduire les messages de cours aux idées essentielles de chaque module et les rendre faciles à comprendre. Ce processus est en cours parce que les leçons apprises, les nouveaux développements et les opportunités dans le PBF évoluent si rapidement qu'ils nécessitent une mise à jour continue du matériel de cours.
- Réduire le temps consacré aux séances plénières et laisser davantage de temps à l'équipe de facilitation pour aider les différents groupes et individus à élaborer leurs plans d'action spécifiques.
- *Passez en revue les points de vue et les attentes des participants* concernant le cours PBF en leur demandant, à leur arrivée, de répondre à un questionnaire. Certains sont novices en PBF et doivent d'abord comprendre et accepter les changements qu'il implique. D'autres ont déjà des connaissances en PBF ou ont été récemment recrutés pour un poste en PBF. Ils n'ont pas besoin d'être convaincus des sujets de changement, mais souhaitent plutôt acquérir des connaissances et des compétences spécifiques au FBP.
- Effectuer un prétest des *connaissances en PBF pour chaque participant*. Les résultats influencent-ils dans quelle mesure le cours devrait se concentrer sur les

bases du FBP ou accélérer rapidement vers le « comment » du FBP et se concentrer davantage sur les instruments tels que les indicateurs de résultats, l'outil de gestion des indices, le « costing » et la manière de mobiliser les différentes parties prenantes ?

- *Organiser des cours nationaux PBF* (environ 50% de tous les cours). Habituellement, ces cours réunissent des groupes de participants spécifiquement sélectionnés, par exemple des responsables de la régulation du Ministère central, des directeurs d'hôpitaux, des régulateurs régionaux ou de district et/ou du personnel des ACV. Dans de tels cours, nous nous concentrons généralement sur l'élaboration de plans d'action SMART pour chaque participant ou pour chaque groupe.
- Mieux coordonner les débats en adoptant l'approche « village », où les participants font également partie de l'équipe de facilitation et influencent le contenu et la méthodologie. Pendant le cours PBF en République centrafricaine, les participants ont facilité le débat au lieu de l'équipe de facilitation.

## 2.4 Observations sur le cours PBF de Mombasa et son évaluation

**Le cours PBF a accueilli des participants de cinq pays.**

- L'équipe du *Nigéria* comprenait huit participants du niveau fédéral (FMoH et NPHCDA) et 13 personnes des sept États de Katsina, Kebbi, Taraba, Kano, Nasarawa et Adamawa, y compris le Commissaire de la santé de Nasarawa.
- L'équipe du *Zimbabwe* était composée de cinq personnes du ministère de la Santé, de trois directeurs du niveau central et de deux directeurs médicaux provinciaux.
- L'équipe du *Libéria* était composée de cinq personnes du Ministère central de la Santé.
- Le *Lesotho* a envoyé une délégation du ministère de la Santé nationale pour évaluer la qualité du programme FBR dans le pays.
- Cordaid a envoyé un expert en santé publique spécialisé en tuberculose pour son programme *au Soudan du Sud*.

**L'équipe de facilitation était composée de :**

1. Dr Godelieve van Heteren, travaillant comme expert principal du système de santé pour la Health Systems Governance Collaborative, organisée par l'OMS
2. Dr. Fanen Verinumbe, coordinateur de la formation de l'État d'Adamawa au Nigeria
3. Dr Claire Rwiyereka, consultante indépendante du Rwanda
4. M. Christian Habineza, directeur de HDP, Rwanda
5. Dr Robert Soeters, directeur de SINA Health et coordinateur général du cours.

Le chef du village 64, Dr Daniel IYA, avec son adjoint, le Dr Cuallau JABBEH-HOWE, le gardien de temps, Simon NYADUNDU, et la collectrice des impôts, Mme Lineo MOHLOMI, ont activement soutenu le processus de facilitation et ont contribué à créer une atmosphère agréable dans le village.

Les évaluations quotidiennes ont obtenu des scores supérieurs à la moyenne par rapport aux cours précédents. Les scores de méthodologie et de facilitation étaient de 93,9%, soit 7% de plus que la moyenne des 20 cours d'anglais précédents. Le score de participation était de 87,2 %, ce qui est comparable à celui des cours précédents. L'organisation du cours à Mombasa était de 90,7%, soit 5% de plus que la moyenne des cours précédents. Pourtant, les participants étaient cette fois moins satisfaits du

Sai Rock Hôtel, en particulier en raison de problèmes d'approvisionnement en eau et en nourriture, jugés trop monotones. Le sujet du respect du temps a obtenu 67,9%, soit 5% de moins que la moyenne des cours précédents.

L'évaluation finale a montré que le programme répondait aux attentes des participants, mais que des améliorations pourraient être apportées en les informant à l'avance du contenu du cours. La méthodologie du cours a été jugée bonne avec un score moyen de 91%.

## 2.5 Recommandations spécifiques par pays

### 2.5.1 Nigéria

Le système de santé du Nigéria souffre d'un sous-financement, d'une inefficacité due au financement des inputs, les agents de santé sont peu motivés et les grèves sont fréquentes. Les indicateurs de santé sont inférieurs à ceux des autres pays comparables. La qualité des services de santé est inégale et n'inspire pas confiance aux clients, de sorte que certaines personnes consultent des médecins peu orthodoxes, se rendent directement dans les établissements de soins tertiaires (contournant les établissements de santé primaires et secondaires), ou même sortent du pays.

Des programmes PBF ont été lancés jusqu'à présent dans huit États et d'autres semblent prêts à suivre. Les résultats de la récente étude d'impact du projet PBF, financé par la Banque mondiale, menée dans les trois États d'Adamawa, d'Ondo et de Nasarawa depuis 2012, montrent des résultats encourageants pour les districts PBF par rapport aux districts témoins. Une expérience de recherche (DFF) visant à verser de l'argent, mais sans les mécanismes de vérification du PBF, a également montré quelques améliorations de la qualité. Cependant, les participants présents à Mombasa, dans les États qui ont mené cette expérience, ont soutenu que cette expérience de recherche DFF était fortement influencée par l'approche PBF, au point qu'il y avait une contamination sérieuse.

**Analyse des problèmes du système de santé du Nigéria**

- Le FBP au Nigéria est resté trop longtemps un « projet » dirigé par la Banque mondiale, plutôt qu'une « stratégie nationale de réforme de la santé » visant à utiliser plus efficacement les ressources gouvernementales rares, à l'instar de la politique de santé au Burundi et au Cameroun.
- Le système de santé nigérian est encore principalement basé sur les intrants, dispose de plusieurs éléments de soins de santé gratuits.
- Le secteur privé de la santé au Nigeria joue déjà un rôle important pour la population, mais il est mal intégré au système de santé nigérian et reste très peu réglementé.
- Le niveau fédéral est encore indécis quant aux mérites de PBF et à son potentiel pour la couverture santé universelle. En dépit des preuves limitées de son efficacité, le gouvernement propose l'assurance maladie obligatoire comme stratégie en vue de la CSU.
- Les États n'exercent pas leur pouvoir pour orienter leurs systèmes de santé vers le PBF.
- Le projet Save One Million Lives (SOML), financé par la Banque mondiale, utilise comme critère principal de paiement les indicateurs de production liés au décaissement pour chaque État. Une fois déboursés (la première tranche s'élevait à 1,5 million de dollars américains par État), ces fonds sont utilisés par les États

pour le financement traditionnel des intrants, ce qui favorise l'inefficience et même la corruption. De plus, l'approche SOML ne favorise ni l'autonomie des prestataires, ni la séparation des fonctions, ni les partenariats public-privé.

**Recommandations :**

- Les États (States) sont encouragés à lancer des programmes PBF en s'appuyant sur diverses sources de financement. Cela a été proposé à Mombasa par le Commissaire à la santé de l'État de Nasarawa, qui s'est engagé à lancer un programme PBF à l'échelle de l'État.
- Transformer le financement de la SOML en une approche PBF pure, tout en ciblant la réalisation des mêmes indicateurs liés au décaissement (DLI) au niveau de l'État.
- La Banque mondiale peut accorder un financement de 50 % à 50 % aux États désireux de lancer une approche PBF pure, avec des recettes générées à l'interne, des fonds SOML, des ressources propres de l'État ou des ressources d'autres partenaires. Cela résoudrait également le problème de l'espace budgétaire pour les programmes PBF financés par la Banque mondiale (de préférence au moins 4 dollars EU par habitant et par an) et assurerait en même temps l'adhésion des États et des autorités fédérales.
- Revoir la mise en place institutionnelle du programme PBF fédéral et identifier les rôles et les profils du personnel pour la NPHCDA et le FMOH.
- Assurer la liaison avec les 193 participants aux précédents cours PBF de Mombasa depuis 2010 afin de former une masse critique de personnes pour faire pression en faveur de montages FBP plus purs dans davantage d'États.

### 2.5.2 Lesotho

Le programme PBF au Lesotho a débuté par un projet pilote dans deux districts, puis a été étendu en 2016 à six districts sur dix. Des études ont montré des améliorations de la production et de la qualité des services, et le gouvernement a décidé, à l'échelle nationale, de mettre en place le programme PBF en 2018.

**Il y a toujours les problèmes suivants :**

- Le système de santé au Lesotho n’est pas rentable. C'est l'un des rares pays à faible revenu à atteindre presque l'objectif recommandé de 15 % des dépenses budgétaires du gouvernement consacrées à la santé. Pourtant, malgré ce financement important, les indicateurs de santé ne s'améliorent pas et certains sont même en baisse.
- La politique de soins de santé gratuits au Lesotho conduit à des services de mauvaise qualité et les patients sont contraints d'acheter des médicaments auprès de pharmacies mal réglementées en dehors des établissements de santé ;
- Le soutien des donateurs est fragmenté et le MS ne coordonne pas adéquatement les différentes interventions des partenaires ;
- La gestion des ressources humaines dans les établissements de santé gouvernementaux est fragmentée en raison du recours à du personnel fourni par des ONG ou d'autres partenaires externes.
- La conception du programme PBF du Lesotho présente encore des problèmes, avec un score de 72 %.

**Recommandations :**

- Revoir le montage du programme FBP et améliorer son score de faisabilité.
- Recommander la révision de la politique relative à l'abolition du recouvrement des coûts.
- Plaider pour la concurrence entre les fournisseurs pharmaceutiques publics et privés.
- Plaider pour une plus grande autonomie des établissements de santé, par exemple pour l'affectation des revenus issus du recouvrement des coûts et pour l'achat d'intrants auprès de distributeurs accrédités.
- Réviser et porter le nombre d'indicateurs à au moins 25. Séparer les indicateurs de qualité et de quantité et assurer l'inclusion d'indicateurs communautaires.
- Résoudre les problèmes de leadership au niveau central du ministère de la Santé en améliorant la description des profils, des résultats attendus (outputs) et des exigences de qualité pour chaque acteur. Les contrats PBF peuvent consolider ces relations, et les acteurs peuvent être stimulés par des paiements à la performance.
- Les autorités sanitaires du district devraient être dotées de contrats de performance afin de mettre en œuvre les réformes de type PBF.

### 2.5.3 Soudan du Sud

Depuis son indépendance en 2011, la situation politique au Soudan du Sud a continué d'être dominée par des menaces internes et externes à la paix et à la stabilité durables. En décembre 2013, le pays est entré dans des combats prolongés, ce qui a accru l'incertitude. En août 2015, les parties au conflit ont signé un accord de paix, mais sa mise en œuvre demeure un défi majeur.

**Analyse des problèmes du système de santé**

- Le système de santé du Soudan du Sud est trop axé sur les partenaires techniques et financiers et ne tient pas suffisamment compte du dynamisme du secteur privé de la santé dans les zones urbaines et rurales.
- Le système de santé souffre d'un leadership et d'une gouvernance médiocre, d'une gestion des ressources humaines inefficace, d'une infrastructure médiocre, de la duplication des services et d'une très forte proportion de la population vulnérable.
- La plupart des intrants sont distribués de manière centralisée par des fournisseurs monopolistes.
- La performance des autorités de régulation est médiocre, avec un développement insuffisant de la politique de santé et des mécanismes d'assurance qualité.

**Recommandations :**

- Le participant du Soudan du Sud propose de se joindre aux anciens diplômés du cours PBF de Cordaid de mai 2017 et de former une masse critique pour défendre, auprès du gouvernement et des donateurs, la nécessité de programmes basé sur la performance. Un partenaire important peut être la Banque mondiale, qui peut également plaider en faveur de réformes de type PBF.
- Élaborer et mettre en œuvre un projet pilote de PBF bien conçu dans les zones où l'ONGI Cordaid est le partenaire principal. Le programme PBF devrait contenir tous les paquets de niveau primaire et hospitalier et disposer d'un financement adéquat.

### 2.5.4 Zimbabwe

Les résultats d'une évaluation d'impact en 2014 ont été encourageants, et le Ministère a adopté le PBF à l'échelle nationale, financé par la Banque mondiale et le Health Transition Fund (maintenant Fonds de Développement de la Santé = Health Development Fund). Des améliorations significatives de la mortalité maternelle et infantile, des indicateurs de couverture des soins prénataux et de l'accès à la PF ont été atteintes au cours des dernières années, auxquelles le PBF est susceptible d'avoir contribué.

Cependant, il subsiste des problèmes de montage du système PBF, et les participants ont évalué la pureté de l'intervention PBF à 66 % dans les districts financés par la Banque mondiale et soutenus par Cordaid, et à 32 % dans les districts financés par le Fonds de Développement de la Santé et appuyés par Crown Agents.

**Recommandations :**

- Plaider pour une forme plus pure de PBF auprès des participants aux cours PBF précédents.
- Plaider pour que le ministère de la Santé modifie les lignes budgétaires de genre « input » provenant des sources gouvernementales, des taxes et des contributions des gouvernements, en faveur du financement PBF.
- Offrir des chances égales d'obtenir des contrats PBF à tous les établissements de santé, publics, religieux ou privés, urbains ou ruraux.
- Permettre un environnement plus concurrentiel dans la fourniture de produits de santé en supprimant les restrictions favorisant les monopoles.
- Autoriser la Direction des services pharmaceutiques à travailler à l'accréditation des distributeurs pharmaceutiques de gros publics et privés, y compris les exigences d'enregistrement et tous les travaux nécessaires pour permettre l'entrée dans le PBF.

### 2.5.5 Libéria

Beaucoup de choses ont changé au Libéria à la suite de la crise de la maladie à virus Ébola, avec une réduction de la croissance économique et une détérioration des indicateurs de santé. Le Libéria a commencé avec deux programmes PBF : l'un au niveau primaire, financé par l'USAID, et l'autre au niveau hospitalier, financé par la Banque mondiale. L'équipe du Libéria présente à Mombasa pense que le PBF peut faire une grande différence,

**Analyse du problème**

- Le montage des programmes PBF actuels présente des problèmes et le score de l'analyse de faisabilité n'est que de 6 sur 50, soit 12 %, alors que 80 % est le minimum recommandé.
- Le Libéria met en œuvre une politique de soins de santé gratuits pour tous, mais, au cours de sa mise en œuvre, il est devenu évident que ce dont les gens ont besoin, ce ne sont pas seulement des « services », mais plutôt des « services de qualité ».
- Dans les établissements de santé publics, la qualité des soins est médiocre et les ruptures de stock de médicaments et d'équipements médicaux sont fréquentes, ce qui a poussé les consommateurs à se tourner vers les établissements de santé privés.

- Le secteur de la santé est fortement dépendant des bailleurs de fonds, avec des interventions verticales et difficiles à coordonner.

**Recommandations :**

- Examiner le montage institutionnel et de mise en œuvre du FBP ainsi que l'ensemble des indicateurs à subventionner.
- Envisager d'introduire le recouvrement des coûts et de compenser les personnes vulnérables par des primes d'équité ciblées.
- Séparer les fonctions grâce à la « division acheteur-fournisseur ».
- Introduire des contrats PBF non seulement avec les établissements de santé mais aussi avec les autres acteurs du système de santé.

Ces recommandations sont similaires à celles proposées par d'autres groupes libéraux. Cependant, en augmentant le nombre critique de participants formés au PBF au Libéria, il devrait devenir possible de mettre en œuvre ces recommandations.

# 3. INTRODUCTION

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

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

There is little controversy left around the main theories and concepts of PBF reforms. PBF aims to capture the efficiency of a regulated market economy to distribute scarce resources and ensure more sustainable systems. Its effects on transparency, good governance, and ownership are comparable to the top-down and hierarchical style of existing (health) systems.

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

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

## 3.2 Aims and objectives of the Mombasa PBF course

### General aims of the PBF course

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

**Specific Objectives**

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

## 3.3 The November 2017 Mombasa course

The 64th group included a mix of people with varied PBF implementation experience across Africa (Lesotho, Nigeria, various states and federal, South Sudan, Liberia, and Zimbabwe). Throughout the course, the participants were assigned to develop a "business or action plan", following a number of steps: (a) Elaboration of the country background of the particular PBF initiative; (b) Analysis of specific PBF implementation challenges through the application of the PBF feasibility scan of module 9; (c) Development of an action plan for the participants and country groups on how to tackle the various problems identified, following the logic of the PBF modules.

The updated course guidebook, "PBF in Action: Theory and Instruments," was distributed to participants before the program started, upon confirmation of participation. The course materials (a hard copy of the course book, a PDF of the latest version of the course manual, PowerPoint presentations and country presentations, course photos, and articles) were distributed during the course, along with the participants' contact-details list. On Friday, November 25, 2017, the team organized field excursions to five health facilities: Mtwapa Health Center, Kadzinuni Dispensary, Vipingo Health Center, Tagaungu HC, and Kilifi County Hospital.

## 3.4 The final exam, adult learning and accreditation

SINA Health issues a Certificate of Merit to those who pass the exam at the end of the course. Those who do not score 53% or more obtain a Certificate of Participation. The exam was conducted on Friday, December 1st, from 8.30 am and consisted of 30 multiple-choice questions tailored to the main subjects covered during the course.

The exam's average score, 79%, was higher than in other courses. This positive result has become rare in recent years, with an average failure rate of around 10%. Participants obtain distinctions when the score is 90% or more, and we also mention those with 87%.

We congratulate the following participants, who received certificates with honors.

*With 97% - 1 mistake*
Dr Daniel IYA, Commissioner of Health from Nasarawa State
Dr Simon NYADUNDU, Provincial Medical Director, Zimbabwe

*With 90% - 3 mistakes*
Mss Heather MACHAMIRE, Director, Finance and Administration, MOH Zimbabwe
Mr. Anthony ADOGHE, Federal Ministry of Health, Abuja, Nigeria
Dr. Amos UJULU, Director, Planning, Research and Statistics, Adamawa SPHCDA

## 3.5 Who attended the May – June 2017 PBF course?

Twenty-one from Nigeria; 5 from Zimbabwe; 5 from Liberia; 2 from Lesotho; and 1 from South Sudan.

**The list of participants to the 64th PBF course of November 2017**

| No | Surname | Name | Sex | Organisation | Function | Profession | Country | Region / State |
|---|---|---|---|---|---|---|---|---|
| 1 | MOHLOMI | Lineo | f | Ministry of Health | Senior Health Inspector | Nurse | Lesotho | Maseru |
| 2 | SEFAKO | Celinah | f | Ministry of Health | Public Health Specialist | Dentist | Lesotho | Maseru |
| 3 | NEUFVILLE | Harry | m | World Bank | Deputy Project Manager Worldbank Health Portfolio | Project Manager | Liberia | Monrovia |
| 4 | QUAYE | Georgia | f | Ministry of Health | Program Officer Worldbank Health Portfolio | Programme officer | Liberia | Montserrado |
| 5 | BELLEH | Ishmael | m | Ministry of Health | Management Tool Officer PBF Unit | Health Information | Liberia | Montserrado |
| 6 | KESSELLY | Roland | m | Ministry of Health | Director Health Financing Unit | Public Health | Liberia | Montserrado |
| 7 | JABBEH-HOWE | Cuallau | f | Ministry of Health | Director County Health Services Unit | Administrator | Liberia | Montserrado |
| 8 | MUSTAPHA | Amina | f | National Primary Health Care Development Agency | Consultant | | Nigeria | Abuja |
| 9 | IYA | Daniel | m | State Ministry of Health | Hon Commissioner of Health | Medical Doctor | Nigeria | Nasarrawa |
| 10 | YAHAYA | Rukaiyya | f | Federal Ministry of Health | Scientific Officer | Scientist | Nigeria | Abuja |
| 11 | ONWUDINJO | Ifeyinwa | f | National Primary Health Care Development Agency | Training Coordinator | Community officer | Nigeria | Abuja |
| 12 | ANGYU | Solomon | m | State Ministry of Health | Director Planning Research and Statistics | Pharmacist | Nigeria | Taraba |
| 13 | MAHMUD | Mustafa | m | National Primary Health Care Development Agency | Zonal Director North East | | Nigeria | North East |
| 14 | TIMOTHY | David | m | Adamawa State Primary Health Care Development Agency | Social Protection / DSF Focal Person | Public Health | Nigeria | Adamawa |
| 15 | HASSAN | Adamu | m | Adamawa State Primary Health Care Development Agency | Data Manager PBF Unit | Health Economist | Nigeria | Adamawa |
| 16 | KWABE | Nkunihya | m | Adamawa State Primary Health Care Development Agency | Planning Officer PBF Unit | Accountant | Nigeria | Adamawa |
| 17 | UJULU | Amos | m | Adamawa State Primary Health Care Development Agency | Director Disease Control and Immunization | Medical Doctor | Nigeria | Adamawa |
| 18 | MUHAMMAD | Sani | m | State Ministry of Health | Director Planning Research and Statistics | Medical Doctor | Nigeria | Kebbi |
| 19 | HASSAN | Manir | m | Kebbi State Primary Health Care Development Agency | Executive Secretary Kebbi SPHCDA SOML | Pharmacist | Nigeria | Kebbi |
| 20 | GWANDU | Jibril | m | State Ministry of Health | State program Manager SOML | Medical Doctor | Nigeria | Kebbi |
| 21 | WADA | Imam | m | State Ministry of Health | State program Manager SOML Kano SMoH | Medical Doctor | Nigeria | Kano |
| 22 | ADAMU | Bashir | m | Katsina State Primary Health Care Developemnt Agency | State program Manager SOML Kano SMoH | Medical Doctor | Nigeria | Katsina |
| 23 | YAHAYA | Shamsuddeen | f | Katsina State Primary Health Care Developemnt Agency | Director Primary Health Care Katsina SPHCDA | Medical Doctor | Nigeria | Katsina |
| 24 | SOLANKE | Ojuolape | m | Federal Ministry of Health | Senior Program Officer SOML | Medical Doctor | Nigeria | Abuja |
| 25 | ABATTA | Emmanuel | m | Federal Ministry of Health | Head NHMIS | Medical Doctor | Nigeria | Abuja |
| 26 | ADOGHE | Anthony | m | Federal Ministry of Health | Head of M&E coordinating Unit | Medical Doctor | Nigeria | Abuja |
| 27 | ODIDI | Lawrence | m | Federal Ministry of Health | Senior Program Officer SOML- PforR | Community officer | Nigeria | Abuja |
| 28 | BAHIMA | Alex | m | Cordaid | TB expert | Public Health | South Sudan | County |
| 29 | HOVE | Ropafadzai | f | Ministry of Health | Director Pharmaceutical Services | Medical Doctor | Zimbabwe | Harare |
| 30 | MACHAMIRE | Heather | f | Ministry of Health | Director Finance and Administration | Medical Doctor | Zimbabwe | Harare |
| 31 | MUDYARA | Jane | m | Ministry of Health | Director Human Resources | Administrator | Zimbabwe | Harare |
| 32 | NYADUNDU | Simon | m | Ministry of Health | Provincial Medical Director | Medical Doctor | Zimbabwe | |
| 33 | CHIKODZORE | Rudo | f | Ministry of Health | Provincial Medical Director | Medical Doctor | Zimbabwe | Matabelelano South |
| 34 | OWOLABI | Olaide Anne | m | Federal Ministry of Health | Asst. Dir. Policy and Plans | Administrator | Nigeria | Abuja |

## 3.6 Facilitation team

The facilitation team consisted of:

- Dr. Godelieve van Heteren, MD, a Public Health Specialist with a long medical career, a Member of the Dutch Parliament, Director of Cordaid, and currently a senior health systems and governance consultant for WHO.
- Dr Fanen Verinumbe, a medical doctor and training coordinator at the Adamawa PBF unit in Nigeria.
- Mr. Christian Habineza – Coordinator, HDP Rwanda, and PBF expert.
- Dr Claire Rwiyereka, Dentist and training coordinator at HDP Rwanda, expert in adult learning.
- Dr. Robert Soeters, MD, PhD, chief course facilitator

# 4. DAILY EVALUATIONS BY PARTICIPANTS

## 4.1 Daily evaluations by participants

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

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

The overall average score for the four criteria combined was 85%. This is satisfactory, 1% above the previous 20 English-spoken courses and 6% above the previous 37 French-spoken courses.

| Daily evaluation topics as scored for 10 days | French speaking courses (37x) | English speaking courses (20x) | Mombasa November 2017 | Comparison Mombasa November 2017 / Previous English courses |
|---|---|---|---|---|
| Methodology and facilitation | 84.6% | 87.0% | 93.9% | 7% |
| Participation | 82.4% | 87.6% | 87.2% | 0% |
| Organization | 73.5% | 85.9% | 90.7% | 5% |
| Time – keeping | 75.1% | 73.4% | 67.9% | -5% |
| **Overall score** | **79%** | **83%** | **85%** | **1%** |

Table 1: Overall daily evaluation scores of the course.

## 4.2 Methods and facilitation

**Methods and facilitation** scored 7 percentage points higher at 93.9% than the previous English courses (87.0%) and 5 percentage points above the average of the French-spoken courses (84.6%). This score is satisfactory.

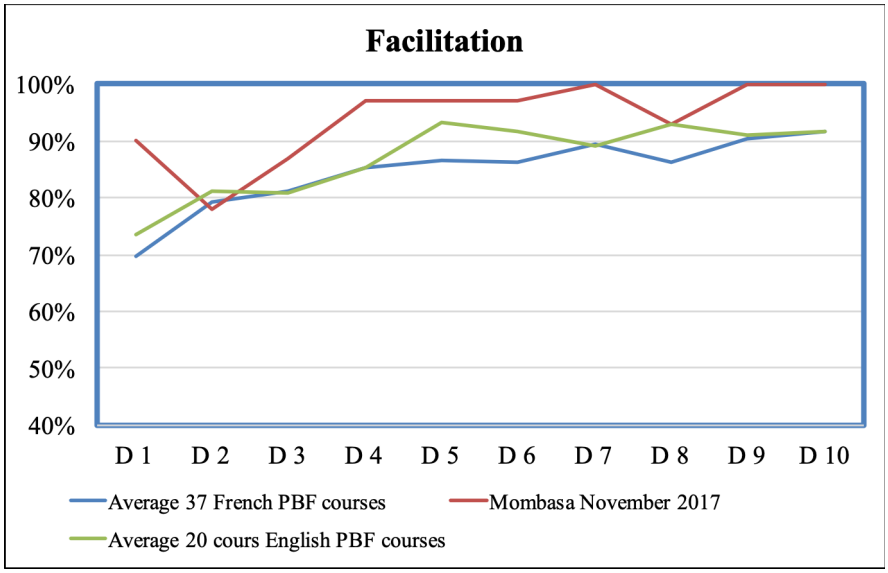



Figure 1: Evolution of the daily evaluations: *methods and facilitation.*

## 4.3 Participation

The satisfaction with the level of **participation** was 87.2%. This is like the previous English courses (87.6%) and 5 percent higher than the French courses (82.4%). This score is satisfactory.

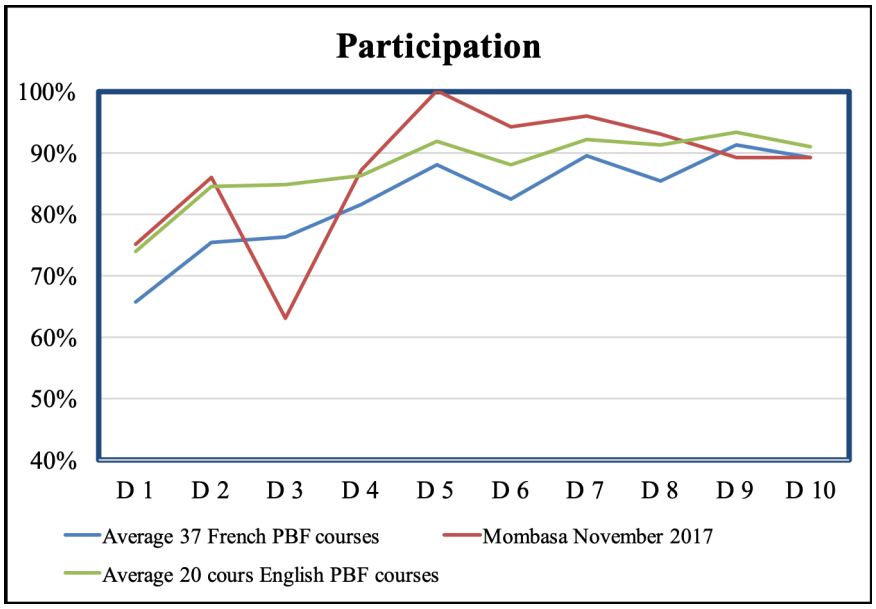



Figure 2: Evolution of the daily evaluation: *participation.*

## 4.4 Organization

The **course organization** in Mombasa had an average score of 'very positive or positive' of 90.7%, which is 5% *above* the average of 85.9% for the previous English courses and 17% *above* the average of 73.5% for the previous French courses.

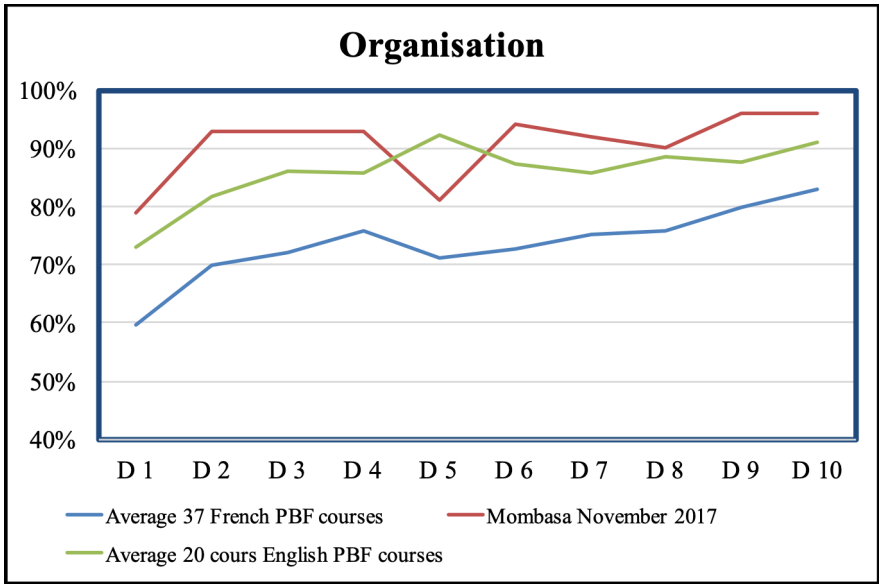



Figure 3: Evolution of the daily evaluation: *organization.*

## 4.5 Timekeeping

Satisfaction with timekeeping was 67.9%, which is 5% *below* the previous English courses and 7% below the French courses.

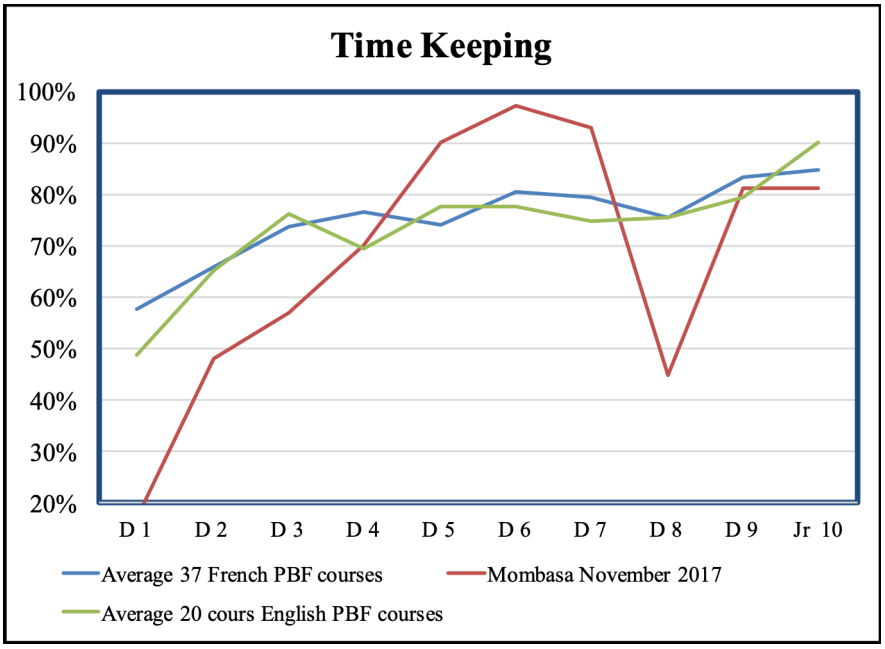



Figure 4: Evolution of the daily evaluation: *timekeeping.*

# 5. DESCRIPTION of the COURSE

***Arrival day: Sunday, November 19th, 2017***

The 64th International PBF course in Mombasa, Kenya, welcomed 34 participants from 5 African countries: Nigeria, Zimbabwe, Lesotho, Liberia, and South Sudan. All participants came from the health sector, most from various ministries of health. Lesotho, Zimbabwe, Liberia, and a few Nigerian states had PBF at different implementation levels and wanted to gain more knowledge and possibly improve their PBF program design. Others were contemplating starting a new PBF program and how it could work in unstable/conflict areas, while the remainder were here to learn about PBF for the first time.

Most participants arrived on Sunday 19th November ready for the course, with high expectations, many questions, and a lot of experience to share. Overall, the activities went very well. Many participants were well prepared and directed in advance. On arrival, facilitators guided participants on short visits to the local mall, which helped them settle in quickly.

During the course, facilitators led interactive daily recaps, reinforced key messages from previous days' modules, and clarified areas needing further explanation. This method proved more effective and supported time management.
Facilitators held evening sessions with country groups to gather overall feedback and discuss specific country challenges and participants' needs. These sessions also helped facilitators understand participants' expectations and how the course could respond to their needs. The interactions were rich and enlightening. Throughout the two weeks, participants received individual and group guidance on their respective action plans. Participants highly appreciated these sessions

| **Evening country meetings** | | |
|---|---|---|
| Tuesday November 21, 2017 | 17:00 – 18:30hr | Lesotho |
| Tuesday November 21, 2017 | 18.30 – 19:30hr | Nigeria – Federal MoH |
| Wednesday November 22, 2017 | 17:00 – 18:30hr | Nigeria – Kano, Katsina & Kebbi |
| Wednesday November 22, 2017 | 18.30 – 19:30hr | Nigeria - NPHCDA |
| Thursday November 23, 2017 | 17:00 – 18:30hr | Liberia |
| Thursday November 23, 2017 | 18.30 – 19:30hr | Zimbabwe |
| Friday November 24, 2017 | Lunch time | South Sudan |
| Friday November 24, 2017 | 17:00 – 18:30hr | Nigeria – Adamawa, Nasarawa & Taraba |
| Monday November 27, 2017 | 17:00 – 18:30hr | Liberia |
| Tuesday November 28, 2017 | 17:00 – 19:00hr | Lesotho |
| Tuesday November 28, 2017 | 19.00 – 20:00hr | Zimbabwe |

***Monday November 20th***

At 9:00 am, Godelieve welcomed all participants to the course and explained the course outline and methodology. She also welcomed participants into their country groups. To help participants get acquainted, the creative marketplace was introduced, where participants wrote their expectations and posted them on the wall next to others with similar ones. Here, most participants indicated they were in the course to gain more knowledge on various aspects of PBF (principles, implementation, theories, etc.). Most participants also said they wanted to learn how to sustain the efficiency gains from PBF.

This was followed by the first group activity, where participants in their country groups worked on the crucial conversation: health care today, the challenges and why. The presentation, PBF in context, then followed, covering PBF history, definition, lessons learned, and academic evidence.
The day ended at 17:30 with the election of the village chief and other authorities, presentation of the Mombasa village rules, and then the daily evaluations.

***Tuesday November 21st***

Day 2 started at 8:30 with the daily recap and summary of important points by Robert Soeters. This was followed by the module on PBF best practices and change topics. As always, we allocated sufficient time to discuss this and allow participants to express their concerns. Turning Point Questions (TPQs) stimulated interesting, highly relevant discussions and active participation.
The main areas of debate were autonomy and separation of functions, where participants expressed concerns, especially as they related to their roles as regulators; competition, particularly regarding essential-drug monopolies; and free health care, with reference to financial accessibility for the vulnerable.
These discussions and debates were useful, as participants needed a clear understanding of best practices to build PBF.
Next, the module on equity was presented. Participants understood the differences between equality and equity and were shown smart ways PBF applies various equity instruments to ensure financial accessibility for the vulnerable more efficiently.
The day ended at 16:30 with the daily evaluations and selection of the best debater of the day.
In the evening, facilitators met with participants from Lesotho to discuss their specific issues and concerns. The Nigeria Federal Ministry of Health group followed.

***Wednesday November 22nd***

The day started at 8:30, as usual, with a recap and summary of key points from day 2 activities, facilitated by Robert. The presentation on PBF theories took up most of the day. Participants were split into four working groups to study the theories underpinning PBF (systems analysis, public choice, contracting, decentralization and governance). The groups discussed their findings in plenary, with input from the working groups.

The module on microeconomics (module 5A) then followed. Participants were taken through basic economic principles as a foundation to understanding how markets operate – and subsequently the health market.
The session closed at 16:30, and in the evening facilitators met with the Nigeria SOML States (Kano, Katsina and Kebbi), followed by the Nigeria NPHCDA group.

***Thursday November 23rd***

The daily recap and summary of important points were presented by Fanen and Robert. The team completed Module 5A on microeconomics and presented Module 5B on health economics. In these sessions, participants discussed basic economic principles, how the health market differs, and the different failures affecting the health care market. The team also understood how economic instruments (taxes and subsidies) could be used to intelligently correct market failures in health.

In the afternoon, participants were introduced to the various actors/stakeholders in the PBF system. Participants were then asked to use the PBF institutional arrangements model to map their health systems and identify existing structures that could assume these functions.

Module 6, on National Policies, regulation and quality assurance, facilitated by Christian, took the rest of the afternoon, during which participants discussed the regulator's roles and responsibilities in PBF.
The day ended at 16:30 with the daily evaluations and election of the best debater of the day.
In the evening, facilitators met with the groups from Liberia and Zimbabwe.

***Friday November 24th***

The morning started at 8:20 with a brief introduction to the terms of reference for field visits by Godelieve and Robert. The groups then set out into the field to visit five Kilifi County facilities for a tour and guided interviews with the facilities' in-charges and other staff.
The facilities visited were:

1. Kadzinuni Dispensary: Quaye Georgia, Solomon Angyu, Nkunihya Kwabe, Bahima Alex, Machamire Healther and Adoghe Anthony.
2. Vipingo Health Center: Neufville Harry, Abubakar Amina, Ujulu Amos, Sani Muhammad, Imam Bello, Yahaya Shamsuddeen, Abatta Emmanuel and Nyadundu Simon.
3. Kilifi District Hospital: Howe Jabbeh, Sefako Celina, Iya Daniel, Zubairu Mahmud, Jibril Gwandu, Solanke Olutosin, Odidi Lawrence and Mudyara Jane.
4. Mtwapa Health Center: Kesselly Roland, Onwudinjo Ifeyinwa, David Timothy, Hove Ropafadzai and Mohlomi Lineo.
5. Tagaungu Health Center: Belleh Ishmael, Yahaya Rukayya, Hassan Adamu, Adamu Bashir, Owolabi Anne, Chikodzure Rudo.

Each team was led by one group member as facilitator. The facilities varied in size (from dispensaries/health posts to a county hospital), so groups had different but complementary findings on 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.

Issues reported from the field trip include the following:

- All health facilities receive inputs and equipment from KEMSA, but support from other partners and donors varies. Some facilities could purchase inputs from accredited distributors only if they used internally generated resources and up to a certain amount.
- The procedure of receiving drugs and other inputs from KEMSA was tedious, took a long time, and health facilities frequently experienced stock-outs.
- No health facility had autonomy to set user fees, manage their financial resources, or to hire and fire their staff
- Most health facilities had already informally reintroduced cost sharing to continue providing services to the population.
- Revenue per capita does not meet the required standard of USD 7, with most facilities generating less than USD 3 per capita.
- Generally poor separation of functions.
- Some health facilities assess client satisfaction through a suggestion box, direct patient interviews, and feedback through community committees, but these methods were found ineffective. This aspect needs strengthening per PBF.
- Most health facilities had staffing gaps of up to 50%.
- Overall, facility managers and staff are satisfied with PBF and see it as a way to improve the health system and better motivate staff.

Following the feedback from the field visit, Module 7 (CDV Agency) was presented. The day ended at 16:30 with the daily evaluations. In the evening, facilitators met with the team from the Nigeria NSHIP States: Adamawa, Nasarawa, and Taraba.

***Saturday November 25th***

The course program on Saturday was confined to the morning. The module on CDVA and data quality assurance was presented.
Module 8 on the feasibility scan was then presented, and participants in their country groups were asked to perform a scan of their various PBF designs. Those not already implementing PBF were asked to scan their existing health interventions.
The group appreciated this exercise, as most participants who thought they were implementing PBF programs discovered many issues with their program design.
After lunch, many participants joined the SINA Health bus ride to Fort Jesus and the town market for some local shopping.

***Sunday November 26th***

Trip to the Shimba Hills National Park. In the park, we saw some protected animals (Impala, Giraffes, Sable Antelopes, Buffalos, Warthogs, etc.). At the Giriama top, the group had a breathtaking view of the park and took memorable pictures.

The climax of the trip was at the hilltop, as we descended to the waterfalls, 2km through a winding, slippery, narrow path. Along the route, we stopped several times, and the guide took time to explain the names and special characteristics of some of the vegetation, such as the dome palm, the bottom plant, lesser flamboyant, pod mahogany, and crocodile liana.

At the beautiful, serene waterfall site, most of the team took a leisurely bath and took memorable pictures. Heading back to the hilltop was the most taxing phase, as most people attempted to race to the top.
Lunch was at the beautiful Shimba Hills Lodge within the game reserve, with a beautiful view and sightings of squirrels and huge alligators. The taste of the meal shall remain memorable.

***Monday November 27th***

Module 9 – Feasibility scans, killing assumptions, and advocacy was completed, with participants presenting scan results and preparing role plays on subjects they identified for advocacy.

Most challenges discovered during the scans related to budgetary allocation, indicator selection, etc. Most countries already implementing PBF found they had killing assumptions, which they prepared role plays for.
The feasibility scores and the various activity plans/recommendations are presented in the section dedicated to country specifics further in this report.
This was followed by Module 9 on the role of the community in PBF, and then Module 10 on conflict resolution and negotiation techniques began.
At the end of the day, participants began working on their action plans in their country groups, with facilitators available to support those who needed it.
In the evening, facilitators met with the Liberia team to assist with their action plans.

***Tuesday November 28th***

The Module on conflict resolution and negotiation techniques was completed. Next, facilitators presented Module 11 on output indicators. Two group exercises followed for plenary review and discussion.
Participants had enough time to complete the exercises, giving them hands-on experience in determining SMART indicators to be incentivized (for the health center and hospital packages) and calculating targets for each indicator.
The day ended at 17:00 to allow sufficient time to complete the module and indicator exercises.

In the evening, country groups continued working on their group and individual action plans using the outline produced, to be presented on Wednesday morning. Facilitators worked with the teams from Lesotho and Zimbabwe to develop their action plans.

***Wednesday November 29th***

The morning allocated more time to developing the country and individual action plans. The country presentations of the action plans then began with the Nigerian state of Nasarawa, followed by the remaining Nigerian groups (Adamawa/Taraba; Kano/Katsina/Kebbi States; Federal Ministry of Health and National Primary Health Care Development Agency). Next were presentations from the participants from Lesotho, Zimbabwe, Liberia, and South Sudan. The presentations showed that most groups had already advanced in developing their action plans, which was commendable.

Module 13 - Godelieve then presented the Business Plan.
Module 14 - The indices management tool was presented in the afternoon and was completed on Thursday morning.

In the evening, participants in their country groups continued finalizing their action plans, using feedback from the presentations.

***Thursday November 30th***

The last part of Module 14 on indices management tools was presented.
Module 11 on baseline studies and action research was then presented before the groups broke out to work on the indices tools exercise, which ended with a plenary restitution. The day was confined to the morning to allow participants time to prepare for the exams.

Module 15 (costing) and 16 (PBF in emergency situations) were not presented in class, but participants were asked to study them on their own.

The overall course evaluation was carried out before the class broke up for general revision in the afternoon to prepare for the exam.

***Friday December 1st***

The exam started at 8:30. All participants took the exam except 2, who had already left due to official and personal obligations.
In the afternoon, from 13:00 onwards, the exam was reviewed. This was followed by a ceremony to hand out the certificates.

In the evening, Sairock Hotel management proposed a happy hour to the remaining participants, as 3 participants had already left in the afternoon to catch their flight back home.

***Saturday December 2nd***

Most participants left on Saturday on different flights, and the last 11 participants, including Robert and Maggy, left Sunday morning/afternoon on flights at 04:20 and 17:30 from Mombasa.

# 6. FINAL COURSE EVALUATION BY PARTICIPANTS

## 6.1 General impression of the course

The score for 'general impression of the course' was 81.3%, 3% *below* the average of the 21 previous English-spoken courses. The criterion "I was sufficiently informed" scored 61%, 18% below the average for the previous English courses. The criterion "the program answered my expectations" scored 90% (= 5% *above* the previous courses). The criterion "the course objectives related well to participants' professional activities" scored 93% (= 4% above the average).

| Preparation | 34 previous French PBF courses | 21 previous English spoken PBF courses | Mombasa November 2-17 | Comparison Mombasa November 2017 / 21 previous English spoken PBF courses |
|---|---|---|---|---|
| Q1. I was sufficiently informed about the objectives of the course | 88% | 79% | 61% | -18% |
| Q2. The program has answered my expectations | 85% | 85% | 90% | 5% |
| Q3. The objectives of the course relate well to my professional activities | 89% | 89% | 93% | 4% |
| Average | **87.4%** | **84.3%** | **81.3%** | **-3.0%** |

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

Participants' appreciation of the methodology and content scored 91%, 4% above the average for previous English courses and 8% above the average for previous French courses. The three criteria "content helped me to attain my objectives", "interaction in working groups" and "methodology" all scored 93%. The balance between lectures and working groups scored 89%, and "working methods stimulated my participation" scored 86%.

| Methodology and contents of the course | 36 previous French PBF courses | 22 previous English spoken PBF courses | Mombasa November 2017 | Comparison Mombasa November 2017 / 22 previous English spoken PBF courses |
|---|---|---|---|---|
| The content of the PBF modules has helped me to attain my objectives | 83% | 90% | 93% | 3% |
| The methodology of the course | 84% | 87% | 93% | 6% |
| Balance between lectures and exercises | 71% | 78% | 89% | 11% |
| Interaction and exchanges in working groups | 89% | 91% | 93% | 2% |
| The working methods adopted in the course have stimulated my active participation | 87% | 90% | 86% | -4% |
| **Average** | **83%** | **87%** | **91%** | **4%** |

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

## 6.2 Appreciating the duration of the course

83% of participants felt the course duration was right, while 10% thought it was too short and 7% thought it was too long. This confirms that the 2-week duration of the PBF courses remains about right.

| Duration of the course | 34 previous French PBF courses | 21 previous English spoken PBF courses | Mombasa November 2017 | Comparison Mombasa November 2017 / 22 previous English spoken PBF courses |
|---|---|---|---|---|
| Too Short | 33% | 24% | 10% | -14% |
| Fine | 61% | 64% | 83% | 19% |
| Too Long | 6% | 12% | 7% | -5% |

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 74% was 3% *lower* than the previous 22 English courses with 77% and 4% *above* the 36 previous French courses. The conference center (63%) and the food (33%) scored 11% and 27% lower, respectively, than the previous courses. The conference hall was OK, as were the staff's friendliness and the facilitation team.

As with issues already noted in May/June 2017, several participants again complained about problems with the hotel's water system. Food was also thought to be slightly monotonous by several participants.

Transportation scored satisfactory (82%), and we congratulate the TOMASI Company, which has organized all transport for SINA Health since 2011. The quality of the educational material, the lecture room, and the friendly reception scored OK (93%, 82%, and 93%, respectively).

| How do you value the organization of the training? | 36 previous French PBF courses | 22 previous English spoken PBF courses | Mombasa November 2017 | Comparison Mombasa November 2017 / 22 previous English spoken PBF courses |
|---|---|---|---|---|
| Quality and distribution educational material | 78% | 87% | 93% | 6% |
| The lecture room | 68% | 67% | 82% | 15% |
| Conference centre in general | 60% | 74% | 63% | -11% |
| How were you received and friendliness | 87% | 92% | 93% | 1% |
| Food and drinks, including tea/coffee breaks | 65% | 60% | 33% | -27% |
| Transportation | 63% | 82% | 82% | 0% |
| **Average** | **70%** | **77%** | **74%** | **-3%** |

Table 5: Evaluation of the organization of the course.

## 6.4 Comments on the execution of the course and the facilitators

The program execution scored an average of 76%, 1% below the average of the previous 22 English courses. Facilitators' openness was rated 57%, 19% below the average of the previous English spoken courses. Time allocated for group work was 82%, 7% *above* the previous courses' scores. Discussion time was evaluated at 90%, 8% above the average of the previous English courses.

| Aspects related to the execution of the program and the facilitation | 36 previous French PBF courses | 22 previous English spoken PBF courses | Mombasa November 2017 | Comparison Mombasa November 2017 / 22 previous English spoken PBF courses |
|---|---|---|---|---|
| The facilitators had an open mind towards contributions and criticism | 81% | 76% | 57% | -19% |
| Time allocated to group work was adequate | 63% | 75% | 82% | 7% |
| Time for discussions was adequate | 77% | 82% | 90% | 8% |
| **Average** | **74%** | **78%** | **76%** | **-1%** |

Table 6: How was the facilitation?

## 6.5 Evaluation per module

Satisfaction per module among Mombasa participants was 91.6%. This is 4.2% above the average of the 21 English courses (87.4%). Participants appreciated the completeness and the illustrations provided by the facilitation team. Five modules obtained 100%, including the first-day modules, regulation, and the PBF feasibility scan. Economics and the Indices Management tool scored slightly lower with 75%. The course did not cover the Module costing.

| Module | 37 previous French PBF courses | 21 previous English spoken PBF courses | Mombasa November 2017 | Comparison Mombasa November 2017 / 21 previous English spoken PBF courses |
|---|---|---|---|---|
| Why PBF & What is PBF? | 93% | 92% | 100% | 8% |
| Notions of micro-economics and health economy | 65% | 83% | 75% | -8% |
| PBF Theories, best practices, good governance and decentralization | 86% | 92% | 97% | 5% |
| Baseline research – household survey launching process | 78% | 78% | 83% | 5% |
| Output indicators in PBF interventions | 87% | 89% | 86% | -3% |
| CDV agency, data collection, audit | 87% | 88% | 96% | 8% |
| Regulator – quality assurance | 83% | 92% | 100% | 8% |
| Negotiation techniques and conflict resolution | 89% | 89% | 97% | 8% |
| Black box Business Plan | 86% | 88% | 93% | 5% |
| Black box Indices tool: revenues – expenditure – performance bonuses | 81% | 81% | 75% | -6% |
| Community voice empowerment and social marketing | 82% | 88% | 97% | 9% |
| PBF feasibility, killing assumptions & advocacy | 88% | 90% | 100% | 10% |
| Elaboration of a PBF project – costing | 66% | 67% | NA | |
| **Average for all modules** | **83.7%** | **87.4%** | **91.6%** | **4.2%** |

Table 7: Evaluation per module.

## 6.6 Written comments during the final evaluation by the participants

### Pre-Course Preparations

- Participants should be told/advised of the need to collect luggage at Nairobi airport and check in again in Mombasa
- Advise participants to bring beachwear, as the program includes an outing.
- Course organizers should give more information about the program
- Describe the facilities and what people need to bring

### About Course methodology

- Robert must listen to participants to understand them. He should not be too strong about PBF. We are here to learn as well as discuss the real-life scenario in our countries so that we can learn how to overcome some of the challenges
- Group work should be in the afternoons/evenings when people are tired.
- Better-controlled discussions in class
- Interactions were sometimes not inclusive, as some people who already knew the methods seemed to fly solo.
- Each facilitator was good, open-minded, and down-to-earth.
- Other facilitators, Godelieve, Fanen, and Claire, were nice throughout.

**Course Book and Modules**

- I didn't receive any material beforehand on the course objectives, though I had some pre-information on some of the course content.
- Some concepts were hard to comprehend (Economics and Health Economics). The same module should be simplified so that those without an economics background can follow.
- Output indicators need a bit more time for clearer comprehension.
- The indices tool needs more time. Still a bit confusing.
- The book is too bulky for the period of the course
- The course should be split into Basic, Medium, and Advanced courses.
- The exam issue should be discussed, as this is an adult class.

**Hotel**

- The course environment was nice, but it needs improvement, especially in regular room maintenance and menu changes.
- The hotel needs to improve its attitude towards maintenance. Also, they should provide internet in all the rooms
- Rooms were OK, but the air conditioning, Intercom, and remote controls did not work properly.
- Inconsistent water supply in the bathrooms.
- No hot water in the bathroom
- Leaking toilet
- Water pressure is sometimes low for the shower
- Rooms to be thoroughly cleaned daily
- Cracks and leaks need to be fixed.
- A snake was found in one of the rooms
- Fridge not working
- Unsatisfactory food. Cats were everywhere and sometimes licked the spoons. Monkeys were also feeding on the snacks
- The meals were monotonous, the same every day.
- Too many flies in the restaurant.

**Transportation**

- No Air conditioner in the small van during the excursions
- Personnel were good, but vehicles were not so comfortable
- I enjoyed the tours

# 7. COUNTRY & TOPIC PRESENTATIONS

## 7.1 Nigeria - Federal Level

### 7.1.1 General context

Nigeria is in West Africa on the Gulf of Guinea and covers 923,768 $km^2$. The Republics of Niger and Chad border it to the north, the Republic of Cameroon to the east, the Republic of Benin to the west, and the Atlantic Ocean to the south. The main rivers are the Niger and the Benue, which converge at Lokoja and empty into the Niger Delta. Nigeria has a tropical climate, with wet and dry seasons tied to the intertropical convergence zone moving north and south of the Equator. Nigeria has a federal political system. It has 36 states, 774 Local Government Areas, and the Federal Capital Territory, with Abuja as the national capital.

**Nigeria Population Structure**
Nigeria is Africa's most populous country, with a projected population of 182.9 million in 2017. The growth rate is 3.2%. The population structure is predominantly young, with a median age of 18.2 years. The youth dependency ratio is 84%, and the total dependency ratio is 89.2%. The total fertility rate has dropped slightly from 5.7 in 2008 to 5.5 in 2013. With an urbanization growth rate of 3.75%, the urban share of the population rose from 34.8% in 2000 to 46.9% in 2014.

**Socio-economic indicators**
The economy depends largely on oil revenues and grew by 3.0% and 3.7% in 2015 and 2016, respectively. Economic growth is projected to rise to 5.4% annually between 2017 and 2019, driven by investments in non-oil sectors such as Power, works & housing, and agriculture, which began in 2016. The unemployment rate is currently estimated at 9.9%, with an underemployment rate of 17.4%, the highest among the 15-34 age group, especially in urban areas. An estimated 69% of the population lives below the poverty line, or 112.7 million people (Harmonized Nigeria Living Standards Survey 2010).

**Education**
About half of the women and three-quarters of the men in Nigeria are literate. Literacy is higher among women and men in urban areas than those in rural areas. About 38% of women and 21% of men never attended school. Women and men in urban areas are more likely to achieve higher levels of education.

**Water and Sanitation**
Sixty-one percent of households in Nigeria have access to an improved drinking water source. Only thirty percent of households have an improved toilet facility not shared with other households.

### 7.1.2 Health system context

The Nigerian health system is described as weak and fragmented, with poor financial and human resources and decaying infrastructure. The 3 tiers of government currently have no clearly defined roles and responsibilities for providing and financing health services. There is a double burden of disease, with communicable diseases accounting for 66% of the total burden of morbidity. Non-communicable diseases account for 24% of total deaths. At the federal level, health financing challenges include gross underfunding of the health system, poor budgetary allocation (3.9%, 6%, 4% in 2010, 2012, and 2013, respectively), and poor budgetary release, leading to inadequate

public health funding that does not align with national priorities. Out-of-pocket expenditure (OOPE) as a proportion of total health expenditure ranged between 73.8% in 2006 and 70% in 2009.

Many health facilities are situated in rural and hard-to-reach areas. A large percentage of the population lacks access to services because providers in public facilities are engaged in ongoing industrial action. The private sector has played a vital role in expanding access to health services, but it remains poorly integrated into the Nigerian health system. Poor service quality undermines client confidence, so some people seek care from unorthodox medical practitioners, bypass primary and secondary health facilities to go directly to tertiary institutions, or seek care outside the country.

Standards and protocols lack clarity, and health guidelines and regulations are inadequately implemented. Human resource challenges include high health worker attrition, poor remuneration, poor supervisory & logistic support, and a poor working environment. Capacity for continuing education is limited, and the quality of training provided is inadequate. As a result, health workers tend to migrate to "greener pastures"; professional rivalry and divisions, conflicts of interest, and frequent strike actions may follow.

The health system faces poor data management and poor-quality data. The regulator does not adequately coordinate donor agencies and development partners, leading to vertical health programs. Mechanisms to address frequent outbreaks of communicable diseases are inadequate (*Cholera outbreak in Borno, Type C meningitis outbreak in Zamfara)*. There is a rising prevalence of lifestyle disorders further compounded by natural disasters.

**In summary, the health sector has collapsed,** with substantial unmet needs, high expectations, monumental health emergencies, and crises. The health agenda's ambitions may be high but often lack the required government resources, a situation aggravated by reduced partner resources such as GAVI.

**Based on the MDGs report**

- Infant mortality is high: 126 per 1,000 live births
- Under-5 mortality is high at 109 per 1,000 live births
- Maternal mortality is high – 814 per 100,000 births
- Malnutrition rate (underweight children) – 31%
- Immunization coverage – MICS/NICS 23%

### 7.1.3 PBF in Nigeria

PBF aims to improve health care delivery for the population. Performance payments are likely to increase health care providers' commitment. Frequent health worker strikes hamper the Nigerian health system, and PBF can help contain them. Applying the PBF strategy encourages hiring qualified health workers and ensuring the availability of drugs and essential health commodities, thereby building community confidence to seek health services. Evidence comes from an ongoing pilot study in Nasarawa, Ondo, and Adamawa states. It allows true decentralization to the periphery.

Regulation, payment, verifier, provider, and community actors play **independent** roles to make health systems functional and deliver *Quality (Health Services)*, *Efficiency (in the use of economic resources)*, and e*quity (to address concerns about the vulnerable, emergencies, etc.)*. It uses economic instruments such as subsidies and

taxes to change the paradigm. PBF also promotes public-private partnerships with equal treatment of public, religious, and private providers.

**Potential advantages & benefits of PBF**

- Autonomy for health service provision at the facility levels (funds, human resources, quality improvements, etc.)
- Eliminating inefficiency and corruption
- Helping the local economy by injecting funds to the periphery
- Incentivizing service providers through payment of result-based bonuses.

### 7.1.4 PBF feasibility scan per State

The following table shows the PBF feasibility score for the States, Nigeria in general, and for the Safe One Million Lives program. It shows scores between 0% (SOML) and 78% (Nasarawa and Adamawa States).

| Criteria to establish in how far the project is "PBF" | Points | Natio-nal | SO ML | SO ML | Ada-mawa | Nasa-rawa | Ta-raba | Kano | Kat-sina | Kebb |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. The PBF program budget is not less than $ 4 per capita per year of which at least 70% is used for health facility subsidies, local NGO contracts and infrastructure input units | 5 | 0 | **0** | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives | 3 | 3 | **3** | | 3 | 3 | 2 | 0 | 0 | 0 |
| 3. The PBF program finances the full health centre and hospital health packages and is not restricted to a limited number of vertical program indicators | 2 | 0 | **0** | | 0 | 0 | 0 | 0 | 0 | 0 |
| 4. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders. | 2 | 0 | **0** | | 2 | 2 | 2 | 0 | 0 | 0 |
| 5. The project includes (or is part of) baseline and evaluation household and quality studies that establish priorities and allow measuring progress | 3 | 3 | **3** | | 3 | 3 | 3 | 3 | 3 | 3 |
| 6. Cost recovery revenues are spent at the point of collection (facility level) | 2 | 0 | **0** | | 2 | 2 | 2 | 0 | 0 | 0 |
| 7. Health facility managers have the right to decide where to buy their inputs | 4 | 4 | **0** | | 4 | 4 | 0 | 0 | 0 | 0 |
| 8. The project introduces business plans | 3 | 3 | **3** | | 3 | 3 | 3 | 0 | 0 | 0 |
| 9. The project introduces the indices tool for autonomous management | 3 | 3 | **0** | | 3 | 3 | 0 | 0 | 0 | 0 |
| 10. CDV agencies sign contracts directly with the daily managers of the health facilities – not with the indirect owners such as a religious leader. | 2 | 0 | **0** | | 0 | 0 | 3 | 0 | 0 | 0 |
| 11. Health facility managers are allowed to influence cost sharing tariffs | 2 | 0 | **0** | | 2 | 2 | 2 | 0 | 0 | 0 |
| 12. Health facility managers have the right to hire and to fire | 2 | 0 | **0** | | 2 | 2 | 2 | 0 | 0 | 0 |
| 13. There is a CDV Agency that is independent of the local health authorities with enough staff to conduct contracting, coaching and medical & community verification. | 2 | 0 | **0** | | 0 | 0 | 2 | 0 | 0 | 0 |
| 14. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function | 2 | 0 | **0** | | 2 | 2 | 2 | 0 | 0 | 0 |
| 15. CDV agents accept the promotion of the full government determined health packages (this in Africa mostly concerns discussions about family planning) | 2 | 2 | **2** | | 2 | 2 | 2 | 0 | 0 | 0 |
| 16. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans | 2 | 2 | **0** | | 2 | 2 | 2 | 0 | 0 | 0 |
| 17. Public religious and private facilities have an equal chance of obtaining a contract | 3 | 3 | **0** | | 3 | 3 | 0 | 0 | 0 | 0 |
| 18. There are geographic and/or facility specific equity bonuses | 3 | 0 | **0** | | 3 | 3 | 0 | 0 | 0 | 0 |
| 19. The project provides equity bonuses for vulnerable people | 3 | 3 | **0** | | 3 | 3 | 3 | 3 | 3 | 3 |
| **TOTAL** | **50** | **26 (52%)** | **11 (22%)** | **0 (0%)** | **39 (78%)** | **39 (78%)** | **30 (60%)** | **6 (12%)** | **6 (12%)** | **6 (12%)** |

### 7.1.5 Activities Planned

- Finalize the Basic Health Services Provision Fund Manual and include the PBF best practices and equity instruments for UHC.
- Facilitate the process of identifying and convening PBF fellows (SINA Health Alumni) meeting
- Assure the integration of PBF principles in the M&E Plan of the BHCPF manual
- Support pilot States in understanding the concept of PBF through workshops.

## 7.2 Action plan - National PHC Development Agency (NPHCDA)

**Immediate 3-6 months**

| OBJECTIVE | WHO | WHERE | WHEN | WHAT MEANS |
|---|---|---|---|---|
| Obtain evidence on impact and progress till date of the NSHIP program implementation in the 3 pilot states in Nigeria | NSHIP PIU NPHCDA, Zonal Director Northeast Zone | NPHCDA | 28th November 2017 | Attend Mid Term Review Meeting |
| Mobilize Alumni within NPHCDA to convince the Executive Director NPHCDA | Nov. Dec 2017 PBF Alumni | NPHCDA | 2nd week of December 2017 | Conduct Negotiation Meeting with Executive Director NPHCDA |
| Obtain critical mass of PBF Alumni to put PBF subject on the National Health Agenda | NSHIP PIU NPHCDA, PBF Alumni | NPHCDA | 2nd week of December 2017 | Hold First Round Table Meeting of the PBF Alumni |
| Identify champions **(technocrat)** to engage health sector leaders: – Executive Director, Executive Secretaries National Health Insurance, Permanent Secretary of Health, Hon. Minister of State for Health, Hon. Minister of Health. Health Partners, Inter Coordinating Committee | NSHIP PIU NPHCDA, PBF Alumni | Any State from the PBF pilot state | 3rd week of January 2018 | Negotiation Meetings |
| Develop Advocacy Materials to advocate to:<br>i. PBF pilot States PIU to include PBF into the state annual budget<br>ii. Engage with non PBF implementing State on the possibility of improving the negative health outcomes using PBF | NSHIP PIU NPHCDA, PBF Alumni | NPHCDA | January - February 2018 | Advocacy |
| PBF pilot States PIU to include PBF into the state annual budget | NSHIP PIU NPHCDA, PBF Alumni, State NSHIP PC from the pilot states SPHCB | NPHCDA | Last week of March 2018 | Online Communication (Phone & Conference calls, E-mails) |
| Engage with non PBF implementing State on the possibility of improving the negative health outcomes using PBF | NSHIP PIU NPHCDA, PBF Alumni, State NSHIP PC from the pilot states & other SPHCB Ex Secretaries | NPHCDA | 2nd week of April 2018 | One Day Stakeholders Meeting |

**Action plan – 2 (medium term 6-12 months)**

| OBJECTIVE | WHO | WHERE | WHEN | WHAT MEANS |
|---|---|---|---|---|
| Engage the political leaders:<br>Senate and House Committees on Health | Executive Director NPHCDA,<br>PBF Champion NSHIP NPC | NAS | 1st week of June, 2018 | Advocacy |
| Engage the political leaders:<br>- Ministry of Budget and National Planning/Ministry of Finance,<br>- Executive Secretaries National Health Insurance,<br>- Permanent Secretary of Health, Hon. Minister of State for Health,<br>- Hon. Minister of Health.<br>- Health Partners,<br>Inter Coordinating Committee | Executive Director NPHCDA,<br>PBF Champion NSHIP NPC | Abuja | 2nd Quarter 2018 | National Steering Committee Meeting |
| Introduce PBF to state Governors in the NGF through identified champion e.g. Kaduna State, Sokoto State, Anambra etc. | Executive Director NPHCDA,<br>PBF Champion,<br>NSHIP NPC | NGF Office | 2nd Quarter 2018 | Governor's Forum |
| Study visit to the PBF sites within Nigeria by selected champions of technocrats, and political leaders | ED NPHCDA,<br>PBF Champion,<br>NSHIP NPC,<br>Zonal Representatives from Northwest, North Central, South East, South West & South South Zones | Ondo, Adamawa & Nasarawa States | 1st - 2nd week of July 2018 | Visit to the 3 pilot states |
| Obtain National Council on Health endorsement, and pronounce a policy of incorporation into the 2016 -2020 National Health Plan | ED NPHCDA,<br>PBF Champion,<br>NSHIP NPC | National Council on Health | **TBD by NCH** | Inclusion in NPHCDA presentations |
| Develop scale up plan to implement these programs using PBF strategies:<br>- 10,000 PHC centres Initiatives<br>- Strengthen and re-position NPHCDA<br>- National Emergency Routine Immunization Coordination Centre<br>- Community Health Influencer Promotion Service program<br>- Close out polio | ED NPHCDA,<br>PBF Champion,<br>NSHIP NPC,<br>HCH/SPHCB Zonal Representatives from the 6 geopolitical zones | Abuja | October - November 2018 | - Consensus Building Meetings<br>- Revision strategic documents to PBF principles & practice |

**Action plan – 3 (long term >12months)**

| OBJECTIVE | WHO | WHERE | WHEN | WHAT MEANS |
|---|---|---|---|---|
| Develop scale up plan and implement for prepared states<br>- Accreditation of facilities<br>- Training of health workers<br>- Establish flow of funds<br>- Service delivery<br>- Verification<br>- Re-imbursement | NPHCDA, PBF Champion, NSHIP NPC,<br>HCH/SPHCB/DPRS from the Prepared States | Prepared States | 1st Week of December 2018 | Meetings, Workshops |

## 7.3 Safe One Million Lives program

### 7.3.1 Background

Several participants working with the SOML program at the federal and state levels attended the PBF course in Mombasa. The SOML program is based on 6 mainly reproductive health disbursement-linked indicators (DLIs). The idea is that a State which makes good progress receives a performance bonus. The first payments to each State, however, were a lump sum of US$ 1.5 million irrespective of factors such as population size.

### 7.3.2 Action plan for advocacy at SOML PforR

The Government of Nigeria's intervention program, the Saving One Million Lives Program for Results (SOML PforR), is planning a two-point agenda. The Program Management Unit will coordinate implementation at the National level, with direct oversight at the state level.

| Activity | Responsible | Timeline |
|---|---|---|
| **ADVOCACY TO COLLEGUES AT THE SOML-PforR – PROGRAM MANAGEMENT UNIT**<br>With the assumption that other team members of the SOML PforR program Management Unit (SOML PforR-PMU) have been part of the PBF course in the past. The report of the 2017 cohort (Dr. Ojuolape Solanke and Mr. Lawrence Odidi) is expected to bring a refreshing to the other members of the team who are alumni of the course.<br>The key message of the advocacy shall be the best practices of PBF and how we can leverage on the experiences of the three (3) NSHIP State- Adamawa, Ondo and Nasarawa.<br>The ongoing midterm review of NSHIP in Nigeria would serve as advocacy tool, providing evidence that PBF can work in Nigeria | 1. Dr. Ojuolape Solanke<br>2. Mr. Lawrence Odidi | 4 weeks |
| **ADVOCACY TO THE HONOURABLE COMMISSIONERS OF HEALTH OF THE 36 STATES + FCT IN NIGERIA**.<br>The second part of this will be for colleagues to advocate to the Honorable Commissioners of the States they supervise under the program.<br>Each team member has at least five (5) states under their purview that they conduct quarterly supervision on. This particularly activity affords the s PMU to have one-on-one discussion with the Honorable Commissioners of the state. It is thus an opportunity to discuss and advocate for the commissioners to have a pilot PBF in selected LGAs and Health Facilities within their state, using SOML PforR funds | Program Management Unit of SOMLPforR | 1st Qrt 2018 |
| **IMPACT STUDY ON PBF PILOT LGAs & HF USING SOML PforR FUNDS**<br>An impact study on the outcome of the pilot LGAs and HF on PBF can be carried out which will form the basis for scale up to other LGAs. | 1.The program Management Unit<br>2.Independent Verification Agent (IVA) | Year 2 of SOML PforR implementation (2018) |

## 7.4 Nigeria – Nasarawa State

*Dr. Daniel Iya – Commissioner of Health*

### 7.4.1 Situation Analysis:

Nasarawa State is one of three states in Nigeria (Adamawa, Nasarawa, Ondo) that have piloted Performance-Based Financing (PBF) through the Nigeria State Health Investment Project (N-SHIP). This is financed through a World Bank loan.

After a preliminary mapping of Health facilities, the project commenced in 2011 as a pilot scheme in one local Government area (Wamba Local Government Area). The project has since scaled up to all thirteen local government areas of the state. However, not all the health facilities in the state are PBF facilities. The pilot scheme included a research component; therefore, a control group referred to as Decentralized Facility Financing (DFF) received input financing but did not earn Bonuses from output indicators, referred to as Disbursement-Linked Indicators (DLIs). Currently, 453 facilities are covered: 240 facilities (235 PBF and 185 DFF), 17 General Hospitals, 14 private hospitals (all PBF), and 2 Tertiary hospitals partly covered under the PBF program (NSHIP).

Nasarawa State is in Nigeria's North-Central Geopolitical zone. It borders the Federal Capital Territory. Its projected population from the 2006 National Census is 3.4 million. However, a more accurate GIS estimate is 5.6 million. The corridor to the FCT has an annual population growth rate of about 9% (three times the national average), while the country's annual growth is about 3%. The health indices are average for the nation. The nation is agrarian, although rich in mineral resources.

### 7.4.2 Results so far with PBF in Nasarawa

Five years in, the Mid-Term Review (MTR) findings are expected any time now. All LGAs have PBF, but not all health facilities. Coverage in “functional” PBF health facilities is 38.3%; DFF is 26.4%, leaving 35.3% of health facilities in the state outside PBF. 60% of the health facilities in the state are public, while 40% are private. Until 2016, all PBF health facilities were public, but from 2016 onwards, 14 private health facilities were given performance contracts. The Mid-Term Review of the three PBF states is awaited at any time now to guide the Government’s decision on the way forward. However, the principles of PBF are being extended to six states in the country's North-East Geopolitical zone.

**Quality improvements**
Earned bonuses from PBF subsidies / DLIs have resulted in better-motivated staff at the PBF facilities, who are now more committed to providing a full package of services. The autonomy has meant the elimination of drug stock-outs, which were common before the introduction of PBF. Customer satisfaction rose in those facilities, reflected in an increase in the number of patients attending them.

PBF autonomy allowed the employment of skilled staff, improving the quality of services such as Antenatal Care (ANC) and births attended by skilled staff. Infrastructural maintenance and facility improvements provide a hygienic, conducive environment for patient care.

7.4.3 Problems that could be solved at state level

1. The Hospital Management Board attempted to withdraw the health facility autonomy after a district hospital applied its right to buy drugs from an accredited private drugs distributor with which the Hospital Management Board did not agree. This attempt NOT TO ACCEPT autonomy was then stopped by the State Ministry of Health.
2. Despite the improvement in Quality of Services in the PBF facilities, which is partially also the result of increased cost-sharing revenues, the political leadership continued to make political statements such as the promise to provide 'free health care' but without the required funding. Total free health care for children, pregnant women, and deliveries would cost around USD 8 per capita per year. Yet the political leadership did not provide such a budget, and the State Ministry of Health could convince the State political leadership that this was not a good idea. By comparison, a targeted PBF intervention can already be realistically financed with a budget of USD 4 per capita per year.
3. The State Executive Council proposed applying the Single Treasury Account (TSA) to all government facilities. This would have meant that all health facility revenues would have to go into this account, from which it is very cumbersome to withdraw funds, and it would stifle facilities' autonomy to use profits generated at the facility to improve quality. Yet the State Ministry of Health obtained an exemption from this rule for health facilities.

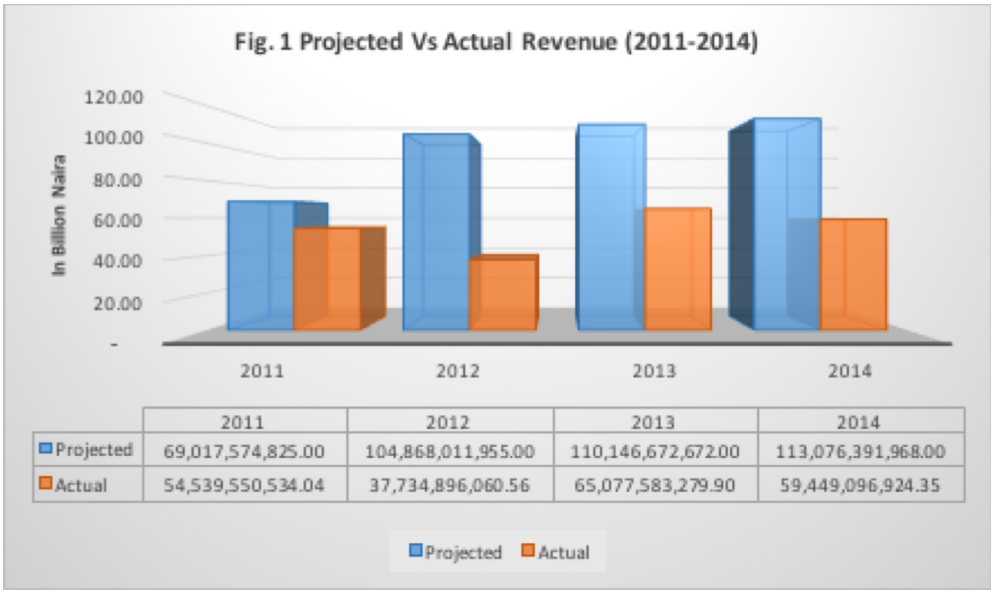
7.4.4 Problems that have not yet been resolved

1. The World Bank financed Save One Million Lives, which, although it has output indicators, still uses input financing for equipment and drug supply. This is an inefficient way to fund because it creates an environment for corruption. The introduction of SOML does not provide the autonomy and separation of functions needed at the facility level, as PBF does.
2. Uncoordinated Partner interventions run parallel programs that are not in consonance with the PBF transformation of output financing.
3. Multiplicity of data collection.

***In summary, the health system still suffers from:*** 1. the partial separation of functions (regulation, provision, contract development and verification, payment and community voice strengthening)*; 2.* Sticking to "Business as Usual" of input financing; and 3. Unwillingness to let the free-market economy operate, enforcing price ceilings and promoting input monopolies.

### 7.4.5 Advocacy strategy

The *allies* for change towards PBF include: 1. Staff at the current PBF facilities; 2. Staff at the DFF facilities who are eager to move on to the PBF approach; 3. Communities at the PBF facilities who have expressed satisfaction with the improved quality of service now being provided.
The *neutral* group is: 1. Communities that have not yet been fully informed of the workings of the PBF way of providing Quality Health Services; 2. Traditional Leaders; 3. Religious leaders, the media, 4. Non-Governmental Organizations (NGOs); 5. Community-based Organizations (CBOs) and 6. Women and Youth groups that need better information.
*Opposition* may come from: 1. Professional Associations who are used to getting paid even without working; 2. Government Officials at the Ministry of Finance, especially the Commissioners of Finance, Budget & Planning, who struggle to raise limited resources amid competing demands; 3. Executive Council members (Commissioners from different ministries who also demand financial resources for their ministries); 4. Legislators who also request capital projects in their constituencies for political gain.
Nasarawa State Projected Revenue Based on Budgetary need and Actual Revenue collected




| | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|
| Projected | 69,017,574,825.00 | 104,868,011,955.00 | 110,146,672,672.00 | 113,076,391,968.00 |
| Actual | 54,539,550,534.04 | 37,734,896,060.56 | 65,077,583,279.90 | 59,449,096,924.35 |

Prepare messages appropriate for each group. Short and clear; use even slogans. Note that politicians are busy people, with no time for long scientific arguments; appeal to their hearts first before any appeal to their heads. Note that health is a matter for all, young or old, rich or poor, male or female, and each person can relate to health issues or has a story to tell of a family member, friend, etc. that relates to health issues or may have lost someone close to them from a health-related problem.

### 7.4.6 Implementation strategy

1. The State has constituted the Universal Health Coverage Steering Committee chaired by the Deputy Governor, which operates as an ad hoc Board to spearhead the program. Linked to the Steering Committee, the State has constituted a Technical Working Group chaired by the Commissioner of Health. I will use these high-level advocacy bodies to cement these alliances by arguing that the PBF is the most effective way to ensure efficient, quality healthcare service

delivery before addressing equity issues. This will also strengthen the Health System.
2. As an implementation strategy, the State has already piloted the PBF approach, characterized by separated functions, autonomous provider management, enhanced collaboration with the private sector, and competition for inputs from accredited distributors. I will leverage this, citing our experience in the state, and the MTR just out. I will therefore solidify my allies' support. These bodies will champion PBF in Nasarawa State.
3. For those undecided, I will disseminate information through town hall meetings, panel discussions on Television, jingles, and pamphlets in the major languages spoken in the state to turn them into my allies.
4. My strategy for opponents would be robust debate with superior arguments that workers be paid according to their performance. “NO WORK: NO PAY” slogan!

### 7.4.7 Action plan when back in Nasarawa State

1. Transforming the input implementation budget line of Saving One Million Lives (SOML) into output performance financing. Within 2 weeks.
2. Transforming the DFF funding for the PBF control LGAs into a pure PBF approach. Within the 1st Quarter of 2018
3. Advocate for using the counterpart MOH budget for the NSHIP program to scale up PBF to health facilities in LGAs not selected for PBF. Within one month.
4. Provide the Governor with the financial commitment needed based on PBF recommendations at the primary and secondary hospital levels. Within 4 weeks.
5. Also, considering the results of the Mid-Term Review, soon to be released, I will advocate to the Governor, providers, and other stakeholders to scale up all DFF facilities to PBF. First quarter 2018.
6. UHC must be through mandatory contributions, with a well-defined package that includes public-good services such as immunization, HIV and TB treatment, and family planning services. Fees for quality services must be charged. However, the government should subsidize vulnerable groups, but before implementing such policies, it must know and budget for the implementation costs. Co-payment is necessary for all beneficiaries at secondary and tertiary levels; however, the key is to reduce high out-of-pocket (OOP) expenditure, so it does not lead to financial catastrophe or impoverishment. OOP of between 20-30% is desirable. 1st Quarter - 2nd Quarter 2018.

## 7.5 Nigeria - Adamawa State

### 7.5.1 State Profile

Adamawa State is in Nigeria's Northeast and has many rivers; the major one is the River Benue, which originates in the highlands of Cameroon and flows south to join the Niger River.

Adamawa State covers 39,742 square kilometers and had a projected population of 4.3 million in 2017. The state is divided into 21 Local Government Areas (LGAs) and 226 political wards. It has vast, fertile land suitable for farming, and 90% of the population farms and engages in animal husbandry.

According to the UN Global Multi-Dimensional Poverty Index report, 46% of Nigerians lived below the national poverty line of less than $2 per day (2015). This is 59% for Adamawa State (28% in urban areas and 72% in rural areas).

Adamawa State has been affected by the insurgency in the north-east of Nigeria, but since mid-2015, there has been relative calm and a reduction of the formal government-run IDP camps from over then to three, with an estimated IDP population of 136,000, so that there remains a large number of displaced people.

### 7.5.2 Fiscal space in Adamawa State

The State has established a mixed input/output-based financing model: health facilities provide PHC services, the SPHCDA purchases PHC services, the SMoH regulates, and the State Ministry of Finance serves as the payment agency. Health facilities also receive input from partners, and the overall aim is to strengthen capacity to deliver quality services to pregnant women, children, and vulnerable groups. Health facilities are managed at the ward level, supported by the Ward Development Committees (WDCs) and the LGA PHC Authorities.

The fiscal space for health is below expectations, marked by low budgetary allocation, delayed budget releases, bureaucratic bottlenecks, and inefficient input-based financing. With recurrent expenditure averaging N4.75bn ($13 million) monthly as against average monthly revenue of N4.05bn ($11.1 million), the State needs to borrow to cover its recurrent expenditure obligations.

### 7.5.3 Adamawa State health system

Nigeria’s National Health Act 2014 establishes the Primary Health Care-Under-One Roof (PHCOUR) and the standard mechanism to integrate primary healthcare governance. Adamawa State has 21 LGAs and 226 wards, with primary health care as the mainstay of population health services, complemented by secondary and tertiary levels of care. The lowest administrative unit of governance, the Local Government PHC Authorities, manages primary health care and provides basic health promotion, disease prevention, treatment/cure, and rehabilitation services. The secondary health care system falls within the purview of State governments and provides referral and secondary-level healthcare. The tertiary level healthcare system, operated mainly by the federal government, provides specialized care.

The State government provides policy and strategic leadership for health sector development through the State Ministry of Health, its departments, and agencies.

The State Primary Health Care Development Agency ensures the development of the primary healthcare system across LGAs and the equitable roll-out of State policies

and standards for delivering basic health care services. State Primary Health Care Development Agency manages and oversees the delivery of primary healthcare services.

The State operationalizes primary health care by delivering a Ward Minimum Health Care Package (WMHCP), a package of essential, cost-effective interventions delivered through a combination of facility- and community-based approaches. The service is delivered by motivating health unit teams to plan and implement the WMHCP for their geographic unit population, through fixed (health facilities) or mobile services. Prioritized within the Minimum Health Care Package are six main intervention areas: (1) Control of Communicable Diseases; (2) Child survival; (3) Maternal and Newborn Care; (4) Nutrition; (5) Non-Communicable Disease Prevention; and (6) Health Education and Community Mobilization.

Communicable diseases include malaria, pneumonia, diarrhea, TB, HIV, and STIs. The plan includes neonatal care, routine immunization, and integrated management of childhood illnesses (IMCI), while maternal and Newborn care prioritizes Basic Essential Obstetric Care, skilled birth attendance, and facility delivery. Water supply and sanitation, and Emergency preparedness and response, along with cross-cutting themes like essential medicines, human resources for health, and M&E, are the other intervention areas of the national WMHCP. State-level Minimum Service Packages mirror the national provisions, though with slight variations based on state-level priorities.

Adamawa State has over 1,297 health facilities, including 1,160 public health facilities (89%) and 137 private facilities (11%), such as 1 Federal Medical Center, 1 Specialist Hospital, 16 General Hospitals, 403 Health Teams, and 7 Private facilities contracted to implement performance-based financing.

Adamawa State uses a mixed system of paper and electronic methods for health information management; however, it faces challenges with weak infrastructure support for DHIS2 electronic reporting at the LGA and facility levels. This is due to poor integration of DHIS managed by different agencies/departments and a limited number of trained monitoring and evaluation personnel to support data collection and reporting. Adamawa State is part of ongoing efforts across the country to integrate all existing health DHIS2 databases to strengthen Nigeria's NHMIS.

Adamawa’s primary healthcare service delivery system cannot meet its population's basic health needs: With an estimated population of 4.3 million and an annual growth rate of 2.9%, over 200,000 women become pregnant annually, and over 17,000 children are born monthly. The under-5 mortality rate is 129/1000 NE (NDHS2013), while as many as 576/100,000 women die annually of pregnancy-related causes. Access to essential child health interventions remains low: 23% of children under 5 are fully immunized, while only 61% received the 3rd dose of the pentavalent vaccine. TT2 coverage for pregnant women stands at 50%. Whereas malaria (13%), diarrhea (10%), and pneumonia (10%) cumulatively account for 34% of deaths of children under the age of five, access to recommended treatments remains grossly suboptimal. Recent data (MICS 2016) indicate that only 18.5% of children U5 with diarrhea can access oral rehydration salts (ORS), while 16% and 43% respectively are treated with artemisinin-based combination therapy ACT for malaria and antibiotics for acute respiratory infection (ARI).

### 7.5.4 Underlying systemic issues before the implementation of PBF are:

Fragmentation and poor separation of roles among federal, state, and local government levels; unclear accountability and performance frameworks; lack of performance incentives; and input-based financing of health facilities without autonomy to operate.

Compared with other Sub-Saharan African countries, Nigeria has relatively abundant human resources for health. Yet the Adamawa health care worker-to-population density ratio is well below the national average, with health professionals unevenly distributed between urban and rural areas. Moreover, health workers have weak capacity, worsened by poor remuneration and a lack of structured training opportunities. Adamawa State has one doctor for 35,719 people and one nurse for 3,604 people. At primary health care centers, essential drugs are chronically out of stock (average 55%), equipment is often below minimum standards (average 25% equipped), sanitation/waste management are poor, and health workers are idle and absent (average 29%).

### 7.5.5 The PBF approach in Adamawa

Adamawa State started piloting the Performance-based financing (PBF) approach in November 2011 with the following lessons learned: strategic utilization of initial investment funds, strengths of contracting units known, experienced in managing contracts, unprecedented improvement in quality of services, 40-50% increase in coverage indicators because of sub-contracting of specific services, and gained confidence in facility autonomy.

The following assumptions guided the implementation of PBF. The set of services is redefined with targets based on static population, and institutional arrangements are clearly defined, with functions separated. Contracted facilities must have the minimum required capacity, workspace, staff, and equipment. The 403 contracted facilities operate autonomously in hiring and firing staff, using cash for local procurement, and paying bonuses. The PBF budget is $3 / capita per year ($2 subsidies, $1 overheads).

### 7.5.6 Feasibility Scan for Adamawa State

| Criteria to establish in how far the project is "PBF" | Max Points | Ada-mawa | Comments |
|---|---|---|---|
| 1. The PBF program budget is not less than $ 4 per capita per year of which at least 70% is used for health facility subsidies, local NGO contracts and infrastructure input units | 5 | 0 | Budget of $3 per capita |
| 2. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives | 3 | 3 | |
| 3. The PBF program finances the full health centre and hospital health packages and is not restricted to a limited number of vertical program indicators | 2 | 0 | The DFF covers only 5 indicators |
| 4. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders. | 2 | 2 | |
| 5. The project includes (or is part of) baseline and evaluation household and quality studies that establish priorities and allow measuring progress | 3 | 3 | |
| 6. Cost recovery revenues are spent at the point of collection (facility level) | 2 | 2 | |
| 7. Health facility managers have the right to decide where to buy their inputs | 4 | 4 | |
| 8. The project introduces business plans | 3 | 3 | |
| 9. The project introduces the indices tool for autonomous management | 3 | 3 | |

| | | | |
|---|---|---|---|
| 10. CDV agencies sign contracts directly with the daily managers of the health facilities – not with the indirect owners such as a religious leader. | 2 | 0 | All functions apart from contract signing |
| 11. Health facility managers are allowed to influence cost sharing tariffs | 2 | 2 | |
| 12. Health facility managers have the right to hire and to fire | 2 | 2 | |
| 13. There is a CDV Agency that is independent of the local health authorities with enough staff to conduct contracting, coaching and verification. | 2 | 0 | |
| 14. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function | 2 | 2 | |
| 15. CDV agents accept the promotion of the full government determined health packages (this in Africa mostly concerns discussions about family planning) | 2 | 2 | |
| 16. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans | 2 | 2 | |
| 17. Public, religious and private facilities have equal chance for a contract | 3 | 3 | |
| 18. There are geographic and/or facility specific equity bonuses | 3 | 3 | |
| 19. The project provides equity bonuses for vulnerable people | 3 | 0 | Only OPD indigent |
| **TOTAL** | **50** | **36 (78%)** | |

### 7.5.7 Main problems

1. **Low budgetary Allocation:** Even though the PBF approach of attaining universal health coverage has been implemented in 11 LGAs in the State, it operates on $ 3.00 per capita, which is lower than the recommended $ 4-7 per capita for low- and middle-income countries, in particular if we wish to achieve Universal Health Coverage through subsidizing PBF equity instruments at the provider level. Currently, only the curative indicator "consultations" includes a component exempting the indigents. In other countries, there may be as many as 5-6 equity indicators for the poor, including admissions, surgery, and delivery care.
2. **Incomplete separation of functions:** The importance of separation of functions in PBF cannot be overstated, as it is central to PBF-related theories. In Adamawa, though separation of functions exists in most cases, the contract development component has not yet been transferred from the regulator to an independent Contract Agency. The SPHCDA has negotiated and signed contracts since 2011 while also playing a regulatory role.

### 7.5.8 Action Plan

| Where we are | Proposed activity | How | Responsible Person | Six weeks | Six months |
|---|---|---|---|---|---|
| Budget of $3 per capita per year | - Advocate for increased to $5 per capita per year | - Government to allocate 15% of total budget to health | HCOH ES, ADSPHCDA, Chair ALGON | | XXX |
| NSHIP funding PBF in 11 LGAs and DFF in 10 LGAs | - Implement PBF in 21 LGAs | - Advocacy to World Bank, leverage on midterm review | HCOH, EC ADSPHCDA | XXX | |
| PBF funded by NSHIP | - Apply 70% of SOML funds using PBF logic | - Coordination meeting between actors of NSHIP and SOML | HCOH, EC ADSPHCDA, PM SOML, PC NSHIP | XXX | |
| CDV 90% autonomous | - Ensure total autonomy | - Engage local | HCOH, EC | XXX | |

| | | | | | |
|---|---|---|---|---|---|
| | | CDV agents | ADSPHCDA | | |
| 5 years of implementing PBF in 21 LGAs, 226 wards, 223 PBF, 180 DFF PHCs, 15 Hospitals, &private facilities | - Develop sustainability plan<br>- Develop Mid-term expenditure framework<br>- PHC strategic operational plan | - Allocation of 15% of total budget to health<br>- State allocation from Basic Health Care Fund<br>- | PIU NSHIP, State planning commission | | XXX |

## 7.6 Nigeria - Kano, Katsina and Kebbi States

### 7.6.1 State Profile/ Background

The North-western states comprise Kano, Katsina, and Kebbi States, with a projected total population of 24 million. Local Government Areas are closest to where people live, linking local communities' needs to national goals, policies, and resource allocation.

**Table: Brief Summary of the States**

| Geo-political statistics | Katsina | Kano | Kebbi |
|---|---|---|---|
| Number of LGAs | 34 | 44 | 21 |
| Number of political wards | 361 | 484 | 225 |
| Major ethnic groups | Hausa/Fulani | Hausa/Fulani | Hausa/Fulani |
| Major religion | Islam | Islam | Islam |
| Annual growth rate | 3.0% | 3.0 % | 3.0 % |
| Total population 2015 | 8 million | 12 million | 4 million |
| Urban population | 30.0% | 30.0% | 30.0% |
| Rural population | 70.0% | 70.0% | 70.0% |
| Total number of public health facilities | 1560 | 1611 | 912 |
| Total number of private health facilities | 79 | 369 | 34 |

### 7.6.2 Problem statement

The 3 states are amongst the states with the highest maternal and infant mortality rates in the country (NDHS 2013, SMART SURVEY 2015). Some of the issues associated with these poor indices include a weak health system, especially at the primary level, acute shortage of human resources for health, poorly trained and motivated staff, low budgetary provision to the health care sector, poor release of the budget, infrastructural decay, lack of essential medicines and equipment, and poor health-seeking behavior.

### 7.6.3 Can PBF make a difference?

Yes, we believe PBF can make a difference

### 7.6.4 Feasibility Score

| Criteria to establish in how far the project is "PBF" | Points | Score |
|---|---|---|
| 1. The PBF program budget is not less than $ 4 per capita per year of which at least 70% is used for health facility subsidies, local NGO contracts and infrastructure input units | 5 | 0 |
| 2. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives | 3 | 0 |
| 3. The PBF program finances the full health centre and hospital health packages and is not restricted to a limited number of vertical program indicators | 2 | 0 |
| 4. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders. | 2 | 0 |
| 5. The project includes (or is part of) baseline and evaluation household and quality studies that establish priorities and allow measuring progress | 3 | 3 |
| 6. Cost recovery revenues are spent at the point of collection (facility level) | 2 | 0 |
| 7. Health facility managers have the right to decide where to buy their inputs | 4 | 0 |
| 8. The project introduces business plans | 3 | 0 |
| 9. The project introduces the indices tool for autonomous management | 3 | 0 |
| 10. CDV agencies sign contracts directly with the daily managers of the health facilities – not with the indirect owners such as a religious leader. | 2 | 0 |
| 11. Health facility managers are allowed to influence cost sharing tariffs | 2 | 0 |
| 12. Health facility managers have the right to hire and to fire | 2 | 0 |
| 13. There is a CDVAgency that is independent of the local health authorities with enough staff to conduct contracting, coaching and medical & community verification. | 2 | 0 |
| 14. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function | 2 | 0 |
| 15. CDV agents accept the promotion of the full government determined health packages (this in Africa mostly concerns discussions about family planning) | 2 | 0 |
| 16. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans | 2 | 0 |
| 17. Public religious and private facilities have an equal chance of obtaining a contract | 3 | 0 |
| 18. There are geographic and/or facility specific equity bonuses | 3 | 0 |
| 19. The project provides equity bonuses for vulnerable people | 3 | 3 |
| **TOTAL** | **50** | **6 =12%** |
| | | |

### 7.6.5 Main problems for introducing PBF

- Authorities may reject the principle of separation of functions because they believe health facility staff cannot make decisions. This is difficult to tackle because authorities often believe health facilities should be micro-managed.
- The budget for a full PBF program with equity instruments costs more than $ 3.00 per capita per year. Serious advocacy is therefore required to increase funding for the health sector amid declining internally generated revenues. Subsidies are then paid in kind and not in cash.
- Authorities may believe that the best methods of providing inputs to health facilities are through central distribution systems (Central Medical Stores).
- Health facility managers may not be allowed to hire or fire health workers.

### 7.6.6 Action plan

**Immediate: 3-6 months**

| Activity | Responsible | Timeline |
|---|---|---|
| Meeting / presentation to the Hon Commissioner, Perm Sec & EC SPHCDA | DPHC | Second Week of December |
| Presentation to TCG of SOML P4R | PM SOML P4R | |
| Study Tour to PBF implementing State (Adamawa) | PM SOML P4R | |
| Engagement of international partner organizations | | |

**Medium term: 6-12 months**

| Activity | Responsible | Timeline |
|---|---|---|
| Engagement of other stakeholders (traditional, religious, CSOs, MDAs) | | |
| Development of work plan & harmonizing it with SOML work plan | DPHC / PM SOML P4R | |

## 7.7 Nigeria - Taraba State

### 7.7.1 State Profile

Taraba State is in Nigeria's Northeast and covers 54.743 square kilometers, with a projected population of 3.6 million people. There are 16 Local Government Areas and 165 political Wards. The State has fertile land suitable for farming, with 90% of the population involved in farming and animal husbandry. Other economic activities in the State concern mining, trade, and tourism. The prevalence of poverty in Taraba State is 59%, and this is more common in the rural areas.

The Boko Haram insurgency has not directly affected Taraba State, but there are several IDP camps, leading to pressure on socio-economic activities and infrastructure. Yet, due to recent improvements in the security situation, the number of IDP camps has declined.

### 7.7.2 Overview of the Taraba State health system

Taraba's primary healthcare service delivery system cannot meet its population's basic health needs because of an inefficient input system and an inadequate health budget. The Taraba State health budget depends primarily on federal allocations, and the state has over 970 functional health facilities: 800 are government-owned (89%) and 170 are private (11%). Taraba State is part of ongoing efforts across the country to integrate all existing health DHIS2 databases to strengthen Nigeria's NHMIS.

### 7.7.3 Taraba PBF pilot

Taraba State began piloting performance-based financing (PBF) in Ardo Kola LGA in May 2017. The initial investment funds of USD 200,000 came from SOML. This allowed the state to develop experience with contracting. Moreover, the first results show improved service quality in the pilot LGA and increased coverage indicators due to subcontracting specific services, which built confidence in facility autonomy. The State aims to expand PBF from the first pilot LGA to two more LGAs, with a view to covering the whole state over time.

| Criteria to establish in how far the project is "PBF" | Points | Taraba | Comments |
|---|---|---|---|
| 1. The PBF program budget is not less than $ 4 per capita per year of which at least 70% is used for health facility subsidies, local NGO contracts and infrastructure input units | 5 | 0 | Budget of $3 per capita |
| 2. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives | 3 | 3 | |
| 3. The PBF program finances the full health centre and hospital health packages and is not restricted to a limited number of vertical program indicators | 2 | 0 | The DFF covers only 5 indicators |
| 4. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders. | 2 | 2 | |
| 5. The project includes (or is part of) baseline and evaluation household and quality studies that establish priorities and allow measuring progress | 3 | 3 | |
| 6. Cost recovery revenues are spent at point of collection (facility level) | 2 | 2 | |
| 7. Health facility managers have right to decide where to buy their inputs | 4 | 4 | |
| 8. The project introduces business plans | 3 | 3 | |
| 9. The project introduces the indices tool for autonomous management | 3 | 3 | |
| 10. CDV agencies sign contracts directly with the daily managers of the health facilities – not with the indirect owners such as a religious leader. | 2 | 2 | All functions apart from contact signing |
| 11. Health facility managers are allowed to influence cost sharing tariffs | 2 | 2 | |
| 12. Health facility managers have the right to hire and to fire | 2 | 2 | |
| 13. There is a CDV Agency that is independent of the local health authorities with enough staff to conduct contracting, coaching and verification. | 2 | 2 | |
| 14. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function | 2 | 2 | |
| 15. CDV agents accept the promotion of the full government determined health packages (this in Africa mostly concerns discussions about family planning) | 2 | 2 | |
| 16. The PBF system has quality investment units, which are paid against achieved benchmarks based on agreed business plans | 2 | 2 | |
| 17. Public religious and private facilities have an equal chance of obtaining a contract | 3 | 3 | |
| 18. There are geographic and/or facility specific equity bonuses | 3 | 3 | |
| 19. The project provides equity bonuses for vulnerable people | 3 | 3 | Only OPD indigent |
| **TOTAL** | **50** | **43 (85%)** | |

### 7.7.4 Taraba action plan

| Where we are | Proposed activity | How | Responsible Person | 2 weeks | 6 weeks | 6 months |
|---|---|---|---|---|---|---|
| Budget of $3 per capita per year | Advocate for an increase to $5 per capita per year | Government to allocate 15% of total budget to health | HCOH ES, SPHCDA, Chair ALGON | | XXX | |
| NSHIP funding PBF | Implement PBF in 15 LGAs | Advocacy to World Bank, leverage on midterm review | HCOH, ES SPHCDA | | XXX | |
| PBF funded by NSHIP | Apply 75% of SOML funds using PBF logic | Coordination meeting between actors of NSHIP and SOML | HCOH, ESX SPHCDA, PM SOML, Planning commission PC NSHIP | | XXX | |
| Meeting with HCH PERM SEC | Inclusion in 2018 budget | Meeting planning | HCOH SPHCDA | XXX | | |
| FIVE MONTHS of implementing PBF in a 1 pilot LGA 10 wards, PBF, 10 PHCs, 1 Hospital, & private facilities | Develop sustainability plan and mid-term expenditure framework. PHC strategic operational plan. Scaling up to more LGAs | Allocation of 15% of total budget to health State allocation from Basic Health Care Fund | PIU NSHIP, State planning commission SPHCDA. | | | XXX |

## 7.8 Lesotho

### 7.8.1 General context

The Kingdom of Lesotho is a mountainous landlocked country surrounded by South Africa. Administratively, the country is divided into 10 districts. Geographically, Lesotho has three distinct zones: the foothills, the mountains, and the lowlands. These zones also create access barriers that hamper uptake of health services. Lesotho has an estimated population of 2.1 million, with 73% living in rural areas. Life expectancy at birth is estimated at 49 years, which is driven downwards primarily because of the HIV epidemic and the high neonatal, infant, under-five, and maternal mortality rates.

Lesotho is a low middle-income country with a per capita income of US$ 1067 and ranks 161 out of 187 countries on the UN Human Development ranking. Lesotho's economy is projected to grow at 2.6% (World Development Indicators, Washington, DC: World Bank, 2015, http://data.worldbank.org), with growth mainly limited to urban areas, while rural communities remain impoverished.

### 7.8.2 Health system context

The Lesotho health system is organized into three administrative levels: central, district and community. The central level provides policy guidance and oversight. At the district level, the district council serves as the administrative arm, and the District Health Management Teams serve as the technical arm. The DHMTs manage and provide technical support for district health service delivery, which includes district hospitals, health centers, and community-level health services.

The Government of Lesotho's Ministry of Health began to implement a Maternal and Newborn Health Performance-Based Financing program in 2014. The Ministry took a conscious decision to adopt PBF as an approach to finance and bolster its efforts to attain three ***Millennium Development Goals***: a) reduce child mortality, b) improve maternal health, and c) combat HIV/AIDS, malaria, and other communicable diseases.

### 7.8.3 Problem analysis

Lesotho's health system is not very cost-effective. It is one of the few low-income countries where the health system accounts for nearly 14% of the recommended government budget. Yet indicators remain poor or are declining.

The following problems can be identified:

- Lesotho's free health care policy (at the below-hospital level) leads to poor-quality health services, regular drug stock-outs, poorly maintained infrastructure and equipment, and staff demotivation.
- Moreover, free health care is not "free" because patients are at times forced to buy medicines and consumables from outside pharmacies.
- Despite a lot of donor support, as well as the fact that line ministries spend 3% of their budget on HIV – AIDS, the rate of new infections is not decreasing, and regarding HIV prevalence, Lesotho is the number 2 in the world. Inadequate utilization of funds results from weak coordination by the Ministry, leading to donor fragmentation.
- The tuberculosis program also receives important donor support, but the indicators are not improving. One major contributing factor is the regular migration of miners, and the number of multidrug-resistant patients is increasing.
- Human resource management in government health facilities is fragmented because NGOs and other external partners post staff. This leads to conflicts between the government and the NGO staff because NGO salaries are higher. Moreover, NGO staff tend to perform only NGO-defined tasks, and some will not accept instructions from government health facility managers.
- Health facilities still provide fewer than 5 services, such as immunization, and only on certain prescribed days. This is also to avoid opening a vial only for one child and thereby "wasting" the other doses in the vial. This affects families' socio-economic status because they spend money on transport for more health visits, and if they do not take their children for vaccination and they get preventable diseases, they may have to spend more on more serious interventions.
- Access to family planning is a problem in the catchment areas managed by Roman Catholic health facilities, which do not provide those services. Other health facilities have also witnessed stock-outs of family planning inputs. Clients who do not have access, when necessary, may have to spend money on transport to go to other facilities, end up defaulting, or have unplanned pregnancies, which could lead to abortions, which can lead to maternal mortality.

The table below indicates the major challenges Lesotho faces with regard to health systems, health indicators, and health care provision:

| Challenges | Reasons |
|---|---|
| 1. Leadership problems | - Frequent personnel changes at the top so that strategies change regularly<br>- Technical positions such as the DG have become political nominations<br>- MOH leadership fails to coordinate partner strategies leading to fragmented or even contradictory activities<br>- Some strategic positions in the MOH are not translated into actual positions |
| 2. Poor decentralization of health services | - National level not wanting to let go of power<br>- Late disbursements of funds to districts<br>- Poor supportive supervision and mentoring |
| 3. Infrastructure | - Poor road network so that health facilities and villages are difficult to reach<br>- In some health facilities electricity and water are absent<br>- Staff accommodation problems in most health centres |
| 4. Poor availability of medical equipment | - Lack/poor maintenance of medical equipment due to lack of biomedical technicians in the country<br>- Tedious procurement procedures in the government system<br>- Inadequate service contracts for medical equipment |
| 5. Poor management of some diseases/conditions | - Doctor - patient ratio of about 20,000 regardless of the high burden of diseases resulting in fatigue of doctors<br>- Language barrier between doctors and patients<br>- Poor history taking and prescription of medicines |

### 7.8.4 Is PBF a solution?

**Yes.**

- Better contract descriptions of the profile, outputs, and quality required of each actor, including at the top regulatory level of the Ministry, can address leadership problems. PBF contracts can formalize such relationships linked to performance payments.
- The autonomy the PBF approach gives health facilities to plan and execute their activities can improve their effectiveness and efficiency.
- Competition between facilities and between districts results in improved provision of services.
- The community PBF approach improves community participation, while social marketing helps communities gain more knowledge about health issues and, as a result, make informed decisions about their health and rights, which can improve indicators (e.g., avoiding home deliveries, going home with placentas, etc.).

### 7.8.5 PBF feasibility score for Lesotho

| Criteria to establish in how far the project is "PBF" | Points | Score |
|---|---|---|
| 1. The PBF program budget is not less than $ 4 per capita per year of which at least 70% is used for health facility subsidies, local NGO contracts and infrastructure input units | 5 | 5 |
| 2. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives | 3 | 0 |
| 3. The PBF program finances the full health centre and hospital health packages and is not restricted to a limited number of vertical program indicators | 2 | 2 |
| 4. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all prim0ary level principal contract holders. | 2 | 0 |
| 5. The project includes (or is part of) baseline and evaluation household and quality studies | 3 | 3 |

| | | |
|---|---|---|
| that establish priorities and allow measuring progress | | |
| 6. Cost recovery revenues are spent at the point of collection (facility level) | 2 | 0 |
| 7. Health facility managers have the right to decide where to buy their inputs | 4 | 4 |
| 8. The project introduces business plans | 3 | 3 |
| 9. The project introduces the indices tool for autonomous management | 3 | 3 |
| 10. CDV agencies sign contracts directly with the daily managers of the health facilities – not with the indirect owners such as a religious leader. | 2 | 2 |
| 11. Health facility managers are allowed to influence cost sharing tariffs | 2 | 0 |
| 12. Health facility managers have the right to hire and to fire | 2 | 0 |
| 13. There is a CDV Agency that is independent of the local health authorities with enough staff to conduct contracting, coaching and medical & community verification. | 2 | 2 |
| 14. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function | 2 | 2 |
| 15. CDV agents accept the promotion of the full government determined health packages (this in Africa mostly concerns discussions about family planning) | 2 | 2 |
| 16. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans | **2** | **2** |
| 17. Public religious and private facilities have an equal chance of obtaining a contract | 3 | 0 |
| 18. There are geographic and/or facility specific equity bonuses | 3 | 3 |
| 19. The project provides equity bonuses for vulnerable people | 3 | 3 |
| **TOTAL** | **50** | **36 =72%** |

Participants felt that the 72% score warrants a review of the PBF design to bring it up to the set PBF approaches.

### 7.8.6 Recommendations

- Review the PBF design to achieve a feasibility score of at least 80%.
- Advocate for more autonomy at the health facility level to use cost-sharing revenues and buy inputs from accredited distributors.
- The National Health Level should decentralize all health services to increase autonomy.
- The regulatory health district authorities should be capacitated and empowered with all necessary resources to implement decentralization effectively.
- PBF should have a full staff complement at national and district level.
- Review and increase the number of indicators to at least 25. Separate quality and quantity indicators, and include community-based and national-level indicators.
- Recommend for review of the policy on the abolition of user fees.
- Advocate for competition between public and private pharmaceutical suppliers.

### 7.8.7 Action plan Lesotho

| Action | How action will be executed | When | Responsible Person | Resources |
|---|---|---|---|---|
| Training feedback to Director Primary Health Care and Director General Health Services and submission of report explaining recommendations | Brief Meeting | 6th December 2017 | Dr. Sefako | None |
| Training briefing to Acting Director PBF | Short meeting | Latest 7th December | Dr. Celinah Sefako | None |
| Full training feedback to PBF Unit explaining recommendations | Meeting | 17th January 2018 | Dr. Sefako and Mrs. Mohlomi | None |

## 7.9 South Sudan

### 7.9.1 Background

On July 9, 2011, South Sudan became an independent nation-state. The Republic of South Sudan is landlocked and borders Ethiopia, Kenya, Uganda, the Democratic Republic of Congo, the Central African Republic, and Sudan. The country covers 645,000 square kilometers and has an estimated population of 12.4 million people. The White Nile, which flows out of Central Africa, is the country's major geographic feature. It supports agriculture and extensive wild animal populations. Administratively, the country was formerly divided into 10 states; however, in 2016, it was divided into 33 states (including the Abyei administrative area), 180 counties, and several Payams and Bomas.

Since independence in 2011, South Sudan's political landscape has remained dominated by internal and external threats to sustainable peace and stability. In December 2013, the country descended into protracted strife, heightening uncertainty. The parties to the conflict finally signed a peace agreement in August 2015, but implementing it on time remained a major challenge.

South Sudan faces challenges, including inadequate financial, human, technical, and infrastructure resources. Displaced people from various regions of the country have moved across borders to neighboring countries, placing these population groups at risk. The refugees and internally displaced people place enormous pressure on already constrained resources.

Access to functional health centers, food, and other basic services is severely constrained. Low population density, severe shortages of health workers and functional facilities, socio-economic barriers, inadequate mechanisms to reach pastoralist communities and displaced populations, and the under-financing of the health system make universal access to health services difficult to achieve.

### 7.9.2 Cordaid

Stichting Cordaid (Catholic Organization for Relief and Development Aid) is a Dutch International Humanitarian aid and Development Non-Governmental Organization (NGO) headquartered in The Hague, the Netherlands. Cordaid has 12 country offices globally and works in over 43 countries with about 400 employees. It has been fighting poverty and exclusion in the world’s most fragile societies and conflict-stricken areas for over a century.

Cordaid has been active in South Sudan for more than 20 years, with a strong focus on civil society capacity-building. Currently, it runs programs in emergency response, DRR, health, food security, extractives, security & justice, women leadership, and investments. Cordaid is active in seven States in South Sudan.

### 7.9.3 Health indicators and service delivery

The organization of the Health Care system in South Sudan in principle follows a three-tier order:

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

The key indicators of health are challenging:

- Under-5 years Childhood mortality rate: 108 per 1000 lives in 2010,
- Infant mortality rate: 79 per 1000 live births,
- Maternal mortality ratio is now estimated at 789 per 100,000 live births
- The doctor and nurse-to-population ratios stand at 0.022/1000 and 0.015/1000, respectively

### 7.9.4 Problem Analysis

The South Sudan health system appears too donor-driven and ignores the vibrant private South Sudanese health sector in urban and rural trading areas. Conflict and humanitarian emergencies worsen this, along with poor health system structures (weak leadership and governance, weak human resource management, poor infrastructure, service duplication, and weak health financing). Very high proportion of vulnerable population. Most inputs are centrally distributed by a single supplier, and health system structures for policy, regulation, and quality assurance are not functional.

***Governance and Leadership***

Good leadership, good governance, transparency, and accountability are the cornerstone of the health system. South Sudan finds itself in a very precarious position, as health services in general and regarding HIV, TB, and malaria services specifically are very poorly coordinated, making planning and accountability extremely difficult. Various partners, coordination bodies and mechanisms, and plans are not aligned with any central government strategy and often report to donors. The situation is exacerbated by a lack of capacity, mechanisms, and structures to coordinate the more than two hundred implementing partners supporting health services.

***Human Resource for Health***

Staffing is suboptimal and severely constrains delivery of the Basic Package of Health Services. The doctor-to-population and nurse-to-population ratios stand at 0.022/1000 and 0.015/1000, respectively. Staffing in primary health care facilities is low (10–20%) and distributed in favor of urban centers and higher levels of care. Poor incentives, high staff turnover, limited output from health sciences training institutions, and a challenging work environment discourage qualified health workers from taking positions and staying to serve in many states. Consequently, most health facilities provide minimal services, denying people in those areas access.

***Health Service Delivery***

Health service quality was widely perceived as poor, with only 44% of South Sudan's population having access to services. This is attributed to the fact that more than 80% of the population is rural and to inequitable distribution with an urban bias. Currently, 70% of health facilities are functioning, and less than 80% of counties have access to primary and referral health services. Health services at the protection of civilian sites (POCs) are provided through implementing partners. This is evidenced by outpatient visits per capita of only 0.6. Four visits for ANC services are only achieved in 17% of cases; the proportion of deliveries in health facilities is at a mere 14%, and Penta3 coverage is 33%

***Supply Chain Management***

Procurement and supply chain management remain extremely challenging in South Sudan. MOH is responsible for pharmaceutical supply to all primary healthcare facilities and has implemented a push system (i.e., dependent on forecasting rather than demand) which is unresponsive to needs. In addition, due to poor storage, tracking, and utilization of medicines, the vertical forecasting mechanism that administers a push system to the lowest levels incurs high losses
Insufficient domestic allocation of financial resources for medicines, and poor coordination of available resources with partners, have hampered the availability of medicines and health supplies to the population and led to the implementation of parallel supply chain mechanisms. This is exacerbated by inadequate quantification and projections of national need to guide medicine procurement, insufficient storage space, distribution and logistical challenges to health facilities, and irrational prescribing. The resulting frequent stock-outs mean people must pay out of pocket for medicines or go without treatment.

***Health Information System***

Over the last 10 years, the paper-based Health Management Information System (HMIS) has been improved to DHIS1.4 and is currently transitioning to DHIS2 for monitoring health service delivery. The nascent Health Management Information System performs about 50% in terms of timeliness and completeness. Despite the operationalization of DHIS2, the HMIS remains fragmented, with vertical programs collecting information that the Ministry of Health's information repository often does not receive or use. It mainly collects data from Primary Health Care facilities, leaving hospital and private-sector data unreported. Surveys and facility assessments have been used to fill these gaps; however, they proved too expensive and irregular.

### 7.9.5 Feasibility scan

The South Sudan participant executed the PBF feasibility scan and identified several challenges:

- The existence of a 'Zero cash policy', which allows only subsidies and in-kind inputs to health facilities. It created a pure input policy;
- Free health care, with insufficient public money to pay for health services. This leads to informal practices in an unregulated private sector (the result of pricing below equilibrium through the FHC).
- Many vertical programs run in parallel, creating inefficiencies.

| Criteria to establish in how far the project is "PBF" | Points | Current Situation | Score | Planned | Score |
|---|---|---|---|---|---|
| 1. The PBF program budget is not less than $ 4 per capita per year of which at least 70% is used for health facility subsidies, local NGO contracts and infrastructure input units | 5 | Most of the budget is input based without positive incentives | 0 | Negotiate with donors on the need for output-based programs.<br>Cordaid to target larger funds and wider geographical coverage in its program.<br>Consolidate funds to provide comprehensive health packages | 0 |
| 2. The PBF project has at least 20 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives | 3 | Programs are vertical, do not meet the Package of activities for both Primary and Secondary care | 0 | Start with selected manageable indicators | 3 |

| | | | | | |
|---|---|---|---|---|---|
| 3. The PBF program finances the full health centre and hospital health packages and is not restricted to a limited number of vertical program indicators | 2 | The programs are vertical, do not meet the minimum Package of activities for both primary and Secondary care | 0 | Selected indicators should be within the basic package | 2 |
| 4. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders. | 2 | No community interventions in current incentive schemes, only used in campaigns | 0 | Introducing community indicators to reachable (secure) populations | 2 |
| 5. The project includes (or is part of) baseline and evaluation household and quality studies that establish priorities and allow measuring progress | 3 | Baseline assessment done, but priorities were determined by the Donor | 0 | Baseline done to establish priorities and measure progress | 0 |
| 6. Cost recovery revenues are spent at the point of collection (facility level) | 2 | Yes | 2 | Collected revenue spent at the health facilities | 2 |
| 7. Health facility managers have the right to decide where to buy their inputs | 4 | Yes | 4 | Health facility managers have the right to decide where to buy their inputs | 4 |
| 8. The project introduces business plans | 3 | No business plans in based budgets available | 0 | Introduce business plans for facilities | 3 |
| 9. The project introduces the indices tool for autonomous management | 3 | Available tools are not for autonomous management | 0 | Avail indices tools for autonomous management | 3 |
| 10. CDV agencies sign contracts directly with the daily managers of the health facilities – not with the indirect owners such as a religious leader. | 2 | No contracts sign with facility managers (MOUs signed between implementing partners and (S)/MOH) | 0 | Establish independent CDV Agencies and sign contracts with facility managers | 0 |
| 11. Health facility managers are allowed to influence cost sharing tariffs | 2 | HMT proposes fees structures which is seconded by Board of governors | 2 | Health facility managers are allowed to influence cost sharing tariffs | 2 |
| 12. Health facility managers have the right to hire and to fire | 2 | No, hiring of staff is done by the (S)/MOH | 0 | Negotiate with SMOH to respect decisions made by facility managers | 0 |
| 13. There is a CDV Agency that is independent of the local health authorities with enough staff to conduct contracting, coaching and medical & community verification. | 2 | No independent CDV Agencies | 0 | Establish independent CDV Agencies | 0 |
| 14. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function | 2 | No, there is no separation of functions | 0 | Cordaid reorganise and separate the different functions | 0 |
| 15. CDV agents accept the promotion of the full government determined health packages (this in Africa mostly concerns discussions about family planning) | 2 | No, packages are donor driven | 0 | Consolidate funds to provide health package<br>Negotiate for funding that provides full health package | 0 |
| 16. The PBF system has | 2 | No, infrastructure and | 0 | Infrastructure and investment | 2 |

| | | | | | |
|---|---|---|---|---|---|
| infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans | | investments are input based | | units be place | |
| 17. Public religious and private facilities have an equal chance of obtaining a contract | 3 | No, private facilities are excluded from the input-based system | 0 | Equal treatment for all facilities | 3 |
| 18. There are geographic and/or facility specific equity bonuses | 3 | No equity considerations in positive incentives distribution | 0 | Equity considerations be basis for bonuses | 3 |
| 19. The project provides equity bonuses for vulnerable people | 3 | In places where there is cost sharing, there are exemptions to cost sharing. However, projects do not have cash recovery for free services provided by the facility | 0 | Project should provide cost recovery for vulnerable people | 3 |
| TOTAL | 50 | | 8/50 = 16% | | 32/50 = 64% |

### 7.9.6 Recommendations

Despite the challenging operating environment in South Sudan, PBF as a health systems strengthening reform can still be applicable. The May/June 2017 and November 2017 participants therefore concurred in their proposals:

- To join hands with the other PBF course graduates to form a critical mass that will boost the advocacy programs
- To conduct high-level advocacy with government and donors on the need for output-based programs. An important partner for this is the World Bank, which is in negotiation with the government along the same lines;
- To develop a well-designed PBF pilot in areas where Cordaid has a large presence, especially where it leads implementation. For this, the May and November Mombasa team proposes a full package with sufficient funding;
- To consolidate funds to provide the comprehensive health packages;
- To start with a selected set of manageable indicators, but not less than 20;
- To also introduce the community PBF indicators to reachable (secure) populations;
- Health facility managers should have the right to decide where to buy their inputs;
- To introduce the management tools of the business plan and the indices management tool for facilitating autonomous health facility management;
- Establish independent CDV agencies to sign contracts with facility managers and conduct verification and coaching. As an intermediate solution, Cordaid could propose that the payment function is done by the central Juba office, while the CDV role is played by the Cordaid field offices;
- Negotiate with the SMOH/CHDs to respect decisions made by facility managers
- Introduce investment units or quality improvement bonuses for infrastructure improvements
- Introduce equity bonuses for vulnerable people, while allowing health facilities to charge user fees from patients who can afford them.
- To pool resources from the donors (TB REACH, UNDP-GF) to fund TB out-based performance program

### 7.9.7 South Sudan action plan

The team drafted the following action plan:

| Activity | Who | When | Where | How | Resources |
|---|---|---|---|---|---|
| Debrief the Cordaid Health program senior management team on recommendations | Alex Bahima | 6th December 2017 | Juba | PBF course Report | Time, stationery |
| Finalize steps of designing a PBF program for TB | Alex Bahima<br><br>Gerald Agaba | 15th January 2018 | Kapoeta State Hospital<br>Chukudum Hospital<br>Kapoeta Mission Hospital<br>All PHCCs and Hospitals in the other States | | Funds<br>Stationery |
| Sign contract with facilities/ HHPs implementing TB and TB/HIV activities | Alex Bahima<br>Other TB program officers | 30th January 2018 | Kapoeta State Hospital<br>Chukudum Hospital<br>Kapoeta Mission Hospital<br>All other PHCCs in the other States | | Funds<br>Stationery |
| Apply & continue to roll out community PBF | Alex Bahima<br>Other TB program officers | 15th February 2018 | All TB and TB/HIV implementing sites (35) | | Funds<br>Stationery |

## 7.10 Zimbabwe

| | |
|---|---|
| *Ropafadzai Hove* | *Director Pharmacy Services* |
| *Heather Machamire* | *Director Finance and Administration* |
| *Jane Mudyara* | *Director Human Resources* |
| *Dr Rudo Chikodzore* | *Provincial Medical Director* |
| *Dr Simon Nyadundu* | *Provincial Medical Director* |

### 7.10.1 Context

The Ministry of Health and Child Care in Zimbabwe started implementing performance-based financing in 2011 as a pilot. The PBF program started in 18 districts and was funded by the World Bank. A 2014 impact evaluation showed encouraging results, and the Ministry adopted PBF nationwide, supported by the World Bank and the Health Transition Fund (now the Health Development Fund).

PBF has significantly improved maternal mortality, child mortality, ANC coverage indicators, and access to FP. Currently, Cordaid and Crown Agency serve as the purchasers. To ensure sustainability, the Ministry seeks to institutionalize PBF and establish a more sustainable implementation arrangement.

The Mid-Term Framework (MTF) recommended transforming the Program Coordination Unit (PCU) to also take on the role of the purchasing agency. The PCU has been serving as the Global Fund Principal Recipient (PR) for the Ministry. The MTF suggested that, with adequate capacity building and streamlining, the PCU was best positioned to take over from Cordaid as the purchasing agency.

### 7.10.2 Indicator package

The indicator package is based on diseases and conditions prevailing in the country, with selected priority areas targeted to support an integrated approach. These include reproductive health, maternal health, newborn health, child health, adolescent health, and nutrition, HIV, TB, malaria, and NCD indicators.

As of 2017, the total number of indicators changed as follows: -

| Level of Care | Old | New |
|---|---|---|
| Primary | 15 | 18 |
| Secondary | | 8 |
| Hybrid | 19 | 27 |

Depending on public health importance, some indicators remained unchanged, while others were removed, and some definitions/ names changed.

### 7.10.3 Feasibility scan

The PBF Feasibility scan shows a score of 32% in the HDF (Crown Agents) districts, and 66% in the World Bank (Cordaid) districts.

## World Bank RBF approach

| Criteria to establish in how far the project is "PBF" | Points | Score |
|---|---|---|
| 1. The PBF program budget is not less than $ 4 per capita per year of which at least 70% is used for health facility subsidies, local NGO contracts and infrastructure input units | 5 | 5 |
| 2. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives | 3 | 3 |
| 3. The PBF program finances the full health centre and hospital health packages and is not restricted to a limited number of vertical program indicators | 2 | 2 |
| 4. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders. | 2 | 0 |
| 5. The project includes (or is part of) baseline and evaluation household and quality studies that establish priorities and allow measuring progress | 3 | 3 |
| 6. Cost recovery revenues are spent at the point of collection (facility level) | 2 | 0 |
| 7. Health facility managers have the right to decide where to buy their inputs | 4 | 4 |
| 8. The project introduces business plans | 3 | 3 |
| 9. The project introduces the indices tool for autonomous management | 3 | 0 |
| 10. CDV agencies sign contracts directly with the daily managers of the health facilities – not with the indirect owners such as a religious leader. | 2 | 2 |
| 11. Health facility managers are allowed to influence cost sharing tariffs | 2 | 0 |
| 12. Health facility managers have the right to hire and to fire | 2 | 0 |
| 13. There is a CDV Agency that is independent of the local health authorities with enough staff to conduct contracting, coaching and medical & community verification. | 2 | 2 |
| 14. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function | 2 | 2 |
| 15. CDV agents accept the promotion of the full government determined health packages (this in Africa mostly concerns discussions about family planning) | 2 | 2 |
| 16. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans | 2 | 2 |
| 17. Public religious and private facilities have an equal chance of obtaining a contract | 3 | 3 |
| 18. There are geographic and/or facility specific equity bonuses | 3 | 0 |
| 19. The project provides equity bonuses for vulnerable people | 3 | 0 |
| **TOTAL** | **50** | **33 = 66%** |

## Health Development Fund RBF approach (Crown Agents)

| Criteria to establish in how far the project is "PBF" | Points | Score |
|---|---|---|
| 1. The PBF program budget is not less than $ 4 per capita per year of which at least 70% is used for health facility subsidies, local NGO contracts and infrastructure input units | 5 | 0 |
| 2. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives | 3 | 3 |
| 3. The PBF program finances the full health centre and hospital health packages and is not restricted to a limited number of vertical program indicators | 2 | 0 |
| 4. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders. | 2 | 0 |
| 5. The project includes (or is part of) baseline and evaluation household and quality studies that establish priorities and allow measuring progress | 3 | 0 |
| 6. Cost recovery revenues are spent at the point of collection (facility level) | 2 | 0 |
| 7. Health facility managers have the right to decide where to buy their inputs | 4 | 0 |
| 8. The project introduces business plans | 3 | 3 |
| 9. The project introduces the indices tool for autonomous management | 3 | 0 |
| 10. CDV agencies sign contracts directly with the daily managers of the health facilities – not with the indirect owners such as a religious leader. | 2 | 2 |
| 11. Health facility managers are allowed to influence cost sharing tariffs | 2 | 0 |
| 12. Health facility managers have the right to hire and to fire | 2 | 0 |
| 13. There is a CDV Agency that is independent of the local health authorities with enough staff to conduct contracting, coaching and medical & community verification. | 2 | 2 |
| 14. There is a clear separation between the contracting and verification tasks of the CDV agency and | 2 | 2 |

| | | |
|---|---|---|
| the payment function | | |
| 15. CDV agents accept the promotion of the full government determined health packages (this in Africa mostly concerns discussions about family planning) | 2 | 2 |
| 16. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans | 2 | 2 |
| 17. Public religious and private facilities have an equal chance of obtaining a contract | 3 | 0 |
| 18. There are geographic and/or facility specific equity bonuses | 3 | 0 |
| 19. The project provides equity bonuses for vulnerable people | 3 | 0 |
| **TOTAL** | **50** | **16 = 32%** |

### 7.10.4 Problem analysis

- HDF districts have no performance bonus, while World Bank districts do.
- In HDF districts, only primary care facilities receive performance-based subsidies, while district hospitals receive a fixed $4,000 per quarter. In the Cordaid districts, all health facilities receive subsidies based on performance payments.
- There is a lack of coordination with other programs working at the community level (Nutrition, Immunization, Breastfeeding, TB and Malaria, Water and Sanitation). This distorts the community PBF indicators, such as household visits following protocol.
- Government and other partners still mainly take an input approach. Many partners are still not implementing PBF.
- Government counterpart financing is 20% for the World Bank-financed 18 districts, while the 42 health development fund districts have no counterpart financing.
- Free health care is mainly politically driven, while fee-paying does pose less of a problem for the community. Some partner organizations still advocate the free health care agenda, such as DFID, the EU, and HDF partners like Swedish Bilateral Cooperation.
- The country has limited human resources fiscal space and relies on an outdated HR establishment system that does not match the workload. It also cannot recruit enough qualified personnel, such as medical specialists and nursing staff.
- The facility does not receive fee-paying revenues collected in council clinics.
- Government contribution to health has consistently been below 15%, as per the Abuja Declaration. Total health expenditure is estimated at $ 1 billion, of which the government contributes 40%. Moreover, 90% of this 40% goes to the wage bill, diverting spending from investment and operational expenses.
- The government's central medical stores system drives the distribution of essential drugs and equipment. Health facilities must first verify whether drugs are available at the central medical stores to prevent free access to private distributors, even when their prices are lower. As a result, tracer items such as latex gloves and ferrous sulfate regularly go out of stock.
- The current procurement act also runs counter to PBF best practices on free access to competing distributors.
- Private health facilities are not included in PBF contracts. Regulatory authorities need to work with private health facilities and pharmaceutical distributors, so they are licensed, accredited, and allowed to sign PBF contracts.
- Access to health services remains a challenge, with some villages more than 10km from the health facility.
- The current PBF excludes the urban health facilities. The proposed voucher system for urban health facilities has failed.

- Health facilities in the HDF districts do not yet pay staff performance bonuses.
- Partners pay community health workers varying amounts of allowances.
- Some partners apply different forms of PBF with incentives paid for certain indicators.

7.10.5 Can PBF make a difference?

*Yes.* A significant amount of government funds still reaches health facilities as inputs. We recommend changing this towards RBF performance financing. Public resources are limited; therefore, implementing PBF maximizes the impact of public funding.

7.10.6 Recommendations

**National**
- All Zimbabwe PBF training alumni should contribute towards in-country PBF implementation.
- Ministry of Health financial resources should fully shift from input financing towards PBF performance funding (GOZ, levies, taxes, partner funding).
- All health facilities, whether public, religious, or private, and urban or rural, should have an equal opportunity to obtain a PBF contract.
- The Ministry of Health should give health facilities and hospitals more autonomy.
- The Ministry of Health should create a more competitive environment for supplying health commodities by removing restrictions that favor monopolies.
- Health facilities in all districts (HDF and World Bank supported) should start paying performance bonuses.
- Gradually introduce cost sharing and drug revolving funds.

**Finance Directorate**
- Put in place a system to account for funds received by the Ministry of Finance
- Capacity building of the revenue department in accounting, as there will be additional work
- Undertake a quarterly regularly oversight role for PBF sites versus the current annual visit
- Revision of the rural financial manual incorporating PBF principles
- Configuration of PBF funding into PFMS

**Human Resources Directorate**
- Retention allowances to be performance-based
- Sensitize HR staff on PBF

**Pharmacy Directorate**
- DPS to work on accrediting public and private wholesale pharmaceutical companies, including registration requirements and scope of work, to allow entry into PBF.

**PMD**
- Introduce the indicator “household visits following a protocol” during the next review of indicators.
- Introduce the use of the indices management tool in all facilities.
- Negotiate to pay community health workers under PBF, rather than the current situation where they receive a varying allowance directly from partners.
- Introduce PBF principles in our local context, including other stakeholders such as PHE, PDCs, and DHEs.

### 7.10.7 Action Plan Zimbabwe

| Activities | Responsible persons | Timeline |
|---|---|---|
| Feedback report to Permanent secretary of Health | - Director Finance and Admin<br>- Director HR<br>- Director Pharmacy | 08 December 2017 |
| Feedback report to Provincial Health Team | - Provincial Medical Director | 31 Dec 2017 |
| Feedback report on PBF to Resident Minister/ PA | - PMD | 08 Dec 2017 |
| Conduct a PBF all stakeholder meeting including PBF training alumni to plan on PBF implementation going forward | - Director Finance and Admin | Q1 2018 |
| Advocate for Ministry of health financing to fully transition from input based to PBF (GOZ, levies, taxies, partner funding) | - Director Finance and Admin<br>- Director HR<br>- Director Pharmacy<br>- PMDs | Ongoing |
| Advocate for retention allowances to be performance based in the National PBF steering committee meetings | - Human Resources Director | Ongoing |
| Advocate for quarterly regulatory/ oversight on finances to PBF sites versus the current annual visiting the National PBF steering committee meetings | - Director Finance and Admin<br>- Director HR<br>- Director Pharmacy | Ongoing |
| Advocate for addition of an integrated household visit following protocol indicator in the National PBF steering committee meetings | - Director Finance and Admin<br>- Director HR<br>- Director Pharmacy | Ongoing |
| Advocate for community health workers to be paid under PBF versus the current situation where they get varying allowances in the PBF steering committee | - Director Finance and Admin<br>- Director HR<br>- Director Pharmacy | Ongoing |
| Sensitization of PBF principles at provincial level targeting other stakeholders (Provincial Development Committee) | - PMDss | Q1 2018 |
| **Finance activities** | | |
| Develop a system to account for funds received by MOF for Health under PBF | - Director Finance and Administration | Q 1 2018 |
| Revision of the rural financial manual incorporating PBF principles | - Director Finance and Administration | Q1 2018 |
| Configuration of PBF funding into PFMS | - Director Finance and Administration | Q2 2018 |
| Capacity building of revenue department on PBF | - Director Finance and Administration | Q2 2018 |
| Sensitization of HR staff on PBF | - Director Human Resources | Q2 2018 |
| **PMD** | | |
| Implement pilot of an ‘integrated household visit following protocol’ within the province | - Provincial Medical Director | Q1 2018 |
| Introduction of the use of indices management tool in health facilities | - Provincial Medical Director | Q1 2018 |

## 7.11 Liberia

### 7.11.1 Context

Liberia is in West Africa with a population of 4 million (2015). The country is divided into five regions and fifteen counties. Liberia has 91 health districts and 727 health facilities, 64% of which are public. 71% of the population can access health services within 5 km or a 1-hour walk.

Much has changed in Liberia because of the Ebola Virus Disease (EVD) crisis. Economic growth was severely affected: the previously projected rate was 6 percent, but in 2014 it fell to less than 1 percent. The country's fiscal deficit also substantially widened from 1.9 percent of GDP in FY13/14 to nearly 10 percent of GDP in FY14/15. Total Health Expenditure in FY 13/14 was US$ 301 million (15% of the country's nominal GDP), and Total Institutional Health Expenditure (TIHE) was US$ 173 million (9% of nominal GDP), for a per capita health expenditure of US$ 72. Households are contributing 42% to the health sector.

The Ebola Virus Disease (EVD) outbreak eroded several previous gains and further weakened the already fragile health system. Deliveries by skilled birth attendants, for example, declined by 7 percent from 2013 to 2014; ANC 4th (ANC4) visits dropped by 8 percent; measles coverage declined by 21 percent from 2013 to 2014; and health facility utilization plummeted by 40 percent (5.5 visits in 2013 to 3.3 visits per inhabitant in 2014). Interruptions in essential immunizations also led to measles and meningitis outbreaks. Continuing poor health outcomes have been linked to and compounded by the fact that Liberia lost 10 percent of its doctors and 8 percent of its nurses and midwives to Ebola (i.e., 8.1% of its health workers).

Post-conflict conditions, coupled with the more recent impact of the EVD outbreak, place Liberia at the bottom of global rankings for maternal, neonatal and child health (MNCH). The maternal mortality ratio (MMR) remains high, at 1,072 deaths per 100,000 live births, and has continued to increase since 2000. In addition, over one in ten children will die before the age of five, although neonatal mortality has declined by 19% from 32 to 26 (per 1,000). Liberia's maternal and newborn deaths are driven by preventable and treatable complications. Major causes of maternal deaths are haemorrhage (25%), hypertension (16%), unsafe abortion (10%), and sepsis (10%). Low family planning coverage and high teenage pregnancies are also known to be major contributors to maternal mortality. Neonatal deaths account for 35% of under-five deaths, with prematurity, intrapartum-related events, and infections as the major causes of death, with over 55% of neonatal mortality occurring among girls under 15 years compared to 6% for those over 19 years.

### 7.11.2 Problem Analysis

Liberia implements a free health care policy for all. The main objectives of providing free health care services were to increase access and eliminate inequalities. Yet, during implementation, it has become evident that what people need is not just "services" but "quality services". In public facilities, low-quality care, with routine stock-outs of drugs and medical supplies, has driven consumers to patronize private health facilities. Currently, the health sector is heavily donor-dependent, with interventions that are all vertical and difficult to coordinate. The Essential Package of Health Services is mainly provided through input financing using contracting-in, contracting-out, and hybrid contracting models. In three counties (Bong, Nimba &

Lofa, with a cumulative population of 1.3 million) supported by the current USAID-supported Fixed Access Reimbursable Account (FARA), performance-based financing has been introduced, but 90% of the budget is allocated to inputs and only 10% to performance. Health data show large gaps and variations in health service utilization across the continuum of care. Poor quality of care is the major cause of high maternal and under-five mortality. The fact that major causes of maternal and neonatal deaths are preterm complications and intrapartum-related events despite the relatively high service utilization suggests a major challenge with the quality of care provided to women and children (RMNCAH IC, 2016).

Large geographical disparities in health services need urgent attention. According to a post-Ebola health sector assessment by the MoH and development partners, 29 percent of Liberia's population, particularly those in rural areas, must walk more than 60 minutes or 5 kilometres to reach the nearest primary health care (PHC) facility.

A study of remoteness and health care in Liberia found that "greater distance from facilities is significantly associated with reduced care seeking and service utilization among rural populations". This is evidenced by urban-rural disparities in both under-five mortality, which was higher in rural areas (120 deaths per 1,000 live births) than in urban areas (106 deaths per 1,000 live births), and full immunization coverage, which ranged from 68 percent in the North-West region to 38 percent in the South-East region.

7.11.3 Can PBF make a difference in your setting?

**YES.**

Performance-based financing, when carefully designed with all its best practices, can make a difference. This approach focuses on improving quality, efficiency, equity, and sustainability. It promotes autonomous management by providers (clinics, health centers & hospitals) and implements effective strategies to decentralize functions. Moreover, service providers (health workers) can earn bonuses from generated revenues, on top of their monthly fixed salary, as motivation after achieving outputs and quality, and upon verification by the Contract Development and Verification Agency.

7.11.4 Problems identified by the feasibility scan

The Liberia team identified a feasibility score of 6/50 = 12%. This score accurately reflects our existing PBF scheme, the criteria used to establish the feasibility scan, and how far the program is from being "PBF." We identified the following problems.

- The current per capita PBF budget is below $US 4 per capita per year.
- Fewer than 25 PBF output indicators receive subsidy, and there are no separate composite quality indicators.
- The current PBF program finances only PHC-level clinics and is restricted to vertical programs.
- The current PBF program has no community indicator "visit to household following a protocol".
- The current design lacks baseline and evaluation households and quality studies to establish priorities and measure progress.
- The system does not allow cost recovery revenue, and health facility managers do not influence cost-sharing tariffs.
- Facility managers are not allowed to spend cash.

- There is no Contracting Development Verification Agency. The Ministry of Health still handles contracting, verification, and coaching functions at the primary level. Community verification is not being done. However, in the hospital PBF scheme, the verification function for selected hospitals is separated from contracting, and CBOs subcontracted by the National Verification Agency conduct community verification.
- Facility Managers cannot hire or fire. Hiring and firing are done centrally.
- Private providers have no chance of obtaining a PBF contract. Only government health facilities obtain PBF contracts.
- Bonus calculations do not consider the geographic equity bonus or equity bonuses for vulnerable people.

7.11.5 What are the deeper reasons for the PBF design problems**?**

- The Ministry of Health currently implements a free health care policy for all. Policymakers do not allow user fees, even though studies show consumers are willing to pay. Allocation to performance incentives is too ambitious and aims to reach a large population. There is also reluctance to move away from contracting out health services to NGOs and introduce direct contracts with facility managers (contracting-in) to achieve outputs and improve quality.
- The full government-determined package of services to be subsidized has not been defined for clinics and hospitals. A few outputs and administrative indicators (14 indicators) have been selected for subsidization. They are subsidized based on targets reached, not on quantity delivered. The current indicators are not SMART, and their definitions make them hard to verify. Targets are negotiated with NGOs (implementing partners) and County Health Teams (CHTs). NGOs and CHTs further negotiate these targets with the facilities.
- Policymakers are reluctant to separate functions outside the existing Ministry of Health structures. Contracting and verification remain at the central level. Contracting still occurs at the program unit level, and M&E, HMIS, and the PBF Unit jointly verify. Contracts are signed between MoH and NGOs (IPs) or CHT directly. Facilities are expected to do business plans with CHT or Ips, but business plans do not form the basis for contracts between facilities and IPs or CHTs.
- Decentralization is ongoing but slow. Roles such as hiring and firing remain centralized. This stems from the complexities of inter-agency operations between the MoH and the Civil Service Agency. Policymakers are unwilling to delegate these functions to health facilities without a total reform of the Civil Service Act, which is currently under review. Additionally, facility managers are not encouraged to manage and spend cash autonomously. Capacity to manage cash is believed to be lacking, coupled with resistance to changing existing procurement and administrative procedures for managing health providers.
- Currently, decision makers prefer implementing PBF in public facilities rather than in private facilities.

### 7.11.6 Action plan Liberia

**Objective**

- Provide evidence-based information on the PBF approach and how it can improve quality health care services, Universal Health Coverage, and promote equity

**Recommendations**

- Review existing PBF institutional and implementation arrangements, determine the package of services to be subsidized, consider introducing user fees, and include an equity bonus.
- Separate functions through a "purchaser-providers split" and by introducing contracts with health facilities and other actors in the PBF scheme.

| | Action | Who | When | Comments |
|---|---|---|---|---|
| Step 1: | Develop an PBF advocacy Plan | Mombasa PBF training team | 7 - 8, Dec-17 | Hold a work session with the MOH PBF Mombasa team to produce the final draft of the advocacy plan, share the plan for inputs, finalize plan with incorporated comments |
| Step 2: | Presentation to Health Services Dept. | Dr. Howe | 11-Dec-17 | Ensure presentation is included on meeting agenda 1 week prior to the meeting, ensure major key stakeholders such as CMO, Deputy Ministers for Planning are in attendance |
| Step 3: | Present PBF Advocacy Plan to MOH key stakeholders | Mombasa PBF training team | 13 -14-Dec-17 | Conducting an advocacy meeting to inform key stakeholders using evidence from the Mombasa PBF training |