Mombasa – KENYA

Report of the 59th Performance Based Financing Course

May 22 – June 2, 2017

The 25 course participants in Mombasa enjoying happy moments together

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1. LESSONS LEARNED & MAIN RECOMMENDATIONS

This is the report of the ***59th performance-based financing (PBF)*** course, which took place in Mombasa, Kenya from Monday May 22 to Friday June 2, 2017. In general, the PBF course was a success. All participants passed the final exam and the seven country groups produced impressive action plans (see below). The Sai Rock Hotel at the Mombasa beach is an attractive venue to learn and to think about how to improve health systems in the respective countries represented. Yet, this time, the hotel had some problems with the water supply and screening of the windows, which will be solved for the next course. The daily and final evaluation of the course by the participants was above average compared to the previous courses and the continuous improvements of the course content and methodology seem to pay off. The main lessons learned were also that we should continue to condense the course content with key messages, that we should further discipline the debates, make the PowerPoint presentations shorter and to allow for more group work.

1.1 General observations / lessons learned from the course

The PBF course welcomed participants from seven countries.

1. The team from Cameroon consisted of three medical verificators from the South West Region Contract Development and Verification Agency;
2. Cordaid sent their administrator from the Ethiopia health programme;
3. Lesotho sent a delegation working for the national RBF Unit in Maseru also looking at the design of the Lesotho PBF program;
4. The Nigeria team consisted of 2 participants from the Federal level; three persons from the State Government including two Commissioners of Health (Yobe and Bauchi) and the Chief Medical Director of the Borno State Hospitals Management Board; as well as four persons from a leading private sector entity in Nigeria (Private Sector Health Alliance of Nigeria);
5. South Sudan had a strong team of four persons, three of which work for Cordaid and one person is the Health Director of Unity State government;
6. Three representatives from the planning department of the Ministry of Health in Uganda attended the course and were looking at the Uganda RBF design;
7. The Zimbabwe team consisted of three persons from the Ministry with the objective of looking at the institutional set up of the RBF program

The facilitation team consisted of:

1. Dr Godelieve van Heteren, who is currently working with the WHO,
2. Dr. Fanen Verinumbe, who is the training coordinator of Adamawa State in Nigeria;
3. Dr Claire Rwiyereka, who is an independent consultant from Rwanda and;
4. Dr Robert Soeters the director of SINA Health and overall coordinator of the course.

Throughout the two weeks of the course, the country teams engaged in drafting and improving their action plans on how to implement and advance PBF in their countries. The "village 59" chief, Ms Palesa Henson together with her deputy, timekeeper and tax collector, actively supported the facilitation process and contributed to a congenial atmosphere and towards maintaining "order" in the village.

The daily evaluations resulted in above average scores compared to previous courses. The **methods and facilitation** was 92.3%, 6% above the average of the previous 19

English courses. The score for **participation** was good with 90%, which was 7% above the previous courses.

The **organization** of the course in Mombasa had a relatively low score of 76.7%, which was 10% *below* the average of the previous courses. The participants this time were less satisfied with Sai Rock Hotel. The hotel has spacious well-conditioned sitting arrangements for group work and has an idyllic location at the lagoon of the Indian Ocean with white sand, but there were problems with the water supply and the TV as well as too many mosquitos due to the rainy season and poor screening of the windows. We addressed these problems with the hotel management, but they were slow to take action. The subject of **time keeping** scored 81.5%, which was 10% *above* the average of the previous courses.

The final evaluation confirmed the daily positive impressions, with high scores on general impression, methodology, duration, the execution of the program and facilitation. The satisfaction with the content of the modules was also above average. Yet, the score for the venue and food were low compared to last December, 2016. Also, there was a weak score for the module "costing" because time did not allow to fully cover this topic.

Improvements for future PBF courses

- The PBF course content and program materials have expanded considerably since the first course in 2007. Our aim has always been to cover all modules during the 12-days course, but this has become increasingly unrealistic with the new developments and instruments in PBF. The starting level of each participant is also different: some are novice in PBF while other's have already PBF knowledge and come to the course with specific objectives. Therefore, we try progressively to condense the messages in order to gain time and to tailor the content of the course as much as possible to the needs of each participant.
- During the September 2016 PBF course in Douala we piloted for the first time a modular approach whereby we presented during one day in the first week two different modules (module 6 regulation and module 7 CDV Agencies) in two conference halls to those participants who are more focusing on either regulation or CDV agencies. This successfully reduced the time pressure on the course curriculum and also reduced the stress for the participants. Yet, some participants also criticised this approach, wishing to learn all aspects of PBF. The main lessons learned are that we should continue condensing the course with key messages, disciplining the debates, make the PowerPoint presentations shorter and to allow for more group work.
- The pre-course questionnaire, conducted immediately on arrival of the participants, was useful. It establishes the level and background of each participant so that we can better tailor the courses to the needs of each person.
- We have also gradually developed three types of courses: (1) Basic *national* PBF courses with modular approaches during the first and the second week and zooming in on the particularities of the country; (2) Basic *international* courses with modular approaches and; (3) *Modular, advanced courses of one week.* This latter has been planned already for some time but we hope during the coming months to make progress.
- In the basic courses, the introduction modules "What is PBF" as well as the (health) economics and PBF theories remain for all groups. Also, the conflict

resolution and the feasibility scan will remain for all course participants. Each participant will continue to develop their personal action plan.

- The weight of the exam has considerably increased since 2015. As a result, 11% of the participants during the last 9 courses in 2015-2016 did not pass the threshold of 55% compared to 5% during the previous 8 courses in 2014-2015. Yet, in this Mombasa course all participants manged to pass the exam for which we present our congratulations.

1.2 Country specific recommendations

1.2.1 Cameroon

Cameroun started PBF first in the East Region with the Catholic Church and Cordaid in 2006, followed by a World Bank financed pilot programme in 2011 in four Regions. The government has in 2016 declared PBF as their national policy and also as the approach to reach the Universal Health Coverage objectives. During 2017, the government is scaling up PBF from 25% of the country to cover 50% of the population and aims in particular to roll out PBF in the three Northern Regions, which were recently affected by instability due to Boko Haram. The three participants from Cameroun came from the South West Region.

Problem analysis

1. Facility managers at hospital and health centre level are not yet allowed to spend revenues generated at their facility and must send their revenues to the treasury. Only after complicated procedures they can recover those funds;
2. The use of the PBF Quality Improvement Bonuses (QIB) is not yet effective;
3. The number of vulnerable to be exempted with a 10% ceiling per health facility for the equity output indicators, is somewhat irrational. For example, in small remote health facilities with low uptake, the amount of vulnerable may be higher than in other more urban health facilities.

Recommendations

1. Advocate for the MOH technical PBF unit that HF should be truly autonomous and are allowed to use their own revenues.
2. Concerning the Quality Improvement Bonuses: (a) Advocate with the national technical PBF unit that funds should be made available for its implementation and that reimbursement is smooth; (b) The CDVA should recruit an engineer to verify and coach health facilities in the use of the QIBs.
3. The CDVA should be empowered to raise the ceiling per health facility for the number of vulnerable to be exempted from 10% to higher levels per HFs according to need. It should be left to the district validation committee to which level they can increase the ceiling per health facility as long as the overall number of vulnerable exempted per district remains below the ceiling of 10%.

1.2.2 Ethiopia

Ethiopia has so far started a small Cordaid-initiated pilot in four districts with 126,000 inhabitants in Oromia State. The representative of Ethiopia presented several implementation problems concerning the Cordaid pilot programme, including the change in strategy that was required as the result of the prolonged dry season. Another problem presented is the slow uptake of the PBF subsidies by the health facilities. The latter problem points to a more systemic problem with the design of the PBF program.

The Cordaid representative in Mombasa recommends support for the PBF health facilities, in terms of more robust verification and coaching. Another line of recommendations is to better inform the relevant authorities about PBF with the aim to scale up the pilot to other areas of the region and the country.

1.2.3 Lesotho

Lesotho is a landlocked low-middle income country. Its mountainous features make that there are geographic access problems to rural areas. Its development and health indictors are poor with notably the very high maternal mortality rate of 1,024 per 100,000 live births. The HIV prevalence rate among adults is one of the highest in the world with 23%.

Considerable investments in the health sector have been done, but they have not yielded the desired results. In response, the government started since 2014 testing PBF with the aim to reduce inefficiencies and to obtain better results first in two districts and later in six districts covering around 50% of the population. The feasibility score conducted by the Lesotho participants in Mombasa show a score of 50%. This implies that improvements in the design are still required.

The main problems identified, by the feasibility scan, with the PBF design are:

- The PBF unit is placed too low in the hierarchy of the Ministry and this hampers the opportunity to make use of the full potential of the PBF approach;
- The budget per capita for PBF is too low to provide the full PBF package and to roll out the full contract development, verification and coaching capacity;
- The number of indicators used in the Lesotho PBF program is too low and need to be increased to prevent that PBF remains a vertical program;
- There are no community PBF indicators included in the package;
- Health facilities lack enough the autonomy such as to use cost-recovery revenues at the point of collection and they do not have the right to purchase inputs from different distributors. This leads to inefficiencies and frequent stock outs;
- The Lesotho design does not include the use of PBF Investment Units as the preferred method to solve problems with infrastructure and equipment. Currently, there is still an inefficient and centralized management of investments;
- Lesotho does not yet apply the PBF targeted free health care approach for vulnerable districts, health facilities and individuals.

Recommendations

- The PBF Unit should be brought directly under the Principal Secretary of the MoH;
- There should be a higher PBF budget of above USD 4 per capita. This does not need to be done by asking for more funding but can be done by reallocating already existing budget lines for inputs;
- Increase the number of PBF output indicators, including for equity, community PBF and the investment units;
- Establish a more robust national Contract Development and Verification Agency with branches at regional level;
- The PBF Unit should advocate for more autonomy at health facility level for the use of cost-sharing revenues and buying inputs from accredited distributors;
- Accredit pharmaceutical suppliers and train pharmacies in standard protocols
- Integrate PBF data in web based application of DHIS2.
- Train District Quality Assessment Teams

1.2.4 Nigeria

Nigeria with 186 million people is made up of 36 States and the Federal Capital Territory, which is like a state. The country has a per capita income of USD 3,234. The health system has three levels - primary, secondary and tertiary - with no clear role definitions in the responsibility of each tier. The population growth is 3.2% per annum and the population density is 168 people per sq.km. Nigeria has sub-optimal health services and the maternal mortality rate is high with 576 per 100 000 live births with a very unequal distribution over the States and unfavourable for the States in the North-East such as Borno, Yobe and Bauchi. There is weak donor coordination and monitoring systems. Health is seen by many states as a social good with inefficient free medical services.

The per capita health expenditure is $ 217 of which 69% come from out-of-pocket expenditure and only 28% is from public or private institutions. All this is aggravated by declining economic growth and the Boko Haram insurgency displacing millions of people and destroying a lot of infrastructure. Yet, the States have reasonable independence in managing their health systems.

Based on the result so far since 2011 in the three pilot States, the Nigerian team felt that PBF has the potential to significantly improve health outcomes by moving away from input financing and focusing on results in terms of quality and outputs. PBF may increase efficiencies in an adverse environment of declining growth rates and instability. It will also enhance accountability and improve use of data for evidence-based decision-making. The PBF emergency approach may also be important to improve results in unstable areas and to reduce costs.

General recommendations

- The team in Mombasa proposes for Nigeria the slogan: *"Performance Based Financing for Universal Health Coverage - PBF4UHC".*
- Integrate PBF into ongoing activities in the health sector and make it a strategic health reform program that should be included in the National Strategic Health Development Plan;
- Explore ways to ensure prompt payment of subsidies to the relevant PBF actors;
- Ensure improved coordination and ownership for the PBF Program by government at all levels
- Increase funds for the PBF program budget through re-allocation of existing funds and government budget lines
- Mobilize funds from the private sector to complement Government budgets

Specific recommendations

- Send the report of the Mombasa PBF course with recommendations to the Federal Minister of Health;
- Organize a coordination meeting between all the PBF actors at the national level with the FMOH, World Bank, technical assistants and the PIU NPHCDA;
- Convene a technical working group meeting with the NSHIP actors to discuss the health reform approach, its challenges and develop a plan for the inclusion of PBF in the National Strategic Health Development Plan II;
- Align and harmonize the indicator sets used in tracking the NSHIP interventions with the national indicator sets in the DHIS2
- Integrate the RBF platform with DHIS2 platform
- Provide appropriate support to the NSHIP Additional Financing States.

1.2.5 South Sudan

South Sudan is in size a large landlocked country with only 12.4 million inhabitants. After two relatively calm years of peace after its independence in 2011, the country has descended since 2013 in internal and external strive. As a result, the population suffers from displacement, and there is limited access to food and social services. Cordaid is currently working in several States in South Sudan, but so far mostly with classical input oriented health programs. Yet, Cordaid also appreciates the importance of performance based systems and decided to send a four-member team to Mombasa to analyze what can be done.

Problem analysis

- South Sudan has poor health impact indicators such as the very high maternal mortality rate of 789 per 100,000 live births;
- The population has limited access to quality health services;
- The health system is extremely donor-driven and implemented by International NGOs with at least 90% of public health expenses financed by external sources;
- There is a vibrant local – mostly informal - private sector, but which is being ignored by government and development partners.
- There is a high proportion of vulnerable people.
- The distribution system in South Sudan is input oriented and supply ("push") driven and does not allow for competition. Stimulating and regulating fair competition among the South Sudanese private sector is not yet a government priority. As a result, stock outs are frequent and there are doubts about the quality of drugs brought in the country.
- The availability of qualified staff per 1000 inhabitants is very low.
- Despite the operationalization of DHIS2, the HMIS remains fragmented, with vertical programs collecting information that is often not shared with and used by the information repository in the Ministry of Health.
- The 'zero cash policy', only allows for inputs in kind to health facilities. This is a de facto pure centralised planning approach with an inefficient and ineffective input policy;

Recommendations

- 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;
- Develop a well-designed PBF pilot in areas where Cordaid has a large presence, especially where it is the lead partner for its implementation. For this, the Mombasa team propose a full package and with sufficient funding;
- Consolidate funds to provide the comprehensive health packages;
- Start with a selected set of manageable indicators, but not less than 20;
- Introduce also the community PBF indicators to reachable (secure) populations;
- Health facility managers should have the right to decide where to buy their inputs;
- Introduce the management tools of the business plan and the indices management tool for facilitating autonomous health facility management;
- Establish independent CDV Agencies with the objective to sign contracts with facility managers, 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 to respect decisions made by facility managers

- Introduce investment unit or quality improvement bonuses for infrastructure improvements
- Introduce equity bonuses for vulnerable people but also allow health facilities to charge user fees from those patients who can afford.

1.2.6 Uganda

Uganda has 34.6 million inhabitants and a high population growth of 3% per year. The Uganda health system is facing major challenges and the government tries to find a proper RBF/PBF design to tackle them. Since abut 15 years there have been experiments with smaller RBF / PBF pilots, which provided useful lessons.

A new framework has been developed for the implementation of RBF in two third of the country. Yet the team in Mombasa scored the feasibility of the current design with only 42% and they identified several points for improvement:

- The per capita budget for PBF is only USD 2.50, while at least USD 4.00 is considered necessary for a well-designed holistic PBF programme;
- The number of indicators is only 10 with a vertical orientation towards reproductive health care, while a minimum of 25 is recommended.
- The current package does not contain community PBF indicators;
- Government health facility managers are not allowed to spent their locally generated revenues from cost-sharing at the point of collection;
- Health facilities do not have a right to decide where to buy their inputs. They depend on the central distribution for inputs such as essential drugs and equipment;
- The verification agency is the DHMT, which is also the regulatory authority at local government level. This violates the RBF principle of separating functions. Thus, there is a need to create an independent CDV agency.
- There are no geographic and/or facility specific equity bonuses
- There are no equity bonuses for vulnerable people. Instead there is generalised free health care that is inefficient and produces poor quality of care.
- The National RBF program data management system is still manual and not linked to the DHIS 2
- There are no output indicators at the national and regional RBF Units

Recommendations

Given the discrepancies between the PBF best practices and the currently proposed RBF National Framework design, the Uganda team proposes:

- To review the current RBF design and notably: (1) review the budget and the scope of indicators; (2) review and change the CDV function from the regulatory DHT function
- Adoption of the free market system for facility commodities
- Digitalize RBF data management system.

1.2.7 Zimbabwe

The Zimbabwe government made RBF its national policy several years ago with the objective to improve the health services in terms of efficiency, equity and to enhance check and balances and transparency. Its medium-term financing strategy aims to

enhance the institutionalization of RBF and minimizing user fees while also respecting the core tenets of the results based management approach.

The Zimbabwe RBF approach compensates providers based on quantity and quality services provided. This also requires an institutional structure that guides funds flows, establishes adequate services packages and conducts a costing for RBF. The problem analysis according to medium-term financing strategy document concerns: (1) The government feels it has a limited role in executing key RBF functions; (2) The accounting systems lies outside the public management system; (3) There is declining development partner funding.
The MTF strategy therefore proposes: (1) To include RBF in the public financing system by 2018, which implies making the MOFED the payment agency; (2) Strengthen the role of the project coordination unit as program management and purchasing agent.

A high-level team came to Mombasa to further analyse the institutional set up of the RBF system and came to the following problem analysis and recommendations.

Problem analysis and recommendations

- Provide feedback on the PBF Training in Mombasa to the top management team of the Ministry
- The standard feasibility scan of the current PBF design in Zimbabwe showed a low score of 52% and the team concluded that there is a need to revise the Project Implementation Manuel;
- Contrary to what is proposed in the MTF strategic framework 2016-2020 by the Ministry, the team felt that the Ministry need to consider separating the two roles of the PBF-PCU Unit. The team therefore proposes to have a relook at the implementation arrangements with special emphasis on separating the functions of contract development and verification from the regulatory role.
- Come up with a strategy for a deeper public-private partnership that will share the burden of health service provision
- Mobilise additional resources from partners and re-direct available resources meant for input financing activities to cover the gap to meet the minimum PBF per capita requirement currently estimated at USD 2,44 to reach at least USD 4.00 per capita per year

2. INTRODUCTION

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

Performance-based financing is steadily replacing input-based centrally planned health systems, on which the PHC and Bamako Initiative paradigms were based. Since the late 1990s, PBF initiatives and pilots, formerly known as the contractual approach, have been gradually introduced in around 40 countries worldwide. A number of them - such as Benin, Rwanda, Burundi and Zimbabwe - have adopted PBF as their 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 such as in Afghanistan, Tajikistan, Kyrgyz Republic and Laos.

Since PBF is a systemic approach, the application of PBF in other sectors than health is also receiving interest – notably in education. There is no longer controversy around the main theories and concepts of the PBF reforms. PBF aims to capture the efficiency of a regulated market economy to distribute scarce resources and thereby to assure more sustainable systems. Its effects on transparency and good governance are comparing favorably to top-down and hierarchical style of existing (health) systems.

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

The downside of any PBF-led transformation is that it requires change that is sometimes difficult to manage. It entails informing key stakeholders and changing the terms of references of most stakeholders including those in the ministries. The need to increase provider revenues will under most circumstances also require maintaining direct fee paying for patients and parents. This will inevitably constitute financial access problems for the very poor. Hence, we need to include in the design of new PBF interventions demand-side support for the vulnerable in the shape of geographic and individual equity funds. These new PBF instruments are somewhat comparable to the traditional voucher and conditional cash transfer systems but they are more efficient. By contrast, inefficient blanket approaches or populist usage of free health care mechanisms should be avoided. Rigorous empirical research and impact evaluations on the pros and cons of various methods remain adamant.

2.2 Aims and objectives of the Mombasa PBF course

General aims of the PBF course

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

Specific Objectives

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

2.3 The May - June 2017 Mombasa course

The 59th group consisted of a mix of people with a variety of implementation experience in PBF in different countries across Africa (Cameroon, Ethiopia, Lesotho, Nigeria, South Soudan, Uganda and Zimbabwe). Throughout the course, the participants were assigned to develop a "business or action plans", 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) Develop an action plan for the participants and country groups on how to tackle the various problems identified, following the logic of the PBF modules. The updated course guidebook "PBF in Action: Theory and Instruments" was distributed among the participants before the start of the program, upon confirmation of participation. The course materials (a hard copy of the course book, pdf latest version of the course manual, the PowerPoint presentations, the recaps and country presentations, photos of the course and articles) were distributed during the course, together with the participants' contact details list. On Friday May 26, 2017, field excursions were organized to four health facilities: Mtwapa Health Center, Kadzinuni Dispensary, Vipingo Health Center, and Kilifi County District Hospital.

2.4 The final exam, adult learning and accreditation

SINA Health issues a Certificate of Merit to those who passes the exam at the end of the course. Those who do not score 53% or more, obtain a Certificate of Participation. This exam was conducted on Friday June 2nd, from 8.30 am and consisted of 30 multiple-choice questions, tailored around the main subjects treated during the course.

The average score for the exam of 79% was high in comparison with other courses and there were no participants who failed the exam. This positive result has become rare over the last couple of 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 honours.
With 97% - 1 mistakes
Dr Joackin DRANI from Cordaid South Sudan
With 93% - 2 mistakes
Dr Juliet AJOK from Cordaid South Sudan
With 90% - 3 mistakes
Dr Adetayo ADEWOYIN from the Private Sector Health Alliance of Nigeria
Ms Binta ISMAIL from the NPHCDA in Nigeria

With 87% - 4 mistakes
Dr Sarah BYAKIKA, Ministry of Health Planning Unit from Uganda
Dr Aliyu SALIHU Kwayabura, from the Hospital Management Board in Borno State in Nigeria.

2.5 Who attended the May – June 2017 PBF course?

Nine from Nigeria; 4 from South Sudan; 3 from Zimbabwe; Cameroon and Uganda; 2 from the Lesotho and 1 from Ethiopia

The list of participants to the 59th May 2017 PBF course

Name	First name	Profession	Sex	Organisation	Status	Country	State / Region
ASABI	Atongwe	Medical Doctor	f	CDVA	Local NGO	Cameroun	South West
MBONDE	Susan Jofi	Sen Nursing Offficer	f	CDVA	Local NGO	Cameroun	South West
MUKE	Anastasie	Medical Verificator	f	CDVA	Local NGO	Cameroun	South West
BEKELE	Worknet	Medical Doctor	m	Cordaid	Int NGO	Ethiopia	AA
HENSON	Palesa	Sen PBF Officer	f	PBF Unit	Public	Lesotho	Maseru
LEPHEANE	Melida	Administrator	f	PBF Unit	Public	Lesotho	Maseru
ADEWOYIN	Adetayo	Medical Doctor	m	PHN	Private	Nigeria	Lagos
EZIKPE	Chinyere	Medical Doctor	f	PHN	Private	Nigeria	Lagos
COLE	Zeinab	Medical Doctor	f	PHN	Private	Nigeria	Lagos
DANGOTE UMAR	Kabir	Public Health	m	PHN	Private	Nigeria	Lagos
ISMAIL	Binta	Administrator	f	NPHCDA	Public	Nigeria	Abuja
KAWUWA	Mohammed	Commissioner	m	State	Public	Nigeria	Yobe State
MERIBOLE	Emmanuel	Medical Doctor	m	FMOH	Public	Nigeria	Abuja
MUKUDAS	Halima	Commissioner	f	State	Public	Nigeria	Bauchi State
SALIHU	Kwayabura	Medical Doctor	m	Hosp Man Board	Public	Nigeria	Borno
AGABA	Gerald	Medical Doctor	m	Cordaid SS	Int NGO	South Sudan	Central - Jubek
AJOK	Juliet	Medical Doctor	f	Cordaid SS	Int NGO	South Sudan	Eastern Equatoria
DRANI	Joackin	Administrator	m	Cordaid SS	Int NGO	South Sudan	Kapoeta
WIGO	Pieng	Nurse	m	State Director	Public	South Sudan	Unity State
BYAKIKA	Sarah	Public Health	f	MOH - Planning	Public	Uganda	Kampala
KITYO	Collins	Economist	m	MOH - Planning	Public	Uganda	Kampala
TUMWESIGYE	Benson	Medical Doctor	m	MOH QA	Public	Uganda	Kampala
NTINI	Silent	Administrator	m	MOHCC	Public	Zimbabwe	Harare
SANDY	Charles	Medical Doctor	m	MOH - TB	Public	Zimbabwe	Harare
ZHOU	Nornah	Nurse	f	Health Service Board	Public	Zimbabwe	Harare

2.6 Accreditation for organizations to conduct PBF courses

For accreditation to organize a PBF course, an organization needs to fulfill the following criteria:

- The program needs to conduct a final test;
- It needs to assure that 3-4 experienced facilitators are present with proven experience in PBF and that they previously followed one of the SINA PBF courses.
- These facilitators should have credible experience with adult learning
- The facilitators should also be capable of advocating the aims, objectives, theories and best practices of PBF.

For further details on accreditation, organizations are requested to contact SINA Health: robert_soeters@hotmail.com

2.7 The next English PBF course will take place from November 20 to December 2, 2017

3. DAILY EVALUATIONS BY PARTICIPANTS

3.1 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 with 2% above the previous 19 English spoken courses, and 6% above the 32 previous French spoken courses.

Daily evaluation topics as scored during 10 days	French speaking courses (32x)	English speaking courses (19x)	Mombasa May 2017	Comparison Mombasa May 2017 / Previous English courses
Methodology and facilitation	84.7%	86.7%	92.3%	6%
Participation	83.0%	87.5%	90.0%	3%
Organization	74.4%	86.3%	76.7%	-10%
Time – keeping	75.0%	72.0%	81.5%	10%
Overall score	**79%**	**83%**	**85%**	**2%**

Table 1: Overall daily evaluation scores of the course.

3.2 Methods and facilitation

Methods and facilitation scored 6 percent higher with 92.3% than the previous English courses (86.7%) and 7% above the average of the French spoken courses (85%). This score is satisfactory.

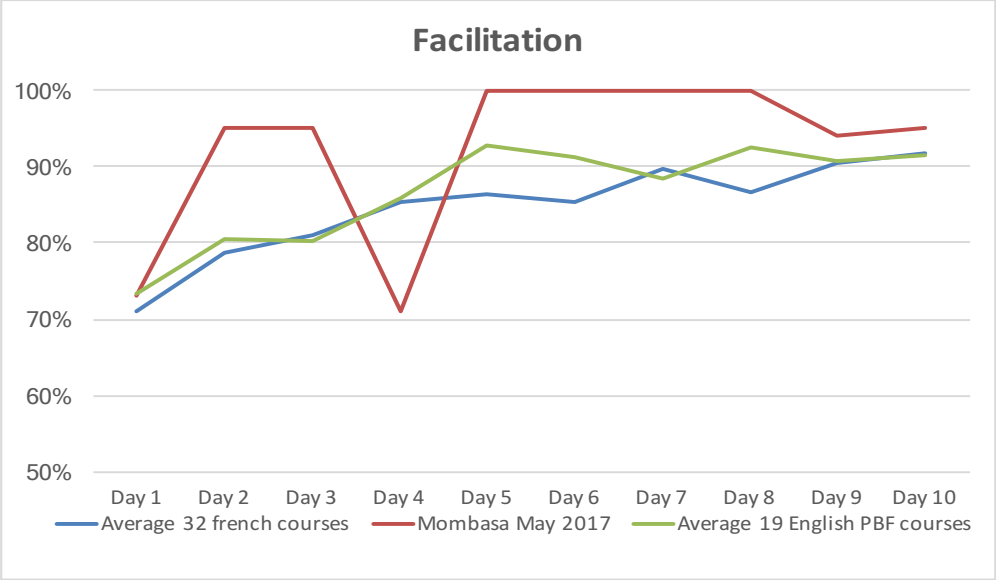


Figure 1: Evolution of the daily evaluations: *methods and facilitation.*

3.3 Participation

The satisfaction with the level of **participation** was 90%. This is 3 per cent above the previous English courses (87%) and 7 per cent above the French courses (83%). This score is satisfactory.

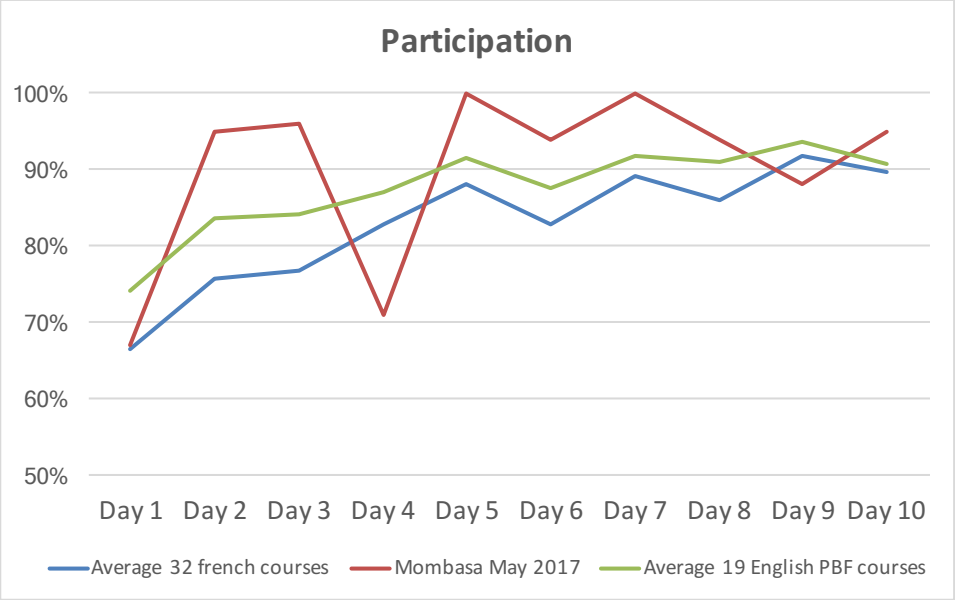


Figure 2: Evolution of the daily evaluation: *participation.*

3.4 Organization

The **organization** of the course in Mombasa had an average score 'very positive or positive' of 76.7%, which is 10% *below* the average of 86.3% of the previous English courses but 2% *above* the average of 74% of the previous French courses. This reduction is score is related to problems with the hotel.

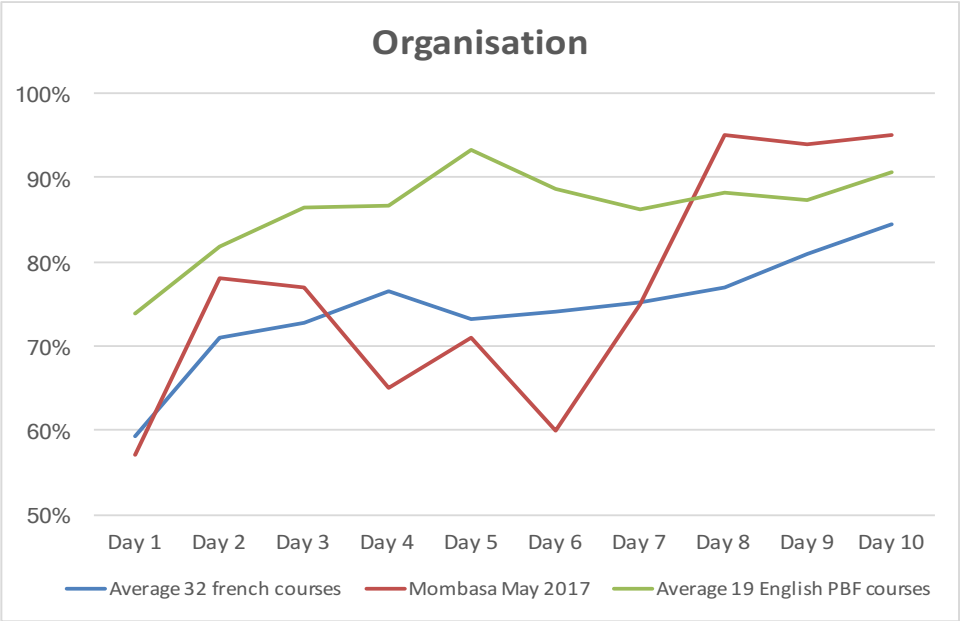


Figure 3: Evolution of the daily evaluation: *organization.*

3.5 Time keeping

Satisfaction with time keeping was 81.5%, which is 8% above the previous English courses and 6% above the French courses.

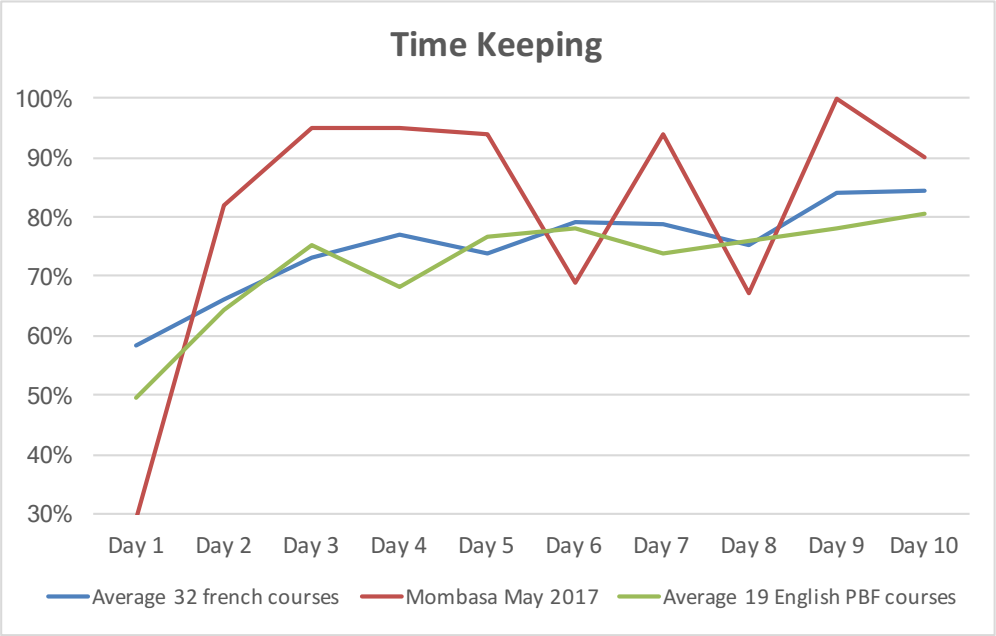


Figure 4: Evolution of the daily evaluation: *time keeping*.

4. DESCRIPTION of the COURSE

Arrival day: Sunday May 21th 2017

The 59th PBF training was an intensive encounter between course participants and facilitators. Most participants arrived on Sunday May 21st, ready for the course and filled with high expectations, many questions that needed to be answered and a lot of experiences to share. In general, the activities proceeded very well. Many participants were well prepared and directed in advance.

On the day of arrival, course participants were guided in short visits to the local mall, which helped to settle in quickly.

All Participants came from the health sector, with some representing the public, private and international NGOs.

Of the 25 participants who attended the course, 16 came from the national level (64%), 8 (32%) from the regional level and 1 participant (4%) came from the peripheral level.

Some countries represented had PBF at different levels of implementation and were looking to gain more knowledge and possibly improve the design of their PBF programs. Others were contemplating starting a new PBF program as well as how this could work in unstable / conflict areas, whilst the remainder were here to learn about PBF for the first time.

Daily evaluations turned out positive and the course overall was highly rated. Many appreciated the time invested and the style of the organisation. They appreciated the seriousness of the course and all the discussions, albeit that the 'intensity' of the course also elicited some comments and request to create some 'free thinking time'.

Evening session were provided for the country groups to discuss specific country challenges and participants' needs. These sessions also helped the facilitators to understand what participants' expectations were and how the course could respond to the participants' needs. The interactions were rich and enlightening. Throughout the two weeks, participants received individual and group guidance on their respective action plans.

Evening country meetings		
Tuesday May 23, 2017	18.15-19.15 hr	Uganda
Wednesday May 24, 2017	18.30 -19.30 hr	Lesotho
Wednesday May 24, 2017	19.30 -20.30 hr	Cameroon
Thursday May 25, 2017	13:00 – 14:00	Ethiopia
Thursday May 25, 2017	18.30-20.15 hr	Nigeria
Friday May 26, 2017	18.30 -19.30 hr	Zimbabwe
Friday May 26, 2017	19.30-20.30 hr	South Sudan

Monday May 22nd

At 9:00am, Godelieve welcomed all participants to the course and explained the course outline and methodology. This was followed by introductions by all participants and facilitators where each stated their fears, and expectations around the course.

Robert presented to the group results of the analysis of pre-course questionnaire which was developed to determine the priorities of different members of the group.

Most participants came from the National level (73%), with a few from the regional (23%) and peripheral (5%) levels.

After selection of recappers for day 1, participants were then split into 5 groups to work on the topic "PBF, why does it matter?

The course started with the module on PBF best practices and change topics. Sufficient time was allocated to discussing the PBF best practices and change issues, which allowed participants to express their concerns. Turning Point Questions (TPQs) were used to stimulate discussions and active participation.
The major topics of debate were around autonomy, free healthcare (abolishing user fees) and essential drugs monopolies (competition). These debates were encouraged and the facilitators ensured that participants had a clear understanding of the best practices as the building blocks for PBF implementation.
Finally, the Mombasa village chief and authorities were elected, and the village rules presented.
In the evening, participants, in their country groups started to work on the first group work of the course; Healthcare as you know it – challenges and why.

Tuesday May 23rd
After the daily recap, Robert continued with the module on change issues to which, as always extra time was devoted, given the interesting and very relevant questions / discussions from the participants.
The First rounds of country presentations then started with the Zimbabwe group, Uganda, South Sudan and Nigeria.
Problems were discussed mainly around the design of a PBF program in Uganda and in Zimbabwe; as well as in the design and implementation of PBF in conflict areas such as in South Sudan and in the North-Eastern states of Nigeria.
To ease the process on the subsequent module about PBF theories, participants were asked to read the topics during the night.
In the evening, facilitators met with participants from Uganda, to look specifically into their issues and concerns.

Wednesday May 24th
After the recap of the previous day's activities, the country presentations continued with Lesotho, Cameroon and Ethiopia presenting. Participants were then split into four working groups to study the theories underpinning PBF (systems analysis, public choice, contracting, decentralization and governance). This was discussed in plenary, with input from the working groups. The module on microeconomics (modules 5A) then followed. Participants were taken through basic economic principles as a foundation to understanding how markets operate – and subsequently the health market.
In the evening, facilitators met to discuss with the participant from Lesotho and then Cameroon on issues peculiar to the group and to help them in preparing their business plans.

Thursday May 25th
Module 5A on microeconomics was completed and module 5B on health economics was presented. In these sessions, basic economic principles were discussed, how the health market differed and the different failures affecting the market for health care. The team also understood how economic instruments (taxes and subsidies) could be used to intelligently correct market failures in health.
Module 6, on National Policies, regulation and quality assurance – facilitated by Fanen and Godelieve; and module 7, on the Contract Development and Verification (CDV) Agency – facilitated by Robert and Claire then started. For the parallel sessions, participants attended that which was most relevant to them, with the participants already working in the CDV agency, implementers at regional level and

those from the private sector in the CDV group; and those working at the national PBF unit and MoH in the regulation group.
This allowed facilitators to go into more depth about each role and how it applies in practice. Participants had the opportunity to see learn how the different arrangements could be applied in their different countries.
In the evening, facilitators met with the team from Nigeria.

Friday May 26th

After a brief introduction by Godelieve and Robert, the groups set out on the field visits to four Kilifi County facilities for a tour and guided interviews with the facilities' in-charges and other staff. Upon return, the groups gave feedback on the questionnaire, which helps to assess the vitality and PBF readiness of the facilities.

The facilities visited were:

1. Kadzinuni Dispensary
2. Vipingo Health Center
3. Kilifi District Hospital
4. Mtwapa Health Center

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

Issues reported from the field trip:

- All health facilities receive inputs and equipment from KEMSA but with variable support from other partners and donors. Some facilities had some autonomy to purchase inputs from accredited distributors only if they were using their internally generated resources to do so.
- No health facility had autonomy to set user fees, manage their resources or to hire and fire their staff
- Main funding sources: fee for service, health insurance, OBA, Health Systems strengthening funds.
- Revenue per capital does not meet required standards with most facilities generating less than USD 7 per capita.
- None OBC, nor any CDV Agents, carry out indirect surveys.
- Generally poor separation of functions. Some form of client satisfaction using suggestion box, which was found to be ineffective. This aspect needs to be strengthened as per PBF.
- General shortage of staff as all health facilities did not meet the recommendation of 1 technical staff per 1000 population.

Following the feedback from the field visit, the teams broke out to complete the parallel sessions on CDV Agency and Regulation.
In the evening, facilitators met with the team from South Sudan and Zimbabwe during these sessions country specific issues were discussed and participants were assisted in developing their business plans.

Saturday May 27th

The course program on Saturday was confined to the morning. The groups competed the modules on CDVA and the role of the regulator. This was followed by the group work, after which the whole class met to discussed the outcomes in plenary. Here

facilitators had the opportunity to summarise and give feedback to the whole class on the two modules. This helped all participants to have an overview of both modules and an in-depth knowledge of that which was most relevant to them. After lunch, many participants joined the SINA Health bus ride to Fort Jesus and the market in town to do some local shopping.
In the evening, the first SINA Health happy hour took place, in family, with drinks and dance.

Sunday May 28th

Trip to the Shimba hills. In the park, we saw some protected animals (Giraffes, Sable antelopes, buffalos, etc.). The climax of the trip was at the hill top as we descended to the waterfalls of a distance of 2km through a curly sloppy narrow path. Along the route, we had stop-overs where the guide took time to explain the names and special characteristics of some of the flora. At the beautiful and serene waterfall site, most members of the team had leisure bath and took memorable pictures. Heading back to the hill top was the most tasking phase.
Lunch was at Shimba Hills Lodge within the game reserve which has a beautiful view site displaying some squirrels and huge alligators. The taste of the meal shall remain memorable.

Monday May 29th

The recap on Monday was different from the regular recaps. Here, facilitators went through all the key messages on the CDVA and the role of the regulator and checked that all participants were comfortable and understood all the topics that were discussed in week 1.
Module 9 – Feasibility scans, killing assumptions and advocacy was facilitated by Godelieve through a brief presentation after which the participants went for the group work including identifying subjects for advocacy and a role play.
Some of the issues that became clear during the group work was that most countries did not have the required PBF budget of $4 per capita. This was a killing assumption and country teams decided to act out during the role plays an advocacy to different stakeholders for increasing the budget for PBF.
This was followed by the module on conflict resolution and negotiation techniques (Module 10).
At the end of the day, participants in their country groups were asked to work begin work on their action plans in the evening where facilitators were also available to provide support to those who needed it.

Tuesday May 30th

The day started with the module on equity which described the different equity mechanisms in PBF. This was followed by a presentation on the new developments in cloud computing and ICT in PBF by the Director of Blue Square – Nicolas de Borman. This was a particularly interesting, especially for participants who were directly involved in the management of data. This raised a lot of questions and discussions around the topic.
Next, module 12 on output indicators was presented by Godelieve. This was followed by two exercises in groups for plenary restitution and discussion.
The feasibility scores and the various activities plans/recommendations are presented in the section dedicated to country specifics further in this report.
In the evening country groups continued work on their action plans to be presented on Wednesday morning.

Wednesday May 31st

The exercise of module 12 - output indicators was completed.
The country presentations of the action plans then started with Cameroon presenting first then Ethiopia, Lesotho, the 2 Nigeria groups, Uganda, South Sudan and Zimbabwe.
Each group presented a detailed action plan to be implemented in the short (2 weeks), medium (2 months) and long (6 months) term, with input from the rest of the participants and from facilitators. All the recommendations and action plans are presented in the section dedicated to country specifics.
Module 13 – The Business Plan was replaced by the country presentations on their individual action plans. Module 14, on Indices management tool was presented by Fanen, to be completed on Thursday morning. On Wednesday (and Thursday) evening several groups paid a visit to the Masai market at the city mall, obtaining a lot of keepsakes.

Thursday June 1st

After a recap of the course so far by Robert, Fanen took off with the last part of module 14 on the Indices management tools and the participants went into group work finalized by a plenary restitution.
The day was confined to the morning to allow participants to prepare for the exams
Module 15 (on costing) and 16 (PBF in emergency situations) were not discussed in class.

Module 11 on baseline studies and action research was replaced by the presentation of Nicolas de Borman on Tuesday from Blue Square.
The overall evaluation on the course was carried out before the class broke up for the group work and general revision in the afternoon in order to prepare for the exam.

Friday June 2nd

The exam took place from 09:30 onwards. By 14:00, the results were being shared with the participants. Participants went for shopping and in the evening, there were still nice exchanges at the dinner table. Four participants as well as Godelieve already left on Friday.

Saturday June 3rd

Most participants left at Saturday on different flights and Robert and Claire were the last to leave Mombasa with early Sunday flights.

5. FINAL COURSE EVALUATION BY PARTICIPANTS

5.1 General impression of the course

The score for 'general impression of the course' was with 88%, 4% above the average of the 21 previous English-spoken courses. The criterion "I was sufficiently informed" scored 87%. The criterion: "program answered my expectations" scored 94% (= 9% *above* the previous courses). The criterion "the course objectives related well to participants' professional activities" scored 84% (= 5% below the average).

General impression of the course	29 previous French PBF courses	21 previous English PBF courses	May 2017 Mombasa	Comparison May 2017 Mombasa course / 21 previous English PBF courses
Q1. I was sufficiently informed about the objectives of the course	89%	79%	87%	8%
Q2. The program has answered my expectations	85%	85%	94%	9%
Q3. The objectives of the course relate well to my professional activities	89%	89%	84%	-5%
Average general impression	**88%**	**84%**	**88%**	**4%**

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

The participants' appreciation of the methodology and the contents scored high with 95%, which was 9% above the average of the previous English courses and 12% above the previous French courses. The three criteria "content helped me to attain my objectives", "interaction in working groups" and "working methods stimulated my active participation" all scored 100%. Balance between lectures and working groups score slightly lower with 82%, which was still 5% above the average of the previous English courses.

Methodology and contents of the course	31 previous French PBF courses	21 previous English PBF courses	May 2017 Mombasa	Comparison May 17 Mombasa course / 21 previous English PBF courses
The content of the PBF modules has helped me to attain my objectives	83%	90%	100%	10%
The methodology of the course	84%	87%	95%	8%
Balance between lectures and exercises	71%	77%	82%	5%
Interaction and exchanges in working groups	90%	90%	100%	10%
The working methods adopted in the course have stimulated my active participation	88%	89%	100%	11%
Average	**83%**	**87%**	**95%**	**9%**

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

5.2 Appreciating the duration of the course

For 75% of the participants, the course duration was right, while 20% thought the course to be too short and 5% thought the course to be too long. This confirms that the 2-week duration of the PBF courses remains about right.

Duration of the course	29 previous French PBF courses	21 previous English PBF courses	May 2017 Mombasa	Comparison May 17 Mombasa course / 21 previous English PBF courses
Too Short	30%	24%	20%	-4%
Fine	64%	64%	75%	11%
Too Long	6%	12%	5%	-7%

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

5.3 Comments on the organization of the course

For "organization", the overall score of 66% was 12% lower than the previous 21 English courses with 78% and 4% lower than the 31 previous French courses. The conference center (39%) and the food (21%) scored respectively 37% and 41% lower than the previous courses. The conference hall was considered to be OK and also the friendliness of the staff as well as the facilitation team.

Contrary to last December's course in the same hotel, this time, several participants complained that there were problems with the water system of the hotel as well as that there were mosquitos in the rooms. The latter due to the poor screening of the windows. Food was also thought to be slightly monotonous by several participants.

Transportation scored satisfactory with 84% for which we congratulate the TOMASI Company who organizes since 2011 the transport for SINA Health. The quality of the educational material, the lecture room and friendly reception scored OK with respectively 83%, 74% and 95%.

How do you value the organization of the training?	31 previous French PBF courses	21 previous English PBF courses	May 2017 Mombasa	Comparison May 17 Mombasa course / 21 previous English PBF courses
Quality and distribution educational material	78%	87%	83%	-4%
The lecture room	68%	67%	74%	7%
Conference center in general	59%	76%	39%	-37%
How were you received and friendliness	87%	92%	95%	3%
Food and drinks, including tea/coffee breaks	66%	62%	21%	-41%
Transportation	62%	82%	84%	2%
Average	**70%**	**78%**	**66%**	**-12%**

Table 5: Evaluation of the organization of the course.

5.4 Comments on the execution of the course and the facilitators

The execution of the program was scored satisfactorily with 82%, which was 5% above the average of the previous 21 English courses. The question in how far facilitators were open minded was evaluated at 90%, which was 15% above the average of the previous English spoken courses. Time allocated for group work was 71%, which was 5% *below* the scores of the previous courses. Time for discussion was evaluated at 86%. We may conclude that the time pressure to finish the different modules negatively affected the time allocated for group work.

Aspects related to the execution of the program and the facilitation	31 previous French PBF courses	21 previous English PBF courses	May 2017 Mombasa	Comparison May 17 Mombasa course / 21 previous English PBF courses
The facilitators had an open mind towards contributions and criticism	80%	75%	90%	15%
Time allocated to group work was adequate	63%	76%	71%	-5%
Time for discussions was adequate	77%	82%	86%	4%
Average	**73%**	**78%**	**82%**	**5%**

Table 6: How was the facilitation?

5.5 Evaluation per module

The satisfaction per module by the Mombasa participants was 91%. This is 5.7% above the average of the 21 English courses (85.6%). The participants appreciated the completeness and the illustration given by the facilitation team of the modules. Five modules obtained 100% including regulation and CDV Agencies. Economics also score higher with 91% than during the previous courses with 82%. Costing scored low with 45%, because time did not allow to cover this module.

Module	32 previous French PBF courses	21 previous English PBF courses	May 2017 Mombasa	Comparison May 17 Mombasa course / 21 previous English PBF courses
Why PBF & What is PBF?	93%	92%	100%	8%
Notions of micro-economics and health economy	68%	82%	91%	9%
PBF Theories, best practices, good governance and decentralization	86%	92%	100%	8%
Baseline research – household survey launching process	79%	77%	90%	13%
Output indicators in PBF interventions	88%	88%	95%	7%
CDV agency, data collection, audit	88%	88%	100%	12%
Regulator – quality assurance	82%	91%	100%	9%
Negotiation techniques and conflict resolution	89%	89%	90%	1%
Black box Business Plan	85%	88%	91%	3%
Black box Indices tool: revenues – expenditure – performance bonuses	82%	80%	90%	10%
Community voice empowerment and social marketing	83%	87%	94%	7%
PBF feasibility, killing assumptions & advocacy	88%	89%	100%	11%
Elaboration of a PBF project - costing	67%	68%	45%	-23%
Average for all modules	**83.1%**	**85.6%**	91%	**5.7%**

Table 7: Evaluation per module.

5.6 Written comments during the final evaluation by the participants

About Course methodology

- Very intense course, very informative
- Huge number of concepts introduced within the 2 weeks
- A little overwhelming sometimes
- Great facilitators, patient enough to take time to explain the concepts and ensure that they are well understood
- Good use of practical exercises to augment understanding and learning
- Group work generally well received and functional

- Action plans and feedback very useful and insightful
- Less tea breaks
- Some sessions too short
- Continue communication between participants and facilitators beyond the course.
- Discussions which are being repeated should be cut off early so that progress can be made in covering the course content.
- The best debater of the day should be suspended until day 3 of the course because participants argue unnecessarily to earn the title.

Course Book and Modules

- Consistency in the language used in the course book
- Pages from the book are falling off
- Power point slides too busy and font too small
- Indices management tool should be well explained
- Time should be allocated to costing
- Community PBF not covered in class
- Errors within the manual
- Business plan module should be covered in more detail

Hotel

- Too many mosquitoes in the rooms
- Staff take too long to fix complaints
- Too much spices in the food
- No internet in the rooms throughout
- Internet facilities should be improved
- Have greater variety of meals and a touch of participants' local preferences

Transportation

- No Air conditioner in the small van during the excursions

6. COUNTRY & TOPIC PRESENTATIONS

6.1 Cameroon

6.1.1 Background Cameroun and South West Region

Cameroon is a country of about 23 million inhabitants, situated in West-Central Africa. It shares borders with Nigeria to the West, Chad, Central African Republic and Congo to the East, Equatorial Guinea, Gabon and Congo to the South and lake Chad to the north. The country is made up of 10 administrative regions with English and French as official working languages.

The South West region of Cameroon with capital in Buea covers about 25,410 km^2 and has a population of about 1.5 million inhabitants. In this region, PBF is piloted in four health districts, covering a population of 818,381 inhabitants since 2012. The Contract Development and Verification Agency (CDVA), of which the team was present in the course, establishes performance contracts with health facilities (MPA and CPA) in the pilot districts (Buea, Kumba, Limbe and Mamfe).

6.1.2 Health indicators and service delivery

Life expectancy at birth in Cameroon (M/F) is 56/59 yrs. The country has seen an increase in maternal mortality from 430 maternal deaths per 100.000 live births in 1998 to 669 in 2010 and 782 in 2011. Infant mortality in 2012 was 61 deaths/1000 live births and the Under-5 mortality rate stands at 95 deaths/1000 live births. There is a low coverage of services (e.g. low ANC uptake & poor family planning coverage due to lack of access, non-availability of commodities, TBAs), generally a poor quality of care with major geographical disparities and a poor allocation of resources.

6.1.3 Feasibility scan

In executing its contracting, verification and coaching roles, the CDVA SW team is faced with certain challenges, which revolve around autonomy and financial management. In establishing in how far the project is 'PBF' best practice, a feasibility scan was carried out and the Cameroon design obtained 92% score with some problematic indicators for which the team scored 0.

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 20 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	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	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	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 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	0
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
TOTAL	**50**	**46 = 92%**

6.1.4 Problem analysis

The Cameroon team wishes to focus on addressing the above challenges, such as:

- Facility managers at hospital and health centre level are not allowed to spend revenues generated at their facility and have to give this part to the treasury with complicated procedures to recover those funds
- The implementation of Quality Improvement Bonuses is not yet effective;
- The health facility managers lack the skills to manage the pharmacy and pay the pharmacy attendant from the proceeds hence are reluctant to assume the responsibility.
- The monthly validated normal output indicators for the output indicators for the vulnerable of 10%, is somewhat irrational in small HFs with low uptake, especially those in the remote areas, some of which may have a higher burden of poor & vulnerable population because of geographical location, poverty etc.

6.1.5 Recommendations

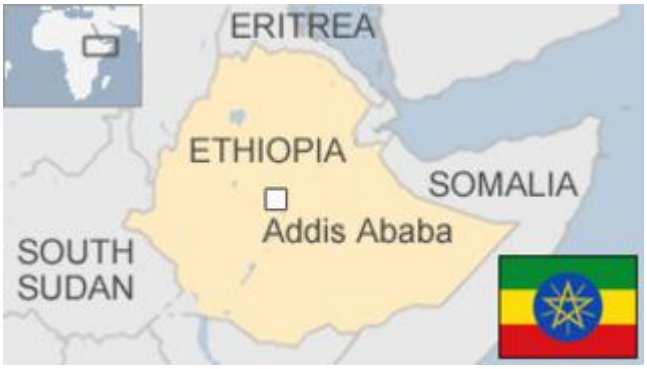
- Advocate for the MOH technical PBF unit that HF will be truly autonomous and are allowed to use their won revenues.
- Concerning the Quality Improvement Bonuses: (a) Advocacy to the national technical PBF central for funds to be made available for its implementation of; (b) Recruitment of an expert (engineer) at the CDVA (c) HF managers should be assisted with their investment plans by the CDVA;
- Coach health facilities in the correct use of pharmaceuticals and management
- The CDVA should be empowered to raise the ceiling per health facility from 10% for the vulnerable to higher levels per HFs on the basis of need. This also requires the district validation committee to assure that the overall number of vulnerable exempted remains below the ceiling of 10% per health district.

6.1.6 Action plan

Criteria in how far pr is PBF	Difficulties and killing assumptions	Proposed solutions	Actions towards	Person responsible	2 w	6 w	6 m
Cost recovery revenues are spent at the point of collection (facility level)	- It is mandatory for Public health centers and hospitals to channel their generated revenues first to the public treasury. - This hinders the adequate use of these resources and creates a black market. - Facility managers are not allowed to spend revenues generated at their facility.	- Advocate for the government to change the existing set-up. - Advocate for the central technical PBF unit to continue working on the issue of autonomy of health facilities.	Ministry of Finance Ministry of Public Health PBF technical unit Regional delegation of Public Health. Public Service Ministry.	CDVA task force PBF Regional task force		X	
PBF system has infrastruc-ture & equip-ment investment units, which are paid against achieved benchmarks in the BP	- Implementation of QIB is not effected. - There is no expert to judge the infrastructural and equipment investments at the level of health facilities.	- Advocacy to PBF central unit for funds to be made available for implementation of QIBs - Recruitment of an expert (engineer) at the CDVA. - HF managers should be assisted with investment plans by the CDVA.	Ministry of Finance Ministry of public health PBF technical unit Regional Delegation of public health	CDVA task force			X
Health facility managers have the right to decide where to buy their inputs	- Some health facilities lack autonomy for drugs management. - Some health facilities do not have a pharmacy. - The health facilities have inadequate funds for procurement of the initial stock of medication and they have frequent stock outs. - The HFs managers lack the skills to manage the pharmacy and pay the pharmacy attendant from the proceeds hence are reluctant to assume the responsibility.	- Coaching and training of facilities managers on management of the pharmacy. - Advocacy to PBF central unit to fast track the implementation of QIBs	CDVA, Regional task force South West Regional Fund for Health Promotion (SWRFHP) PBF CTG.	CDVA task force Regional pharmacist and delegate RDPH			X
The project provides equity bonuses for vulnerable people	- The ceiling of 10% of the monthly validated normal output indicators for vulnerable output indicators, is somewhat irrational in small HFs with low uptake, especially those in the remote areas, some of which may have a higher burden of poor & vulnerable population because of geographical location, poverty etc.	- Empower CDVA to raise the ceiling per health facility from 10% for the vulnerable to higher levels. This requires the district validation committee to assure that the overall number of vulnerable exempted remains below the ceiling of 10% per health district.	National PBF Unit	CDVA task Force. Regional task force.			

6.2 Ethiopia

6.2.1 Background



Ethiopia is situated in the northeast African region known as the Horn of Africa. It is the second-most populous nation in Africa (after Nigeria) with 102 million inhabitants.
Ethiopia is bordered by Eritrea to the north, Djibouti to the northeast, Somalia to the east, Kenya to the south, and Sudan and South Sudan to the west.

Ethiopia is the oldest independent country in Africa. It maintained its freedom from colonial rule except for a short-lived Italian occupation from 1936-41. Amharic is the official language of the country, although English, Italian, French, and Arabic are widely spoken. Ethiopia has its own calendar with **13** months in a year (still within 365 days). The new year starts on Sep 11 of the Gregorian calendar, which puts the country currently in 2009!

6.2.2 Health indicators and health service delivery

Ethiopia is divided into 10 regional states. Oromia is the state in which the International NGO Cordaid is implementing a PBF project along with other resilience building activities. To strengthen the health system in the Borena Zone of Oromia regional state, Cordaid has been implementing a PBF pilot in four districts (i.e.: Yabello rural, Yabello urban, Gomole and Elwoye), addressing nine health facilities with the objective of improving quantity, quality and equity of health service delivery. The pilot has been running for 2 years (since 2015).
The pilot in Borena involves a supply-side financing mechanism that aims at increasing the health facility as well as the health department and health office outputs by incentivizing pre-determined results. The pilot is designed to cover a total of 125,918 inhabitants.

6.2.3 Problem analysis

Since its inception, the PBF pilot implementers have identified a number of challenges:

- They were unable to use PBF subsidies provided to Dikale and Chari health centers during the last quarter according to plan
- A protracted dry season in the implementation area affected the project's progress since government officials were busy with emergency interventions
- Community verification was adversely affected by the wide geographic area the CBOs had to cover. This was compounded by frequent migration of the pastoralist community that moved around for pasture and water due the drought. In addition,

there was some resistance of the community to give the required information during community verification.

- There was a discrepancy between the declared data offered by the health facility and what was found as registered in the HMIS registration book.
- For some indicators, the data at the health facility level were not recorded properly
- Treatment column of IMNCI registration book of Yabello hospital was not properly filled out, i.e.: name of the drug, quantity, frequency and duration of treatment were not properly given, due to which the hospital lost the PBF subsidies for this indicator.
- The pilot only used 48% of the available budget during 2 years (out of a 2.5-year project)
- Difficulties to convince the government at the federal level of the value of PBF.

6.2.4 Recommendations

- In order to propose realistic steps, the Ethiopia delegate recommended to direct his action plan at the Cordaid Health program team and all concerned staff; and first of all, to improve the team's operations regarding the PBF pilot.

6.2.5 Action plan

Action	Responsible	Resource	When
Support health facilities, hospital and health offices in quarterly business plan preparation	Program staff	Project budget	Jun-17
Participate in the development and signing of six-month contract agreements with *health facilities and health offices*	Program staff and administrator	Project budget	Jun-17
Participate in the development and signing of six-month contract agreement with *community based organization* that will conduct community verification	Program staff and administrator	Project budget	Jul-17
Conduct monthly coaching visits to health facilities	Program Staff	Project budget	Bi-monthly
Conduct quarterly review meetings with health facilities and health offices	Program staff	Project budget	June 2017
Taking samples of 25 patients per health facilities that will be given to community based organization to perform quarterly community verification and patient satisfaction surveys at household level	Program staff	Project budget	June 2017
Conduct quarterly performance evaluation of health offices	Program staff	Project budget	June 2017
Being at the last stage of the pilot project the project needs to be scaled up to other areas of the region. Hence actively participate on preparation of the next phase budget and proposal	Administrator	None	Dec 2017
Using opportunities of meeting government officials, tell the results of our pilot PBF program to influence them toward a positive attitude for PBF	All staff	None	ASAP
The budget utilization of the current pilot project is too slow, review the costings and suggest for re-costing of subsidies, and advise the management on the possible way of efficient utilization of the budget including request for additional extension.	Administrator	None	July 2017
Thoroughly review quarter payment requests for health facilities and health office based the lessons got from RBF training	Administrator	None	Next payment request
Review the PBF indicators taking in account the knowledge from the PBF training	Administrator	None	2nd week June
Share the basic knowledge on PBF with the rest of the finance	Administrator	none	2rd

team within the organization			week June
Prepare a training Report for the office consumption	Administrator	none	1st week June

6.3 Lesotho

6.3.1 Background

Lesotho is a sovereign country that got its independence from the United Kingdom on October 4, 1966. It is a small mountainous country completely surrounded by the Republic of South Africa. With a population of just over 2 million people, 61% of the population is between the ages of 15-46 years whilst 34% are under the age of 15 years. There are 10 administrative districts and Maseru is the capital town.

Lesotho is classified as a lower income country with a per capita income of USD 1879 and ranks at 161 out of 187 countries on the UN Human Development ranking (2015). There is high unemployment with widening inequalities (with a Gini Index of 0.52) that have excluded most of the population from participation in economic development. The rural areas are home to the majority of the poor and income distribution remains skewed in favor of the urban areas. Three-quarters of the unemployed live in rural areas and include mostly the youth. Lesotho's economy is projected to grow at the rate of 2.6%, with growth mainly limited to urban areas, while rural communities remain impoverished. The main drivers of growth are the mining, construction and textile industries, as well as government services. Lesotho has one of the highest public spending rates at 63%. The nation's high poverty and unemployment rate poses additional challenges to the economy. Government is a parliamentary constitutional monarchy. The king is the head of state in a ceremonial role, while the elected prime minister serves as head of government with executive powers.

6.3.2 Health indicators and service delivery

Health services in Lesotho are delivered at primary, secondary and tertiary levels. There are 372 health facilities in Lesotho: 1 referral hospital, 2 specialized hospitals, 18 district hospitals, 3 filter clinics, 188 health centers, 48 private surgeries, 66 nurse clinics and 46 pharmacies. Health centers are the first point of care and this is aimed at making the patient load at district and referral hospitals lighter. Forty-two percent (42%) of the health centers and 58% of the hospitals are owned by the Ministry of Health. Thirty-eight percent (38%) of the health centres and the same proportion (38%) of the hospitals are owned by the Christian Health Association of Lesotho (CHAL) mostly in remote areas where coverage by government-owned facilities is relatively poor. In addition to CHAL, NGOs, private-for-profit health care providers (Lesotho Planned Parenthood Association-LPPA, Red Cross Society, Partners in Health-PIH, Lesotho Flying Doctors, Irish Aid, Mission Aviation Fellowship) are involved in health care service delivery both in urban and rural areas. The Ministry of Health also works together with Development Partners (Donors) (Irish Aid, Global Fund, the United State Government, CDC/PEPFAR, Millennium Challenge Account, European Union, Gates Foundation, Gavi Vaccine Alliance, UNDP, UNAIDS, UNFPA, UNICEF, World Health Organization, World Bank and World Food

Program) in the design, financing and delivery of health care services.

The country experiences a very high disease burden, especially regarding the MMR with 1,024 deaths per 100,000 live births: the SDG target is at 70 per 100,000 live births. Target for Lesotho: 300 per 100,000 live births. Under-5 mortality rate is 85 deaths per 1,000 live births, TB incidence 852/100,000 and high co-infection with HIV 74% of TB patients tested were HIV positive. The HIV prevalence among adults between 15-49 years is 23%.

There is a low utilization of existing health services, with both financial and geographic barriers to health access; about 40% of the population lives in remote rural villages, often several hours walk through rough mountain paths to the nearest facility; unavailability of drugs, treatment costs, transportation cost.

6.3.3 Problem analysis

From many accounts, the Lesotho health system appears not to be very cost-effective. Investments in the health care sector per capita are sizeable compared to the regional average yet have not led to the expected commensurate gains in health outcomes. Several main challenges have been identified above. In addition, the system suffers from inefficient management of human resources for health. 50% of established positions remain unfilled, the legislation regarding HR is outdated, as are some policies and strategic plans. The ratios of health workers to population are low, with 1 health professional per 1,000 people; and 9 primary facilities and 1 hospital per 100,000 people.

Collective efforts are deemed urgently needed and should involve all relevant ministries, departments, development partners, civil society and communities if the country's health targets are to be achieved.

6.3.4 PBF pilot in Lesotho

Several years back it was felt that PBF could be an alternative approach to development financing in light of Lesotho's poor progress to achieve the three health Millennium Development Goals of reducing child mortality, improving maternal health, and combatting HIV/AIDS.

A PBF pilot was designed which was meant to address the following:

- Autonomy in management and planning of service providers (health facilities);
- Involvement of the population/community in managing the services;
- Use of instruments: business plans, contracts, external data verification and quality assessments; and
- Strengthening the institutional configuration by separating functions of policy formulation/regulation, service provision and purchasing.

The Lesotho PFF pilot was funded by the World Bank's International Development Association, the Health Results Innovation Trust Fund and the Government of Lesotho for a total of 20 million USD. It became effective in February 2014 and the objectives were to increase utilization and improve the quality of primary health services in selected districts with a particular focus on maternal and child health, TB and HIV, improve contract management of select PPPs, and provide immediate and effective response in the event of crises or emergencies.

During Phase I, the PBF project was piloted in Quthing and Leribe districts (2014/2015). During Phase II (2016) the project was scaled-up to four (4) additional districts: Mafeteng, Mohale's Hoek, Mokhotlong and Thaba Tseka. The program is now fully implemented in 6 of the 10 districts of Lesotho, with a PBF Unit established at the central level to handle the day-to-day management**.** And with a PBFU-recruited Performance Purchasing Technical Assistance agency (PPTA) to assist in the implementing the project.

6.3.5 Feasibility scan

The challenges encountered by the Mombasa team are listed below.

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 20 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 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	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	0
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	0
TOTAL	**50**	**25 = 50%**

In executing the feasibility scan, the Lesotho team identified a number of challenges, which need further attention:

- The PBF program budget should not be 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. This is not the case in Lesotho
- The PBF project should have at least 20 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives, which is still a challenge in Lesotho

- The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders, which is absent in Lesotho.
- Cost recovery revenues are spent at the point of collection (facility level), which is compromised in Lesotho
- Health facility managers have the right to decide where to buy their inputs
- Health facility managers are allowed to influence cost sharing tariffs
- Health facility managers have the right to hire and to fire
- The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans
- The project provides not yet equity bonuses for vulnerable people

6.3.6 Recommendations

- To develop a plan to improve sustainability: The PBF Unit should be brought directly under the Principal Secretary of the MoH
- Establish an external Contract Development and Verification Agency (CDV) at national, regional and district levels
- To advocate with the MoH for accrediting independent pharmaceutical suppliers and allow providers to purchase from them;
- To integrate the PBF Web-Based Applications gradually into the DHIS 2;
- To train District Quality Assessment teams;
- To train Pharmacists on how to abide by standard protocols.

6.3.7 Action plan

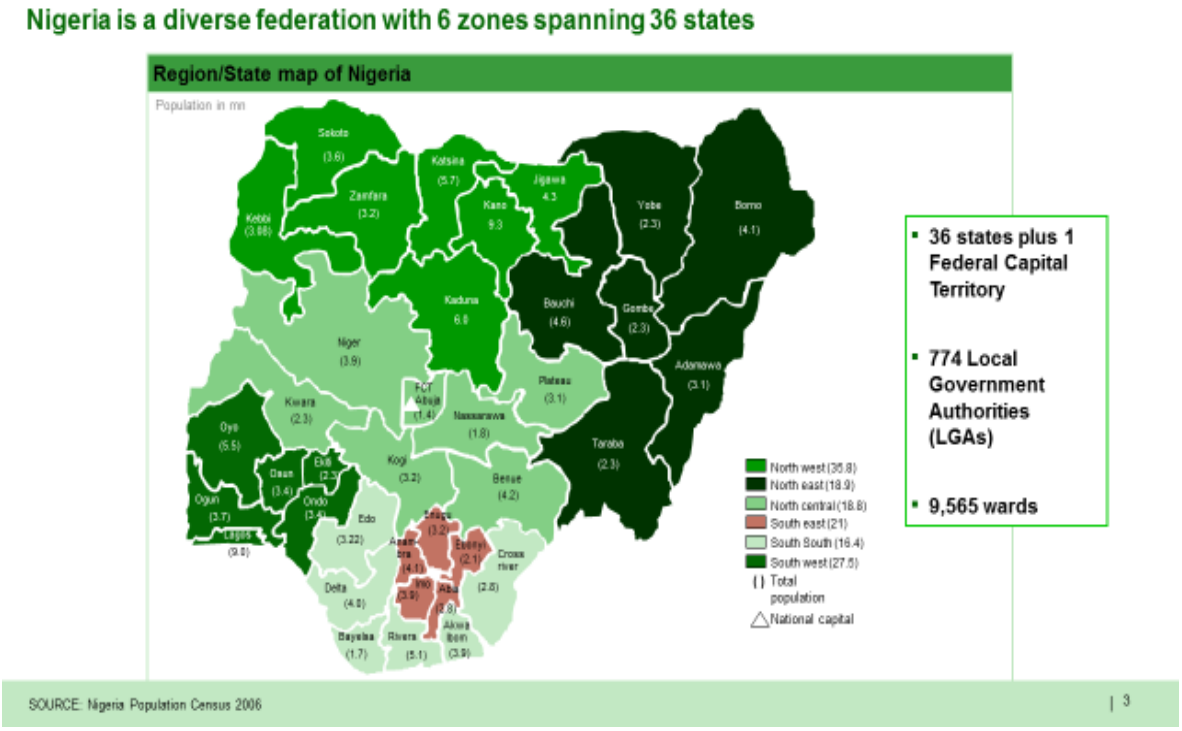
Given the above recommendations, the Lesotho team proposes the following action plan:

Activity	Responsible	Time-line	Where	Comments
Prepare a report and disseminate to share lessons learnt from the training.	Senior PBF Officer/PBF Officer	June 2017	MoH	
Move the PBF unit to the office of the Principal Secretary – MoH (for sustainability)	PS, Director PBF	Jan 2018	MoH office	Approval of MOH structure by Ministry if Public Service.
Establishment of a national Contract Development & Verification Agency with branches at district level	Director PBF	July 2019	MoH office	PBF Unit to coordinate and facilitate processes as the current PPTA is on two-year contract
Accreditation of pharmaceutical supply	Director Pharmacy and Supply Chain Management and DG	Dec 2017	Country-wide	Negotiation ongoing by PBF unit and MoH
Integrate web based application to DHIS 2	Senior PBF Officer	Aug 2017	Central and district offices	Procurement process to start end of June 2017
Train District Quality Assessment Teams	Senior PBF Officer and PBF Officer	Nov 2017	Regional / district	Training will be conducted by Head/managers Quality Assurance team from central
Training of Pharmacists on standards protocols	Senior PBF Officer and PBF Officer	July 2017	Regional / district	Training will be conducted by Pharmacy department

6.4 Nigeria

6.4.1 Background

Nigeria is the most populous country in Africa with an estimated population of 186 million. Nigeria is the largest economy in Africa, following the GDP rebasing in 2014; Nigeria's GDP stands at about US$ 574 billion, and GNI per capita at US$ 3,234 in 2015 (World Bank). Nigeria is located in West Africa, and borders with Cameroon, Chad, Niger, and Benin Republic. Nigeria comprises of 36 States and a Federal Capital Territory. Nigeria is a federal republic with the executive, legislative and judicial arms of government sharing power. Nigeria is further sub-divided into 774 Local Government Areas (LGAs). The LGAs are further divided into almost 10,000 wards. The States are aggregated into six geopolitical zones: North West Zone (NWZ), North East Zone (NEZ), North Central Zone (NCZ), South East Zone (SEZ), South South Zone (SSZ), and South West Zone (SWZ).



6.4.2 Health indicators and service delivery

Nigeria operates a national health system made up of the federal, state, local government and the private sector. It has three levels of health care - primary, secondary and tertiary - with no clear role definitions in the responsibility of each tier. There are currently no clearly defined roles and responsibilities with regard to the provision and financing of health among the 3 tiers of government.

With a birth rate that is significantly higher than the death rate, at 40.4 and 16.9 per 1,000 people respectively; a population growth of 3.2% per annum and a population density of 168 people per sq.km, it is increasingly challenging to meet the health demands of the populace and perhaps even more challenging to improve the quality of services.

According to the World Health Organization, life expectancy at birth (LE at birth) was 53/56 years (male/female). Nigeria's total expenditure on health per capita was about $ 217, and total health expenditure as a proportion of GDP was about 3.7% in

2014 (WHO). Furthermore, 75% of total health expenditure (THE) comes from private sources, and out-of-pocket payments (OOP) alone account for about 72% of THE.

Sectoral context

The state of the health system in Nigeria is characterized by sub-optimal maternal and child health (MCH) outcomes, poor quality of health services, lack of protection from financial risk and a double burden of disease, with persistent vaccine preventable and communicable diseases and rising non-communicable diseases. Maternal mortality ratio stands at about 576 per 100 000 live births, and under-five mortality rate 128 per 1 000 live births.

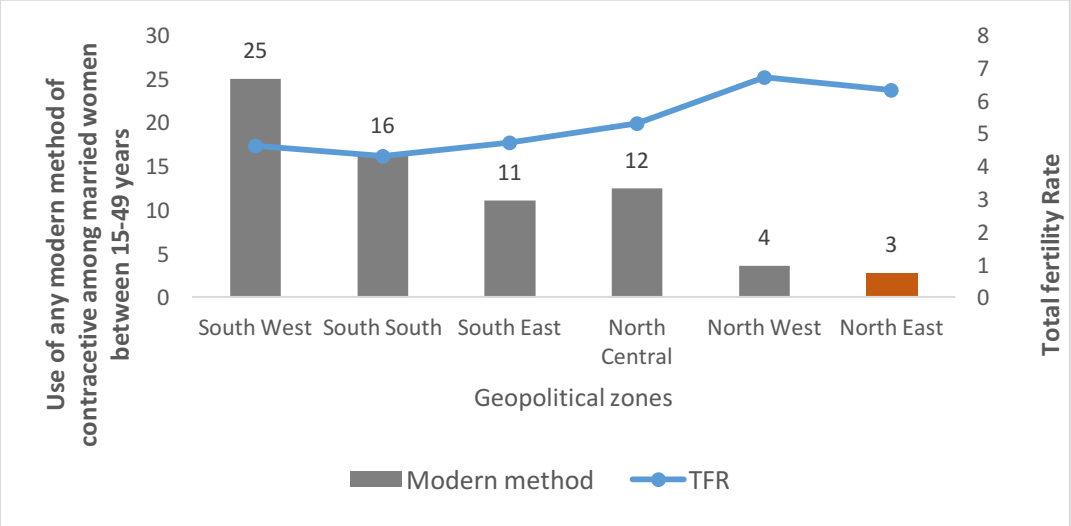
In alignment with the Primary Health Care under One Roof (PHCUOR) policy, States have reasonable independence for managing health care delivery. Nevertheless, interactions exist across all the governance levels of healthcare, but are often fragmented.

The current administration under the leadership of His Excellency President Muhammadu Buhari has outlined an ambitious "Universal Health Coverage Agenda for Change" to address the low-level health system equilibrium and scale up access to a *basic minimum package of free quality healthcare services* and commodities to at least 100 million Nigerians over the next two years through 10,000 revitalized Primary Healthcare Centers (PHCs). Furthermore, relevant reformative health system initiatives are on-going including the NSHIP, SOML and the BHCF.

Regional Focus: North East Nigeria

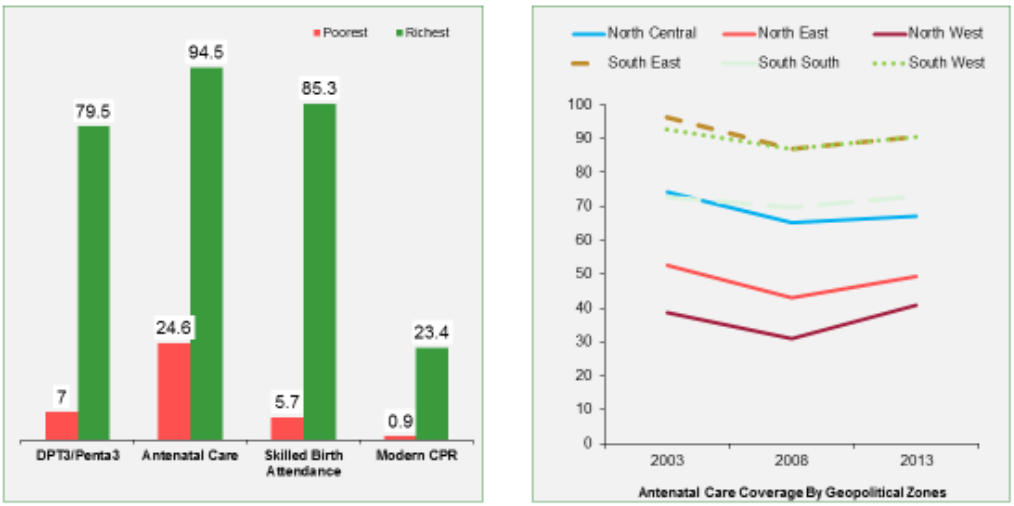
Nigeria is experiencing a decline in economic growth accentuated by macro-economic shocks including low global prices of crude oil, security challenges that have led to sub optimal production of crude oil in the restive Niger Delta and disruption of socio-economic activities in the North East. It is estimated that since June 2013, the Boko Haram insurgency in the North East has affected about 15 million people, with over 20,000 deaths recorded and an additional 2.5 million people displaced. In addition, 3.9 million people in the region are food insecure and about 2.5 million people malnourished – mostly affecting vulnerable women and children.

Poverty is particularly concentrated in the North East – and other social determinants of health such as illiteracy, youth unemployment and access to and utilization of basic services (clean water, primary healthcare etc.) under perform in comparison to other geo-political zones in the country.



The health system performance in the North East also lags far behind other regions and is characterized by limited progress on Health, Nutrition and Population outcomes - driven by low coverage of basic maternal and child health services such as family planning, antenatal care, skilled birth attendance and routine immunization; and further aggravated by poor quality of care, as indicated by the recent World Bank-supported Service Delivery Indicators (SDI) Survey.

Furthermore, there are large inequities in demand for essential MNCH services across geopolitical zones, as well as across wealth quintiles



SOURCE: WHO Global Data Repository; NDHS 2003, 2008, 2013 | 11

Furthermore, exacerbated by the insurgency, multiple deficits in the health system on the supply and demand side have also exposed displaced and underserved population pools in IDP camps and host communities to infectious diseases such as cholera, measles and more recently, polio. Outbreaks of cholera and polio were reported in September 2015 (over 1,000 people in IDP camps and surrounding communities in

Maiduguri affected) and August 2016 (in 2 LGAs in Borno state) respectively. There has also been significant damage to the structure of health systems, particularly at the primary care level (PHC). In some LGAs in Yobe and Borno, the insurgency has destroyed much of the building blocks of the health system, resulting in partial or complete breakdown in service delivery, weak governance and limited human resource for health capacity.

6.4.3 Problem analysis

The Health System is saddled with the following challenges:

- Health systems governance is weak
- Health is on the concurrent list
- No clear roles for the actors
- The fiscal space for health is suboptimal with low efficiency (inadequate political will and commitment to health as evidenced by low budgetary allocation to health)
- Health is seen by many states as a social good with inefficient free medical services
- Weak coordination (i.e. ineffective coordination among the three levels of government and between the private and public sectors)
- Maldistribution of human resources for health
- Weak monitoring and evaluation of health interventions
- Weak donor coordination and harmonization of donor aid.

PBF intervention - NSHIP

In this complex setting, Performance Based Financing has been adopted under the Nigeria State Health Investment Project (NSHIP). NSHIP builds on lessons from the Health Systems Development Projects (HSDPs) and principles of fiscal decentralization to support targeted health systems reforms in three states. It aims to enhance the effective use of public resources to deliver essential health services. This is piloted since 2012 in three states of Adamawa, Ondo and Nasarawa with scale-up to 5 AF states in the North East in 2017, the Saving One Million Lives Initiatives and the Revitalization of the Primary Health Care Centers Programme of the Health sector. Other pockets of programs with PBF principles include the Basic Health Care Provision Fund. The Primary Health Care Under One Roof (PHCUOR) which is part of government reform design to improve the management and implementation of PHC. All these programs are part of the strategies to achieve the Universal Health Coverage, which is the agenda of the present administration in the health.

The key challenges in adopting PBF are leadership and governance with the paradigm shift from input-based financing to performance-based financing.

The Nigerian team felt that PBF has the potential to significantly improve health outcomes through better system functionality as use of PBF as a health sector reform will lead to efficient allocation of resources, improve quality of health care and ensure equity in the health sector. By focusing on results / performance, PBF will lead to improved cost-effectiveness and efficiencies of service delivery and the health system as a whole. It will also enhance accountability and improve use of data for evidence-based decision-making as well as public health action.

In the past four years, NSHIP has recorded numerous successes with PBF in Nigeria such as:

- Evidence of structural changes
- Improved patient inflow
- Better motivated workers
- Improvement in quality of care
- Institutional level improvements with the SPHCDAs increasingly turning into well-formed institutions.

Feasibility scan

Criteria to establish in how far the project is "PBF"	Points	Score Nigeria PBF design
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 20 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	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	2
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 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	0
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
TOTAL	**50**	**43 = 86%**

The team noted one major 'killing assumption' notably that the annual PBF budget per capita in the Nigeria NSHIP design is about USD 2.8, which is below the recommended USD 4 per capita per year.

6.4.4 Recommendations - Government team

The Nigerian Government team proposes to focus on:

- Integrating PBF into ongoing activities in the health sector and make it a strategic health reform program that should be included in the National Strategic Health Development Plan;
- Exploring ways to ensure prompt payment of subsidies to relevant actors
- Ensuring improved coordination and ownership of the PBF Program by the government at all levels

6.4.5 Recommendations - PHN team

- Mainstream PBF in national health strategic plan and frameworks
- Increase funds for PBF program budget, perhaps through re-allocation of existing funds
- Fund mobilization from private sector to complement Government budgets

6.4.6 Action plan - Government team

The Nigerian team proposed a slogan: *"Performance Based Financing for Universal Health Coverage PBF4UHC"*. They emphasized the various opportunities they saw to align funding schemes more to PBF logic: in NSHIP, SOML, BHCPF, Revitalisation of Primary Health Care centres, and the on-going development of NSHDP II. They indicated that there are strong potential allies in the PBF Community of Practice, the Federal Ministry of Finance, World Bank, DFID, BMGF and other donor support. They foresaw potential resistance in the Ministry of Budget and National Planning, and the Labour Unions, and indicated the Honourable Minister of Health, Nigeria Governor's Forum were still undecided on PBF and should be interacted with.

The Government team proposed as short-term and medium-term actions:

- To send report of the workshop and recommendations to the Honourable Minister of Health
- To organize a Coordination meeting between all the actors of PBF at the national level- FMOH, World Bank, technical assistants and the PIU NPHCDA
- To convene a Technical Working Group meeting of the NSHIP actors to deliberate on reform approach, challenges and forge a plan for inclusion into the National Strategic Health Development Plan II

- To align and harmonize the indicator sets used in tracking NSHIP interventions with national indicator sets on DHIS2
- To integrate RBF platform with DHIS2 platform
- To provide appropriate support to the NSHIP Additional Financing States

Activity	Responsible person	Where	When	How	Resources
Report of the workshop and recommendations sent to the Honourable Minister of Health	Director M&E	FMoH	June, 2017	Memorandum	Nil
Coordination meeting between all the actors of PBF at the national level- FMOH, World Bank, technical assistants and the NPHCDA	Project Coordinator NSHIP	NPHCDA	June 2017	Meeting	N84,000
Technical Working Group meeting of the NSHIP actors convened to deliberate on challenges and forge a plan for inclusion into the National Strategic Health Development Plan II	Project Coordinator NSHIP	NPHCDA	June, 2017	meeting	TBD
Align / harmonize indicator sets used in tracking NSHIP interventions with national indicator sets on DHIS2	Director M&E	FMOH	July 2017	HDCC & HDGC Meeting	TBD
Integrate RBF platform with DHIS2 platform	Director M&E Project Coordinator NSHIP	FMoH	August, 2017	Harmonization of Data Architecture Interoperability of systems	TBD
Support to Additional Financing States	Project Coordinator NSHIP CMD HMB, Borno State	AF States	June, 2017		TBD

6.4.7 Action plan - PHN team

The PHN team focused its action plan on the presumed important activities to be executed as a CDVA under the NSHIP Additional Financing Program in prioritized States in Nigeria. These activities have been phased over a timeline of 2 weeks to 6 months (from date of submission of this report), and have been outlined based on current events regarding PBF implementation in the NSHIP program.

S/N.	Activities	Activity Period
1.	- Review latest RFP - Commence initial stakeholder engagement, at Federal and State level - Conduct landscape analysis of (relevant) States and respective health systems - Conduct desk reviews: relevant health outcomes and system performance data; current status of PBF (NSHIP) in focal States; review of health facility mapping - Conclude and submit CDVA proposal	Two (2) weeks
2.	- Continue extended engagement and focused consultations with relevant stakeholders (particularly in focal States) - Expand landscape analysis of focal States and relevant elements of their respective health systems - Set up meetings with key actors at State level for formal introductions and alignment on expectations, separation of functions, and contractual arrangements - Develop CDVA organizational structure in focal States - Set up district CDVA offices, and recruit district CDVA officers	Six (6) weeks

	- Facilitate inception stakeholder meetings with district (LGA) public officers (regulators), health facilities (and committees) and local NGOs - Commence field visits/inspection to pilot LGAs to ascertain: health facility positioning and community structures; drivers of effective demand for healthcare; pattern of service delivery in catchment population; potential disruptive factors (security, cross-border influx for service delivery and history of disease outbreaks) - Conduct baseline service delivery utilization study in selected HFs in pilot LGAs - Develop draft implementation schedule (State scale-up)	
3.	- Finalize contractual agreements with States and health facilities - Finalize operational mechanisms with HFs, health committees, local NGOs and community health workforce - Conclude 1st operational cycle (quarterly) of HF PBF verification (PBF data collection, validation & verification; business plan development and performance management coaching), community verification visits/client satisfaction surveys, district/regional validation committee meetings and invoicing, - Finalize phased implementation approach (for eventual state-wide coverage)	Six (6) months

Activities	Target Areas & Beneficiaries	Responsible	Time frame		
Overall Aim: CDVA services in Borno, Yobe and Bauchi States			2 w	6 w	6 m
Objective #1: Respond to RFP for services as CDVA					
Commence initial stakeholder engagement, at Federal and State level	3 North East States: Borno, Yobe and Bauchi FMOH; NPHCDA; SMOH; State HMBs; SHPCHDA; LGA officials	CDVA Program Managers	X		
Conduct landscape analysis of (relevant) States and respective health systems	3 North East States: Borno, Yobe and Bauchi SMOH: SHPCHDA; State HMBs; LGA officials	CDVA Program Management Team (PHN)	X		
Conduct desk reviews: relevant health outcomes and system performance data; current status of PBF (NSHIP) in focal States; review of health facility mapping	3 North East States: Borno, Yobe and Bauchi	CDVA Program Analysts (PHN)	X		
Conclude and submit CDVA proposal	NPHCDA (& SPHCDAs)	CDVA Program Managers (PHN)	X		
Objective #2: Implementation kick-off in 3 States					
Continue extended engagement and focused consultations with relevant stakeholders (particularly in focal States)	3 North East States: Borno, Yobe and Bauchi Federal: FMOH; MoF; MoBP; NPHCDA; State: SMOH; SMoF; State HMBs; SHPCHDA; LGA: LGA Officials; health facilities; community leaders	CDVA Program Managers		X	
Set up PBF meetings with key actors at State level for formal introductions and alignment on expectations, separation of functions, and contractual arrangements	3 North East States: Borno, Yobe and Bauchi Federal: FMOH; MoF; MoBP; NPHCDA; State: SMOH; SMoF; State HMBs; SHPCHDA; LGA: LGA Officials; health facilities; community leaders	CDVA Program Managers		X	
Expand landscape analysis of focal States and relevant elements of their respective health systems	3 North East States – Borno, Yobe and Bauchi	CDVA Program Management Team (PHN)		X	

Develop CDVA organizational structure in focal States		CDVA Program Director		X	
Set up district CDVA offices, and recruit district CDVA officers	3 North East States – Borno, Yobe and Bauchi	CDVA Program Management Team (PHN)			
Commence field visits / inspection to pilot LGAs to ascertain: health facility positioning and community structures; drivers of effective demand for healthcare; pattern of service delivery in catchment population; potential disruptive factors (security, cross-border influx for service delivery and history of disease outbreaks)	3 North East States – Borno, Yobe and Bauchi	CDVA Program Management Team (PHN)		X	
Develop draft implementation schedule (State scale-up)	3 North East States – Borno, Yobe and Bauchi	CDVA Program Managers			
Objective #3: Implementation Scale-up in 3 states (Consolidation & Expansion)					
Finalize contractual agreements with States and health facilities	3 North East States – Borno, Yobe and Bauchi State: SMOH; SMoF; State HMBs; SPCHDA; LGA: Health facilities	CDVA Program Management Team (PHN)			X
Finalize operational mechanisms with HFs, health committees, local NGOs and community health workforce	3 North East States – Borno, Yobe and Bauchi	CDVA Program Management Team (PHN)			X
Conclude 1st operational cycle (quarterly) of HF PBF verification (PBF data collection, validation & verification; business plan development and performance management coaching), community verification visits / client satisfaction surveys, district / regional validation committee meetings and invoicing	3 North East States – Borno, Yobe and Bauchi	CDVA Program Management Team (PHN)			X
Finalize phased implementation approach (for eventual state-wide coverage)	3 North East States – Borno, Yobe and Bauchi	CDVA Program Management Team (PHN)			X

6.5 South Sudan

6.5.1 Background

On July 9, 2011, South Sudan became an independent nation state following a peaceful secession from the Sudan through a referendum in January 2011. The Republic of South Sudan is a land-locked country that is bordered by Ethiopia to the East, Kenya to the South-East, Uganda to the South, the Democratic Republic of Congo to the South-West, the Central African Republic to the West, and Sudan to the North. The country covers a geographical surface area of 645,000 kilometres' square with an estimated population of 12.4 million people. The White Nile, which flows out of Central Africa, is the major geographic feature of the country. It supports agriculture and extensive wild animal populations. Administratively, the country was formerly divided into 10 states, however in 2016, it was decreed that the country will

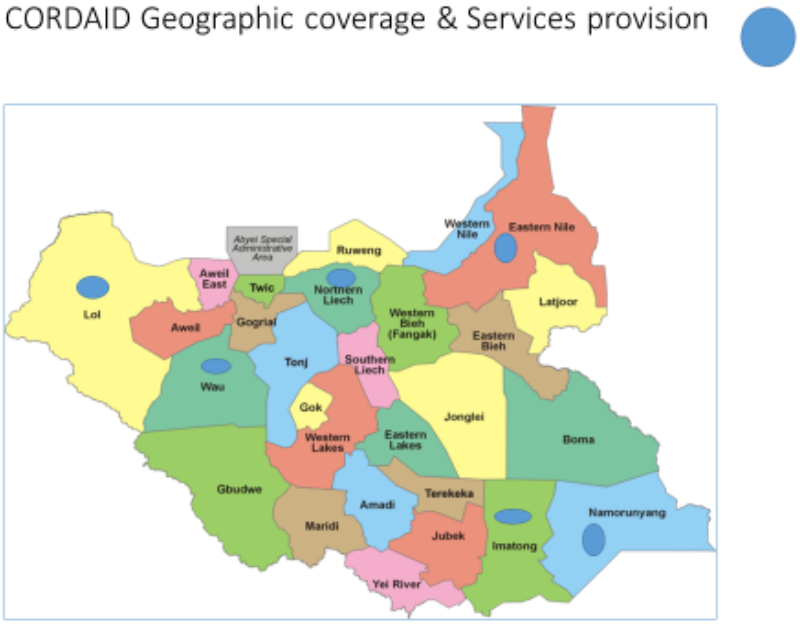
be divided into 33 states (including the Abyei administrative area) and 180 counties and several Payams and Bomas.

Since independence in 2011, the political landscape in South Sudan has continued to be dominated by both internal and external threats to sustainable peace and stability. In December 2013, the country descended into protracted strife, which had heightened uncertainty in the country. The parties to the conflict finally signed a peace agreement in August 2015 but timely implementation was a significant challenge. The peace agreement focuses on establishing and strengthening the state building of South Sudan. The transitional period is expected to last 30 months with an expected national election in the spring of 2018 marking the end of the transitional period.

South Sudan finds itself with unique challenges amongst others the lack of adequate financial, human, technical and infrastructure resources, displaced people from various regions of the country had moved across borders to neighboring countries, thereby placing these population groups at risk and the refugee situation within country places 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.

6.5.2 Cordaid

Stichting Cordaid (Catholic Organisation for Relief and Development Aid) is a Dutch International Humanitarian aid and Development Non-Governmental Organisation (NGO) with the Headquarters 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 currently manages about 1,000 projects worldwide. The activities vary from direct programme implementation to capacity building and technical assistance for the European Union; the World Bank; the Global Fund against AIDS, TB & Malaria (GFATM); the Health Pooled Fund South Sudan, GAVI and the Dutch Ministry of Foreign Affairs & economic cooperation.
Cordaid has been active in South Sudan for more than 20 years, with a strong focus on civil society capacity-building. Currently it has programs in the area of emergency response, DRR, health, food security, extractives, security & justice, women leadership and investments. Cordaid is active in seven States in South Sudan.



6.5.3 Health indicators and service delivery

The organisation 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 stands at 0.022/1000 and 0.015/1000 respectively

6.5.4 Problem Analysis

The South Sudan health system orientation appears too much donor-driven and ignores the vibrant private South Sudanese health sector in urban- and rural trading areas. This is worsened by conflict and humanitarian emergencies, poor health system structures (with poor leadership and governance, weak HRH, poor infrastructures, duplication of services, and poor health financing structures). Very high proportion of vulnerable population. There is the central distribution of most of the inputs from single suppliers and a non-functional health systems structures for policy, regulation and quality assurance.

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 is very poorly coordinated, making planning and accountability extremely

difficult. There are various partners, multiple coordination bodies and mechanisms, multiple plans that were not aligned to any central government strategy and often implementers accounting to donors primarily. The situation is exacerbated by the lack of capacity, mechanisms and structures to coordinate the more than two hundred implementing partners supporting provision of services in the health sector.

Human Resource for Health

The staffing status is suboptimal and severely constrains the delivery of the Basic Package of Health Services. The Doctor and Nurse to population ratios stand at 0.022/1000 and 0.015/1000 respectively. The 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 production from Health Sciences Institutes, and challenging work environment, discourage qualified health workers from taking up positions and remaining to serve in a number of states. Consequently, most health facilities provide minimal levels of services, thus denying access to people living in those areas.

Health Service Delivery

Health service quality was universally perceived as poor with only 44% of population of South Sudan having access to services. This is attributed to the fact more than 80% of population is rural and to issues of equity in distribution with urban bias. Currently 70% of health facilities are functioning, and less than 80% of counties have limited or no 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 the fact that outpatient per capita was only 0.6. Four visits for ANC services is only achieved in 17% of cases; the proportion of deliveries in health facilities is at a mere 14%, and Penta3 coverage is 33%

Supply Chain Management

Procurement and supply chain management continue to be extremely challenging in South Sudan. MOH is responsible for pharmaceutical supply to all primary healthcare facilities and 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 lowest levels incurs high losses

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

Health Information system

Over the last 10 years the paper-based Health Management Information System (HMIS) has been improved to DHIS1.4 and is currently transitioning to DHIS2 for monitoring health service delivery. The performance of the nascent Health Management Information System is about 50% for timeliness and completeness. Despite the operationalization of DHIS2, the HMIS remains fragmented, with vertical programs collecting information that is often not shared with and used by the information repository in the Ministry of Health. It mainly collects data from Primary

Health Care facilities, thus leaving hospitals and private sector data unreported. Surveys and facility assessments have been used to fill the resulting gaps in information, however these proved to be too expensive and irregular.

6.5.5 Feasibility scan

The team executed the PBF feasibility scan and identified several challenges:

- The existence of a 'Zero cash policy', which only allows subsidies and inputs in kind to health facilities. It created a pure input policy;
- Free health care with not enough public money at hand to pay for the health services. This leads to informal practices in an unregulated private sector (the result of pricing below equilibrium through the FHC).
- Many vertical programs being run in parallel leading to 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. Cordaid to target larger funds and wider geographical coverage in its program. 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	The programs are vertical, do not meet the minimum 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	3	Available tools are not	0	Avail indices tools for	3

indices tool for autonomous management		for autonomous management		autonomous management	
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 Negotiate for funding that provides full health package	0
16. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	No, infrastructure and investments are input based	0	Infrastructure and investment units be place	2
17. Public religious and private facilities have an equal chance of obtaining a contract	3	No, private facilities are excluded from the input based system	0	Equal treatment for all facilities	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%

6.5.6 Recommendations

PBF is a health systems reform that is applicable to South Sudan despite the challenging operating environment. The South Sudan team proposes:

- High-level advocacy to the donor (s) and Government
- Develop a well-designed PBF pilot in areas where Cordaid has a large presence, especially where it is the lead partner for the implementation
- Pooling resources from the donors to fund performance based program

6.5.7 Action plan

The South Sudan team drafted the following action plan:

Activity	Who	When	Where	How	Resources
Debrief the country SMT Cordaid and State MOH on recommendations	Gerald, Wigo	8th June 2017	Juba	Report	Time, stationery
Design a PBF program for TB and Maternal child indicators	Gerald Drani Juliet	1st July 2017	Torit State Hospital Chukudum Hospital Bentiu state Hospital Raja state Hospital		Funds Stationery
Sign Contract with Facilities implementing TB and TB/HIV activities	Gerald	15th September 2017	Torit State Hospital Chukudum Hospital Bentiu state Hospital Raja state Hospital		Funds Stationery
Exposure and learning visits to other Cordaid Programs already implementing PBF	Drani, Juliet	November 2017	DRC Ethiopia		Time Funds
Apply Community PBF	Gerald	1st July 2017	TB and TB/HIV implementing sites (34)		Funds Stationery

6.6 Uganda

6.6.1 Background

Uganda has a population of 34.6 million with almost half (48.5 percent) living below the age of 15 years, with an estimated population growth rate of 3 percent between 2002 and 2014 (UBOS 2014). Uganda is expected to continue experiencing significant population growth, as large cohorts of children enter the reproductive age. The majority of the population (80 percent) lives in rural areas where poverty is prevalent (22.8% compared to 9.3 % in urban areas). In addition, a large share of the population (43.3%) remains highly vulnerable and at a risk of falling back into poverty. While the gross domestic product (GDP) grew at an average annual rate of 4.6 percent during 2013–2015, the gross national income (GNI) per capita increased at a much slower pace, and in 2014, was estimated at USD 670, slightly above the average (USD 629) for low-income countries. Moreover, key Millennium Development Goals (MDG) health related indicators like maternal mortality, infant and neonatal mortality have remained particularly high to date.

6.6.2 Health indicators and service delivery

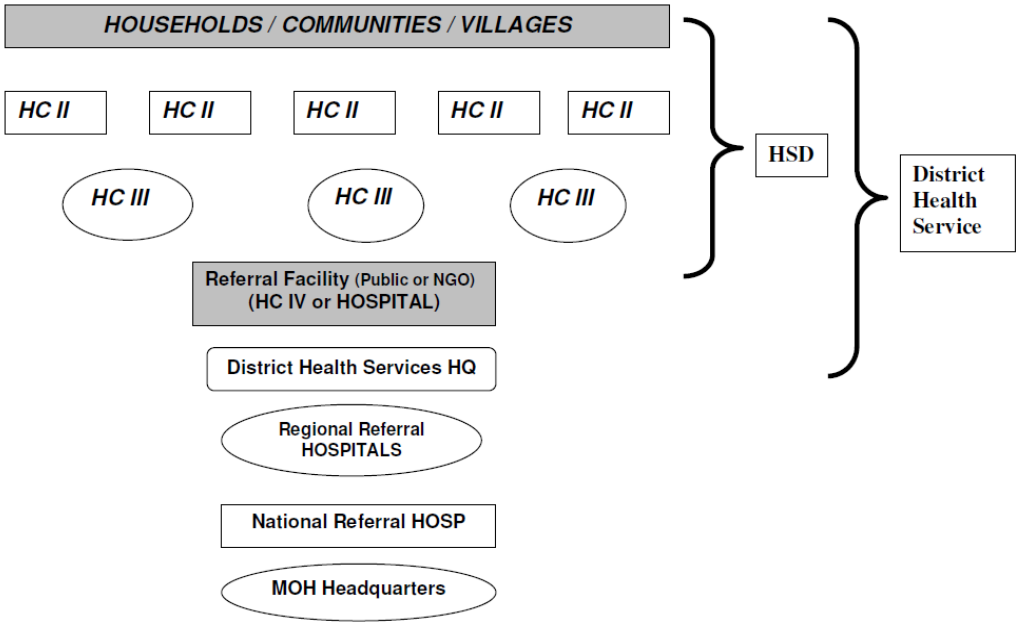
Key health indicators are as follows: Life expectancy has increased over the last 2 decades from 45 years in 1991 to 50 years in 2002 and to 57 and 63 years in 2014. The Under-5 mortality rate declined from 156 in 1995 to 64 deaths per 1,000 live

births; infant mortality rate decreased from 85 to 43 deaths per 1,000 live births; and the Maternal Mortality Ratio (MMR) has been reduced from 527 to 336 per 100,000 live births. Teenage pregnancy rate at 24% in 2011 and up to 25% in 2016 significantly contributes to the overall MMR in Uganda. The newborn mortality rate was 26 per 1,000 live births in 2011 and increased to 27 in 2016. 29% of children under 5 are considered to be short for their age or stunted and 11% of all children are underweight. 60% of pregnant women surveyed had four or more ANC visits, 74% of live births in the 5 years preceding the survey were delivered by a skilled provider and 73% were delivered in a health facility. Contraceptive prevalence rate for all methods increased from 30% in 2010 to 39% in 2016 (UDHS 2016)
The Uganda health system is facing major challenges and is attempting to find a proper RBF/PBF design to tackle them, nationally.

In summary, the indicators are as follows:

Total Population	34.9 million
Population that is 15 years of age/%	17.0 million (48.7%)
Total Fertility Rate	5.4
Life Expectancy	63 years
Maternal Mortality Ratio	336
Under 5 Mortality Rate	M64/1000
Infant Mortality Ratio	43/1000
Neonatal Mortality Rate	23/1000
U5 Mortality Rate - Stunted	29%
Under Weight	11
Contraceptive Prevalence Rate	39%

The Ugandan Health Service Delivery system is composed of the two (2) National Referral hospitals, 13 Regional referral hospital, General/District Hospitals, Health Centre IVs at sub district level, Health Centre IIIs at sub county level, Health Centre IIs at village level and VHTs at community. The National and Regional referral hospitals are under the central Government (Ministry of Health) whereas General Hospitals and the health centers which provide primary health care are under the Local Governments.
Diagrammatic representation of the health service delivery structure:



6.6.3 Problem analysis and previous RBF / PBF initiatives

For several years now, the Ugandan health system has been experimenting with smaller RBF/PBF pilots, to not much avail. Thus: a number of RBF schemes have been implemented in Uganda over the last decade. In order to address critical intervention areas and to harness the benefits of RBF to improve health systems performance.

The RBF schemes included:

1. The World Bank financed Performance-Based Contracting (PBC) Study (2003-2005),
2. The Northern Uganda Health project (NuHealth) (2011-2015).
3. Another project using the RBF approach, the Strengthening Decentralisation for Sustainability (SDS) (2010-2016) is managed under MoLG
4. The Reproductive Health Voucher Project supported by WB (2006-2011, 2015 - 18),
5. Saving Mothers Giving Life Initiative by USG (2011-ongoing),
6. Jinja Diocese PBF Project supported by Cordaid (2009-2016),
7. PNFP Project – BTC (2014 – 2017),
8. Institutional Capacity Building Project – BTC (2015 – 2018),
9. RMNCAH Services Improvement Project (2017 – 2021)

The RBF projects implemented in Uganda have provided several lessons that were useful for guiding the development of the National RBF framework and the National RBF Implementation Plan. They have demonstrated that supply and demand side RBF projects are both useful for increasing access to health services. The demand side approach can play a key role in increasing utilization of critical underutilised services while supply side RBF is instrumental in strengthening the health system and human resources for health in particular. They also demonstrated that RBF can be implemented in both public and private facilities.

The factors that were identified as critical for successful implementation included the design and implementation of RBF initiatives, stakeholder involvement, amount of the bonus payment and participatory decision making about the use of the bonus, use of existing local structures, teamwork at health facility level, availability of essential requirements for service delivery, fraud control measures (NuHealth 2013, Cordaid PIM, 2015, Bua 2015, Ssengooba 2015, Intrahealth 2016).

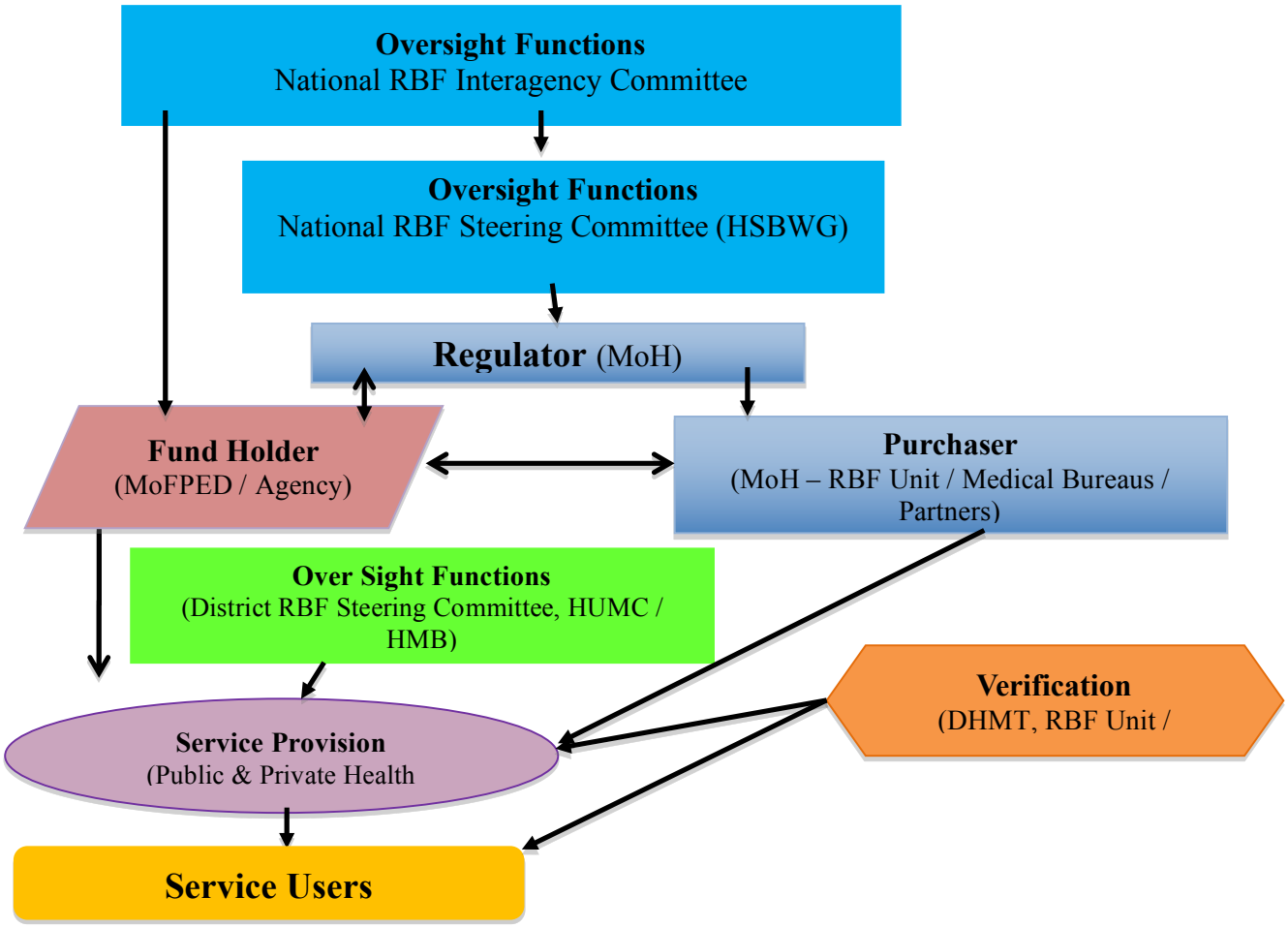
Going forward, the need for improving the functionality of health facilities alongside introducing RBF has been considered a precondition for the successful RBF implementation in Uganda. Other supportive efforts such as capacity building and policy reforms related to autonomy of facilities and human resources management in the public sector have been recommended for RBF to work well in Uganda.

6.6.4 The new National RBF Framework

A new National RBF Framework has been designed to contribute to the reduction of morbidity and mortality by improving access to an affordable package of essential health care services to the people in Uganda, with equal rights and opportunities. Its specific objectives are: (1) To enhance the utilization, quality, efficiency and of health

services delivered to the population of Uganda while improving equitable access to these services; (2) To increase the strategic purchasing of cost effective services

The currently proposed Uganda RBF Model



6.6.5 Feasibility scan

The Uganda team executed the PBF feasibility scan to assess the extent to which its currently designed RBF National Framework meets international PBF best practice standards.

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 20 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	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
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	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
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	0
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	0
TOTAL	**50**	**21 = 42%**

Arising from the above feasibility scan, the following gaps in the current Uganda RBF National Framework were identified by the team:

- The proposed per capita per year PBF budget is USD 2.5, which is below the PBF standard of USD 4 (most basic holistic PBF program) to USD 7 (enlarged PBF program with assistance for the vulnerable, nutrition component, community PBF component).
- The current PBF program has only 10 output indicators which are restricted to the RMNCAH service package yet the PBF Standard recommends a minimum of 25-40 of output indicators.
- The National PBF program does not contain a community indicator e.g. patient satisfaction, household visit following protocol.
- Facility managers of public facilities are not allowed to spent locally generated revenue at the point of collection.
- Facilities do not have a right to decide where to buy their inputs. They depend on central distribution for their inputs (essential drugs, equipment)
- Health facility managers do not have the right to hire and to fire
- The verifier is the DHMT, which is also the regulatory authority at Local Government Level. This violates the RBF principle of separation of function. Thus, need to create an independent CDV agency.
- There are no geographic and/or facility specific equity bonuses
- There are no equity bonuses for vulnerable people
- The National RBF program data management system is still manual and not linked to the DHIS 2
- There are no output indicators at the national and regional RBF Units

6.6.6 Recommendations

Given the discrepancies between PBF best practice and the current RBF National Framework design, the Uganda team proposes:

- To review the current RBF program implementation model
  - Review the scope of indicators
  - Review and changes the CDV function from the DHT

- Adoption of the free market system for facility commodities
- Digitalize RBF data management system

6.6.7 Action plan

Gap / Challenge	Action	Who	Time-frame	How	Resources
Program has only 10 output indicators focusing on RMNCAH & does not contain a community indicator	- Advocate for expansion of the RBF program service package - Review of program indicators	- RBF Coordinator & the RBF taskforce - RBF Coordinator	- Jun-17 Jun-18	- Meetings - Program Review meetings	- Time - Venue - Logistics
Facilities do not have a right to decide where to buy their inputs.	- Develop concept note for the free market system for access to commodities	RBF Coordinator & pharmacy department	Sep-17	- Literature review - Discussions	- HR - Time
No independent CDV agent	- Establish an independent CDV agent at regional level	RBF Coordinator & RBF task force	Sep-17	RBF task force meetings	- Venue - Time
RBF program data management system is still manual and not linked to the DHIS 2	- Develop an electronic RBF program database system - Roll out the digitalized system	- BTC-ICB-project coordinator - RBF Project coordinator and Health information division	- Oct-17 - March 2018	- Hire and engage the consultancy firm - Orientation meetings and trainings	- Funds for consultancy - Roll out activities - Funds for orientation, IT equipment and purchase for the soft wars

6.7 Zimbabwe

6.7.1 Background

Results-based financing (RBF) in Zimbabwe is a government-initiated approach focused on improving poor populations' access to health services, including reducing financial barriers, strengthening health services quality through improving health facility performance and management and promoting results orientation, thus contributing to sustainability in health service provision. The present RBF program has a rural and urban component.

6.7.2 Problem analysis

The Zimbabwe team focused on the Medium-Term Financing strategy for the national RBF. The challenges are:

i) The current limited role of the government in executing key RBF functions from national to district level (governance, fundholding, management, purchasing, and verification of services);

ii) The accounting system that lies outside the Public Finance Management system, and;
iii) Declining development partner funding. The Ministry of Health and Child Care (MOHCC) and the Ministry of Finance and Economic Development (MOFED) have initiated the development of the present Medium-Term Strategic Framework (MTF) that spells out the institutional, technical and financial set-up for the RBF program in Zimbabwe.

The MTF strategy is supposed to guide the Government in institutionalizing RBF and advancing its vision of minimizing user-fees at the point of care—while advancing the core tenets of the Results Based Management Strategy that emphasizes compensating providers based on quantity and quality of services provided.

The medium-term strategic framework defines:

(i) The institutional arrangements for RBF implementation in Zimbabwe
(ii) The funds flow and accountability arrangements; and
(iii) A core package of services linked to the burden of disease.

It will also provide cost-estimates and an indicative commitment from the Government to finance RBF for a set period. For the preparation of the draft RBF MTF a team consisting of MOHCC supported by the World Bank engaged in extensive consultations for guidance and strategic options with most direct stakeholders from MOHCC, MOFED and development partners. The latter including Cordaid, Crown Agents, UNICEF, DFID, World Bank, EU, UNAIDS, WHO, UNFPA, USAID, PEPFAR, CDC, and ZACH. The present draft RBF MTF took evidence and lessons from other LMICS into consideration.

Within the context of results-based management (RBM) and building on RBF structures and processes that have been developed so far, the strategy of the RBF MTF is to further strengthen the checks and balance mechanism within the health sector and further build a health system that aims at equity and is cost effective and sustainable in terms of financing and operations while it shows robustness in accountability and transparency. It is realized that in order to increase government funding and attract supplementary external funding for health, the system should prove its effectiveness and accountable nature.
The RBF MTF lays out an institutional structure, funds flow, stewardship mechanisms, service package and an indicative cost envelop for the RBF in Zimbabwe. By doing so, the MOHCC anticipates key partners and line ministries to align their capacity building towards advancing the process of institutionalizing RBF in Zimbabwe's health sector.

6.7.3 Institutional Arrangements

The team assessed the currently proposed institutional arrangements for the future of the RBF program in Zimbabwe.

In the draft documents, they involve:

Fundholding – intergovernmental connection: In which it is proposed that RBF will be included in the Public Finance Management system (PFM) when that system is in full operation, targeted for 2018. Therefore, MOFED is best positioned to become the payment agency of RBF in Health. MOFED is keen on lessons learned in RBF for application in other sectors of government.

Program management, purchasing and payment – a solution within: MOHCC and MOFED are of the opinion that RBF program management and purchasing functions could be best performed by the Program Coordination Unit (PCU) at MOHCC. The PCU already fulfills part of these functions and therefore the proposition is to strengthen and align this unit to the organizational and technical requirements for RBF. The existing RBF National Management Team would be replaced by the PCU in terms of RBF management (*extract from the medium term strategic framework 2016-2020)*.

Following the finalization of the strategic framework the Ministry sent two officers from the PCU to participate in the 57th International PBF Course organized by SINA Health in Mombasa Kenya from 27 November to 09 December 2016 and a further five high-level officers to attend the 59th International course. Only three out of five of the planned high level officers managed to attend the course. Their attending the SINA Health courses was meant to contribute to reaching a critical mass of people who adhere and can apply performance based financing according to best practice; and who will replace health systems based on traditional input financing. In addition, the purpose was to equip participants with the theories, best practices and tools in PBF and ffacilitate participants identify key challenges and develop an action plan to strengthen the implementation of PBF.

6.7.4 Feasibility scan

The Zimbabwe team executed the PBF feasibility scan.

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	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	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	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 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	0
TOTAL	**50**	**26 = 52%**

6.7.5 Recommendations

The team considered the training very relevant for the Ministry and well in line with the Ministry's policies of decentralization and plans to increase scale and scope of PBF. Contrary to what was proposed in the Medium Term Strategic Framework 2016-2020 by the Ministry, the team felt that the Ministry needed to reconsider separating the two roles of the PBF/PCU Unit which are as follows:

- Monitoring of Provincial/Regional Contract Development and Verification Agencies (CDVAs) and counter verification agencies, checking invoices, cloud computing and organising conferences for all stakeholders in the PBF systems.
- Contract Development and verifications to promote good governance, assure that providers' results are strictly verified and that subsidies can be paid. This functions also involves coaching of providers in the use of business plans and indices management tool.
- Giving the two roles mentioned above to the PBF/PCU Unit goes against the basic principles and best practice of performance-based financing and may result in the Ministry being unable to achieve the desired goals and objectives of providing quality health care services.
- Have a relook at the implementation arrangements with special emphasis on contracting organisations that will do contract development and verifications.
- Revise the Project Implementation Plan (PIM) to reflect changes in implementation arrangements and indicators.
- Come up with a strategy for Public Private Mix that will share the burden of health service provision
- Mobilise additional resources from partners and re-direct available resources meant for input financing activities to cover the gap to meet the minimum PBF per capita requirement currently estimated at US$2,44 to reach at US$4.

6.7.6 Action Plan

Activity	Strategy	Timeline	Responsible
Provide feedback on the PBF Training in Mombasa to Top Management Team	Presentation TMT Meeting	June 2017	PCU
Revision of the PIM	Meeting	June 2017	PCU
Resource mobilization meeting with Partners and the Private sector	Meetings	June and July 2017	PCU