Mombasa – KENYA

Report of the 64th Performance Based Financing Course

November 20 – December 1, 2017

The 34 course participants in Mombasa enjoying happy moments together

Final Version, 18th December, 2017
Mombasa, Kenya

Dr. Robert Soeters
Dr. Godelieve van Heteren
Dr. Claire Rwiyereka
Dr Fanen Verinumbe
Dr Christian Habineza

TABLE OF CONTENT

1. SUMMARY

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

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

34 participants attended the course in Mombasa with 21 participants from Nigeria, 5 from Zimbabwe and Liberia, 2 from Lesotho and 1 from South Sudan. Participants were high-level from various Ministries of Health and agencies. 32 participants conducted the final exam and the average score was high with 79%. Five participants obtained distinctions. The Sai Rock Hotel is an attractive venue at the Mombasa beach, but there were concerns about the internet and the maintenance of the rooms with sometimes interruption of water supply. We aim to keep the PBF courses relatively low cost and organizing the courses in a 5-star accommodation would mean increasing the course fees. A very luxurious environment would also give the wrong signal whereby we enhance the efficient use of public resources.

1.1 Overview of the nine PBF courses during 2017

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

In the following table, we observe a number of trends in the PBF courses since 2007:

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

1. The *proportion of female participants* to the PBF courses of 25% remains low. This is a concern that we do not fully understand but requires attention.

2. The *difficulty for the final* exam increased during the last years. The average score during the 2007-2015 courses was 78% and reduced towards 72% in 2017. There was also a higher proportion of participants, who failed the exam from 3% during the 2007-2014 courses towards 12% in 2017. The proportion of distinctions reduced from 23% during the 2007-2014 courses towards 12% in 2017.

1.2 New developments in course content during 2017

The course facilitation team continuously updates the course content with the latest developments that take place in the PBF reform approach. This is facilitated by the fact that the facilitators also work in the field so that their experiences can be translated into the course content. This hands-on experience seems to be appreciated by the participants and their organizations and the demand for the PBF courses remains strong, also already for 2018.

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

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

based on the achievement of output and quality indicators instead of just receiving fixed salaries and money for fixed input budget lines such as per diems or operational costs.

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

1.3 Changes in training methodology

During the last 10 years of PBF courses the aim has always been to cover all course book modules in the 12 or 13 days of the course. This has become difficult because of the many new developments and instruments that were developed. As a result, the course book expanded from an 80-page manual into a 260-page hand book with 17 modules.

We therefore made the following changes in the course methodology:

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

- Better coordinate the debates also by making use of the "village" approach whereby the participants also become part of the facilitation team and influence the content and methodology. During the PBF course in Central African Republic the participants facilitated the debate instead of the facilitation team.

1.4 General observations about the Mombasa course and evaluation

The PBF course welcomed participants from five countries.

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

The facilitation team consisted of:

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

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

The daily evaluations resulted in scores, which when compared to previous courses were above average. The **methods and facilitation** scores were 93.9%, 7% above the average of the previous 20 English courses. The score for **participation** was ok with 87.2%, which is comparable with the previous courses. The **organization** of the course in Mombasa was with 90.7% 5% *above* the average of the previous courses. Yet, the participants this time were less satisfied with Sai Rock Hotel and in particular concerning problems with the water supply and the food, which was considered too monotonous. The subject of **timekeeping** scored 67.9%, which was 5% *below* the average of the previous courses.

The final evaluation showed the program answered the expectations of participants, but that improvement could be achieved in informing participants in advance about the course. The methodology of the course was considered good with an average score of 91%.

1.5 Country recommendations of the November 2017 Mombasa course

1.5.1 Nigeria

The health system in Nigeria suffers from underfunding, inefficiency due to input financing, poorly motivated health workers, and frequent strikes. Health indicators are poor compared to other countries. The quality of health services is varied and does not install the confidence of clients so that some people seek care from unorthodox medical practitioners, go directly to tertiary health institutions (by-passing the primary and secondary health facilities), or even go outside the country.

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

Problem analysis

- PBF in Nigeria remained too long a World Bank-led "project" instead of a "national health reform strategy" to efficiently use scarce government resources comparable to the health policy in Burundi and Cameroun.
- The Nigerian health system is still predominantly input based, has several free healthcare elements and would greatly enhance its efficiency and quality of services by adopting performance-based financing.
- The private health sector in Nigeria already plays a vital "de facto" role for the population, but it is poorly integrated into the Nigerian health system and almost not regulated.
- The Federal level is still undecided about the merits of PBF and its potential for Universal Health Coverage. Despite little evidence about its effectiveness, the government proposes obligatory health insurance as the strategy towards UHC.
- States do not exercise their powers to influence their health systems towards PBF.
- The World Bank financed Save One Million Lives (SOML) project uses the achievement of disbursement linked output indicators of each State as the main criteria for payment. Yet once disbursed (the first instalment was $US 1.5 million per State), the States use this money for the traditional financing of inputs and thereby foster inefficiency and even corruption. Moreover, the SOML approach does not promote providers autonomy, the separation of functions and public-private partnerships.

Recommendations:

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

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

1.5.2 Lesotho

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

There are still the following problems:

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

Recommendations:

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

1.5.3 South Sudan

Since independence in 2011, 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 fights, which heightened uncertainty in the country. In August 2015, the parties to the conflict signed a peace agreement but implementation remained a significant challenge.

Problem analysis

- The South Sudan health system is too much donor-driven and ignores the vibrant private South Sudanese health sector in urban- and rural trading areas.
- The health system suffers from poor leadership and governance, weak HRM, poor infrastructure, duplication of services and a very high proportion of vulnerable population.
- There is the central distribution of most of the inputs from single suppliers.
- The performance of the regulatory authorities is poor with inadequate health policy development, and quality assurance mechanisms.

Recommendations:

- The South Sudan participant proposes to join hands with the previous Cordaid PBF course graduates from May 2017 and to form a critical mass to advocate with government and donors on the need for performance-based programs. An important partner may be the World Bank, which may also advocate for PBF style reforms.
- Develop and implement a well-designed PBF pilot in areas where the INGO Cordaid is the lead partner. The PBF scheme should contain the full primary- and hospital level packages and have adequate funding.

1.5.4 Zimbabwe

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

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

Recommendations:

- Advocate for a purer form of PBF together with previous PBF course participants.
- Advocate that the Ministry of Health changes input budget lines from GOZ funding, levies, taxes and partners towards PBF performance funding.
- Provide equal opportunity for obtaining PBF contracts to all health facilities whether public, religious or private; urban or rural.
- Enable a more competitive environment in the supply of health commodities by removing the restrictions that favor monopolies.

- Allow the Directorate of Pharmacy Services to work on accreditation of the public and private wholesale pharmaceutical companies including registration requirements and scope of work to allow entry into PBF.

1.5.5 Liberia

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

Problem analysis

- The design of the current PBF programs has problems and the feasibility scan score is 6 over 50, which is 12% while 80% is the recommended minimum.
- Liberia implements a free health care policy for all but during implementation, it has become evident that what people need is not just "services" but "quality services".
- In public health facilities, there is a poor quality of care with routine stock-outs of drugs and medical supplies and this has driven consumers towards patronizing private health facilities.
- The health sector is heavily donor dependent with interventions that are all vertical and difficult to coordinate.

Recommendations:

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

These recommendations are similar to what previous groups from Liberia also proposed. Yet, by increasing the critical mass of PBF trained participants from Liberia the implementation of these recommendations should become possible.

2. RESUME

Le ***64ème cours de financement basé sur la performance (PBF)*** a eu lieu du lundi 20 novembre au vendredi 1er décembre 2017, à Mombasa, au Kenya. Les groupes de pays ont procédé à une analyse de leurs systèmes de santé et ont élaboré des plans d'action détaillés sur la manière de faire progresser le FBP dans leurs pays respectifs.

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

2.1 Aperçu des neuf cours PBF en 2017

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

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

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

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

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

2.2 Nouveaux développements dans le contenu des cours en 2017

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

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

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

3. Signer des contrats de performance non seulement avec les établissements de santé et les autorités périphériques de la régulation, mais aussi avec les directions centrales du Ministère. Les autorités de régulation centrales devraient également recevoir des paiements variables basés sur la réalisation d'indicateurs outputs et de qualité au lieu de recevoir uniquement des salaires fixes et de l'argent pour les lignes budgétaires fixes d'intrants telles que les per diems ou les coûts opérationnels.

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

2.3 Changements dans la méthodologie des cours

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

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

- Réduire les messages de cours vers les idées essentielles de chaque module et rendre ces messages simples à comprendre. Ce processus est un travail en cours parce que les leçons apprises, les nouveaux développements et les opportunités dans le PBF sont si rapides qu'il nécessite une édition continue du matériel de cours.
- Réduire le temps consacré aux séances plénières et laisser plus de temps à l'équipe de facilitation pour aider les différents groupes et individus à développer leurs plans d'actions spécifiques.
- *Passez en revue les points de vue et les attentes des participants* sur le cours PBF en demandant à chaque participant à l'arrivée de répondre à un questionnaire. Certains sont novices en PBF et doivent d'abord comprendre et accepter les sujets de changement du PBF. D'autres ont déjà des connaissances PBF ou ont été récemment recrutés pour un emploi dans le PBF. Ils n'ont pas besoin d'être convaincus des sujets de changement, mais souhaitent plutôt apprendre des connaissances et des compétences spécifiques au FBP.

- Effectuer un pré-test sur la *connaissance PBF de chaque participant*. Les résultats influencent dans quelle mesure le cours devrait se concentrer sur les bases du FBP ou accélérer rapidement vers le « comment » du FBP et se concentrer davantage sur les instruments tels que les indicateurs outputs, l'outil de gestion des indices, le « costing » et e comment contracter les différentes parties prenantes.
- *Organiser des cours nationaux PBF* (environ 50% de tous les cours). Habituellement, ces cours ont des groupes de participants spécifiquement sélectionnés, par exemple du niveau de la régulation du Ministère central, des directeurs d'hôpitaux, des régulateurs régionaux ou de district et / ou du personnel des ACV. Dans de tels cours, nous nous concentrons généralement sur le développement de plans d'action SMART pour chaque participant ou groupe.
- Mieux coordonner les débats en faisant appel à l'approche « village » où les participants font également partie de l'équipe de facilitation et influencent le contenu et la méthodologie. Pendant le cours PBF en République Centrafricaine, les participants ont facilité le débat au lieu de l'équipe de facilitation.

2.4 Observations sur le cours PBF de Mombasa et son évaluation

Le cours PBF a accueilli des participants de cinq pays.

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

L'équipe de facilitation était composée de :

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

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

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

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

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

2.5 Recommandations spécifiques par pays

2.5.1 Nigéria

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

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

Analyse des problèmes du système de santé de Nigéria

- Le FBP au Nigéria est resté trop longtemps un « projet » dirigé par la Banque mondiale au lieu d'une « stratégie nationale de réforme de la santé » pour utiliser d'une manière plus efficiente les ressources rares gouvernementales comparables à la politique de santé au Burundi et au Cameroun.
- Le système de santé nigérian est encore principalement basé sur les intrants, dispose de plusieurs éléments de soins de santé gratuits.
- Le secteur privé de la santé au Nigeria joue déjà un rôle important pour la population, mais il est mal intégré dans le système de santé nigérian et n'est presque pas réglementé.
- Le niveau fédéral est encore indécis sur les mérites de PBF et son potentiel pour la couverture santé universelle. En dépit de peu de preuves sur son efficacité, le gouvernement propose l'assurance maladie obligatoire comme la stratégie vers la CSU.
- Les États n'exercent pas leurs pouvoirs pour influencer leurs systèmes de santé vers le PBF.
- Le projet Save One Million Lives (SOML), financé par la Banque mondiale, utilise comme principal critère de paiement les indicateurs de production liés au décaissement de chaque État. Une fois déboursés (la première tranche s'élevait à

1,5 million de dollars américains par État), les États utilisent cet argent pour le financement traditionnel des inputs et favorisent ainsi l'inefficience et même la corruption. De plus, l'approche SOML ne favorise pas l'autonomie des prestataires, la séparation des fonctions et les partenariats public-privé.

Recommandations :

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

2.5.2 Lesotho

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

Il y a toujours les problèmes suivants :

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

Recommandations :

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

2.5.3 Soudan du Sud

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

Analyse des problèmes du system de santé

- Le système de santé du Soudan du Sud est trop axé sur les partenaires techniques et financiers et ne tient pas compte du dynamisme du secteur privé de la santé dans les zones commerciales urbaines et rurales.
- Le système de santé souffre d'un leadership et d'une gouvernance médiocre, d'une faible gestion des ressources humaines, d'une infrastructure médiocre, de la duplication des services et d'une très forte proportion de la population vulnérable.
- Il y a la distribution centrale de la plupart des intrants provenant de fournisseurs monopolistes.
- La performance des autorités de la régulation est médiocre avec un développement inadéquat de la politique de santé et des mécanismes d'assurance qualité.

Recommandations :

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

tous les paquets de niveau primaire et hospitalier et disposer d'un financement adéquat.

2.5.4 Zimbabwe

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

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

Recommandations :

- Plaider pour une forme plus pure de PBF avec les participants au cours PBF précédents.
- Plaider pour que le Ministère de la Santé modifie les lignes budgétaires relatives aux inputs provenant des sources de gouvernement, des taxes et des contributions des gouvernements vers le financement PBF.
- Fournir des chances égales d'obtenir des contrats PBF pour tous les établissements de santé publics, religieux ou privés ; urbain ou rural.
- Permettre un environnement plus concurrentiel dans la fourniture de produits de santé en supprimant les restrictions qui favorisent les monopoles.
- Autoriser la Direction des services pharmaceutiques à travailler sur l'accréditation des distributeurs pharmaceutiques publiques et privées de gros, y compris les exigences d'enregistrement et tous les travaux pour permettre l'entrée dans le PBF.

2.5.5 Libéria

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

Analyse du problème

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

qui a poussé les consommateurs à se tourner vers les établissements de santé privés.
- Le secteur de la santé est fortement dépendant des bailleurs de fonds avec des interventions qui sont toutes verticales et difficiles à coordonner.

Recommandations :

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

Ces recommandations sont similaires à celles proposées par d'autres groupes libériens. Cependant, en augmentant la masse critique de participants formés au PBF du Libéria, la mise en œuvre de ces recommandations devrait devenir possible.

3. INTRODUCTION

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

Performance-based financing has been steadily replacing input-based centrally planned health systems, on which the PHC and Bamako Initiative paradigms were based. Since the late 1990s, PBF initiatives and pilots, formerly known as the contractual approach schemes, have been gradually introduced in around 40 countries worldwide. A number of them - such as 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.

There is no longer much 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 assure more sustainable systems. Its effects on transparency, good governance and ownership are comparing favorably to the 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. PBF also developed standards on the revenues and staff per capita that are required to deliver the full packages of good quality in health and education. This implies that health facilities and schools in low- and middle-income countries sometimes need to increase their revenues and qualified staff by a factor 3-5.

The challenge of any PBF-led transformation is that it requires change that is not always easy to manage. It entails informing key stakeholders and changing their terms of reference including those of 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. In PBF, we tend to avoid inefficient blanket approaches or populist usage of free health care mechanisms. Rigorous empirical research and impact evaluations on the pros and cons of various methods remain necessary and welcome.

3.2 Aims and objectives of the Mombasa PBF course

General aims of the PBF course

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

Specific Objectives

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

3.3 The November 2017 Mombasa course

The 64th group consisted of a mix of people with a variety of implementation experience in PBF in different countries across Africa (Lesotho, Nigeria various states and federal, South Soudan, Liberia and Zimbabwe). Throughout the course, the participants were assigned to develop a "business or action plan", following a number of steps: (a) Elaboration of the country background of the particular PBF initiative; (b) Analysis of specific PBF implementation challenges through the application of the PBF feasibility scan of module 9; (c) 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 and country presentations, photos of the course and articles) were distributed during the course, together with the participants' contact details list. On Friday November 25, 2017, field excursions were organized to five health facilities: Mtwapa Health Center, Kadzinuni Dispensary, Vipingo Health Center, Tagaungu HC and Kilifi County Hospital.

3.4 The final exam, adult learning and accreditation

SINA Health issues a Certificate of Merit to those who 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 December 1st 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. 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 mistake
Dr Daniel IYA Commissioner of Health from Nasarawa State
Dr Simon Nyadundu, Provincial Medical Director

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

3.5 Who attended the May – June 2017 PBF course?

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

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

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

3.6 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 1 experienced facilitator is present for each 8 participants 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

3.7 Facilitation team

The facilitation team consisted of:

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

3.8 Next English PBF course May – June 2017

4. DAILY EVALUATIONS BY PARTICIPANTS

4.1 Daily evaluations by participants

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

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

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

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

Table 1: Overall daily evaluation scores of the course.

4.2 Methods and facilitation

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

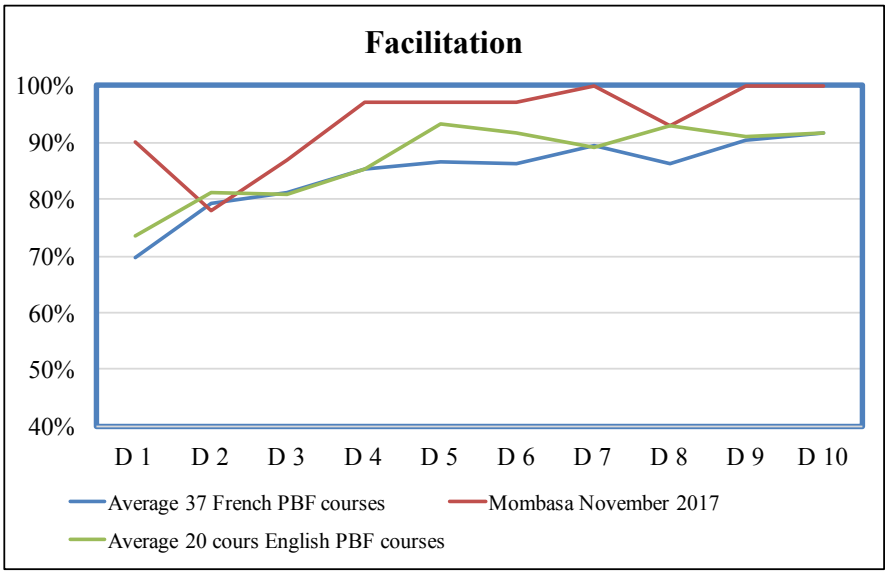


Figure 1: Evolution of the daily evaluations: *methods and facilitation.*

4.3 Participation

The satisfaction with the level of **participation** was 87.2%. This is similar compared to the previous English courses (87.6%) and 5 per cent above the French courses (82.4%). This score is satisfactory.

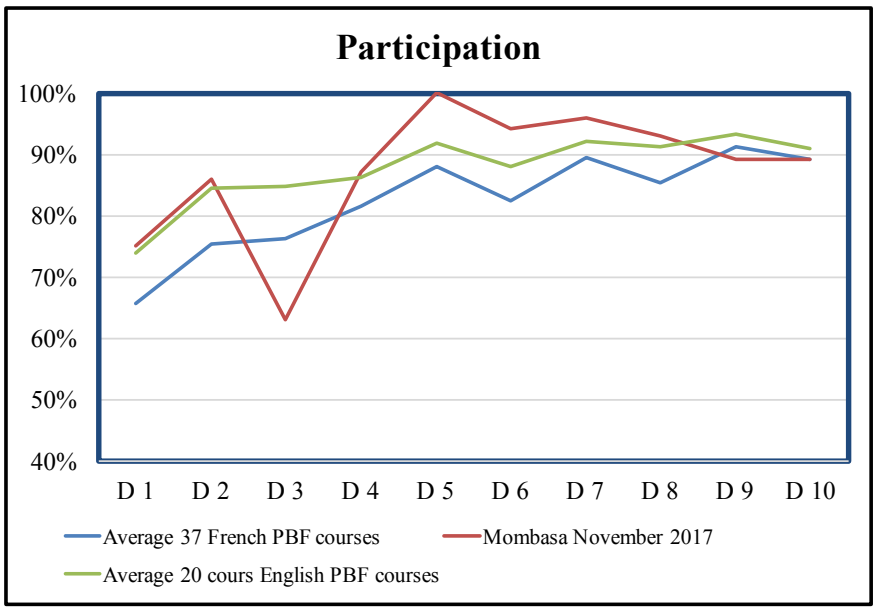


Figure 2: Evolution of the daily evaluation: *participation.*

4.4 Organization

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

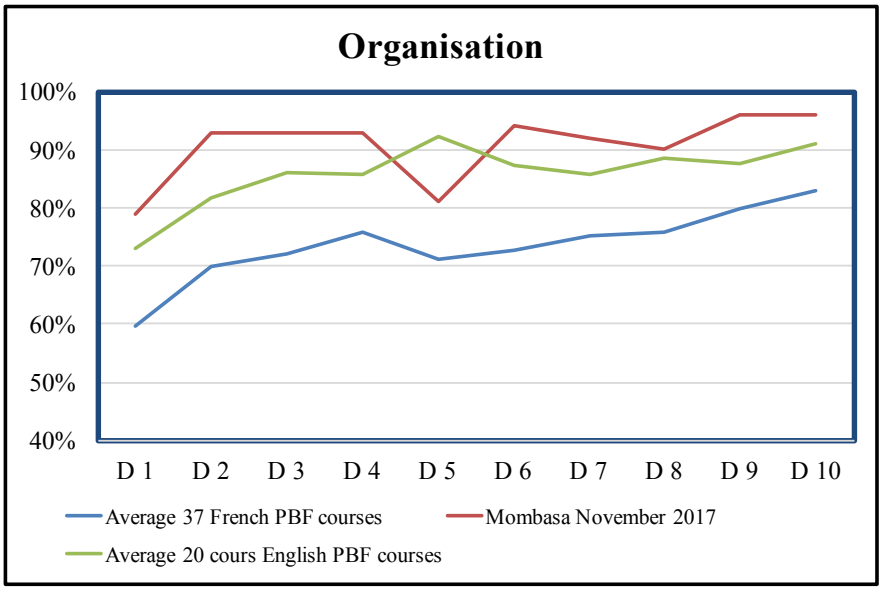


Figure 3: Evolution of the daily evaluation: *organization.*

4.5 Time keeping

Satisfaction with time keeping was 67.9%, which is 5% *below* the previous English courses and 7% below the French courses. The f

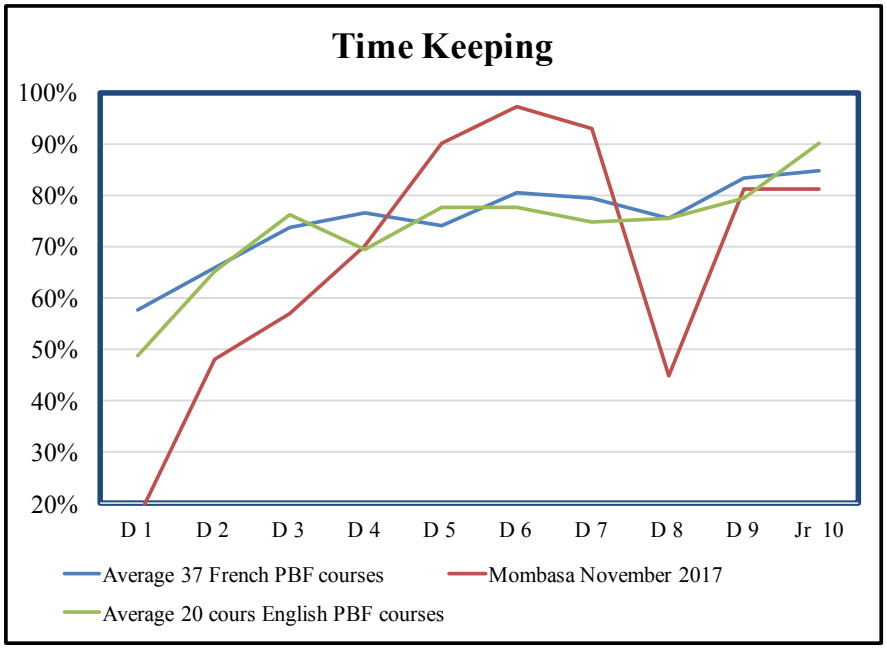


Figure 4: Evolution of the daily evaluation: *time keeping.*

5. DESCRIPTION of the COURSE

Arrival day: Sunday November 19th 2017

The 64th International PBF course in Mombasa – Kenya welcomed 34 participants from 5 African countries; Nigeria, Zimbabwe, Lesotho, Liberia and South Sudan. All participants came from the health sector, with most coming from the various ministries of health.

The countries such as Lesotho, Zimbabwe, Liberia and few Nigerian states had PBF at different levels of implementation and were looking to gain more knowledge and possibly improve in 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.

Most participants arrived on Sunday 19th November, 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 them to settle in quickly.

During the course, the daily recaps were made interactively by the facilitators, who further emphasized on the key messages from the previous days' modules and clarified areas that needed further clarifications. This method was found to be more effective and helped in the time management.

Evening sessions were provided for the country groups to give feedback on the course in general as well as 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 their needs. The interactions were rich and enlightening. Throughout the two weeks, participants received individual and group guidance on their respective action plans.

Participants highly appreciated these sessions

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

Monday November 20th

At 9:00am, Godelieve welcomed all participants to the course and explained the course outline and methodology. She further welcomed all participants in their country groups. In trying to get acquainted, the creative market place was introduced, where participants wrote their expectations and pasted on the wall next to others who had similar ones. Here most participants indicated they were in the course to gain more knowledge on various aspects of PBF (principles, implementation, theories,

etc.) also most participants had indicated to learn about how the efficiency gains with PBF might be sustained.

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

Tuesday November 21st

Day 2 started at 8:30 with the daily recap and summary of important points by Robert Soeters.
This was followed by the module on PBF best practices and change topics. As always, sufficient time was allocated to discussing this, which allowed participants to express their concerns. Turning Point Questions (TPQs) were used to stimulate interesting and very relevant discussions as well as active participation.
The main areas of debate were around autonomy and separation of functions, where participants expressed their concerns especially as it related to their roles as regulators; competition, as it relates to essential drugs monopolies and free health care with reference to financial accessibility for the vulnerable.
These discussions and debates were found to be useful, as a clear understanding of the best practices as building blocks for PBF by participants was necessary.
Next, the module on equity was presented. Here participants understood the differences between equality and equity and were presented with the smart ways in which PBF applies various equity instruments to assure financial accessibility for the vulnerable in a more efficient manner.

The day ended at 16:30 with the daily evaluations and selection of the best debater of the day.
In the evening, facilitators met with participants from Lesotho, to look specifically into their issues and concerns. This was followed by the Nigeria Federal Ministry of Health group.

Wednesday November 22nd
The day started at 8:30 as usual with a recap and summary of important points from day 2 activities which was facilitated by Robert.
The presentation on the PBF theories constituted most of the day's activities. Participants were 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 (module 5A) then followed. Participants were taken through basic economic principles as a foundation to understanding how markets operate – and subsequently the health market.
The session closed at 16:30 and in the evening facilitators met with the Nigeria SOML States (Kano, Katsina and Kebbi), followed by the Nigeria NPHCDA group.

Thursday November 23rd
The daily recap and summary of important points was presented by Fanen and Robert.
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.
In the afternoon, participants were introduced to the various actors / stakeholders in the PBF system. Here participants were asked to use the PBF institutional arrangements model to already plot in their health systems and identify existing structures that could assume the various functions.
Module 6, on National Policies, regulation and quality assurance – facilitated by Christian took the rest of the afternoon where the various roles and responsibilities of the regulator in PBF were discussed.
The day ended at 16:30 with the daily evaluations and election of the best debater of the day.
In the evening facilitators met with the groups from Liberia and Zimbabwe.

Friday November 24th
The morning started at 8:20 with with a brief introduction of the terms of reference of field visits by Godelieve and Robert. The groups then set out on the field to visit five Kilifi County facilities for a tour and guided interviews with the facilities' in-charges and other staff.
The facilities visited were:

1. Kadzinuni Dispensary: Quaye Georgia, Solomon Angyu, Nkunihya Kwabe, Bahima Alex, Machamire Healther and Adoghe Anthony.
2. Vipingo Health Center: Neufville Harry, Abubakar Amina, Ujulu Amos, Sani Muhammad, Imam Bello, Yahaya Shamsuddeen, Abatta Emmanuel and Nyadundu Simon.
3. Kilifi District Hospital: Howe Jabbeh, Sefako Celina, Iya Daniel, Zubairu Mahmud, Jibril Gwandu, Solanke Olutosin, Odidi Lawrence and Mudyara Jane.

4. Mtwapa Health Center: Kesselly Roland, Onwudinjo Ifeyinwa, David Timothy, Hove Ropafadzai and Mohlomi Lineo.
5. Tagaungu Health Center: Belleh Ishmael, Yahaya Rukayya, Hassan Adamu, Adamu Bashir, Owolabi Anne, Chikodzure Rudo.

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

Issues reported from the field trip include the following:

- 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 input from accredited distributors only if they were using their internally generated resources to do so and up to a certain amount of money.
- The procedure of receiving drugs and other inputs from the KEMSA was tedious, took a long time and health facilities frequently experienced stock-outs.
- No health facility had autonomy to set user fees, manage their financial resources or to hire and fire their staff
- Most health facilities already informally re-introduced cost sharing to enable them continue providing services to the population.
- Revenue per capital does not meet required standards of 7 USD per capita, with most facilities generating less than USD3 per capita.
- Generally poor separation of functions.
- Some form of client satisfaction using suggestion box, direct patient interviews and feedback through community committees, which was found to be ineffective. This aspect needs to be strengthened as per PBF.
- Most health facilities had a gap in staffing levels, up to 50%.
- Generally, facility managers and staff are happy about PBF and see it as a way of improving the health system and better motivating their staff.

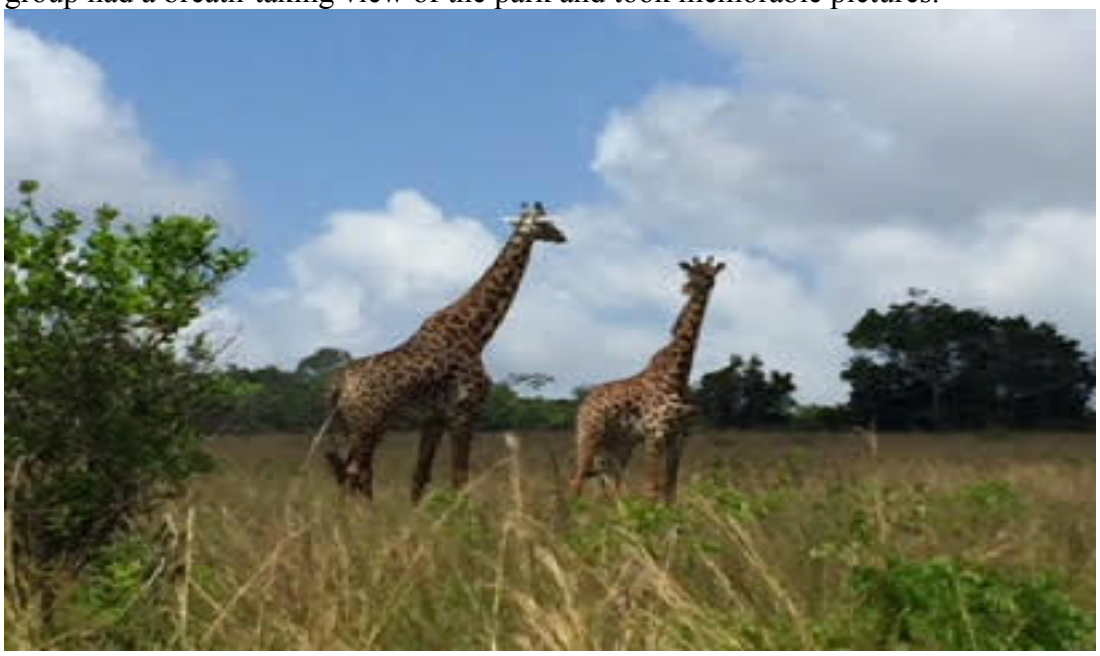
Following the feedback from the field visit, the module 7 (CDV Agency) was presented.
The day ended at 16:30 with the daily evaluations. In the evening, facilitators met with the team from the Nigeria NSHIP States; Adamawa, Nasarawa and Taraba.

Saturday November 25th

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

Sunday November 26th

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



The climax of the trip was at the hill top as we descended to the waterfalls, 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 vegetation such as the dome palm, the bottom plant, lesser flamboyant, pod mahogany and crocodile liana.

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 as most people attempted to race to the top.

Lunch was at the beautiful 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 November 27th

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

Most challenges that were discovered during the scans were related to the budgetary allocation, choice of indicators etc. Most countries already implementing PBF discovered they had killing assumptions for which they prepared the role plays.

The feasibility scores and the various activity plans / recommendations are presented in the section dedicated to country specifics further in this report.

This was followed by the module 9 on the role of the community in PBF and then module 10 on conflict resolution and negotiation techniques began.

At the end of the day, participants 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.

In the evening, facilitators met with the team from Liberia to assist with their action plans.

Tuesday November 28th

The Module on conflict resolution and negotiation techniques was completed. Next, module 11 on output indicators was presented. This was followed by two exercises in groups for plenary restitution and discussion.

Participants were allowed to spend sufficient time on the exercises which gave them a hands-on experience on how to determine SMART indicators that should be incentivised (for the health centre and hospital packages), as well as how to calculate the targets for each indicator.

The day ended at 17:00 to give sufficient time to complete the module and exercise on indicators.

In the evening country groups continued work on their group and individual action plans using an outline that was produced, to be presented on Wednesday morning. Facilitators worked with the team from Lesotho and Zimbabwe in developing their action plans.

Wednesday November 29th

More time was allocated in the morning to the development of the country and individual action plans

The country presentations of the action plans then started with the Nigerian state of Nasarawa presenting first then the remaining Nigerian groups (Adamawa/Taraba; Kano/Katsina/Kebbi States; Federal Ministry of Health and National Primary Health Care Development Agency). Next was presentations from the participants from Lesotho, Zimbabwe Liberia and South Sudan.

The presentations revealed that most groups had already advanced in the development of their action plans which was commendable.

Module 13 – The Business Plan was then presented by Godelieve.

Module 14, on Indices management tool was presented in the afternoon, to be completed on Thursday morning.

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

Thursday November 30th

The last part of module 14 on the Indices management tools was presented.
The module 11 on baseline studies and action research was then presented before the groups broke out to work on the indices tools exercise, finalized by a plenary restitution.
The day was confined to the morning to allow participants time to prepare for the exams.
Module 15 - costing, and 16 - PBF in emergency situations were not presented in class but participants were asked to study these on their own.
The overall evaluation on the course was carried out before the class broke up for the general revision in the afternoon in order to prepare for the exam.

Friday December 1st

The exam day started at 8:30. all participants took the exam except for 2 participants who already left due to official and personal obligations.
In the afternoon from 13:00 onwards the exam was reviewed. This was followed by a ceremony to hand out the certificates.
In the evening Sairock Hotel management proposed a happy hour to the remaining participants as 3 participants left already in the afternoon to catch their flight back home.

Saturday December 2nd

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

6. FINAL COURSE EVALUATION BY PARTICIPANTS

6.1 General impression of the course

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

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

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

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

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

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

6.2 Appreciating the duration of the course

For 83% of the participants, the course duration was right, while 10% thought the course to be too short and 7% 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	34 previous French PBF courses	21 previous English spoken PBF courses	Mombasa November 2017	Comparison Mombasa November 2017 / 22 previous English spoken PBF courses
Too Short	33%	24%	10%	-14%
Fine	61%	64%	83%	19%
Too Long	6%	12%	7%	-5%

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

6.3 Comments on the organization of the course

For "organization", the overall score of 74% was 3% *lower* than the previous 22 English courses with 77% and 4% *above* the 36 previous French courses. The conference center (63%) and the food (33%) scored respectively 11% and 27% 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.

Like issues already noted in May/June 2017, several participants complained again that there were problems with the water system of the hotel. Food was also thought to be slightly monotonous by several participants.

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

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

Table 5: Evaluation of the organization of the course.

6.4 Comments on the execution of the course and the facilitators

The execution of the program was scored average with 76%, which was 1% below the average of the previous 22 English courses. The question in how far facilitators were open minded was evaluated at 57%, which was 19% below the average of the previous English spoken courses. Time allocated for group work was 82%, which was 7% *above* the scores of the previous courses. Time for discussion was evaluated at 90%, which was 8% above the average of the previous English courses.

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

Table 6: How was the facilitation?

6.5 Evaluation per module

The satisfaction per module by the Mombasa participants was 91.6%. This is 4.2% above the average of the 21 English courses (87.4%). The participants appreciated the completeness and the illustration given by the facilitation team of the modules. Five modules obtained 100% including the first day modules, regulation and PBF feasibility scan. Economics and the Indices Management tool scored slightly lower with 75%. Costing was not covered during the course.

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

Table 7: Evaluation per module.

6.6 Written comments during the final evaluation by the participants

Pre-Course Preparations

- Participants should be told/advised on the need to collect luggage at Nairobi airport and check in again to Mombasa
- Participants should be advised to bring beach wears and that the program includes an outing.
- Course organisers should give more information about the program
- Describe the facilities and what people need to bring

About Course methodology

- Robert has to listen to participants in order to understand them. He should not be too strong about PBF. We are here to learn as well as discuss the real-life scenario in our countries so that we can learn how to overcome some of the challenges

- Group work should be in the afternoons / evenings when people are tired.
- Better controlled discussions in class
- The interactions were sometimes not all inclusive since some people who already know the methods seem to fly alone.
- Each facilitator was good and had an open mind and down to earth.
- The chief facilitator Dr Robert does not accept criticism or contrary views. He sometimes becomes irritated if participants do not agree.
- Other facilitators like Godelieve, Fanen and Claire were nice all through.

Course Book and Modules

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

Hotel

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

Transportation

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

7. COUNTRY & TOPIC PRESENTATIONS

7.1 Nigeria Federal Level

7.1.1 General context

Nigeria is located in Western Africa on the Gulf of Guinea and has a total area of 923,768 km^2. Its territorial borders are defined by the Republics of Niger and Chad in the north, the Republic of Cameroon in the east, the Republic of Benin in the west and the Atlantic Ocean in the south. The main rivers are the Niger and the Benue, which converge at Lokoja and empty into the Niger Delta. The climate of Nigeria is tropical, with wet and dry seasons associated with the movement of the inter-tropical convergence zone north and south of the Equator. Nigeria has a federal political system. It has 36 states, 774 Local Government Areas and the Federal Capital Territory with Abuja as the national capital.

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

Social economic indicators
The economy is largely dependent on oil revenues and grew at a rate of 3.0% and 3.7% in 2015 and 2016 respectively. The economic growth is projected to rise to 5.4% annually between 2017 to 2019 as the result from investments in the non-oil sectors such as Power, works & housing and agriculture, which started in 2016. The unemployment rate is currently estimated at 9.9% with an underemployment rate of 17.4% which is highest in the 15-34 age group living especially in urban areas. 69% of the population are estimated to be living below the poverty level, translating to 112.7 million vulnerable persons (Harmonized Nigeria Living Standards Survey 2010).

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

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

7.1.2 Health system context

The Nigeria health system is described as weak and fragmented with poor financial and human resources and a decaying infrastructure. There are currently no clearly defined roles and responsibilities regarding the provision and financing of health among the 3 tiers of government. There is a double burden of disease with communicable diseases accounting for 66% of the total burden of morbidity. Non-

communicable disease accounts for 24% of total deaths. At the federal level, health financing challenges include gross under-funding of health system with poor budgetary allocation (3.9%, 6% 4% in 2010, 2012 and 2013 respectively) and poor budgetary release leading to inadequate public health funding which is not in tandem with national priorities. Out-of-pocket expenditure (OOPE) as a proportion of total health expenditure range between 73.8% in 2006 to 70% in 2009.

Many health facilities are situated in rural and hard-to-reach areas. Services are not available for a large percentage of the population due to the constant industrial actions providers in public facilities. The private sector has played a vital role in making health services available but they are poorly integrated in the Nigerian health system. The quality of health services is poor and does not instill the confidence of their clients so that some people seek care from unorthodox medical practitioners or they by-pass the primary and secondary health facilities to seek care directly at tertiary health institutions; or outside the country.

There is a lack of clarity concerning standards and protocols as well as inadequate implementation of health guidelines and regulations. Human resource challenges include high health worker's attrition, poor remuneration, poor supervisory & logistic support and a poor working environment. There is limited continuing education capacity and the quality of the training provided is inadequate. As a result, health workers tend to migrate to "greener pastures", there may be professional rivalry and divisions, conflicts of interest and frequent strike actions.

The health system is faced with poor data management and poor-quality data. The regulator does inadequately coordinate donor agencies and development partners leading to vertical health programs. There are inadequate mechanisms to address frequent outbreaks of communicable diseases (*Cholera outbreak in Borno, Type C meningitis outbreak in Zamfara)*. There is a rising prevalence of lifestyle disorders further compounded by natural disasters.

In summary, we may conclude that the health sector has collapsed with substantial unmet needs, high expectations, monumental health emergencies and crisis. The ambitions of the health agenda may be high but often without the required government resources, a situation which is aggravated by reducing partner resources such as GAVI.

Based on the MDGs report

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

7.1.3 PBF in the Nigeria

PBF aims to improve health care delivery for the population. Health care providers are likely to be more committed to work due to the performance payments. The Nigerian health system is hampered by frequent strike actions by health workers and this can be contained by PBF. The application of the PBF strategy encourages the hiring of qualified health workers, the availability of drugs and essential health commodities thereby guaranteeing the confidence of the community to seek health

services. Evidence can be seen from on-going pilot study in Nasarawa, Ondo and Adamawa states. It allows true decentralization to the periphery.

Regulation, payment, verifier, provider and community actors play **independent** roles to make the health systems functional to deliver *Quality (Health Services)*, *Efficiency (in the use of Economic Resources)*, *Equity (to address concerns on the vulnerable, emergencies etc.)*. It uses economic instruments such as subsidies, taxes to change the paradigm. PBF also promotes public-private partnerships with equal treatment of public, religious and private providers.

Potential advantages & benefits of PBF

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

7.1.4 PBF feasibility scan per State

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

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

of obtaining a contract										
18. There are geographic and/or facility specific equity bonuses	3	0	**0**		3	3	0	0	0	
19. The project provides equity bonuses for vulnerable people	3	3	**0**		3	3	3	3	3	
TOTAL	**50**	**26 (52%)**	**11 (22%)**	**0 (0%)**	**39 (78%)**	**39 (78%)**	**30 (60%)**	**6 (12%)**	**6 (12%)**	**(12**

7.1.5 Activities Planned

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

7.2 Action plan - National PHC Development Agency (NPHCDA)

Immediate 3-6 months

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

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

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

Action plan – 3 (long term >12months)

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

7.3 Safe One Million Lives programme

7.3.1 Background

Several participants working with the SOML programme at Federal and State level attended the PBF course Mombasa. The SOML programme is based on 6 mainly reproductive health disbursements linked indicators (DLI). The idea is that a State which makes good progress receives a performance bonus. The first payments to each State, however, was a lump sum of US$ 1.5 million irrespective of factors such as population size.

7.3.2 Action plan for advocacy at SOML PforR

A two points agenda is being planned at the level of the Government of Nigeria's intervention programme, the Saving One Million Lives Programme for Results (SOML PforR). This will be done through the Programme Management Unit which coordinates the implementation of the programme at the National level with direct oversight function at the state level.

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

7.4 Nigeria – Nasarawa State

Dr. Daniel Iya – Commissioner of Health

7.4.1 Situation Analysis:

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

After a preliminary mapping of Health facilities, the project commenced in 2011 as a pilot scheme in one local Government area (Wamba Local Government Area). This has now been scaled up to all the thirteen local government areas of the state. However not all the health facilities in the state are PBF facilities. The pilot scheme had a research component to it, hence a control group referred to as Decentralized Facility Financing (DFF) that received some money as input financing but did not earn Bonuses from output indicators, referred to as Disbursement Linked Indicators (DLI). Currently a total of 453 facilities representing 240 facilities (235 PBF, and 185DFF) 17 General Hospitals, and 14 private hospitals (all PBF), and 2 Tertiary hospitals partly covered under the PBF programme (NSHIP).

Nasarawa state is in the North-Central Geo-political zone of Nigeria. It is congruent to the Federal Capital Territory. Its projected population from 2006 National census it put at 3.4 million. However, the more accurate estimation from GIS is put at 5.6 million. It has been documented that while the annual population growth of the country is about 3%, the corridor to FCT is 9% (three times the average in the nation.) The health indices are average for the nation. The nation is an agrarian state although rich in mineral resources.

7.4.2 Results so far with PBF in Nasarawa

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

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

The autonomy of the PBF facilities allowed for the employment of skilled staff at the facilities, thereby improving the quality of services such as, for example, Antenatal Care (ANC) and birth attended to by skilled staff. Infrastructural maintenance and improvements of the facilities provides a hygienic and conducive environment for patient care.

7.4.3 Problems that could be solved at state level

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

7.4.4 Problems that have not yet been resolved

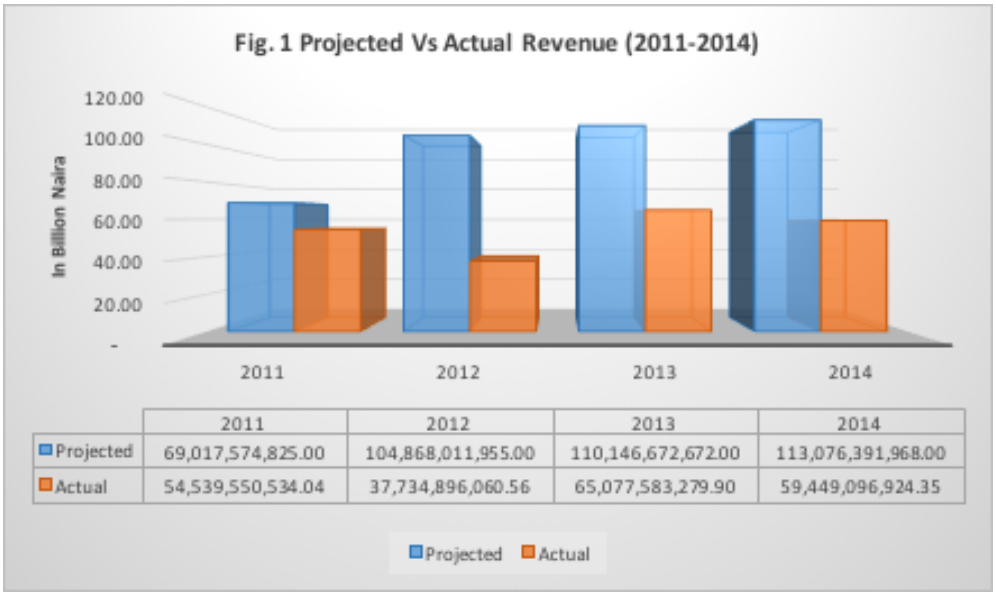
1. The World Bank financed Save One Million Lives, which although it has output indicators, still applies input financing in the areas of equipment and drug supply. This is a very inefficient way of funding because it provides an environment for corruption. The introduction of SOML does not provide the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

In summary, the health system still suffers from: 1. the partial separation of functions (regulation, provision, contract development and verification, payment and community voice strengthening)*; 2.* Sticking to "Business as Usual" of input

financing and; 3. Lack of willingness to allow the free market economy to operate by enforcing price ceilings and promoting monopolies for inputs.

7.4.5 Advocacy strategy

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



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

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

7.4.6 Implementation strategy

1. The State has constituted the Universal Health Coverage Steering Committee chaired by the Deputy Governor, which is operates as an ad-hoc Board to

spearhead the programme. Linked to the Steering Committee the State has constituted a Technical Working Group is chaired by Commissioner of Health. I will utilize this high advocacy bodies to cement these allies with the argument the PBF is the most effective way of ensuring QUALITY of Healthcare Service Delivery in an efficient manner before addressing the issues of EQUITY. This will also strengthen the Health System.

2. As implementation strategy, the State has already piloted the PBF approach, which characterized by the separation of functions, the autonomous management of providers, enhanced collaboration with the private sector and promoting completion for inputs from accredited distributors. I will leverage on this, citing our experience in the state, and on the MTR just out. I will therefore solidify the support of my allies. These bodies will be the Champions of PBF in Nasarawa State.
3. As regards those not decided, I will utilize information dissemination through town hall meetings, panel discussion on Television, jingles and pamphlets on major spoken languages in the state to make the non-decided become my allies.
4. The strategy for my opponents would be through robust debate with superior argument that workers be paid according to their performance. "NO WORK:NO PAY" slogan!

7.4.7 Action plan when back in Nasarawa State

1. Transforming the input implementation budget line of Saving One Million Lives (SOML), into output performance financing. Within 2 weeks.
2. Transforming the DFF funding for the PBF control LGAs into pure PBF approach. Within 1st Quarter of 2018
3. Advocate that the counterpart MOH budget of the NSHIP program be used to scale up PBF towards those health facilities in the LGAs that were not selected for PBF. Within one month.
4. Provide the Governor with the financial commitment needed based on PBF recommendation at the primary as well as the secondary hospital level. Within 4 weeks.
5. Also, taking into considering the results of the Mid -Term-Review, soon to be released, I will advocate to the Governor, Providers and other stake holders of the need to scale up all DFF facilities to PBF. First quarter 2018.
6. UHC must be through mandatory contribution, with a well- defined package that include services that are of public goods such as immunization, HIV and TB treatment, Family Planning Services. Fees for quality service must be charged. However, government should subsidize for vulnerable groups, but before such policy implementation, the cost of implantation of such policies must be known and provided for in the budget. Co -payment is necessary from all beneficiaries at secondary and tertiary levels, the important thing, however, is to reduce high out-of- pocket (OOP) expenditure, such that it does not lead to financial catastrophe, or impoverishment. OOP of between 20-30% is desirable. 1st Quarter -2nd Quarter 2018.

7.5 Nigeria - Adamawa State

7.5.1 State Profile

Adamawa State is in the North East of Nigeria and has many rivers; the major one is the River Benue whose source is from the highlands of the Cameroon and flows southwards to join the Niger river.

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

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

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

7.5.2 Fiscal space in Adamawa State

The State has established a mixed input / output based financing model focusing on the health facilities as providers of PHC services, the SPHCDA as purchaser of the PHC services, the SMoH as the regulator and the State Ministry of Finance as the payment agency. Health facilities also receive inputs from partners and the overall aim is to strengthen the capacity to deliver quality services for pregnant women, children, and the vulnerable. Health facilities are managed at the ward level with the support of the Ward Development Committees (WDCs) and the LGA PHC Authorities.

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

7.5.3 Adamawa State health system

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

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

The State Primary Health Care Development Agency is entrusted with the responsibility of ensuring development of the primary healthcare system across LGAs and the equitable roll out of State policies and standards for the delivery of basic health care services. State Primary Health Care Development Agency manages and oversees the delivery of primary healthcare services.

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

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

Adamawa state has over 1,297 health facilities with 1,160 public health facilities (89%) while 137 are private (11%) comprising of 1 Federal Medical Centre, 1 Specialist Hospital, 16 General Hospitals, 403 Health Teams and 7 Private facilities contracted and implementing performance based financing.

Adamawa state practices a mixed system of paper and electronic methods for health information management, however the state experiences challenges with weak infrastructural support for the DHIS 2 electronic reporting at the LGA and facility level. This is due to both poor integration of DHIS managed by different agencies/departments and limited number of trained personnel in monitoring and evaluation to support the data collection and reporting. Adamawa state is part of ongoing efforts across the country to integrate of all existing health DHIS2 databases towards strengthening the NHMIS in Nigeria.

Adamawa primary healthcare service delivery system performance is unable to meet the basic health needs of her population: With an estimated 4.3 million population and annual growth rate 2.9%, over 200,000 women become pregnant annually and over 17,000 children are born monthly. The under-5 mortally is 129/1000 NE (NDHS2013) while as many as 576/100,000 women die annually of pregnancy related causes. Access to essential child health interventions is low: 23% of children under-5 are fully immunized while only 61% received the 3rd dose of pentavalent vaccine. TT2 coverage for pregnant women stand at 50%. Whereas malaria (13%), diarrhea (10%), and pneumonia (10%) cumulatively account for 34% of deaths of children under the age of five, access to recommended treatments remains grossly suboptimal. Recent data (MICS 2016) indicates that only 18.5% of children U5 with diarrhea can access oral rehydration salts (ORS), while 16% and 43% respectively are

treated with artemisinin-based combination therapy ACT for malaria, and antibiotics for acute respiratory infection (ARI).

7.5.4 Underlying systemic issues before the implementation of PBF are:

Fragmentation and poor separation of roles between federal, state and local government levels, unclear accountability and performance framework, lack of incentives for performance, input based financing of health facilities without the autonomy to operate.

Nigeria, compared to other countries in Sub-Saharan Africa, has relatively abundant human resources for health. Yet the Adamawa health care worker to population density ratio is well below the national average with in particular an un-even distribution of health professionals between urban and rural areas. Moreover, there is weak capacity of health workers worsened by poor remuneration and lack of structured training opportunities. Adamawa State has one doctor for 35,719 people and one nurse for 3,604 people. At the primary health care centers, there is a chronic stock-outs of essential drugs (average 55%), a lack of minimum equipment (average 25% equipped), poor sanitation/waste management, idle health workers and absenteeism (average 29%).

7.5.5 The PBF approach in Adamawa

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

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

7.5.6 Feasibility Scan for Adamawa State

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

6. Cost recovery revenues are spent at the point of collection (facility level)	2	2	
7. Health facility managers have the right to decide where to buy their inputs	4	4	
8. The project introduces business plans	3	3	
9. The project introduces the indices tool for autonomous management	3	3	
10. CDV agencies sign contracts directly with the daily managers of the health facilities – not with the indirect owners such as a religious leader.	2	0	All functions apart from contract signing
11. Health facility managers are allowed to influence cost sharing tariffs	2	2	
12. Health facility managers have the right to hire and to fire	2	2	
13. There is a CDV Agency that is independent of the local health authorities with enough staff to conduct contracting, coaching and verification.	2	0	
14. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	2	
15. CDV agents accept the promotion of the full government determined health packages (this in Africa mostly concerns discussions about family planning)	2	2	
16. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	2	
17. Public, religious and private facilities have equal chance for a contract	3	3	
18. There are geographic and/or facility specific equity bonuses	3	3	
19. The project provides equity bonuses for vulnerable people	3	0	Only OPD indigent
TOTAL	**50**	**36 (78%)**	

7.5.7 Main problems

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

7.5.8 Action Plan

Where we are	Proposed activity	How	Responsible Person	Six weeks	Six months
Budget of $3 per capita per year	- Advocate for increased to $5 per capita per year	- Government to allocate 15% of total budget to health	HCOH ES, ADSPHCDA, Chair ALGON		XXX
NSHIP funding PBF in 11 LGAs and DFF in 10 LGAs	- Implement PBF in 21 LGAs	- Advocacy to World Bank, leverage on midterm review	HCOH, EC ADSPHCDA	XXX	

PBF funded by NSHIP	- Apply 70% of SOML funds using PBF logic	- Coordination meeting between actors of NSHIP and SOML	HCOH, EC ADSPHCDA, PM SOML, PC NSHIP	XXX	
CDV 90% autonomous	- Ensure total autonomy	- Engage local CDV agents	HCOH, EC ADSPHCDA	XXX	
5 years of implementing PBF in 21 LGAs, 226 wards, 223 PBF, 180 DFF PHCs, 15 Hospitals, &private facilities	- Develop sustainability plan - Develop Mid-term expenditure framework - PHC strategic operational plan	- Allocation of 15% of total budget to health - State allocation from Basic Health Care Fund -	PIU NSHIP, State planning commission		XXX

7.6 Nigeria - Kano, Katsina and Kebbi States

7.6.1 State Profile/ Background

The North-western states comprise of Kano, Katsina and Kebbi State with a projected population of in total 24 million. The Local Government Area is the closest to where people live as a point of linkage between local communities' needs and the National goals, policies and resources allocation.

Table: Brief Summary of the States

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

7.6.2 Problem statement

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

7.6.3 Can PBF make a difference?

Yes, we believe PBF can make a difference

7.6.4 Feasibility Score

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

7.6.5 Main problems for introducing PBF

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

7.6.6 Action plan

Immediate: 3-6 months

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

Medium term: 6-12 months

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

7.7 Nigeria - Taraba State

7.7.1 State Profile

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

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

7.7.2 Overview of the Taraba state health system

Taraba primary healthcare service delivery system performance is unable to meet the basic health needs of her population due to the current inefficient input system and inadequate health budget. The Taraba State health budget primarily depends on federal allocations and has over 970 functional health facilities of which 800 are government owned (89%) while 170 are private (11%). Taraba state is part of ongoing efforts across the country to integrate all existing health DHIS2 databases towards strengthening the NHMIS in Nigeria.

7.7.3 Taraba PBF pilot

Taraba State started in May 2017 piloting performance-based financing (PBF) in the LGA of Ardo Kola. The initial investment funds of 200.000USD from SOML were used. This allowed the state to develop experience with contracting. Moreover, first results show improvements in the quality of the services in the pilot LGA and increases in the coverage indicators because of the sub-contracting of specific services and gained confidence in facility autonomy. The aim of the State is to expand PBF

from the first pilot LGA to two more LGAs with view to cover the whole state with time.

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

7.7.4 Taraba action plan

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

7.8 Lesotho

7.8.1 General context

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

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

7.8.2 Health system context

The Lesotho health system is organized into three administrative levels: central, district and community. The central level is responsible for providing policy guidance and oversight. At district level the administrative arm is the district council and technical arm the District Health Management Teams. The DHMTs are responsible

for the management and technical support to the district health service delivery composed of district hospitals, health centers and community level health services.

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

7.8.3 Problem analysis

The health system in Lesotho is not very cost effective. It is one of the few low-income countries where the health system gets close to 14% of the recommended government budget. Yet, indicators are still poor or declining.

The following problems can be identified:

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

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

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

7.8.4 Is PBF a solution?

Yes.

- Leadership problems can be solved by a better description in contracts the profile, output and quality required of each actor including at the top regulatory level of the Ministry. PBF contracts can formalize such relationships linked to performance payments.
- The autonomy given by the PBF approach to health facilities to plan and execute their activities can improve their effectiveness and efficiency.
- Competition between facilities and between districts results in improved provision of services.
- The community PBF approach improves community participation, while social marketing facilitates for communities to gain more knowledge on health issues and as a result make informed decisions about their health and rights which will improve indicators e.g. to avoid home deliveries, going home with placentas etc.

7.8.5 PBF feasibility score for Lesotho

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

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

The participants felt that the score of 72% warrants a review of the PBF design to bring it up to scratch with the set approaches of PBF.

7.8.6 Recommendations

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

7.8.7 Action plan

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

7.9 South Sudan

7.9.1 Background

On July 9, 2011, South Sudan became an independent nation state. The Republic of South Sudan is a land-locked country and has borders with Ethiopia, Kenya, Uganda the Democratic Republic of Congo, the Central African Republic and Sudan. 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.

South Sudan finds itself with challenges such as inadequate financial, human, technical and infrastructure resources. There are displaced people from various regions of the country, who moved across borders to neighboring countries, thereby placing these population groups at risk. The refugees and internally displaced 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 to achieve.

7.9.2 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 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.

7.9.3 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

7.9.4 Problem Analysis

The South Sudan health system 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.

7.9.5 Feasibility scan

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

- The existence of a 'Zero cash policy', which 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	3	The programs are	0	Start with selected	3

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

government determined health packages (this in Africa mostly concerns discussions about family planning)				Negotiate for funding that provides full health package	
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%

7.9.6 Recommendations

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

- To join hands with the other PBF course graduates to form a critical mass that will boost the advocacy programs
- To conduct high level advocacy with government and donors on the need for output-based programs. An important partner for this is the World Bank, which is in negotiation with the government along the same lines;
- To develop a well-designed PBF pilot in areas where Cordaid has a large presence, especially where it is the lead partner for its implementation. For this, the May and November Mombasa team propose a full package and with sufficient funding;
- To consolidate funds to provide the comprehensive health packages;
- To start with a selected set of manageable indicators, but not less than 20;
- To introduce also the community PBF indicators to reachable (secure) populations;
- Health facility managers should have the right to decide where to buy their inputs;
- To introduce the management tools of the business plan and the indices management tool for facilitating autonomous health facility management;
- To 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/CHDs 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.
- To pool resources from the donors (TB REACH, UNDP-GF) to fund TB out based performance program

7.9.7 Action plan

The South Sudan team drafted the following action plan:

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

7.10 Zimbabwe

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

7.10.1 Context

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

Significant improvements in maternal mortality, child mortality, coverage indicators in ANC care and access to FP have been achieved after the introduction of PBF. Currently the role of the purchaser is being played by Cordaid and Crown Agency. For sustainability purposes, the Ministry seeks to institutionalize PBF and establish an alternative implementation arrangement which is more sustainable.

The Mid Term Framework (MTF) recommended that the Program Coordination Unit (PCU) be transformed to take up the role of the purchasing agency as well. The PCU has been playing the role of the Global Fund Principal Recipient (PR) for the Ministry. The MTF suggested that with adequate capacitation and streamlining, the PCU was best positioned to take over from Cordaid as the purchasing agency.

7.10.2 Indicator package

The indicator package is based on diseases and conditions prevailing in the country with the selected priority areas targeted with a view of an integrated approach. These include, reproductive health, maternal health, new-born health, child health adolescents, and nutrition, HIV, TB, malaria and NCDs indicators.

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

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

Depending on the public health importance, some indicators remained as they were whilst some were removed with others changing definition / naming.

7.10.3 Feasibility scan

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

World Bank RBF approach

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

Health Development Fund RBF approach

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

11. Health facility managers are allowed to influence cost sharing tariffs	2	0
12. Health facility managers have the right to hire and to fire	2	0
13. There is a CDV Agency that is independent of the local health authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	2
14. There is a clear separation between the contracting and verification tasks of the CDV agency and 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	0
19. The project provides equity bonuses for vulnerable people	3	0
TOTAL	**50**	**16 = 32%**

7.10.4 Problem analysis

- In the HDF districts, there is no performance bonus while it exists in the World Bank districts.
- In HDF districts only the primary care facilities receive subsidies based on performance while district hospitals receive a fixed $ 4000 per quarter. In the Cordaid districts, all health facilities receive subsidies based on performance payments.
- There is a lack of coordination with other programs working at community level (Nutrition, Immunization, Breast Feeding, TB and Malaria, Water and Sanitation). This distorts the community PBF indicators such as household visits following protocol.
- Government as well as other partners still mainly have an input approach. A large number of partners are still not implementing PBF.
- Counterpart financing from the government is 20% for the World Bank financed 18 districts while for the 42 HDF districts there is no counterpart financing.
- Free health care is mainly politically-driven, while fee paying does pose less of a problem for the community. Some partner organizations still advocate the free health care agenda such as DFID, EU and the HDF partners such as Swedish Bilateral cooperation.
- The human resources fiscal space is limited and the country works with an outdated HR establishment system not matching the workload. There is also an inability to recruit enough qualified skills such as medical specialists and nursing personnel.
- Fee-paying revenues collected in council clinics are submitted to the council and not used by the facility.
- Government contribution to health has been consistently below the 15% as per the Abuja declaration. Total health expenditure is estimated at 1-billion-dollar of which 40% is contributed by the government. Moreover, 90% of this 40% goes towards the wage bill and this distorts the expenditures away from investment and operation expenses.
- The essential drugs and equipment distribution system is supply driven through the government central medical stores system. Health facilities must first verify whether drugs are available at the central medical stores so that there is no free access to private distributors also when their prices are lower. As a result, there are regular stock outs of tracer items such as latex gloves and ferrous sulphate.

- The current procurement act is also against the PBF best practices as far as the free access to distributors operating in competition. Apparently, IMF and also the World Bank are supporting centralized input procedures on Zimbabwe – to be verified …..
- Private health facilities are not included in PBF contracts. We need the regulatory authorities to work with private health facilities and pharmaceutical distributors so that they are licensed, accredited and are allowed to sign PBF contracts.
- Access to health services is still a challenge with some villages being at more than 10km from the health facility.
- The current PBF excludes the urban health facilities. The proposed voucher system for urban health facilities has failed.
- Health facilities in the HDF districts do not yet pay staff performance bonuses.
- Partners pay community health workers varying amounts of allowances.
- Some partners apply different forms of PBF with incentives paid for certain indicators.

7.10.5 Can PBF make a difference?

Yes. A significant amount of government funds is still coming to the health facilities in the form of input. We recommend to change this towards RBF performance financing. This because there are limited public resources and hence with the implementation of PBF we maximize the effects of public funding. A "business as unusual" approach.

7.10.6 Recommendations

National

- All Zimbabwe PBF training alumni should contribute towards in country PBF implementation.
- Ministry of health financial resources to fully change from input financing towards PBF performance funding (GOZ, levies, taxes, partner funding).
- All health facilities whether public, religious or private; urban or rural to have an equal opportunity for obtaining a PBF contract.
- The ministry of health should allow health facilities and hospitals to obtain more autonomy.
- The ministry of health should enable a more competitive environment in the supply of health commodities by removing the restrictions that favour monopolies.
- Health facilities in all districts (HDF and World Bank supported) should start paying performance bonuses.
- Gradual introduction of cost sharing and drugs revolving funds.

Finance Directorate

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

Human Resources Directorate

- Retention allowances to be performance based
- Sensitize HR staff on PBF

Pharmacy Directorate

- DPS to work on accreditation of the public and private wholesale pharmaceutical companies including registration requirements and scope of work to allow entry into PBF

PMD

- Introduce the indicator "household visits following a protocol" during the next review of indicators.
- Introduce the use of the indices management tool in all facilities.
- Negotiate for community health workers to be paid under PBF versus the current situation where they directly obtain a varying allowance from partners.
- Introduction of PBF principles into our local context including the other stakeholders such as PHE, PDCs, DHEs.

7.10.7 Action Plan

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

protocol' within the province		
Introduction of the use of indices management tool in health facilities	- Provincial Medical Director	Q1 2018

7.11 Liberia

7.11.1 Context

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

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

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

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

7.11.2 Problem Analysis

Liberia implements a free health care policy for all. The main objectives of providing free health care services were to increase access and eliminate inequalities. Yet, during implementation, it has become evident that what people need is not just "services" but "quality services". In public facilities, low quality of care with routine

stock-outs of drugs and medical supplies at health facilities has driven consumers towards patronizing private health facilities. Currently, the health sector is heavily donor dependent with interventions that are all vertical and difficult to coordinate. Provision of the Essential Package of Health services are mainly done through inputs financing using contracting-in, contracting-out and hybrid contracting models. In three counties (Bong, Nimba & Lofa with a cumulative population of 1.3 million) supported by the current USAID supported Fixed Access Reimbursable Account (FARA), performance-based financing has been introduced but with 90% of the budget allocated towards inputs and only 10% towards performance. Health data shows large gaps and variations in the utilization of health services along with the continuum of care. Poor quality of care is the major cause of high maternity and under-five mortalities. The fact that major causes of maternal and neonatal deaths are pre-term complications and intra-partum related events despite the relatively high services utilization suggests a major challenge with the quality of care provided to women and children (RMNCAH IC, 2016).

There are large geographical disparities in health services that need to be urgently addressed. According to the post-Ebola health sector assessment carried out by the MoH and development partners, a total of 29 percent of Liberia's population, particularly those in rural areas, must walk more than 60 minutes or 5 kilometres to reach the nearest primary health care (PHC) facility.

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

7.11.3 Can PBF make a difference in your setting?

YES.

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

7.11.4 Problems identified by the feasibility scan

The Liberia team identified a feasibility score is 6/50 = 12%. This score is a true reflection of our existing PBF scheme using the criteria to establish the feasibility scan in how far the program is "PBF". We identified the following problems.

- The current per capital PBF budget is below $US 4 per capital per year.
- The current PBF output indicators that receive subsidy is less than 25 and there are no separate composite quality indicators
- The current PBF program finance only PHC level clinics and it is restricted only to vertical programs.

- The current PBF program has no community indicator "visit to household following a protocol"
- The current design has no baseline and evaluation households and quality studies that established priorities and allow measuring progress
- The system does not allow cost recovery revenue and health facility managers do not influence cost sharing tariffs.
- Facility managers are not allowed to spend cash/
- There is no Contracting Development Verification Agency. Contracting, verification, coaching functions at primary level is still held within the Ministry of Health. Community verification is not being done. However, in the hospital PBF scheme, selected hospitals verification function is separated from contracting and there is community verification by CBOs sub contracted by the National Verification Agency.
- Facility Managers cannot hire or fire. Hiring and firing are centrally done.
- Private providers have no chance of obtaining a PBF contract. Only government health facilities obtain PBF contracts.
- Bonus calculation does not consider the geographic equity bonus as well as the equity bonuses for vulnerable people.

7.11.5 What are the deeper reasons for the PBF design problems

- The Ministry of Health currently implements a free health care policy for all. There is no indication that policy makers allow user's fees even when studies have proven that consumers are willing to pay. Allocation to performance incentive is too ambitious and aim to reach a large population. There is also reluctance in going away from contracting out health services to NGOs and introducing direct contracts with facility managers (contracting-in) for achieving outputs and improving quality.
- The full government determined package of services to be subsidized has not been defined for clinics and hospitals. Few (14 indicators) outputs and administrative indicators have been selected to subsidize. They are subsidize based on targets reached and not on number of quantity delivered. The current indicators are not SMART and their definition makes it difficult to verify. Targets are negotiated with NGOs (implementing partners) and County Health Teams (CHTs). NGOs and CHTs further negotiate these targets with the facilities.
- Policy makers are reluctant to separate functions outside of the existing Ministry of Health structures. Contracting and verification function are still kept at central level. Contracting is still at the program unit level and verification is done jointly by M&E, HMIS and PBF Unit. Contracts are signed between MoH and NGOs (IPs) or CHT directly. Facilities are expected to do business plans with CHT or IPs but business plans do not form the basis for contracts between facilities and IPs or CHTs.
- Decentralization is ongoing but at a slow pace. Roles such as hiring and firing are still kept centrally. This is due to the complexities of inter-agencies operation between the MoH and the Civil Service Agency. Policy makers are not willing to delegate such functions to health facilities without a total reform of the Civil Service Act which is currently under review. Additionally, autonomy to facility managers to manage and spend cash is not encouraged. It is believed that the capacity to manage cash is not there, couple with resistance to change the existing setup for procurement and administrative procedures on how to manage health providers.

- Currently, decision makers prefer implementing PBF in public facilities instead of also on private facilities.

7.11.6 Action plan

Objective

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

Recommendations

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

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