Mombasa – KENYA

Report of the 54th Performance Based Financing Course

July 11-22, 2016

The 35 course participants in Mombasa enjoying happy moments together

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1. LESSONS LEARNED & MAIN RECOMMENDATIONS

This is the report of the ***54th performance-based financing (PBF)*** course, which took place in Mombasa, Kenya from July 11 to July 22, 2016.

1.1 General observations / lessons learned from the course

The PBF course welcomed participants from four countries. The Nigerian team consisted of 17 participants from the NSHIP PBF program from Adamawa, Nasarawa and Ondo states (including Ondo's Commissioner of Health) and from the new NSHIP-Additional Financing States. Three senior representatives of civil society also joined the team. The PBF approach aims to stabilise the health systems in the fragile States of North East Nigeria.

The 15-person Ghana team consisted of participants from the national Ghana Health Services and of leading regional and district health directors. They came to Mombasa in the context of moving ahead with PBF in the World Bank-funded Maternal, Child Health and Nutrition Improvement Project (MCHNP).

The team of Cameroon was made up of two PBF practitioners from the South West Region working in the national scaling up of the Cameroon PBF program.

The single participant from DRC came with the assignment to elaborate a proposal in the context of the start of the Government of DRC – World Bank program on improving the quality of education and literacy in 1350 schools in the country, of 100 million dollars 18 million of which devoted to PBF.

The various challenges for each group were identified in the first few days of the course, during initial country and program presentations and targeted evening sessions. The program's modules such as in particular the feasibility scan followed by discussing conflict resolution with role-plays were subsequently directed so as to address the specific needs of the groups.

The facilitation team was this time enlarged with two extra facilitators: Dr. Olivier Basenya (of Burundi's PBF Unit) and Dr. Francis Simo (Manager of the South West CDV Agency in Cameroon). This broadened the scope of the facilitation team by adding their daily expertise with PBF at national regulatory level and regional contract development and verification level. Throughout the two weeks, the country teams engaged in drafting their action plans on how to implement and advance PBF.

The "village 54" chief, the Rev. Moses Jubula Thliza, together with his deputy, timekeeper and tax collector, actively supported the facilitation process and contributed to a congenial atmosphere and towards maintaining "order" in the village.

The 54st PBF course group was made up of some participants who had already experience with PBF and others without. Thanks to the constructive dynamics in the group, issues that in the beginning posed some debates were gradually cleared up and resolved. The debates focused on the drawbacks of the existing policies in the participating countries and how these can be resolved through holistically applying the PBF best practices. We also stressed the importance of full provider autonomy as well as the separation of functions and assuring the buy-in to PBF by decision makers. PBF also serves as a more realistic reform approach to attain Universal Health Care and the Sustainable Development Goals without forgetting that quality and efficiency should remain the leading principles.

The daily evaluations resulted in above average scores compared to previous courses. The **methods and facilitation** scored 89%, which was 3% above the average of the previous 18 English courses. The satisfaction with **participation** was also good with 91%, which was 4% above the previous courses. The **organization** of the course in Mombasa had a score of 91%, which was 6% above the average of the previous courses. A point of concern remained the conference hall: it is too small, the lighting is not optimal, the air conditioning system sometimes poses problems and there were a few power cuts that interrupted the conference process. The seating arrangement, however, was judged better than before. The subject of **time keeping** scored 74%, which is 2% *above* the average of the previous 18 English-speaking courses.

The final evaluation confirmed these daily positive impressions, with high scores on methodology, organization, and participation. The scores on the venue and transportation had gone up considerably.

The main points of criticism were:

a. The course content and program materials have expanded over the last years. For example the course book in 2009 had 80 pages and has grown to 230 pages by 2016. With the ambition to cover 17 modules, classroom hours are dense and we request participants to read in the evening and preferably also already before the course. Considering that PBF is not anymore a new reform approach, the weight of the exam slightly increased since mid-2015. As a result, 12% of the participants during the last 8 courses in 2015-2016 did not pass the threshold of 55% compared to 7% during the previous 8 courses in 2014-2015. The French courses scored relatively better during the last 15 courses between 2014 and 2016 with a 92.1% pass rate compared to the English courses with 85.7%. This may be related to the fact that more participants in the French courses had prior PBF experience. The facilitation team therefore proposes to sharper focus on the key messages of each module. For this purpose, since 2016 we provide a summary of the main messages at the beginning of each module in the course book. Yet, the facilitation teams may need to better adapt the methodology around those messages. We should allow for more group work and more reflection during the course on the change issues and how the country groups can realistically advance the PBF change topics after their return to their respective working places. These measures should assure that the course continues to respond to the highest possible standards. It implies that a participant, who has successfully attended the PBF course, in her or his CV can show credible evidence of having good knowledge and some skills in PBF.
b. Some participants felt that the menu of the hotel is too monotonous and not to their taste. This complaint is common among participants from West Africa not habituated to the East Africa diet. Other participants requested to change some of the amenities in the rooms such as the reading light, towels, but overall the hotel venue scored positively

1.2 Country specific recommendations

1.2.1 Nigeria

The Maternal Mortality Rate (MMR) in Nigeria is high with 576 deaths per 100,000 live births. There is also a high regional variation in MMR and it is worse in the North Eastern (NE) States of which several were represented in the Mombasa PBF course. Antenatal care coverage is 43% in the North East States compared to 91% in the

South East States. Skilled attendance at birth is 12% in the NE States and 78% in the SE States. The reasons for poor performance and the regional differences are multiple but are related on the demand side to cultural barriers, low educational standards and poor economic status. On the supply side there are problems with high tariffs, shortage of qualified staff and a shortage of resources.

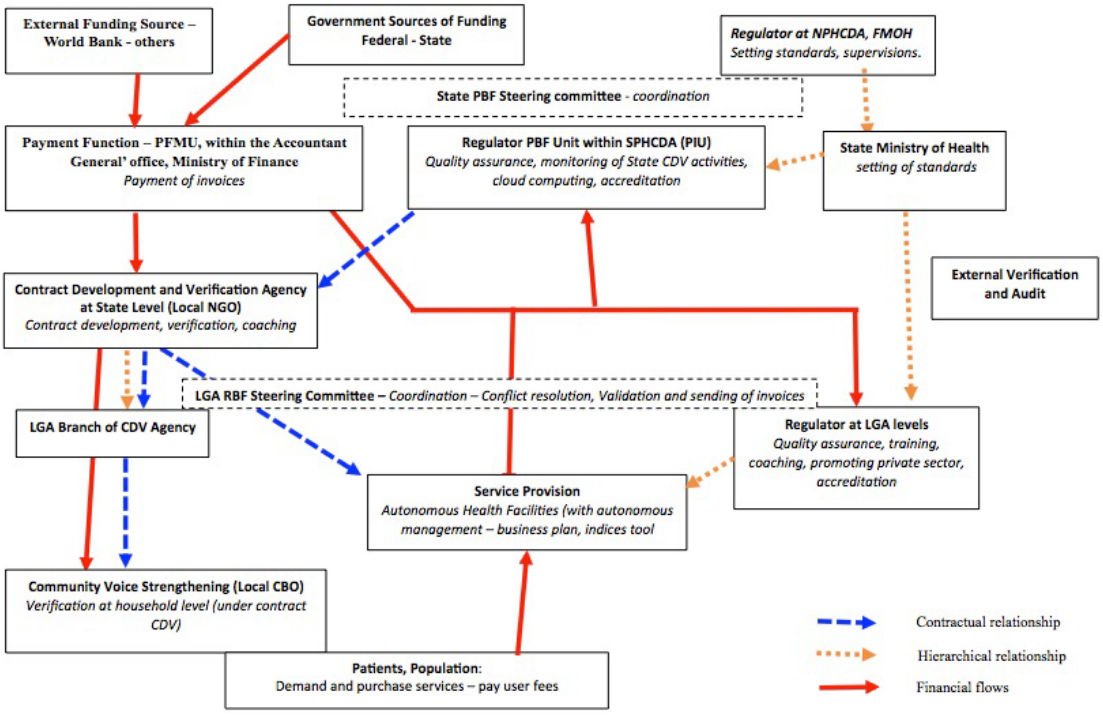
The three States of Adamawa, Ondo and Nasarawa in Nigeria have implemented PBF since 2011 and the results are encouraging. PBF has proven to solve the problems related to the quality of services as well as to how to and distribute funding and qualified staff to remote States, LGAs and health facilities. Moreover the good governance approach of PBF to separate the different functions in the health system is seen as a positive. This led to the decision of expanding PBF to an additional 5 States in the fragile Nord-East of Nigeria.

There is no PBF program yet in Bauchi, Borno, Gombe, Taraba and Yobe States, but the States secured a World Bank Additional Financing Facility of $ 125 million. Meanwhile, before the actual disbursement of the financing facility each State will use $ 200,000 from the Saving One Million Lives to start the pilot scheme.

The design of PBF programs in Nigeria is good. Yet some issues still need to be solved such as the incomplete separation of functions at the level of the SPHCDA. Adamawa and Ondo States do not fulfil the criterion of injecting at least USD 4 per capita per year in the PBF system. So far most financing comes from the World Bank, which poses concerns about the long-term sustainability of PBF.

Recommendations

- It is proposed that the State PHCDAs should concentrate more on their regulatory role while autonomous NGOs might be contracted to implement the role of contract development and verification agencies. The State Financial Management Units should also become more independent from the SPHCDA and could be under the State Accountant's Office. The following scheme shows the possible institutional set up.



- Organise feedback sessions with the SPHCDA, the Governor's Office, the Commissioner of Health and partner organisations once back in the respective States.
- There is a need to integrate the different vertical programs sponsored by government or partner organisation in one holistic PBF approach.
- There is also a need to harmonise the PBF indicators with the HMIS system.
- Contract Nigerian NGOs to play the role of State CDV Agency
- PBF may also work on the demand side, creating supply incentives for patients through higher PBF subsidies. This would operate like conditional cash transfers for antenatal care, facility deliveries and postnatal care

1.2.2 Cameroun

Maternal mortality is high with 782 per 100.000 live births in 2011. Family planning coverage is also inadequate due to limited access, non-availability of commodities and non-respect of FP protocols. National HIV/AIDS prevalence is at 5.4%.

The health system has several weaknesses such as a shortage of qualified staff and in particular in remote areas, financial access problems and high out-of-pocket expenditures for health. There has been a pilot PBF project in Cameroun since 2011 in the four regions of the East, Littoral, North West and South West regions covering approximately 15% of the total population. The South West region of Cameroon has piloted PBF in four health districts with a combined population of 600.000.

The PBF feasibility scan, conducted by the Cameroun team in Mombasa, showed that the PBF pilot has a score of 84%. This is above the required 80% but there are some problems remaining such as: (a) cost-recovery revenues still need first to go to the treasury; (b) a lack of autonomy of some health facilities to buy drugs and; (c) the lack of freedom at provider level to recruit and manage human resources.

Recommendations

- Arrange for an advocacy meeting with the regional authorities of the ministry of finance (in the regional treasury) to address the issue of financial autonomy for health facilities in the project and the use of cost recovery revenues at facility level instead depositing the money in the government treasury
- Health facility managers should have the right to decide where to buy their inputs and not be forced to buy from the South West Regional Fund for Health Promotion (SWRFHP)
- Health facilities manager should have the managerial autonomy
- The PBF Unit should continue working with the decision body on the issue of autonomy of health facilities.
- Advocate for training of a South West regional pool of experts (regulators, university staff, others)
- Revise the quality checklist.
- Establish a list of non-autonomous health facilities with the CDV Agency so that they can be targeted for making them autonomous
- The regional regulators to encourage the RFHP to grant autonomy to all pharmacies in the PBF districts of Southwest region.

1.2.3 Ghana

Challenges of the Ghana health system are related to the inadequate distribution of staff in remote areas due to lack of amenities and lack of incentives. The national health insurance system only caters for curative care and there are frequent delays in payment. Moreover, 40% of health financing is partner-based and they mostly finance the non-salary budget lines. Traditional partner finding is also reducing, which puts into danger the stable and sustainable financing of health facilities. Future PBF reforms and funding are therefore important due to the better efficiency and the opportunities to attract additional financing from an increasing number of (external and internal) organisations. Most maternal childcare indicators are stagnated in terms of performance.

There is no PBF program yet in Ghana but a PBF pilot project has been planned at the Community Health Planning and Services (CHPS) level. Yet, the design is not in line with the PBF bets practices such as discussed during the PBF course in Mombasa and the feasibility score was only 26%, which is below the 80% average score as a basic score to start. This implies that without major changes the chance of successful implementation of PBF is limited. The Ghanaian team therefore proposes some major points of revision in the design, which could be achieved within the budget available.

Recommendations

- Select additional districts in each region to obtain a representative population of at least 400,000 to sum up to a total of 1.6 million in the four regions. This will improve the economies of scale and prevent a too high proportion of the PBF budget to be spent on administrative costs.
- Increase the number of indicators from the current 8 to at least 25 outputs indicators required for a full package at both primary and first referral (hospital) levels.
- Expand the PBF program from a community intervention towards a more holistic approach including the district, hospital and health centre levels. This vertical integration is important for the referral and counter referral system and in line with the WHO district approach towards health systems.
- Develop the ToR for Regional CDV Agencies, which will verify all output data at health provider level. This separation of functions is important for advancing good governance and to prevent conflicts of interest between the regulator and the contract development and verification agencies.
- Develop sample contracts for all stakeholders.
- Revise the Ghana PBF manual to explain the details of the above recommendations. All these measures should lead to a new feasibility scan that will reach the 80% minimum standard and should avoid any killing assumptions.
- Set up a national PBF unit within the GHS but also with members form the Ministry of Health to guide the program and for the evaluation of performance of the regions, CDV agencies and districts.
- Develop an advocacy plan to better inform stakeholders about PBF. This may imply exchange visits to other countries, PBF courses and short workshops.
- Bring regulatory and decision making authorities on board. Schedule meeting with regulatory authorities (NHIA, Pharmacy council, FDA etc.).

1.2.4 Democratic Republic of Congo

Schools in DRC have serious weaknesses such as overcrowded school classes, lack of books and poor outcomes of primary schools in terms of functional literacy. It is estimated that about 3.5 million children of primary school age in DRC are not in school. 84% of children from Grade 4 cannot read comprehensively, 38% read most used words, 50% could formulate words and 52% cannot write a simple word.

More than 70% of schools are initiated and owned by non-state actors and the government must adapt itself to their independence. Yet, without the private sector the majority of children would not be schooling at all. It is therefore necessary to improve the regulatory capacity of the State to assure the quality of the educational services both in public and private schools and to improve access for the children of vulnerable families.

The Democratic Republic of Congo has conducted several pilot PBF programs in the health sector with encouraging results and adopted most PBF best practices with the important exception of maintaining input monopolies for the distribution of essential drug, consumables, equipment, etc. Also the education sector piloted a PBF program in South Kivu Province but it has not yet been scaled up such as in the health sector.

The international NGO Cordaid is supporting the National PBF Unit since 2014. The government obtained financing from the World Bank to improve the education system through a mixed traditional input- and PBF program. The Congolese participant in Mombasa carried out a feasibility scan and identified some key challenges in the design of this program. The main one the budget for PBF will not be enough to cover the targeted 1350 schools. Moreover the largest part of the remaining World Bank project will be put into buying inputs such as schoolbooks. The World Bank health program in DRC abandoned this input approach due to the risk of corruption and the inefficient use of resources. It is therefore surprising that the education World Bank project continues this failed approach.

Recommendations

- Organize a workshop for restitution of PBF course findings
- Towards Cordaid: Efficient use of the available budget for PBF: either reduction of the target or another advocacy for additional funding. Reduce the number of schools to be covered from 1350 to 560 or increase the budget so that it will meet the minimum possible ($ 20). The total budget will then be $ 45 225 000 (gap of $ 26 505 000).
- Towards EPS-INC: Conversion of certain input budget lines in the World Bank program into the PBF common basket.
- Organize a workshop for the revision and harmonization of the existing tools before implementation.

2. INTRODUCTION

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

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

Since PBF is a systemic approach, the application of PBF in other sectors than health is also receiving interest – notably in education. There is no longer 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 thereby to assure more sustainable systems. Its effects on transparency and good governance are comparing favorably to the more top-down and hierarchical style of existing (health) systems.

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

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

2.2 Aims, objectives and intended results of the Mombasa PBF course

General aims of the PBF course

- To contribute to the improvement of the health status and the educational level of the population by providing accessible and equitable services of good quality while respecting the free choice for public & private providers and by making rational and efficient use of limited government and household resources.
- To contribute to the understanding of the advantages of using market forces in distributing scarce resources and of how to address market failures by applying

market-balancing instruments such as subsidies (and taxes), regulatory tools and social marketing.

Specific Objectives

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

2.3 The July 2016 Mombasa course

- The 54th group consisted of a mix of people with strong implementation experience in PBF and PBF newcomers, and included one participant from the field of education.
- Throughout the course, the participants were assigned developing an "action plan", following a number of specific 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. All course materials (a hard copy of the course book, pdf latest version of the course manual, the PowerPoint presentations, the recaps and country presentations, photos of the course and articles) were also distributed during the course, together with the participants' contact details list.
- On Friday July 15, 2016, field excursions were organized to five health facilities: Mtwapa Health Center, Kadzinuni Dispensary, Vipingo Health Center, Takaungu Health Center and Kilifi County District Hospital.

2.4 The final exam, adult learning and accreditation

SINA Health issues a Certificate of Merit to those who passed the exam at the end of the course. This exam was conducted on Friday July 22, from 9.00 am onwards and consisted of 30 multiple-choice questions, tailored around the main subjects treated during the course.

Participants can obtain distinctions for those, who obtained this time a score of 87% or more. We congratulate the following seven participants, who received certificates with honours.

With 97% - 1 mistake
Dr NWANGWU, Chike working for HSDF (NGO) in Abuja, Nigeria

With 93% - 2 mistakes
Dr Verinumbe, Fanen, training expert of the SPHCDA in Adamawa State, Nigeria

With 90% - 3 mistakes
Mr. BOAKYE Yaw, accountant for the Ghana Health Services in Accra, Ghana.

With 87% - 4 mistakes
Ms AMOAFUL, Esi, Deputy Director Nutrition, Accra, GHS HQ, Ghana
Mr ALHASSAN, Abukari, District Director, Northern, North Gonja District, Ghana
Dr MAHAMA, Jacob, Regional Director, Northern Region, Ghana.
Dr SASETU, Stephen, Ag Director Disease Control SPHCDA, Nasarawa, Nigeria

2.5 Who attended the July 2016 PBF course

- 18 from Nigeria
- 15 from Ghana
- 1 from the Democratic Republic of Congo
- 2 from Cameroon

The list of participants to the 54th July 2016 PBF course

Name	First name	Organisation	Country	State / County	Profession
GREEN ENJEMA	Adeline	MOH- Region	Cameroun	South-West	Regional Delegation
MBOME NJIE	Victor	MOH	Cameroun	South-West	Regional Delegate
MILUMBU	George	Cordaid	DRC	Kinshasa	Education
AGGREY	Benjamin	Ghana Health Service	Ghana	Upper East Reg	District Director
ALHASSAN	Abukari	Ghana Health Service	Ghana	Northern	District Director
AMARTEFIO	Doris	Ghana Health Service	Ghana	Greater Accra	Program Officer
AMEGASHIE	Faustina	Ghana Health Service	Ghana	Volta Region	District Director
AMOAFUL	Esi	Ghana Health Service	Ghana	Greater Accra	Dep Director
BOAKYE	Yaw	Ghana Health Service	Ghana	Greater Accra	Accountant
MAHAMA	Jacob	Ghana Health Service	Ghana	Northern	Regional Director
MANSAH	Edith	Ghana Health Service	Ghana	Greater Accra	Administrator GHS
NAASO	Evelyn	Ghana Health Service	Ghana	Upper East Reg	District Director
NUERTEY	Joseph	Ghana Health Service	Ghana	Volta	Regional Director
QUNDAHOR	Nana Kwame	Ghana Health Service	Ghana	Greater Accra	Dep Director
SULEMANA	Fuseina	Ghana Health Service	Ghana	Northern	MD - DMO
VITALE	Gbeddy	Ghana Health Service	Ghana	Volta	MD - DMO
YIRIPARE	Genevieve	Ghana Health Service	Ghana	Upper West Reg	MD - DMO
ZENGE	John	Ghana Health Service	Ghana	Upper West Reg	Nutrition Officer
ABUBAKAR	Aminu Saleh	SPHCDA	Nigeria	Gombe	Health Education
BAJOGA	Kolo	SPHCDA	Nigeria	Gombe	Community Health
BELLO	Attahiru	SPHCDA - PIU	Nigeria	Adamawa	Medical Doctor
FABUSIWA	Festus	SPHCDA	Nigeria	Ondo	Medical Doctor
ADENYANJU	Dayo	State Ministry of Health	Nigeria	Ondo	Commissioner
GAMAWA	Adamu	Bauchi SPHCDA	Nigeria	Bauchi	Pharmacist
ILU ABUBAKAR	Garba	SPHCDA	Nigeria	Bauchi	Health Officer
JATAU	Stephen	NSPHDA	Nigeria	Nasarawa	Health Officer
MSHELIA	Hyelni	SPHCDA	Nigeria	Borno	Medical Doctor
NWANGWU	Chike	HSDF (NGO)	Nigeria	Abuja	Medical Doctor
ONWUATUELO	Ifegyinwa Rita	APIN	Nigeria	Abuja	Dentist
SASETU	Stephen Iliya	NPHCDA	Nigeria	Nasarawa	Medical Doctor
THLIZA	Moses Jubula	Christan Fight AIDS	Nigeria	Adamawa	Other - Reverend
TIMOTHY	Anthony	LGA	Nigeria	Adamawa	Health Prof
UBANUS	Ezekiel	SPHCDA	Nigeria	Taraba	Medical Doctor
VERINUMBE	Fanen	SPHCDA	Nigeria	Adamawa	Medical Doctor
YUNUSARI	Dauda Bukar	SPHCDA	Nigeria	Yobe	Env health

2.6 Accreditation for organizations to conduct PBF courses

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

- The program needs to conduct a final test;
- It needs to assure that 3-4 experienced facilitators are present with proven experience in PBF and that they previously followed one of the Cordaid – 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).

2.7 The next English PBF course in Mombasa in November/December 2016

The next Mombasa PBF course will take place from November 28 to December 10, 2016.

3. DAILY EVALUATIONS BY PARTICIPANTS

3.1 Daily evaluations by participants

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

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

The overall average score for the four criteria was 87%. This is satisfactory with 4% above the previous 18 English spoken courses, and 7% above the 28 previous French spoken courses.

Daily evaluation topics as scored during 10 days	French speaking courses (28x)	English speaking courses (18x)	Mombasa July 2016	Comparison Mombasa July 2016 / Previous English courses
Methodology and facilitation	85%	86%	89%	3%
Participation	83%	87%	91%	4%
Organization	75%	86%	91%	5%
Time – keeping	75%	72%	74%	2%
Overall score	**80%**	**83%**	**87%**	**4%**

Table 1: Overall daily evaluation scores of the course.

3.2 Methods and facilitation

Methods and facilitation scored 3 percent higher with 89% than the previous English courses (86%) and 4% above the average of the French spoken courses (85%). This score is satisfactory.

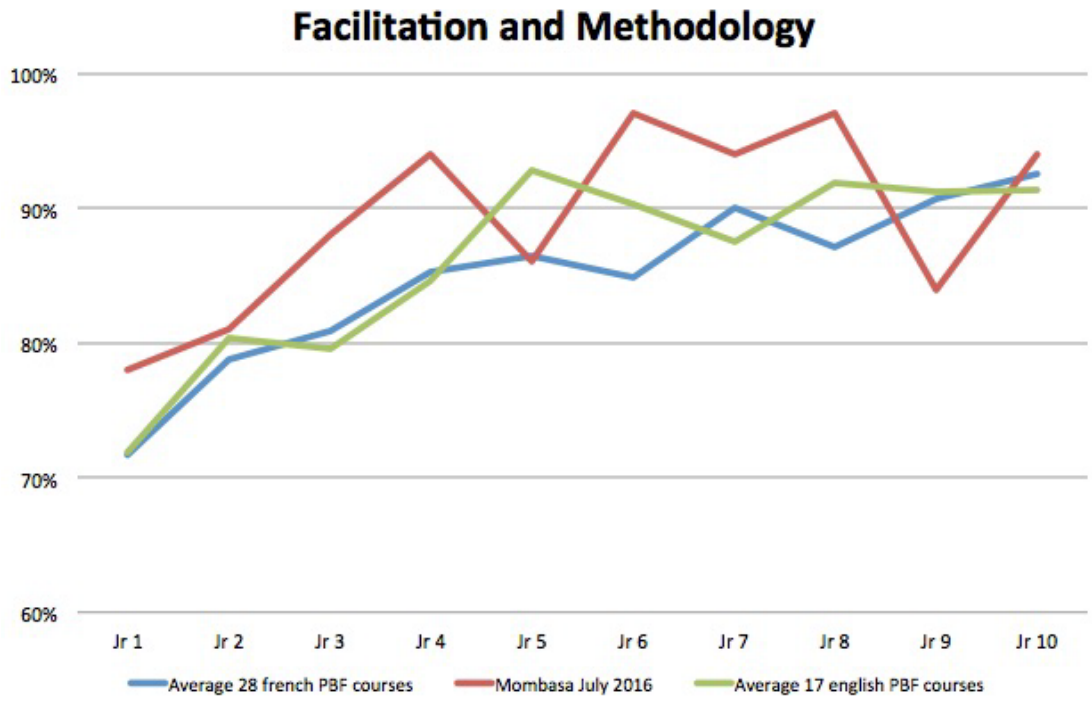


Figure 1: Evolution of the daily evaluations: *methods and facilitation.*

3.3 Participation

The satisfaction with the level of **participation** was on average 91%. This is 4 per cent above the previous English courses (87%) and 8 per cent above the French courses (83%). This score is also satisfactory.

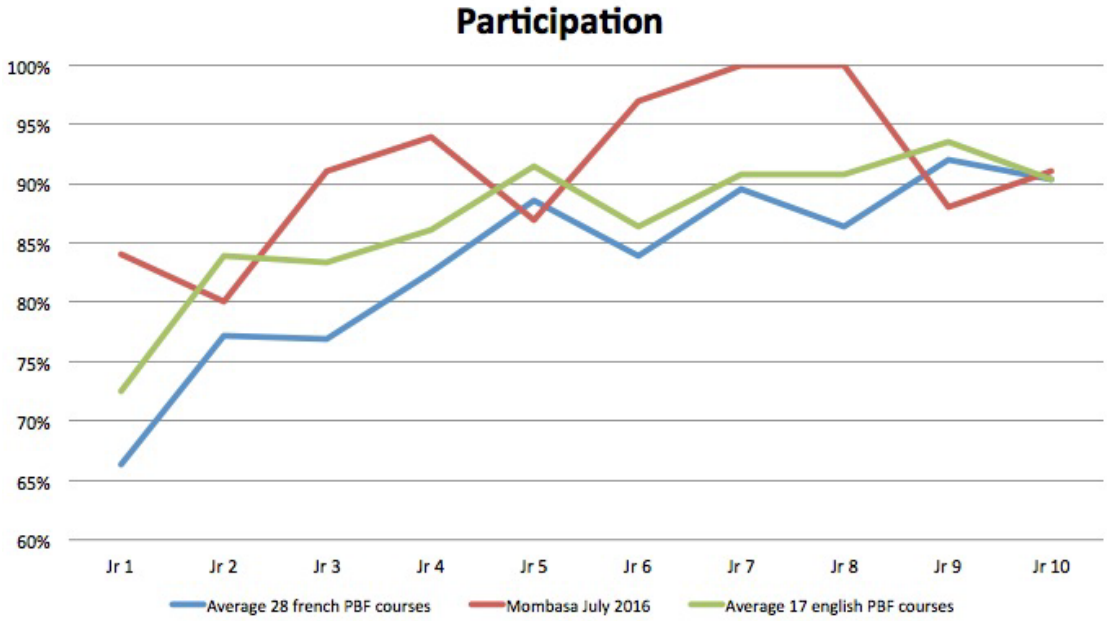


Figure 2: Evolution of the daily evaluation: *participation.*

3.4 Organization

The **organization** of the course in Mombasa had an average score 'very positive or positive' of 91%, which is 5% *above* the average of 86% of the previous English courses and 16% *above* the average of 75% of the previous French courses. This is satisfactory.

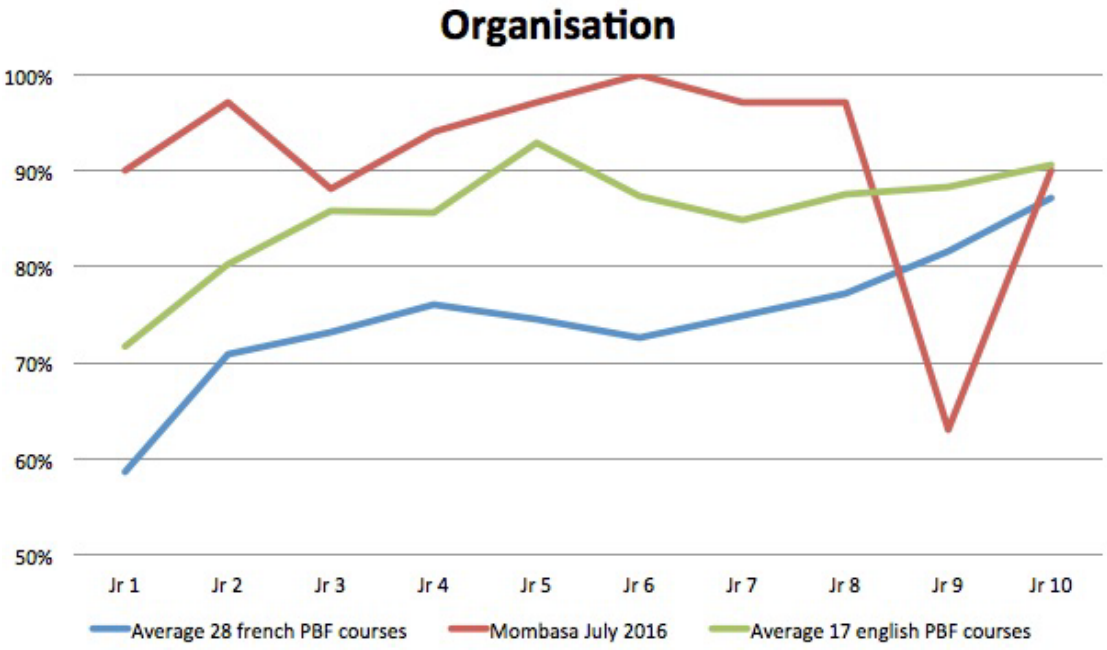


Figure 3: Evolution of the daily evaluation: *organization.*

3.5 Time keeping

The relatively most challenging criterion is time keeping, which was with a 74% satisfaction rate 15% below the other three criteria of facilitation, participation and organization. This is due to the dense program, which also becomes each course more challenging due to the new topics that enter the sphere of PBF. Yet, the score of 74% for **time keeping** in this PBF course was 2% *above* the average of 72% of the previous 17 English-speaking courses and 1% *below* the average of 75% of the 28 previous French spoken courses.

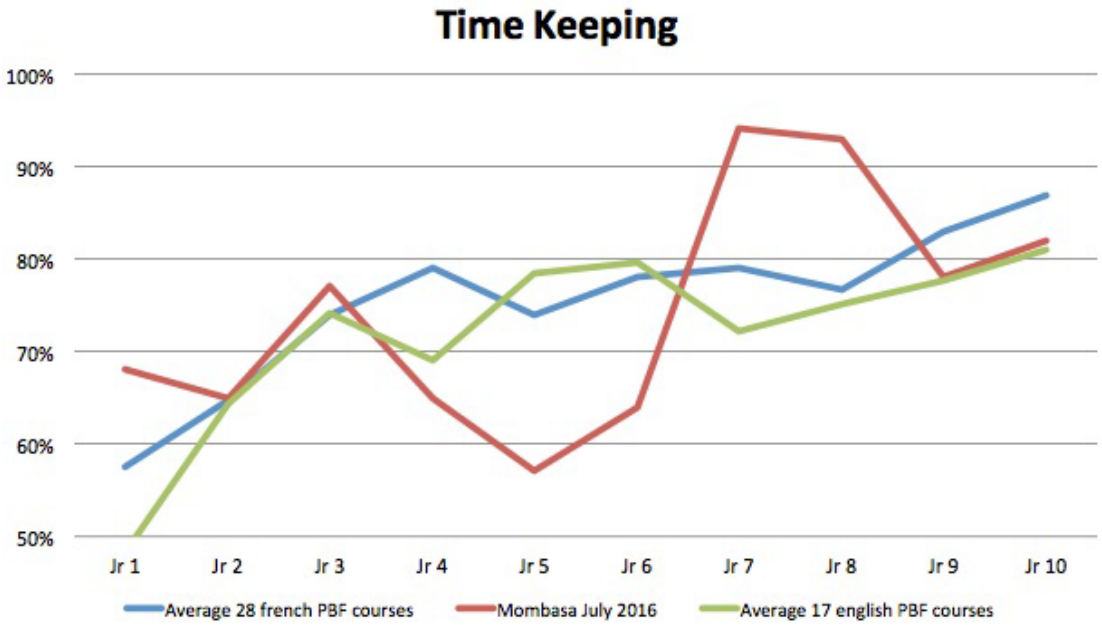


Figure 4: Evolution of the daily evaluation: *time keeping*.

4. DESCRIPTION of the COURSE

Arrival day: Sunday July 10th 2016

The 54th PBF training was an intensive encounter between course participants and facilitators. Most participants arrived on Sunday July 10th, 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.

While almost all course participants came from the health sector this time, we had one participant from the Democratic Republic of Congo (DRC) working in education, who wanted to extend his knowledge of PBF in education given the pending PBF program in the educational sector in targeted regions in the country.
The first few days, course participants were guided in short visits to the local mall, which helped to settle in quickly.

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

The following participants made the daily recaps:

Monday July 11th	Edith & Sesetu
Tuesday July 12th	Ifeyinwa & Mshelia
Wednesday July 13th	Yaw & John
Thursday July 14th	Attahiru & Fanen
Friday July 15th	Doris & Alhasan
Saturday July 16th	Genevieve & Fuseina
Sunday July 17th	*Everybody had fun*
Monday July 18th	Benjamin & Dennis
Tuesday July 19th	Victor & Georges
Wednesday July 20th	Faithful & Chike
Thursday July 21st	Day to prepare for the exam
Friday July 22nd	Exam and closing ceremony

Evening session were provided for the country groups to discuss specific country challenges and participants' needs. These sessions also helped the facilitators to understand what participants' expectations were and how the course could respond to the participants' needs. The interactions were rich and enlightening. Throughout the two weeks, participants received individual and group guidance on their respective action plans. During the second week, shorter evening meetings were organised with the country teams to see how in far the action plan development was on track and if any further support was needed.

Evening country meetings		
Monday July 11, 2016	18.30-20:30 hr	Nigeria
Tuesday July 12, 2016	18.15-20.30 hr	Ghana
Wednesday July 13, 2016	18.30-19.30 hr	Cameroon
Thursday July 14, 2016	18.30-20.00 hr	DRC education
Friday July 15, 2016	18:30-20.00 hr	Education module
Monday July 18, 2016	18:30-20:00 hr	Ghana second round
Tuesday July 19, 2016	18:30- 20:00 hr	Nigeria second round

Monday July 11th

After welcoming the participants and explaining the methodology for the course, Claire and Godelieve explained the rules for the workshop and the election of the village 'officials' was announced. Olivier and Francis then facilitated the 1st and 2nd modules. Ample time was given to change issues as important building block for PBF implementation. Equally, time was spent on the definition of PBF and on explaining a simple example of PBF in a health facility.
Many participants who had previously been implementing PBF or were about to do so asked a range of questions. In particular, participants with senior duties actively engaged to understand the fundamental reasons for starting PBF. They were keen to assess how PBF could be used in solving current issues in their home countries.

Tuesday July 12th

After the daily recap, Francis continued the modules on change issues to which extra time was devoted, given the interesting and very relevant questions from the participants.
To ease the process on the subsequent module about PBF theories, 4 workgroups were formed with the task of each discussing one theory in detail. In plenary, the theories were subsequently discussed one by one, with input from the working groups. In the evening, facilitators met to discuss with the full Nigerian team.

Wednesday July 13th

The last slides on the changes issues were presented, followed by the equity module. The first rounds of country presentations started with the Nigerian groups followed by the Cameroon team, the Ghanaian and lastly the Democratic Republic of Congo. Problems faced by the various health care systems and the education sector (DRC) were discussed. All the participants acknowledged that PBF could be a solution and recommended that it should be adopted.

Module 5A on microeconomics was started.

In the evening, the first SINA Health happy hour took place, in family, with drinks and dance.

Thursday July 14th

Module 5A was completed and the 5B on health economics followed.

Friday July 15th

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

1. Takaungu Dispensary (Benjamin, Yaw, George, Fabusiwa, Ifeyinwa, Edith, Adamu)
2. Kadzinuni Dispensary (Moses, Francis, Dauda, Fuseina, Doris, Ezzkiel, John, Vitale)
3. Vipingo Health Center (Adeline, Joseph, Chike, Olivier, Faustina, Esi, Garba)
4. Kilifi District Hospital (Victor, Dayo, Abukari, Quandahor, Stephen, Hyelni, Yaw, Fanen)
5. Mtwapa Health Center (Evelyn Naaso, Jacob, Kolo, Stephen Jatau, Genevieve, Aminu Saleh, Attihiru, Godelieve).

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

Issues reported from the field trip:

- All health facilities receive inputs and equipment from KEMSA but with variable support from other partners and donors.
- No autonomy
- Main funding sources: fee for service, insurance, OBA, Health Systems strengthening funds.
- Revenue per capital does not meet required standards.
- None OBC, nor any CDV Agents, carry out indirect surveys.
- Monopoly on distribution of inputs.
- Generally poor separation of functions. Some form of client satisfaction assessment upon exiting the facility, but need to be strengthened as per PBF.
- General shortage of staff

Saturday July 16th

The course program on Saturday was confined to the morning. The recap reiterated the results of the field visits and the changes issues. Modules 6 on the role of the regulator was presented by Olivier Basenya and the module 7 on the contract development and verification was started by working groups on setting up a CDV agency.

After lunch, many participants joined the SINA Health bus ride to Fort Jesus and the market in town.

Sunday July 17th

Trip to the Shimba hills. In the park we saw some protected animals (elephants, antelopes etc), went down to the freshwater spring falls. Most of us were very enthusiastic, had refreshing showers. We climbed the hill back to the main point of the park. Robert and Rufo were the first to reach the top. By 3 pm we all enjoyed a 3 course meal at the Shimba hills lodge which has a beautiful view site displaying some squirrels and huge alligators.

Monday July 18th

Module 9 on feasibility scan, killing assumption and advocacy was facilitated by Godelieve through a brief presentation after which the participants went for the group work including identifying subjects for advocacy and a role play. The main challenging issues per country and group were identified, as well any proposed solutions. Feedback was given on the scores, followed by questions and comments from the other participants. Ghana's current design scored low, in large part due to the fact that the design focused merely on the CHPS and a limited set of indicators and had not been drafted as a full-fledged PBF program. The 'old' Nigeria pilot states scored relatively high, but still identified issues with budget and the independence of the verification function. The new Nigerian NSHIP-AF states scored around 39 points, the main issue being that in the one-year transition period before the program starts in full not sufficient budget appeared to be there. Cameroon identified issues with autonomy. The educational program in DRC suffered from the fact that out of the 100 million available budget only 18 million is reserved for PBF where the other parts are planned to go to inputs. This lowered the score considerably. After completing the exercise, participants indicated that they found the deliberations it provoked very useful, which also came out in the final evaluation.

Francis presented the module 8 on community interaction and social marketing. Afterwards, Godelieve initiated Module 10 on conflict resolution and negotiation techniques.

Tuesday July 19th

Francis presented module 12 on output indicators. Then later was followed by two exercises in groups with plenary restitution and discussion.

Wednesday July 20th

Francis presented the Business plan module and the participants went into the group work for the second round of their own country Business/action plan elaboration. A plenary session was organized in the afternoon in which the various plans were presented (see below). The feasibility scores and the various activities plus recommendations are presented in the section dedicated to country specifics further in this report.

On Wednesday (and Thursday) evening several groups paid a visit to the Masai market at the city mall, obtaining a lot of keepsakes.

Thursday July 21st

After the daily recap, Robert presented an updated diagram of the PBF with the various actors, their roles and importance but utmost the necessity of breaking down the formal traditional centralized input system. Then Francis took off with the last part of module 14 on the Indices management tools and the participants went into group work finalized by a plenary restitution. The exercise was found very interesting and useful but some participant's didn't have enough time to complete the exercise. After lunch, the day ended on the presentation (optional) of the Module 15 on costing with half of the participants who voluntarily participated.

Modules 11 (on baseline studies and action research), and 16 (PBF in emergency situations) were not discussed in class. The overall evaluation on the course was carried out before the class broke up for revision time in the afternoon in order to prepare for the exam.

Friday July 22nd

The exam day, all participants took the exam except for Dr. Dayo the Commissioner of Health for Ondo State in Nigeria who only attended the first week.
In the afternoon from 15:00 onwards we reviewed the exams and there was a ceremony to hand out the certificates attended by a health official from Kilifi County who also addressed the challenges of the Kenyan health system and proposed that PBF should equally be applied in Kenya. We indeed hope that in the upcoming December course there will again be a Kenyan group to attend the Mombasa PBF course. In the evening SINA Health proposed a happy hour to the remaining participants as 5 participants left already in the afternoon to catch their flight back home.

Saturday July 23rd

Most participants left at Saturday on different flights and the last three participants left Sunday morning with the first flight of 04:20 from Mombasa.

5. FINAL COURSE EVALUATION BY PARTICIPANTS

5.1 General impression of the course

The score for 'general impression of the course' of 82% was 3% below the average of the 18 previous English-spoken courses. The criterion "I was sufficiently informed" scored low with only 61%. This was in part due to the fact that some participants in the Nigerian new states group were invited on a short notice and had less time to prepare. SINA Health will ask the organizers, who send participants to Mombasa, to inform and prepare participants for future courses. The criterion: "program answered participants" expectations scored 88%, which is 3% higher than the previous courses. The criterion "the course objectives related well to participants' professional activities" scored high with 97%.

Preparation	25 previous French courses	18 previous English courses	Mombasa July 2016	Comparison Mombasa July 2016 / 18 previous English courses
Q1. I was sufficiently informed about the objectives of the course	89%	80%	61%	-19%
Q2. Program answered expectations	85%	85%	88%	3%
Q3. The objectives of the course relate well to my professional activities	90%	89%	97%	8%
Average	**88%**	**85%**	**82%**	**-3%**

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

The participants' evaluation of the methodology and contents scored high with 91%, which was 5% above the average of the previous English and 7% above the French courses. The criterion "balance between lectures and exercises" scored relatively lower with 78%. This may be due to the overloaded program, which did not allow enough time for exercises.

Methodology and contents of the course	27 previous French courses	18 previous English courses	Mombasa July 2016	Comparison Mombasa July 2016 / 18 previous English courses
The content helped me to attain my objectives	84%	90%	97%	7%
The methodology of the course	85%	86%	91%	5%
Balance between lectures and exercises	71%	77%	78%	1%
Interaction and exchanges in working groups	89%	90%	91%	1%
The working methods adopted in the course have stimulated my active participation	88%	89%	97%	8%
Average	**84%**	**86%**	**91%**	**5%**

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

5.2 Appreciating the duration of the course

For 72% of the participants, the course duration was right, while 19% thought the course to be too short and 9% 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	25 previous French courses	18 previous English courses	Mombasa July 2016	Comparison Mombasa July 2016 / 18 previous English courses
Too Short	27%	25%	19%	-6%
Fine	67%	63%	72%	9%
Too Long	6%	13%	9%	-4%

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

5.3 Comments on the organization of the course

For "organization", the overall score of 84% was 7% higher than the previous 18 English courses with 77% and 14% higher than the 27 previous French courses. The lecture room (63%) and the food (52%) scored lower than the previous courses. The lecture room is too small for the 40 participants and facilitators and this criticism is coming back every course. The food issue is also a recurring point of criticism due to the difference in food between West and East Africa. Transportation scored considerably higher than previous courses for which we congratulate the TOMASI Company who organizes since 2011 the transport for SINA Health. The quality of the educational material, conference center, the hospitality also scored high with 97%.

How do you value the organization of the training?	27 previous French courses	18 previous English courses	Mombasa July 2016	Comparison Mombasa July 2016 / 18 previous English courses
Quality and distribution educational material	78%	87%	97%	10%
The lecture room	67%	67%	**63%**	-4%
Conference center in general	61%	75%	97%	22%
How were you received and friendliness	86%	91%	100%	9%
Food and drinks, including tea/coffee breaks	69%	61%	**52%**	-9%
Transportation	60%	81%	97%	16%
Average	**70%**	**77%**	**84%**	**7%**

Table 5: Evaluation of the organization of the course.

5.4 Comments on the execution of the course and the facilitators

The execution of the program was scored satisfactorily with 86%, which was 9% above the average of the previous 18 English courses. The question in how far facilitators were open minded was evaluated at 85%, which was 10% above the average of the previous English spoken courses. We acknowledge that discussions can get heated but this was this time not a big problem probably also due to the presence of the two new facilitators Olivier and Francis, who could easily connect with the participants due to their hands-on field experience in Burundi and Cameroun.

Time allocated for group work was 76%, which was comparable to the previous courses. Time for discussion was evaluated at 97%.

Aspects related to the execution of the program and the facilitation	27 previous French courses	18 previous English courses	Mombasa July 2016	Comparison Mombasa July 2016 / 18 previous English courses
The facilitators had an open mind towards contributions and criticism	80%	75%	85%	10%
Time allocated to group work was adequate	64%	75%	76%	1%
Time for discussions was adequate	77%	80%	97%	17%
Average	**74%**	**77%**	**86%**	**9%**

Table 6: How was the facilitation?

5.5 Evaluation per module

The satisfaction per module by the Mombasa participants was with 87% comparable to the average of the earlier English and the French courses (85%). The participants generally appreciated all modules.

Module	28 previous French Courses	18 previous English Courses	Mombasa July 2016	Comparison Mombasa July 2016 / 18 previous English courses
Why PBF & What is PBF?	93%	91%	94%	3%
Notions of micro-economics and health economy	71%	81%	82%	1%
PBF Theories, best practices, good governance and decentralization	88%	91%	97%	6%
Baseline research – household survey launching process	79%	77%	NA	NA
Output indicators in PBF interventions	90%	88%	88%	0%
CDV agency, data collection, audit	91%	88%	78%	-10%
Regulator – quality assurance	85%	91%	88%	-3%
Negotiation techniques and conflict resolution	90%	88%	100%	12%
Black box Business Plan	86%	88%	82%	-6%
Black box Indices tool: revenues – expenditure – performance bonuses	85%	81%	70%	-11%
Community voice empowerment and social marketing	85%	87%	82%	-5%
PBF feasibility, killing assumptions & advocacy	89%	88%	97%	9%
Elaboration of a PBF project – costing	71%	68%	NA	NA
Average for all modules	**84.8%**	**85.2%**	**87.1%**	**+1.9%**

Table 7: Evaluation per module.

5.6 Written comments during the final evaluation by the participants

About Course methodology

- Godelieve approach is fantastic, good participatory methods
- The 2nd day session has been very successful, well facilitated and more participation
- It was a wonderful course, we learnt so much
- Number of people commenting to one point should be limited
- There have been interruptions of other people's thoughts
- Facilitators sometimes ignore the time keeper
- It is important to moderate comments from participants without permission to ensure orderliness
- There should be a limit on how long an issue should be debated. Some discussions have taken about 45 min on one topic.
- Participation was not enforced with the 30-second rule.
- Interference among facilitators may need to be improved
- For people new to PBF, listening to success stories from other countries without referring to the challenges - just give one side of the story. I felt disorganized and lost at the beginning.
- Propose shorter course days, so they can have time to read book and relax. Too long sessions are neither healthy nor good for adults
- There should be free time in the afternoon
- It is important to adopt adult friendly learning methods for ease assimilation, this is why there was less participation in 2nd week
- Need more time for exercises
- Course time was too short
- No much time allocated for black box instruments
- In seating arrangement, tall people prevent the short people to see.

Course Book and Modules

- Course book grammar needs improvement
- Indices modules still challenging but most modules were well digested

Hotel

- The hotel is very safe; staffs are humble, helpful. We did not loose any thing, even forgotten phones and other items were brought to the us
- Food needs improvement and variety of recipes
- In final course evaluation drink and food should be separated (drink were good by but not so much for the food) also there is need to separate quality of food from the type of food.
- Shower water flow poor
- Need tourist information in the room
- Towels and linen are too old
- Mosquitoes during the 1st week

Customer care

- The organization and coordination is very good,
- Thank you SINA Health for the great hospitality, all observations were taken into considerations and corrections were made.
- Participants appreciate the care for our sick colleague

Weekend activity

- The visit to town was wonderful.
- The visit to the Shimba hills was fantastic and a memorable experience. The lunch offered good food.

6. COUNTRY & TOPIC PRESENTATIONS

6.1 Nigeria (new states)

6.1.1 Background Nigeria

Nigeria is located in West Africa and has a Federal System of Government with 36 States and the Federal Capital Territory (FCT). Nigeria has an estimated population of 180 million (projected from 2006 census) with a population density of 189 km^2.

There are 3 tiers of government: (a) Federal; (b) State level which have some degree of autonomy in terms of governance and; (c) 774 Local Government Areas (LGA).

Health care is also provided at 3 levels: primary, secondary and tertiary. Primary care is provided mainly by the LGAs, secondary care mainly by the State and the tertiary care mainly by the State and Federal governments.

6.1.2 Background Adamawa State

Adamawa state is located in the North East of Nigeria. It has a landmass of 36,917km^2. The State is bounded by the Borno state to the Northwest, Republic of Cameroon to the East, Taraba State to the South and to the West by parts of Taraba State and Gombe State. The State is a mountainous land crossed by the rivers Benue, Gongola and Yadzaram. The river Gongola sources from Bauchi State highland and joins river Benue in Numan Local Government of Adamawa State.

Table 1: Summary of Socio-demographic Indicators

	Indicator	State Estimate	National Estimate	Year	Source
Demography	**Total population**	4,097,674	181,636,784	2015	**2006 Census**
	Children < 5 years[1]	819,535	36,327,357	2015	**2006 Census**
	Pregnant women[2]	204,884	9,081,839	2015	**2006 Census**
	Women of child bearing age[3]	901,488	39,960,093	2015	**2006 Census**
	Crude birth rate (Per 1,000 LB)	-	39.9	2010	**World bank**
	Total fertility rate (Per 1,000 LB)	5.8	5.5	2013	**NDHS**
Mortality/ Morbidity	**Crude death rate (Per 1,000 LB)**	-	14.3	2010	**World bank**
	Infant mortality rate (Per 1,000 LB)	77 NE avg. 81[4]	69	2013	**NDHS**
	Under five mortality rate (Per 1,000 LB)	160 NE avg. 129[5]	128	2013	**NDHS**
	Maternal Mortality ratio (Per 100,000 LB)	-	576	2013	**NDHS**
	Children <5 years stunted below -3 SD (height-for-age)	12.7%	37.5%	2013	**NDHS**

6.1.3 Health Service Provision and Utilization (Adamawa State)

The State provides most of the basic health services with some support from donor agencies. The Hospitals Services Management Board (HSMB), a parastatal of the State Ministry of Health provides secondary health care services, while the State Primary Health Care Development Agency (SPHCDA), provides primary healthcare. Private and faith-based providers also contribute to the provision of health services.

[1] 20% of total population
[2] 5% of total population
[3] 22% of the population
[4] Adamawa state estimate, MICS 2011
[5] Adamawa state estimate, MICS 2011

Table 2: Summary of Health Service Indicators

Indicators (Health Services Coverage)		State Estimate		National Estimate		Source
Year		**2008**	**2013**	**2008**	**2013**	
Reproductive Health	Antenatal care by health professional	61.2%	85.1%	57.7%	61%	NDHS
	Deliveries supervised by a health professional	14.6%	36.3%	31.9%	38%	NDHS
	Women who had a live birth delivered in a health facility	11.8%	33.4%	35.0%	36%	NDHS
	Currently married women who used any modern method of contraception	2.8%	3.5%	3.5%	9.8%	NDHS
Immunization	DPT-3 coverage	30.2%	49.7%	35.4%	38%	NDHS
	Measles coverage	41.4%	68.7%	41.4%	42%	NDHS
	Fully immunized	19.1%	40.4%	22.7	25%	NDHS
Management of childhood illnesses	Children <5 years with ARI symptoms who sought for treatment from health provider	31.2%	32.7%	46.5%	35%	NDHS
	Children <5 years with Diarrhoea who sought for treatment from health facility/provider	37.8%	24.4%	32.0%	29%	NDHS
	Children < 5 yrs. with diarrhoea given solution from ORT packet	18.9%	28.5%	25.5%	-	NDHS
Malaria	Households who own at least one ITN	27.8%	72.8%	16.9%	50%	NDHS
	Pregnant women in all households who slept under ITNs	2%	13.1%	4.8%	16%	NDHS
	Children <5 years in all households who slept under ITNs	2% [3]	12.6%	12.0%	17%	NDHS
	Pregnant women who received IPT during ANC visit	2%	27%	33.5%	23%	NDHS
TB	Treatment success rate	88%	89%	79%	86%	Annual Report
HIV	Prevalence rate	6.8%	1.9%	4.6%	4.1%	HSS

6.1.4 Problem analysis

PBF in Nigeria was first introduced in the three states of Adamawa, Ondo and Nasarawa in 2011. They face the same problems such as:

- **Poor human resource capacity** and in particular: (a) Poor remuneration; (b) No motivation of health workers to work in rural areas; (c) Inadequate skilled manpower and (d) Mal-distribution of staff
- **Poor Health financing*:*** and in particular; (a) Less than 5% of the national budget allocated to health and (b) Increased out of pocket expenditure by clients
- **Poor health infrastructure and equipment**
- **Lack or insufficient community participation**
- **Lack of political will and sustainability of health interventions**

6.1.5 Does PBF provide solutions?

Since PBF was introduced, it has solved some of the above-mentioned challenges.

Human Resource

- Autonomy to manage the staff autonomously (ability to hire and fire the staff)
- Capacity building of health staff
- Equity bonuses and staff performance bonuses motivates health workers to remain in rural areas

Health Financing

- PBF reduces wastages in the health sector through ensuring efficiency in the health system
- Autonomy is given to health facilities to improve health infrastructure

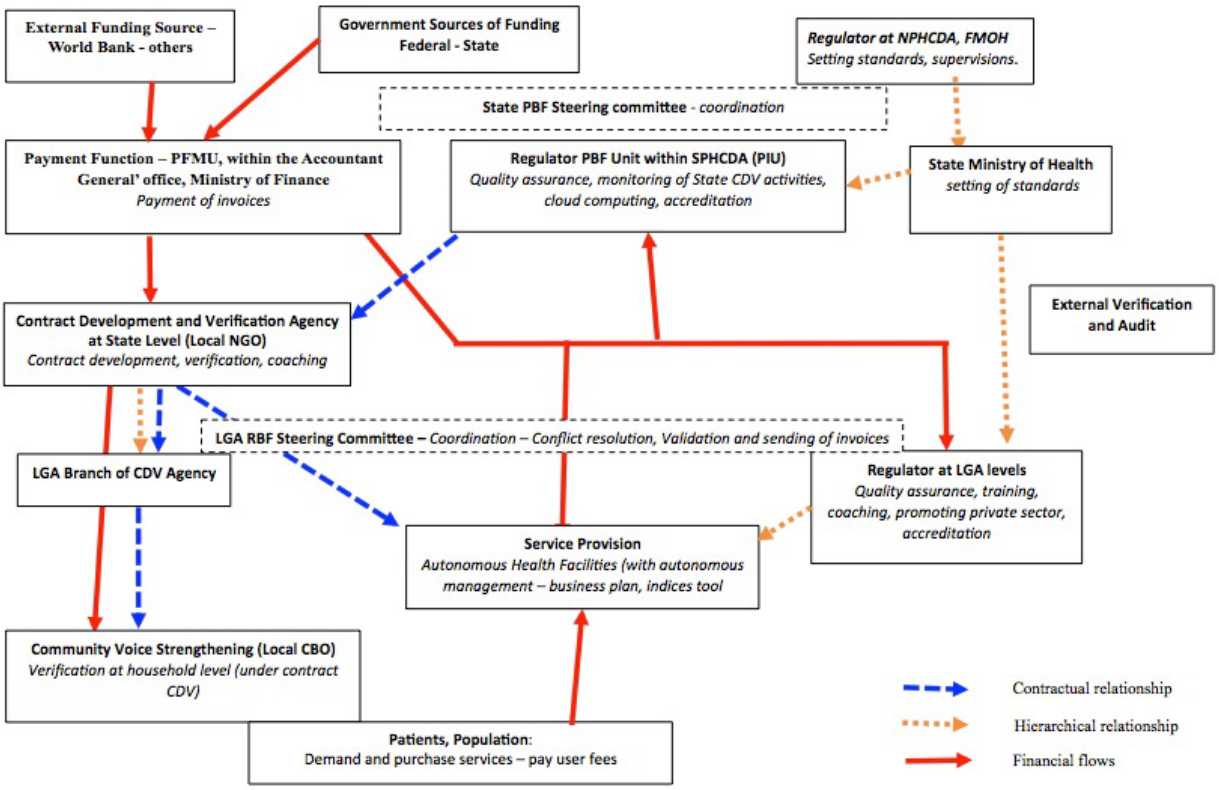
6.1.6 Feasibility scan

Using the feasibility scan, the scores for the Adamawa and Ondo states were at 80% (40/50) and the one of the Nasarawa states was at 90% (45/50).

Criteria to establish in how far the programme is "PBF"	Points available	(Adamawa & Ondo)	(Nasarawa)
1. The PBF program budget is not less than $ 4 (simple intervention) - $ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	5	0	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	0
3. The PBF program finances the full health center and hospital health packages and is not restricted to a limited number of vertical program activities	2	2	2
4. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	2	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	3
6. Cost recovery revenues are spent at the point of collection (facility level)	2	2	2
7. Provider managers have the right to decide where to buy their inputs	4	4	4
8. The project introduces the business plan	3	3	3
9. The project introduces the indices tool for autonomous management	3	3	3
10. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2	2	2
11. Provider managers are allowed to influence cost sharing tariffs	2	2	2
12. Provider managers have the right to hire and to fire	2	2	2
13. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching medical & community verification.	2	0	0
14. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function and	2	2	2
15. CDV agents accept the promotion of the full government investment determined packages (this in Africa mostly concerns discussions about family planning)	2	2	2
16. The PBF system has infrastructure & equipment units, which are paid against achieved benchmarks based on agreed business plans	2	2	2
17. Public religious and private providers have an equal chance of obtaining a contract	3	3	3
18. There are geographic and/or facility specific equity bonuses	3	3	3
19. The project provides equity bonuses for vulnerable people	3	3	3
TOTAL	**50**	**40=80%**	**45 = 90%**

6.1.7 Recommendations

1. Advocacy to increase the budget for PBF to at least $ 4 per capita per year by
   a. Government contribution
   b. Development Partners contribution
2. For government to strengthen the need for basket funding including advocacy to all development partners coming in to contribute into the basket rather than bringing inputs.
3. Integration of all PHC activities
4. Harmonization of PBF and HMIS indicators / data tools (Exchange visit to Zimbabwe / Cameroon).
5. Ensure separation of functions (regulator and verification) by recruiting an independent local NGO as CVD Agency. See the following institutional set-up for how this could be organised.



6.1.8 Action plan for the group from Adamawa, Ondo and Nasarawa States

Based on the feasibility scan, the team suggested giving feedback to their key decision makers at the State and National government in order to advocate and boost the PBF program already in place.

	Activities	Target	Objectives	Responsible	Timeline		
***General objective*: advocate at the administrative level of the state for more efficiency in the PBF project. Also integrate all Primary health care activities and also begin the harmonization of the PBF outputs and the National Health Information system.**					*2 wks*	*6 wks*	*6 months*
1st Objective: Advocate at the SPHCDA, Commissioner and Governor level							
1	Debriefing of the SPHCDA team	SPHCDA	To brief the team on lessons learnt and best practices	Course participants	X		
2	Advocacy to the Hon Commissioner of Health.	Honorable Commissioner of health	To advocate for a plan towards sustainability of the PBF program and the need for government contributions towards PBF To arrange a high level advocacy visit to the Governor for same reason	SPHCDA			X
3	Advocacy to development Partners		Invest in health care through PBF				X
4	Hire Local NGO	Local NGOs	To serve as CDV agency	SPHCDA			X
5	Integration of all PHC activities		A horizontal approach to PHC service delivery through harmonization of indicators and data tools				

6.2 Nigeria North East (Additional Financing) States

6.2.1 Context

Nigeria is the most populated nation in Africa with 180 million.

- The Maternal Mortality Rate (MMR) is high with 576 deaths per 100,000 live births. The MMR contributes to 10% of total global MMR while it has only 2% of the global population. There is also a high regional variation in the MMR and it is the worst in the North Eastern (NE) States of which several were represented in the Mombasa PBF course.
- Antenatal care coverage is *43% in the North East States compared to 91% in the South East States*.
- Skilled attendance at birth is *12% in the NE States and 78% in the SE States.*
- There is also a big variation in the fertility rate of *6.3 in the NE States against 4.7 in the SE States*

6.2.2 Challenges in the (reproductive) health system

1. Low ANC attendance due to:
- Cultural barriers
- Low educational status, especially among women
- Poor socio-economic status
- Limited access to health facilities (HFs)
- High out-of-pocket expenditures

2. Low delivery by skilled birth attendant due to:
- Limited number of qualified nurses and midwives
- There exists an urban-rural disparity in the distribution of human resources
- Poor infrastructure and equipment
- High user-fees
- Poor attitude of health workers

3. Poor postnatal care
- Non availability of services in some hard-to-reach areas
- Poor knowledge / awareness about post-natal care.

6.2.3 Is PBF a solution to the identified problems in the NE States of Nigeria?

Yes, it is essential to address these problems through a PBF program by:

1. Providing better incentives to health workers to work in the rural areas,
2. Changing the attitudes towards performance
3. Improving infrastructure and equipment
4. PBF may also work on the demand side, creating supply incentives for patients through higher PBF subsidies. This would operate like conditional cash transfers for antenatal care, facility deliveries and postnatal care.

6.2.4 Nigeria Additional Financing States feasibility scan

The Additional Financing states carried out a feasibility scan on the current situation regarding the PBF, yielding the scores below:

Criteria to establish in how far the project is "PBF"	Points	Score
1. The PBF program budget is not less than $ 3 per capita per year of which at least 70% is used for health facility subsidies, local NGO contracts and infrastructure input units	5	0
2. The PBF project has at least 20 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	3	3
3. The PBF program finances the full health centre and hospital health packages and is not restricted to a limited number of vertical program indicators	2	2
4. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	2
5. The project includes (or is part of) baseline and evaluation household and quality studies that establish priorities and allow measuring progress	3	3
6. Cost recovery revenues are spent at the point of collection (facility level)	2	2
7. Health facility managers have the right to decide where to buy their inputs	4	4
8. The project introduces business plans	3	3
9. The project introduces the indices tool for autonomous management	3	3
10. CDV agencies sign contracts directly with the daily managers of the health facilities – not with the indirect owners such as a religious leader.	2	2
11. Health facility managers are allowed to influence cost sharing tariffs	2	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	0
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	3
19. The project provides equity bonuses for vulnerable people	3	3
TOTAL	**50**	**39 = 78%**

6.2.5 Action plan for the North East states of Nigeria

There is no PBF program yet in Bauchi, Borno, Gombe, Taraba and Yobe States, but the States secured a World Bank Additional Financing Facility of $ 125 million, which will be used to start the PBF program in these States. Meanwhile, before the actual disbursement of the financing facility each State will use $ 200,000 from the Saving One Million Lives to start the pilot scheme. The $ 200,000 will not be enough

based on the designed PBF standard of $ 4 per capita taking example of MMC LGA in Borno State with more than 2 million population.

Some activities already started or will start during the next months:

- Selection of pilot PBF facilities and LGAs as well as the baseline survey of selected LGAs/HF has already been done.
- Selection of Contract Development and Verification Agencies.
- Dissemination of baseline findings planned for September 2016. The project will also conduct training on PBF concepts, development of business plan and costing.
- The Nigerian group will help with the selection of at least 25-35 output indicators for PBF subsidy in collaboration with the SPHCDA.
- The development / adaptation of existing indices tools for autonomous management by the PIU/CDV will take place at the same time.

	Activities	Target	Objective	Responsible	Time frame		
***General objective*: advocate at various levels**					*2 Wks*	*6 Wks*	*6 Months*
***1st objective*: Advocate at various level**							
	Convene stakeholders meeting	All stakeholders	Initiate consensus building for PBF project	SMoH/ SPHCDA	X		
	Advocacy to key stakeholders:	Governor, MoF, MoLG, LGA Chairmen, Legislators, Traditional & Religious Leaders		SMoH/ SPHCDA	X		
***2nd objective*: Put in place the PBF organs**							
	Setting up a PBF steering committee at state level	All: HF Managers, CDV, Finance, regulators, etc.	Operationalization of PBF project	SMoH	X		
	Setting up PBF implementation unit	Regulatory / CDV / payment / etc.		SPHCDA	X		
***3rd objective*: Implement the PBF project**							
	Evaluation of household and quality studies	Households		PIU/CDV			**X**
	Strengthen collaboration with Quality Management Unit Define PBF indicators	All stakeholders		PIU/CDV			X
	Development of business plans with key stakeholders at both primary and secondary levels	All stakeholders		PIU/CDV			X

6.3 Cameroon

6.3.1 Health context

Cameroon is a west central African country with a population of 23 million, sharing borders with Nigeria to the West (long porous border), Chad, Central African Republic and Congo to the East, Equatorial Guinea, Gabon and Congo to the South and Lake Chad to the north. It is partitioned in 10 administrative regions with English and French being the official working languages.

The Cameroon health structures are divided into 3 levels:

- **Central:** policy making, has 3rd and 4th category referral hospitals,
- **Intermediary or Regional**: translate policy into operational instructions (10 regional delegations), has the 2nd referral level hospitals and
- **Peripheral or District:** executes or implements the operational instructions (190 health districts). It has a strong central control but with a devolution of some management authority to the intermediary and peripheral levels.

6.3.2 Indicators

- Life expectancy at birth (M/F): 56/59
- Total expenditures of health per capita in 2013: USD 138

Reproductive and child health:

- Maternal mortality has increased from 430 maternal deaths / 100.000 live births in 1998 to 669 in 2010 and 782 in 2011.
- Infant mortality in 2012 was 61 deaths / 1000 live births
- Under 5 mortality rate 95 deaths / 1000 live births
- Low ANC uptake (problems of access, awareness, TBA's)
- Poor family planning coverage due to limited access, non-availability of commodities and non-respect of FP protocols.

Vaccination

- Vaccination coverage for 5 antigens is about 80%. Problems linked with poor geographical access, resistance and ignorance persist.

HIV/AIDS

- National prevalence is at 5.4%. Adult HIV prevalence rate in 2012 was 4.5%.
- PMTCT activities are conducted nation wide
- B+ option is national policy. The Option B+ is a prevention of vertical transmission approach for expectant mothers living with HIV in which they are offered treatment for life regardless of their CD4 count.
- Stigmatization problems
- Non respect of HIV testing protocols

6.3.3 Weaknesses in the health sector of Cameroon

- Shortages and poor motivation of human resources
- Difficult geographical access in rural areas
- Financial access problems
- Poverty and inequalities
- High out of pocket payment for health

6.3.4 PBF in Cameroon

The PBF project is being implemented in the East, Littoral, North West and South West regions in Cameroun since about 5 years. The South West region of Cameroon has a population of 1.5 million inhabitants. PBF is being piloted since 2012 in four health districts with a combined population of 600.000. The CDV agency, which has a memorandum of understanding with the SW Regional Fund for the Promotion of Health has signed performance contracts with facilities both at primary (MPA) level and at hospital (CPA) level in the four pilot districts of Buea, Kumba, Limbe and Mamfé.

The regional regulators have signed contracts with the PBF central technical PBF unit and also with the district level. In executing its regulatory role, the SW regional PBF team is faced with challenges, which revolve around autonomy and problems with human resources. The PBF feasibility scan showed that the South West region had a score of 84%. This is above the required 80% but there are some problems remaining such as: (a) cost-recovery revenues still need first to go to the treasury; (b) a lack of autonomy of some health facilities to buy drugs and; (c) the lack of freedom at provider level to recruit and manage human resources.

6.3.5 Cameroon PBF feasibility scan

The feasibility scan arrived at the following scores:

Criteria to establish in how far the project is "PBF"	Points	Score
1. The PBF program budget is not less than $ 4 per capita per year of which at least 70% is used for health facility subsidies, local NGO contracts and infrastructure input units	5	5
2. The PBF project has at least 20 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	3	3
3. The PBF program finances the full health centre and hospital health packages and is not restricted to a limited number of vertical program indicators	2	2
4. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	2
5. The project includes (or is part of) baseline and evaluation household and quality studies that establish priorities and allow measuring progress	3	3
6. Cost recovery revenues are spent at the point of collection (facility level)	2	0
7. Health facility managers have the right to decide where to buy their inputs	4	0
8. The project introduces business plans	3	3
9. The project introduces the indices tool for autonomous management	3	3
10. CDV agencies sign contracts directly with the daily managers of the health facilities – not with the indirect owners such as a religious leader.	2	2
11. Health facility managers are allowed to influence cost sharing tariffs	2	2
12. Health facility managers have the right to hire and to fire	2	0
13. There is a CDV Agency that is independent of the local health authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	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	3
19. The project provides equity bonuses for vulnerable people	3	3
TOTAL	**50**	**42 = 84%**

6.3.6 Action plan for Cameroon

On the basis of the feasibility scores, the team proposed the following actions in the lead up to a further integration plan:

Action Plan	Targets	Objective	Responsible	2 Weeks	6 Weeks	6 Months
General Objective: advocate for more provider autonomy (managerial, financial and drugs management)						
1st Objective: Advocacy among decision makers for managerial and financial autonomy of health facilities.						
Organize an advocacy meeting for managerial and financial autonomy	- Regional members of the Ministry of Finance - Regional task force members	- Sort the issue of financial autonomy needed for all health facilities in the project	PBF secretary and PBF focal person			
Advocacy at the central level and at the technical PBF unit for managerial and financial autonomy	- Governor's office (2) - Finance (5) - Ministry of public service (2) - PBF Technical unit - MOH	- Cost recovery revenues are spent at the point of collection (facility level) - Health facility managers have the right to decide where to buy their inputs - The health facilities manager should have the managerial autonomy on their staff and their materials + equipment. - The PBF Unit should continue working with the decision body on the issue of autonomy of health facilities.	RDPH			
2nd Objective: Strengthen the human resources of the Regional Delegation in the South West Region.						
Constitute a powerful human team of resources person at the RDPH for the PBF activities.	- CDVA - Regional task force - Staff of the RDPH and the Districts.	- Difficulty in smooth and timely execution of various activities including vertical programmes. - Advocate for training of a regional pool of experts (regulators, university staff, others): revision of quality check list, entry of PBF data in the portal in order to increase human resource potential.	PBF Focal person and secretary			
3rd Objective: Assure full autonomy of pharmacies in the health facilities for drugs and other medical supplies						
Some health facilities are not having autonomy for drugs management	- SWRFHP - CDVA	Establish a list of non-autonomous health facilities with the CDV Agency. - The regional regulators to encourage the fund to grant autonomy to all pharmacies in the PBF districts of Southwest region.	PBF Secretary and RDPH			

6.4 Ghana

There are 10 administrative regions in Ghana with a total population of 27 million (GSS 2013). Ashanti, Eastern, and Greater Accra regions together constitute about 50 percent of Ghana's population. Upper East is the least populated region, accounting for 2 percent of the total population of Ghana. The regions are subdivided into 216 districts to ensure equitable resource allocation and efficient, effective administration at the local level (GSS 2014). The Gross Domestic Product (GDP) in Ghana was worth 37.86 billion US dollars in 2015.

6.4.1 The health system in Ghana

Levels of Service delivery:

- Tertiary (Teaching Hospitals)
- Secondary (Regional & District Hospitals)
- Primary (Clinics, Health centres, CHPS)

6.4.2 Key challenges

Geographical Challenges:
- Misdistribution of staff due to lack of amenities to attract and retain staff to hard to reach areas
- Lack of incentives and motivation for staff working in hard to reach areas
- Influence of opinion leaders in human resource allocation to underserved areas

Financial Challenges:
- National Health Insurance Scheme funds caters solely for clinical (curative) care services
- Delayed reimbursement by the National Health Insurance Authority
- About 40% of health financing is donor driven
- No in-country designated fund for public health interventions

Other Challenges
- Public health activities are fully supported by donor funds
- Dwindling donor inflows
- 15% of Government budget allocated for health financing with about 90% of this used to pay health staff salaries
- Leadership interference with distribution of resources

Despite appreciable efforts to improve MNCH service delivery coverage's, some MNCH indicators dwindled or are stagnated according to the 2015 FHD- GHS report.

- ANC coverage: 2013 (90.8%), 2014 (86.7%), 2015 (84.3%)
- Skilled Delivery: 2013 (55.1%), 2014 (56.7%), 2015 (55.7%)
- Postnatal care: 2013 (85.6%), 2014 (100%), 2015 (66.3%)
- Family planning acceptor rate: 2013 (24.7%), 2014 (29.2%), 2015 (28.6%)
- Maternal Mortality Ratio per 100,000 LBs: 2013(153), 2014(143.8), 2015 (142)

6.4.3 The PBF program in Ghana

There is no PBF program yet in Ghana. A PBF project has been planned at the Community Health Planning and Services (CHPS) level. Yet, the design is not in line with the PBF criteria such as discussed during the PBF course in Mombasa and hence there is a need for a revision such as shown below. The feasibility score is only 26%,

which is below the 80% average score recommended. The Ghanaian team proposes some points for revision.

6.4.4 Ghana feasibility scan

Criteria to establish in how far the project is "PBF"	Points	Score
1. The PBF program budget is not less than $ 4 per capita per year of which at least 70% is used for health facility subsidies, local NGO contracts and infrastructure input units	5	5
2. The PBF project has at least 20 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	3	0
3. The PBF program finances the full health center and hospital health packages and is not restricted to a limited number of vertical program indicators	2	0
4. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	2
5. The project includes (or is part of) baseline and evaluation household and quality studies that establish priorities and allow measuring progress	3	3
6. Cost recovery revenues are spent at the point of collection (facility level)	2	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 CDV Agency that is independent of the local health authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	0
14. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	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	3
19. The project provides equity bonuses for vulnerable people	3	0
TOTAL	**50**	**13 = 26%**

6.4.5 Problem analysis

The Ghana manual and PBF proposal were short on the following and the team has indicated what is feasible:

No	Criteria	Proposal
1.	The verification of the indicators were not exhaustive	Can be worked on and expanded
2.	Health facilities do not have full autonomy in policy and management decisions of the facilities	Negotiation can be made
3.	Health facilities are not mandate to solely procure their own inputs	Negotiation can be made
4.	The PBF program only targets the CHPS level	PBF program revised to include health centers and hospitals
5.	Cost recovery revenues are not spent at point of collection	Because it is a pilot, exemption will be requested for the PBF implementing districts.
6.	No business plan and indices tool for management	To be captured in the new proposal.
7.	Set up CDVA and separation of functions	Agreed to be captured in the revised proposal
8.	Cost sharing tariffs for providers	Negotiation can be done
9.	Right to hire and fire	High level discussion among top health managers from GHS, MoH and Ministry of Finance

6.4.6 Ghana Action Plan

Meeting with the national PBF team to decide and suggest areas in the Ghana PBF manual that need to be revised.

Action Plan	Targets	Objective	Responsible	2 Wks	6 Wks	6 Months
General Objective: advocate for more autonomy in PBF health facilities (managerial, financial and for drugs management).						
1st Objective:						
Debrief of GHS and MOH management team on revision PBF design	- GHS - MOH - World Bank	- To inform and sensitise management of the outcome on the new development - Provide feedback - To solicit for support from key stakeholders	Nana Quandahor DG	**X**		
2nd Objective: redesign the implementation of the PBF project						
Selection of additional districts from each region	- Regions and Districts	- To get a representative population of at least 400,000 per region to sum up to a total of 1.6 million	Regional directors – Dr. Joseph Nuertey	**X**		
Minimum service package tied to key indicators	-	- To meet at least 25 outputs indicators required for a good PBF implementation	Esi Amoaful		**X**	
Select Regulator for national, regional and district levels	MOH GHS Regional regulator (RHA) District regulator (DHA)	- To develop policy guidelines and directives for the PBF program - Provide a list facilities (Health centres and hospitals) and NGOs to implement the PBF from districts	Task team - Nana Quandahor Edith Mansah		**X**	
Develop ToR for CDVA	-	- To guide the activities of the CDVA - Make the procurement contract for CDVA.	Task team - Nana Quandahor		**X**	
Meeting to revise the PBF proposal.	- Task team - Technical Assistant (WB)	- To revise the Ghana PBF proposal - Develop a business plan framework - To conduct a new feasibility scan with a satisfactory score (≥80%).	Task team - Esi Amoaful		**X**	
3rd Objective: Implement the new PBF project in Ghana						
Develop an implementation plan	- PBF actors	- The implementation plan serving as a guide is available and ready for use.	National PBF task team- Nana Quandahor			**X**
Set up a PBF unit	- PBF actors	- To coordinate implementation activities - To serve as the institutional design for the PBF system	MoH & GHS team			**X**
Develop sample contracts for all stakeholders	-	- Regulator to coordinate contract proceedings of all CDVAs, facilities	PBF task team		**X**	
3rd Objective: Involve the key stakeholders and build a consensus with regulatory authorities.						
Engagement of key stakeholders and consensus building with regulatory authorities	- NHIA - Pharmacy council - FDA	- To sensitise all stakeholders - To bring regulatory authorities on board - Schedule meeting with regulatory authorise (NHIA, Pharmacy council, FDA etc.)	PBF task team			**X**

6.5 Democratic Republic of Congo

The Democratic Republic of Congo has conducted several pilot PBF programs in the health sector with success and has adopted most PBF best practices with the important exception of maintaining monopolies for the distribution of essential drugs and other inputs. Also the education sector piloted a PBF program in South Kivu Province but it has not yet been scaled up such as in the health sector.

6.5.1 Situation of primary education in DRC

DRC has more than 60 000 schools countrywide. One-third of them meet the minimum standards and those are mostly concentrated in urban areas. The teacher-pupil ratio should meet the standard of 1:55, but the reality is that in many schools there is one teacher per 70 to 90 pupils. Child-textbook ratio stands at 1 book for 2 students in French while there is only 1 textbook for 10 pupils for the other subjects. The proportion of qualified teachers with four years and 6 year after primary school (D4&D6) has increased according the national report from 94,4 % in 2012 to 95,3% in 2013 (Directory 2013). Yet, students can still not read at the end of Grade 6, which are caused by poor teaching methods.

6.5.2 Some results and statistics

It is estimated that about 3.5 million children of primary school age in DRC are not in school. Two million of them will never have the chance to be enrolled without a significant change in the education policy (EADE-RDC 2012). They are still out of school as the result of the huge size of DRC, its difficult political and geographic context and the poverty of households.

This results in:

- A high girl dropout rate of 43% against 29% for boys (RESEN, 2012).
- Those who are in school don't develop the expected learning outcome, in terms of functional literacy and numeracy skills, according to PASEC 2010
- Only 9% of children of Grade 2 and 14% of Grade 5 speak French at home,
- 84% of children from Grade 4 cannot read comprehensively, 38% read most used words, 50% could formulate words and 52% cannot write a simple word (RESEN, 2014).

There is no clear policy in Early Childhood Development (GER: 4%), and many youth who cannot afford secondary school are school leavers and in need of second chance learning, 24% of youth completing secondary school among them 12,1% are girls (annual report, 2014).

The DRC government is currently allocating 16% of their budget to the Ministry of Education (MoE), 8% dedicated to primary education out of which 93% is used for teacher salaries. The DRC education system has more than 500.000 teachers, but only 300,000 of them are paid regularly. The budget allotted to education is insufficient to address the many challenges the system faces, particularly with regard to the promotion of access or basic education for all. A recent analysis estimated that about one out of five children of primary school age (6–11 years old) would never attend school, which means more than 2 million children (INS/UNICEF 2011; MEPSP/UNICEF/DFID 2013).

DRC joined the list of countries that have abolished school fees at primary school. However, the studies show that, despite these efforts made by the government households still support more than 70% of the cost of primary and secondary education (De Herdt et al. 2011; EADE-RDC 2012, MOE/UNICEF/DFID 2013, RESEN, 2014).

The education sector in the DRC consists of a hybrid system whose origins date back to the colonial era whereby public education is based on two pillars: one managed by the government (public schools) and the other by religious denominations (church-owned schools). More than 70% of schools are non-state actors and the government must accommodate itself to the high level of independence. In practice, the religious schools operate as parallel structures inside the public sector, with an administration system similar to that of the government. This is a challenge for governance and quality education. Yet, without the private sector the vast majority of children would not be educated. It is therefore necessary to improve the regulatory capacity of the State to assure the quality and improve the access for the vulnerable families.

6.5.3 Can PBF be a solution for the above problems?

An international NGO, Cordaid is supporting a National PBF Unit since 2014. The government has obtained financing from the World Bank to improve the education system through PBF. The Congolese participant in Mombasa carried out a feasibility scan and identified the following key challenges in the education sector:

- Limited number of classrooms, equipment's, qualified and motivated teachers,
- Lack of in-service teachers training;
- Lack of regular quality monitoring of the teaching process, of teaching materials in local languages, and of governance and accountability in the school management by inspectors;
- Low community engagement;
- Poor school environment: lack of water and latrines, poor infrastructures;
- Disconnection between vocational training and job opportunities for youth;
- Early marriage and child labour;
- Low functional literacy
- Lack of school governances for effectiveness and school improvement.

6.5.4 DRC feasibility scan in the education sector

	Criteria to establish in how far the project is "PBF"	Points	Score	Observations
1.	The PBF budget is not less than $ 4.00 per capita and per year (or $ 20 per child) with at least 70% for the subsidies of BG, BGP, COGES, and COPA. The CBO/FBO contracts exist and there are quality improvement bonuses for infrastructures.	5	**0**	The ratio is $1,72 / capita ≤ $ 4 ($ 8.61 / child ≤ $ 20$) Quality improvement bonus for infrastructures is absent in the proposal.
2.	The PBF program has at least 15 outputs indicators for which the schools receive subsidies and composite indicators for quality assessment.	3	**3**	Ok, condition fulfilled.
3.	The PBF program finances preprimary and the primary schools and is not restrained to a limited number of indicators of a vertical programme.	2	**2**	Ok, condition fulfilled.
4.	The PBF programme include the community indicator "visit to household" following a protocol	2	**2**	Ok
5.	The PBF program includes a household baseline study on the quality of education, which permits to establish priorities and measure progress.	3	**3**	Ok, condition fulfilled.

6.	The money from cost sharing is used at the point of collect by the school management committee (COGES).	2	**2**	Ok, condition fulfilled.
7.	Health facility managers have the right to decide where to buy their inputs	4	**0**	The government supplies inputs by a central supply system.
8.	The project introduces business plans as a development tool for the schools	3	**3**	An annual development plan is previewed.
9.	The project introduces the indices tool for autonomous management of the COGES	3	**3**	Ok, condition fulfilled.
10.	CDV agencies sign contracts directly with the daily managers of the schools – not with the indirect owners such as religious leaders	2	**2**	Ok. The contract will be quarterly
11.	Director of schools are allowed to influence cost sharing tariffs	2	**2**	Ok, condition fulfilled.
12.	Directors have the right to hire and to fire their staffs.	2	**0**	The management of the schools have the right to recruit but not to fire
13.	There is a CDV Agency that is independent of the local school authorities with enough staff to conduct contracting, coaching & community verification.	2	**2**	Ok, condition fulfilled.
14.	There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	**2**	Ok, condition fulfilled.
15.	CDV agents accept the promotion of the full government determined school packages	2	**2**	Ok, condition fulfilled.
16.	The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans.	2	**2**	Ok, condition fulfilled.
17.	Public religious and private schools have an equal chance of obtaining a contract	3	**3**	Ok, condition fulfilled. Faith based school represents 70% of schools
18.	There are geographic and/or school specific equity bonuses	3	**0**	No geographic bonus
19.	The project provides equity bonuses for vulnerable children.	3	**3**	There is a difference between the subsidies paid for the schooling of girls ($ 1.5) and boys ($1). There's a special bonus for the retention of the school at the school
	TOTAL :	**50**	**36**	**(36/50 = 72% ≤ 80%)**

The feasibility score of the PBF program in the education sector of DRC if 72% (39:50) which below the 80% recommended for a good project. In addition there are two killing assumptions that needs to be remediated.

6.5.5 Problem analysis

SN	Target	Beneficiaries	Estimates
01	9 provinces	Subdivisions to be determined	
02	1350 schools	35 pupils in Pre primary 50 pupils at the primary school	452 250 pupils (average)

SN	PBF Standards for subsidies	Budget available	Average / year
01	$20 /pupil/year	$ 18 720 000 / 452 250 pupils /5 years	8,28 $ ≤ 20$
02	$4 Per Capita		1,72$ par habitant ≤ 4$

6.5.6 DRC Action Plan in education

Subsequent to the analysis, the following action plan is proposed:

Action Plan	Targets	Objective	Responsible	2 Weeks	6 Weeks	6 Months
General Objective:						
1st Objective: restitution of the 54th PBF International course results						
Organize a workshop for restitution	- Cordaid - MEPS	-	Georges MILUNDU	**X**		
2nd Objective: Advocacy meetings						
Advocacy meeting to Cordaid	- Cordaid	- Efficient use of the available budget: either reduction of the target or another advocacy for additional funding.	Georges MILUNDU			
Advocacy meeting to EPS-INC	- EPS-INC	- Conversion of certain inputs budget lines into PBF common basket.	Cordaid		**X**	
3rd Objective: Revision of data collecting and quality review tools proposed for the project.						
Organize workshop for the revision and harmonization of the existing tools before implementation.	- Cordaid - MEPS	-	Cordaid-EPS-INC-OSC Georges MILUNDU			**X**

6.5.7 Recommendations or possibilities for efficiency

Reduce the number of schools to be covered from 1350 to 560 or increase the budget so that it will meet the minimum possible ($ 20). The total budget will then be $ 45 225 000 (gap of $ 26 505 000).