



Mombasa – KENYA

Report of the 70th Performance-Based Financing Course

May 28 – June 8, 2018



The 31 course participants in Mombasa enjoying happy moments together

Final Version, 19th of June 2018
Mombasa, Kenya

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TABLE OF CONTENT

1. SUMMARY	4
1.1 <u>GENERAL OBSERVATIONS ABOUT THE MOMBASA COURSE AND EVALUATION</u>	4
1.2 <u>COUNTRY RECOMMENDATIONS OF THE MAY 2018 MOMBASA COURSE.....</u>	5
1.2.1 <u>Nigeria NPHCDA</u>	5
1.2.2 <u>Kano State - Nigeria.....</u>	7
1.2.3 <u>Jigawa State - Nigeria</u>	7
1.2.4 <u>Zamfara State – Nigeria.....</u>	8
1.2.5 <u>Yobe State – Nigeria.....</u>	9
1.2.6 <u>Zambia</u>	9
1.2.7 <u>The Gambia.....</u>	10
1.2.8 <u>Ethiopia</u>	11
2. RESUME	15
2.1 <u>OBSERVATIONS SUR LE COURS PBF DE MOMBASA ET SON EVALUATION.....</u>	15
2.2 <u>RECOMMANDATIONS SPECIFIQUES PAR PAYS</u>	15
2.2.1 <u>Nigéria NPHCDA.....</u>	15
2.2.2 <u>L'État de Kano.....</u>	16
2.2.3 <u>L'État de Jigawa.....</u>	16
2.2.4 <u>État de Zamfara.....</u>	17
2.2.5 <u>L'État de Yobe.....</u>	17
2.2.6 <u>Le Zambie</u>	18
2.2.7 <u>La Gambie.....</u>	18
2.2.8 <u>L'Éthiopie.....</u>	18
3. INTRODUCTION	20
3.1 <u>PERFORMANCE-BASED FINANCING (PBF), A REFORM APPROACH IN PROGRESS</u>	20
3.2 <u>AIMS AND OBJECTIVES OF THE MOMBASA PBF COURSE</u>	20
3.3 <u>THE MAY 2018 MOMBASA COURSE.....</u>	21
3.4 <u>THE FINAL EXAM, ADULT LEARNING, AND ACCREDITATION.....</u>	21
3.5 <u>WHO ATTENDED THE MAY – JUNE 2018 PBF COURSE?</u>	22
3.6 <u>FACILITATION TEAM</u>	22
4. DAILY EVALUATIONS BY PARTICIPANTS.....	23
4.1 <u>DAILY EVALUATIONS BY PARTICIPANTS</u>	23
4.2 <u>METHODS AND FACILITATION</u>	23
4.3 <u>PARTICIPATION</u>	24
4.4 <u>ORGANIZATION.....</u>	24
4.5 <u>TIME KEEPING</u>	25
5. DESCRIPTION OF THE COURSE.....	26
6. FINAL COURSE EVALUATION BY PARTICIPANTS.....	31
6.1 <u>GENERAL IMPRESSION OF THE COURSE</u>	31
6.2 <u>APPRECIATING THE DURATION OF THE COURSE</u>	31
6.3 <u>COMMENTS ON THE ORGANIZATION OF THE COURSE</u>	32
6.4 <u>COMMENTS ON THE EXECUTION OF THE COURSE AND THE FACILITATORS.....</u>	32
6.5 <u>EVALUATION PER MODULE</u>	33
6.6 <u>WRITTEN COMMENTS DURING THE FINAL EVALUATION BY THE PARTICIPANTS</u>	33
7. COUNTRY & TOPIC PRESENTATIONS	35
7.1 <u>NIGERIA FEDERAL LEVEL (NPHCDA).....</u>	35
7.1.1 <u>General context</u>	35
7.1.2 <u>Problem Definition.....</u>	35
7.1.3 <u>PBF Feasibility Scan.....</u>	36
7.1.4 <u>Key Challenges / Killing assumptions.....</u>	38

7.1.5	<u>PBF Design Solutions</u>	40
7.1.6	<u>Action Points</u>	40
7.2	<u>NIGERIA – KANO STATE</u>	41
7.2.1	<u>General context</u>	41
7.2.2	<u>Problem Definition</u>	42
7.2.3	<u>PBF Design Solutions</u>	42
7.2.4	<u>PBF Feasibility Scan (of proposed PBF design)</u>	45
7.2.5	<u>Key Challenges / Killing assumptions</u>	46
7.2.6	<u>Action Points (Advocacy Plan)</u>	47
7.3	<u>NIGERIA – JIGAWA STATE</u>	48
7.3.1	<u>General context</u>	48
7.3.2	<u>Problem Definition</u>	48
7.3.3	<u>PBF Design Solutions</u>	49
7.3.4	<u>PBF Feasibility Scan (of proposed PBF design)</u>	50
7.3.5	<u>Key Challenges / Killing assumptions</u>	51
7.3.6	<u>Action Plan (Advocacy Action Plan)</u>	52
7.4	<u>NIGERIA – ZAMFARA STATE</u>	53
7.4.1	<u>General context</u>	53
7.4.2	<u>Problem Definition</u>	53
7.4.3	<u>PBF Design Solutions</u>	53
7.4.4	<u>PBF Feasibility Scan</u>	55
7.4.5	<u>Key Challenges / Killing assumptions</u>	56
7.4.6	<u>Action Points</u>	56
7.5	<u>NIGERIA – YOBE STATE</u>	57
7.5.1	<u>General context</u>	57
7.5.2	<u>Problem Definition</u>	58
7.5.3	<u>PBF Feasibility Scan</u>	59
7.5.4	<u>PBF Design Solutions</u>	61
7.5.5	<u>Action Plan</u>	61
7.6	<u>ZAMBIA</u>	63
7.6.1	<u>General context</u>	63
7.6.2	<u>Problem definition</u>	63
7.6.3	<u>Feasibility score</u>	63
7.6.4	<u>PBF design solutions</u>	65
7.6.5	<u>Action Points</u>	67
7.7	<u>THE GAMBIA</u>	67
7.7.1	<u>General context</u>	67
7.7.2	<u>Problem Definition / PBF Feasibility Scan</u>	69
7.7.3	<u>Key Challenges / Killing assumptions</u>	71
7.7.4	<u>Can PBF help strengthen the health system?</u>	74
7.7.5	<u>Proposed PBF Design</u>	75
7.7.6	<u>Action Plan</u>	76
7.8	<u>ETHIOPIA</u>	78
7.8.1	<u>General context</u>	78
7.8.2	<u>Objectives</u>	79
7.8.3	<u>How PBF responds to the Health Sector Transformation Agenda</u>	79
7.8.4	<u>Status of PBF in Ethiopia: A showcase in Borena</u>	80
7.8.5	<u>Changes in the design of future PBF interventions</u>	84
7.8.6	<u>Advocacy Action Points</u>	86

1. SUMMARY

The French summary is presented in Chapter 2 - page 14 - of this report.

The 70th performance-based financing (PBF) course took place from Monday, May 28 to Friday, June 8, 2018, in Mombasa, Kenya. Thirty-one participants attended the course: 16 participants from Nigeria, 6 from Zambia, 5 from Ethiopia, 3 from The Gambia, and 1 from the USA. The groups analyzed their health systems and produced detailed action plans on how to advance PBF in their respective countries, states, and regions. Thirty participants took the final exam and achieved an average score of 70%, including three distinctions.

This was the first course at the 4-star Traveler's Hotel, which proved to be an improvement. The Mombasa North Coast beach remains an attractive base for our courses, and the collaboration with Tomasi Company has deepened into a true logistics partnership, contributing to smoother organization and greater Kenyan ownership of the course's practical delivery.

1.1 General observations about the Mombasa course and evaluation

The PBF course welcomed participants from five countries.

1. The Nigeria team consisted of 1 participant from the Federal level (i.e., from the NPHCDA) and 15 persons from the States of Kano, Jigawa, Zamfara and Yobe. We were honored to welcome the Commissioners of Health from Jigawa, Kano, and Zamfara.
2. One Senior Health Expert from the World Bank (Washington, DC) attended.
3. The Zambia team consisted of 6 people: 5 from the Ministry of Health (central level) and 1 from the District Medical Office.
4. The Ethiopia team included 5 people: 2 from the Federal Ministry of Health, 1 from the National Health Insurance Company, 1 from the regional health directorate, and 1 from the Addis office of the International NGO Cordaid.
5. The Gambia sent a 3-person delegation working for the RBF project NaNA.

The facilitation team consisted of:

1. Dr Godelieve van Heteren, a senior health system expert for the Health Systems Governance Collaborative hosted by WHO.
2. Dr Fanen Verinumbe, PBF consultant of the National PHCDA in Nigeria.
3. Mrs Elizabeth Margo is the Technical Assistant for the Gambian RBF program.
4. Dr Robert Soeters is the director of SINA Health and overall coordinator of the course.
5. Mrs Caroline Kere from Kenya assisted us with the daily organization.
6. Mr Tomasi assisted with logistics, staff recruitment, and events.

The "Village 70" authorities consisted of the Village Chief, Dr Abba Zakari UMAR ; the Deputy Village Chief, Mr Mannix NGABWE ; the Timekeeper, Dr Halima ABATE ; and the tax collector, Mrs Makasa NONDE. The energizers were Mr Ensa Jarju, Dr Baba, Mrs Sharon, Dr Abubakar, and Dr Tijjani. They actively supported the facilitation process and contributed to a congenial atmosphere while maintaining "order" in the village.

The daily evaluations produced scores comparable to previous English spoken courses. The **methods and facilitation** scores were 84.9%, 3% below the average of

the previous 22 English courses. The participation score of 87.5% was comparable to previous courses. Course organization in Mombasa scored 91.4%, 7% *above* the average of previous courses. **Timekeeping** scored 71.3%, 1% *below* the average of previous courses.

The final evaluation indicated that participants felt the course content related well to their regular professional activities. Participants were also satisfied with the methodology and organization. Participants rated the course module content much higher than in previous courses.

Some participants commented that facilitators should avoid dogmatism and acknowledge the importance of context-specific issues. Participants fully recognized the importance of respecting country-specific characteristics. At the same time, we consider open and comparative debate in an international forum, which stimulates out-of-the-box thinking, a vital characteristic of the course. In a multicultural setting, facilitation should indeed always try to understand cultural and country-specific sensitivities.

The course was organized around a strong core of ‘developing individual and country action plans’. This conscious focus began a few years ago, and with each course, we give more attention to the action plans. We plan to continue this approach, deepen the quality of individual or group action plans each time, and build the 17 course modules around this core task.

1.2 Country recommendations of the May 2018 Mombasa course

1.2.1 Nigeria NPHCDA

The Nigerian government - with financial support from the World Bank - started its NSHIP RBF program in 2011, with the aim of testing the innovative RBF approach in response to the poor national health indicators. By the end of 2018, NSHIP was supposed to cover approximately 13 million inhabitants. The RBF approach has seen encouraging results in Nigeria. Yet several key concerns remain about its design and sustainability.

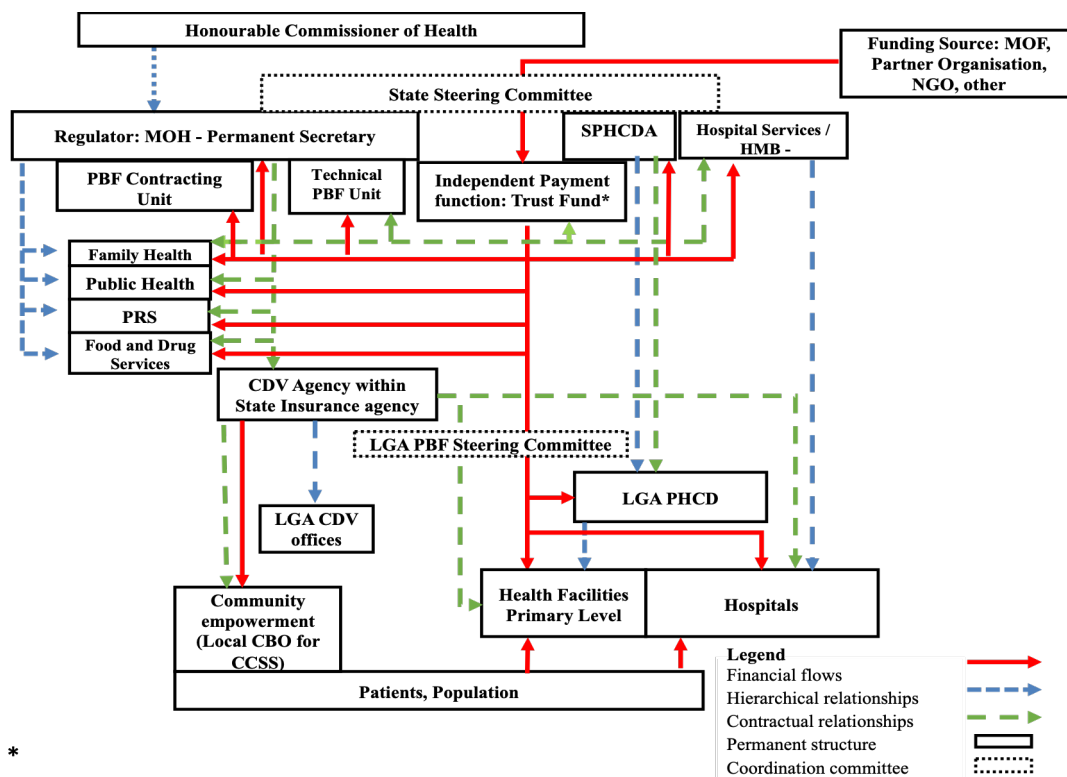
Problems

- So far, the World Bank has financed the RBF approach almost entirely, and this project funding will end by 2020. The approach's sustainability is therefore a challenge.
- The PBF Unit sits outside the MOH hierarchy, making it difficult to sustain the PBF approach, with little MoH buy-in and equally low interest from the hospital sector and Hospital Management Board agencies.
- There is also a lack of coordination between the WB-supported Save One Million Lives initiative and the PBF program, which is also supported by the World Bank. Both are output-based, but the SOML only puts the States under contract, leaving it up to them to meet the Disbursement Linked Indicator targets.
- The impact study that began with a baseline in 2012 proposed a research arm of the program, which would simply give money to health facilities without conditions, the so-called DFF approach, for comparison. This created problems of transparency, contamination, and crossover, which ‘spoiled’ that academic design. Firm conclusions are therefore hard to draw from the practical execution of this research.

- The administrative costs of the PBF approach in Nigeria are too high, with a multitude of actors; this while the regulatory and CDV agencies (in the NSHIP – AF states) are not yet under performance contracts;
- In the current NSHIP and AF-NSHIP design, the SPHCDA has both a role as the regulator (responsible for oversight of all primary facilities in a state) and as the unit that signs purchase contracts with health facilities (both primary and secondary). This confuses roles, and in practice, because of its specific positioning in the NPHCDA and SPHCDA, the PBF unit (called PIU in Nigeria) may not have the clout it needs to coordinate reform efforts.
- Overall, the feasibility scan score for most Nigerian teams under the current design is only 64%, while the proposed minimum is 80%. Design improvements are therefore necessary.

Recommendations:

For new States wishing to start PBF, propose the next institutional set-up.



- Positioning of the PIU at both National and State level within the MOH at an appropriate level, e.g. under the PS;
- Advocate for the CMVAs (CDV Agency) to take on the role of signing and coaching of the health facility contracts rather than the SPHCDA ;
- Finalize proposal on Community PBF to ensure that other incentives exist for the community;
- Remove the Ward Development Committee (WDC) chairman (and other community representative) from the health facility bank account;
- The project documents may also emphasize that health facilities can use other funds for infrastructure, while PBF subsidies should focus more on small rehabilitations, improving equipment, and, in general, quality improvements.

1.2.2 Kano State - Nigeria

Kano State, in northern Nigeria, has a population of 13.8 million. Private health facilities are concentrated in metropolitan areas. Despite years of government efforts and investments, delivering quality health care services remains a challenge: infrastructure is poor. Many facilities lack the required equipment or drugs to deliver basic health services. Facilities face an acute shortage of qualified manpower, and funds are insufficient to cater for basic needs. Key impact indicators such as under-5 mortality, assisted deliveries, and family planning coverage are far below the national average. The health system is unresponsive, inefficient, and inequitable. Resource leakages are mostly associated with public health services.

Recommendations:

- Kano State proposes a new reform approach, performance-based financing (PBF), starting in three LGAs covering 1 million people.
- The aim is to meet the Sustainable Development Goals (SDGs) whereby health facilities provide quality care. Both public and private providers will be contracted to target the population competitively. People entrusted with responsibility in the health system should be held accountable for their performance, work under contracts, and be compensated based on their performance.
- The pilot budget should be around 4 million USD per capita per year. With the ongoing reform and strengthening of health services, the State has a unique opportunity to introduce and finance PBF through the Kano Health Trust Fund Law and through the Saving One Million Lives project.
- The Kano State Contributory Health Care Management Agency is proposed to serve as the contract development and verification agency.
- The State has a pool of employable, qualified health personnel that health facilities could employ through the PBF approach.
- The institutional setup is shown in the NPHCDA report above. The PBF Unit will be situated at the State Ministry of Health with a State PBF Steering Committee and LGA validation committees.
- The PBF will apply best practices as much as possible, including autonomous management, competition for contracts, public-private partnerships, and equity instruments.
- Other problems such as the obligation to bank money in the Treasury Single Account, the central Medical Stores monopoly, and the procurement law for infrastructure need to be analysed and solutions found.

1.2.3 Jigawa State - Nigeria

Health indices in Jigawa State are among the worst in the country due to low investment in the health sector, ineffective health systems, and poor health-seeking behavior among the populace. Different health reform initiatives over the last 10 years have unfortunately been ineffective.

The State aims to implement PBF in response to these challenges.

Some key issues regarding the implementation of PBF

- The Treasury Single Account principle does not allow health facilities to control their own funds, which poses a serious problem for autonomous financial management;

- Human resource management is too centrally controlled. There should be more autonomous management of human resources, also for the contract staff;
- The procurement process for the inputs (drugs, consumables, equipment, etc.) is still based on central planning through the Central Medical Store. This creates frequent stock-out problems and the wasteful use of public resources;
- The financing source for the PBF program has not yet been decided upon;
- There are few private health facilities in the State;
- The 2019 election process may negatively influence the reforms.

Yet, there are also opportunities such as:

- The existence of the PBF know-how in the country;
- The committed Commissioner of Health may also promote PBF during the election process as a solution to improve health services.

Recommendations

- The Jigawa State action plan will focus on the design of a Performance-based financing pilot in 3 large LGAs, Gwaram, Kafin Hausa and Babura, covering a population of about 1 million people representing nearly 20% of the state population.
- The 1% consolidated revenue fund may be tapped into for funding PBF;
- The existence of the SOML funding that may be tapped, which could benefit future PBF funding;
- To conduct awareness creation meetings with various stakeholders during the 3rd week of June 2018
- To conduct an advocacy meeting with members of the State House of Assembly in the 4th week of June 2018
- To conduct a study tour with key stakeholders to Rwanda in July 2018.

1.2.4 Zamfara State – Nigeria

Zamfara State is in North-Western Nigeria and has a population of 4.8 million.

Problems

- The health system in the State is fragmented;
- Health facility autonomy is limited without competition in the procurement of essential drugs;
- There are few adequately skilled human resources;
- There is an unacceptably high level of maternal, neonatal, and child mortality;
- Health funding is limited, services are poorly utilized, and health care services are centralized.

Recommendations

- The State Ministry of Health proposes to initiate performance-based financing (PBF). The approach will be bottom-up and will be piloted in three Local Government Areas across the state (one per senatorial zone) and cover a population of about one million people;
- The current feasibility scan score is only 44%, and the team proposes to discuss the change issues at several levels with the aim of improving the design of the PBF approach, including from where to source the funds;
- An ambitious action plan has been presented in the detailed report.

1.2.5 Yobe State – Nigeria

Yobe is in the Northeastern part of Nigeria with 3.4 million people and 17 LGAs. 80% are poor subsistence farmers. The state's literacy level is 35%. On average, women give birth to 7 children during their reproductive lifespan. The median age at first marriage is 16.3 years, accounting for the high rates of teenage pregnancy and associated health problems. Yobe State has unacceptable health indices with an MMR of 1200 / 100,000. The contraceptive prevalence rate is only 3%.

Yobe started PBF in 2017 and will scale it up in 2018 to 10 LGAs. However, there are design problems, and the feasibility score is only 64%.

Problems:

- The State provides only USD 3 per capita per year for the PBF program. This needs to be around USD 6 per capita per year if the program is to successfully address the problems caused by political instability, dilapidated infrastructure, lack of equipment, and a very poor population.
- The SOML DLI approach is not linked to any PBF program, so it is problematic for the State to achieve the DLI targets.
- The regulatory institutions are not yet under performance contracts;
- There are no Quality Improvement Bonuses.

Recommendations

- Establish a PBF unit under the Office of the Hon Commissioner and establish a PBF coordinating unit in the office of the PS to sign contracts with the Directorates;
- Create legal and policy frameworks for provider autonomy to hire and fire staff;
- Decentralize the procurement of supplies by the health facilities from distributors operating in competition;
- Revise the business plans to include the Quality Improvement Bonuses;
- Review the law to allow government to directly fund private and public health facilities based on PBF principles and best practices;
- Sensitize the decision makers to mobilize PBF resources.

1.2.6 Zambia

The Ministry of Health of Zambia has been engaged in RBF for several years, but it has not yet established a national PBF unit. Four RBF projects financed by the World Bank, USAID, DFID, and SIDA are managed under 4 different departments. This creates coordination and resource-optimization challenges.

This may change, however, since at the beginning of 2018 the Government announced a shift from INPUT-based planning to OUTPUT-based planning. On this basis, the Zambia team proposes lobbying to integrate and establish a professional PBF Unit directly under the Permanent Secretary to better coordinate the different vertical RBF programs.

Main challenges

PBF principles stress the need to establish a PBF Unit, preferably at the decision-making level. PBF also emphasizes efficient and effective use of funds. However, this contrasts with the current situation in the Ministry of Health, where no unit is established, and efforts are duplicated due to vertical, fragmented project implementation.

In the current situation;

- There is *fragmentation of PBF interventions* depending on the source of funds (no resource pooling);
- *There is no standard approach to PBF.*

We estimate the feasibility score of the Zambia PBF programs at 32%.

Action points

- Debriefing of the (NTLP) and Partners in the concept of PBF
- Debriefing of the Permanent Secretary on the concept of PBF

One tough dimension will be convincing the PS and other stakeholders to set up a coordinated funding basket run by a central PBF Unit, rather than having project implementation units run in parallel. We also anticipate resistance from various donors in establishing a common funding basket. This could create conflict at different levels, including senior management at the Ministry of Health.

1.2.7 The Gambia

The Gambia is a small country on West Africa's coast with a population of 1.9 million. The Maternal Mortality Rate is high at 433 / 100,000, and the contraceptive prevalence rate is 9%. The total fertility rate is also high at 5.6. Wasting and stunting, but at the same time, overweight problems, are public health concerns.

Since 2014, The Gambia has run a World Bank-financed PBF pilot that currently covers 40% of the population. It is being implemented in 5 of the 7 health regions of the country, all of which are rural.

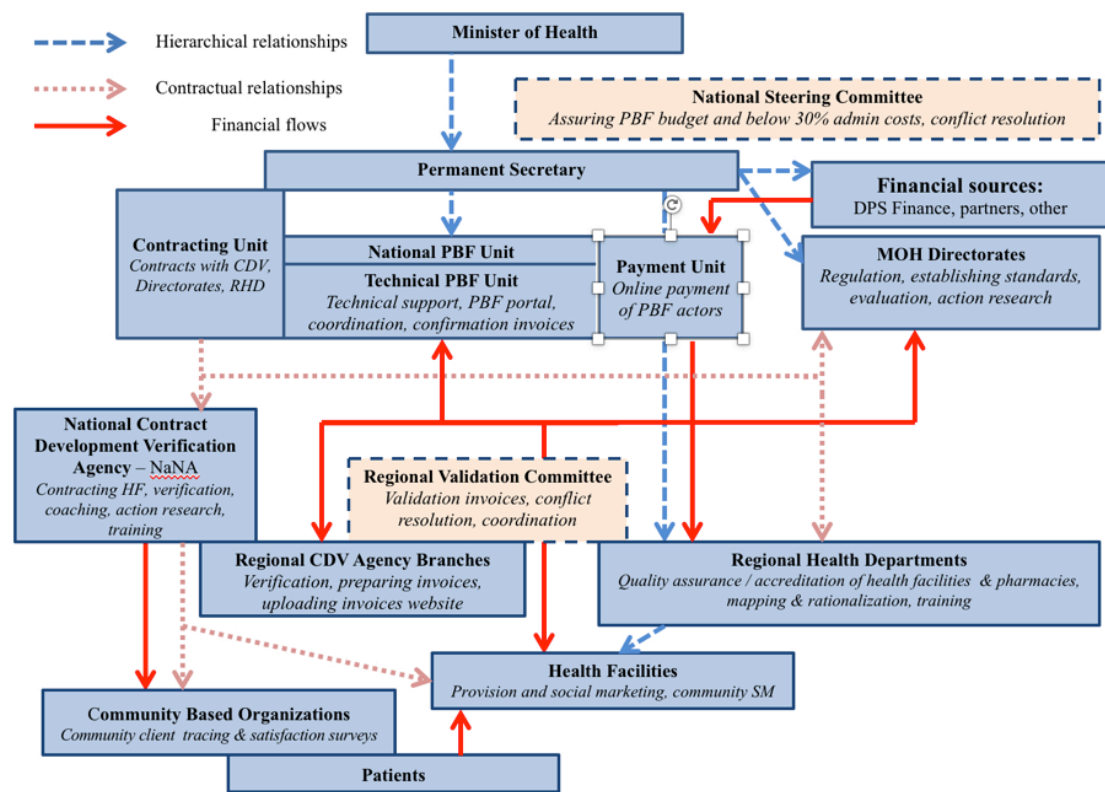
Problems

- The current PBF set-up does not yet promote full sustainability and buy-in by the Ministry of Health.
- Health facilities in urban areas are not included, nor are private and faith-based health facilities.
- Based on the report of the NaNA coordinator who attended the PBF course in 2016, the Mid Term Review of early 2018, and the report of the group that came to the June 2018 Mombasa course, it is clear that there is a need to make the PBF health reform approach more sustainable by bringing the PBF Unit within the MOH.
- The MoHSW is both the Regulator and the CDV, which is not recommended for transparency reasons;
- NaNA also doubles its role as a fundholder and performs the CDV role
- The Regional Health Department is contracted by both NaNA and the MoHSW.
- Health facility business plans are reviewed by three institutions: a. The Region; b. the PHC Unit in the MoHSW an; and c. the NaNA project staff. This confuses facility staff and delays contract negotiation and signing.
- Health facility user fees are paid into a central account of the Treasury Department instead of into a commercial bank account of the health facilities
- Too few indicators are used at both the primary (15) and hospital (6) levels, while at least 25 are required for each level.

Recommendations

- Strengthen health facility autonomy through the business plan and application of the indices management tool;

- Promote the buy-in from the MoHSW for PBF and develop a strategy on how the PBF approach may be institutionalized through a PBF Unit at the MoHSW, developing CDV Agencies and introducing QIB Officers;
- Ask the National Nutrition Agency for support in engaging with the senior management of the Ministry of Health.
- Increase the scope of complimentary health indicators in the primary and hospital packages to a minimum of 25 per package;
- Reduce the verification costs for community RBF;
- Introduce the contracting of the regulator for timely implementation of recommendations, and pro-activeness;
- Allow health facility managers to use funds generated from user fees to improve service quality.



1.2.8 Ethiopia

Ethiopia is the second most populated country in Africa with 102 million inhabitants. Health service delivery and indicators in Ethiopia have been improving over the last 25 years. Yet there are still important caveats, such as the fact that 1 in 3 children are chronically malnourished and that the MMR is high, with 412 per 100,000 live births. Health services also face unequal challenges, with pastoral areas particularly lagging, and health care provision remains basic; in many cases, services are of poor quality.

Therefore, the next phase of improvement will require more investments. That is, if the country wishes to move beyond the basic level of primary care, largely provided by community-based health extension workers, to fully functional primary health facilities and hospitals with skilled health care providers equipped to handle life-threatening conditions, and an effective referral mechanism.

Under the Health Sector Transformation Plan, the Federal Ministry of Health addresses Universal Health Coverage (UHC) as a key component, aiming to provide coverage for all essential health services for everyone without financial hardship. As part of this overall strategy, Performance-based financing (PBF) is mentioned in the HSTP chapter on efficiency and in the draft Health Financing Policy.

Why apply PBF in Ethiopia?

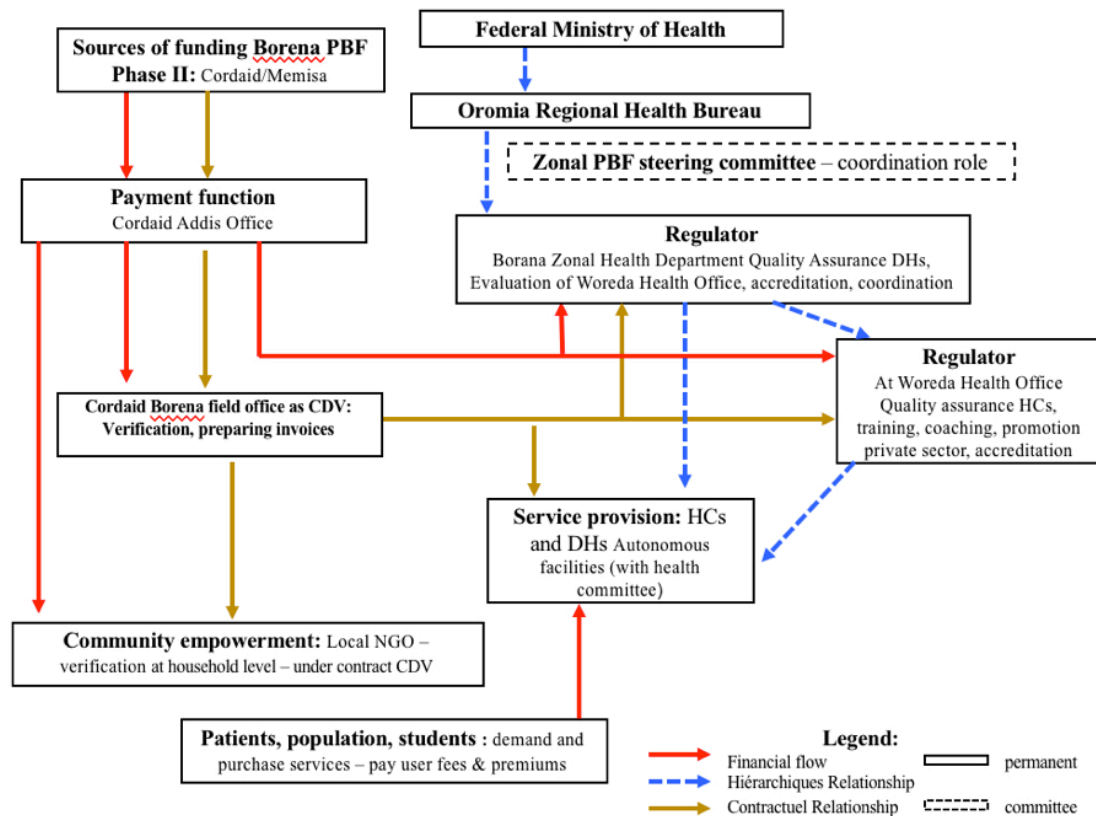
Cordaid has implemented a showcase PBF project since 2015 in Borena Zone, Oromia Region, serving a population of 186,000, with encouraging results. The PBF approach offers several angles for improving service quality, and several equity instruments can be applied if resources are available. Yet, PBF also emphasizes efficiency, aiming to make better use of scarce public resources through competitive contracting, accreditation of health facilities and pharmacies, public-private partnerships, and fostering a group spirit in health facilities by sharing profits through performance bonuses. HMIS also improves through a robust PBF verification and validation system. Performance contracts are also introduced for regulatory authorities at all levels and for CDV Agencies and Community-Based Organizations.

Challenges

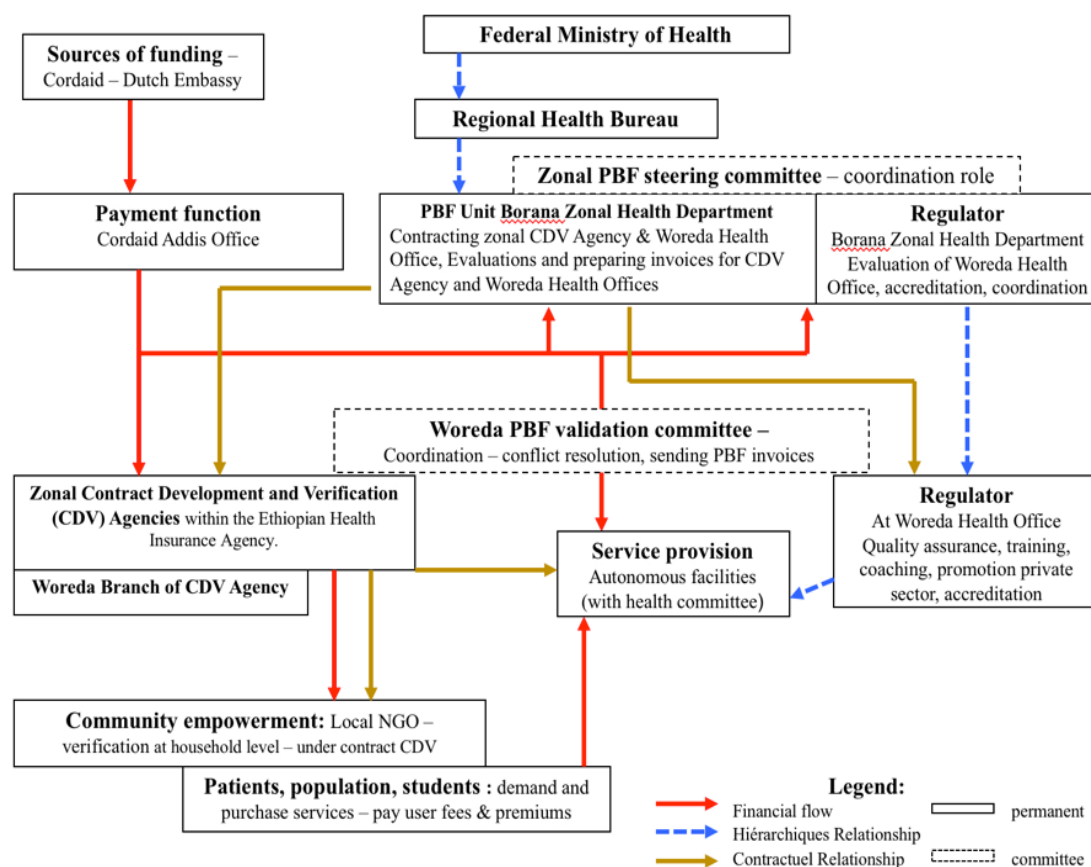
The institutional design of the Cordaid PBF pilot is still project-based, although it works closely with the Oromia Regional Health Bureau, Zonal Health Departments, and Woreda Health Offices, and it does not yet propose a setup that involves government institutions and the national health insurance company.

Recommendations

- To scale up and link PBF to the country's health sector transformation plan, further evidence is needed. This may become a joint responsibility between the Oromia Regional Health Bureau, the Borena Zonal Health Department, the districts (Woreda), and the Health Offices of Borena. The rollout in Borena is intended to include 8 districts to cover a population of around 488,556;
- Establish a PBF unit within the Federal Ministry of Health to oversee the overall implementation process of PBF initiatives in Ethiopia.
- The following institutional setup for the Cordaid Phase 2 scale-up is proposed :



- The Oromia Regional Health Bureau must approve the scale-up financed by Cordaid ;
- The Cordaid Addis Ababa office will serve as the Payment Agency for the PBF project and will continue during Phase 2 of the pilot. Once PBF in the future may become national policy, other payment agencies may also start playing this role;
- The Zonal Contract Development and Verification Agency may be played by the Cordaid sub-office in Yabello town, but this role may be transferred to the Ethiopian Health Insurance Agency (EHIA) in the future.
- The Mombasa group's action plan includes several workshops to advance scale-up, conduct exposure visits, and train frontline champions in PBF.
- The institutional set up for a possible future national PBF program may be as follows:



2. RESUME

Le 70^e cours de financement basé sur la performance (PBF) s'est déroulé du lundi 28 mai au vendredi 8 juin 2018 à Mombasa, au Kenya. Trente et un participants ont assisté au cours : 16 du Nigeria, 6 de la Zambie, 5 de l'Éthiopie, 3 de la Gambie et 1 des États-Unis. Les groupes ont analysé leurs systèmes de santé et ont élaboré des plans d'action détaillés pour faire progresser le FBP dans leurs pays, États et régions respectifs. Trente participants ont passé l'examen final et ont obtenu un score moyen de 70 %, dont trois distinctions. C'était notre premier cours au Traveller's Hôtel, 4 étoiles, qui s'est avéré être une amélioration. La plage de la côte nord de Mombasa reste attrayante pour un cours, et la collaboration avec l'entreprise Tomasi s'est concrétisée par un véritable partenariat logistique, contribuant considérablement à une organisation harmonieuse et à une plus grande appropriation par le Kenya de la mise en œuvre du cours.

2.1 Observations sur le cours PBF de Mombasa et son évaluation

Les évaluations journalières ont donné des scores comparables à ceux des précédents cours d'anglais. Les scores de la méthodologie et de la facilitation étaient de 84,9%, soit 3% de moins que la moyenne des 22 cours d'anglais précédents. Le score de satisfaction, avec un taux de participation de 87,5 %, était comparable à celui des cours précédents. La satisfaction concernant l'organisation du cours à Mombasa, de 91,4%, était supérieure de 7% à la moyenne des cours précédents. Le sujet du respect du temps a obtenu 71,3%, soit 1% de moins que la moyenne des cours précédents.

L'évaluation finale a indiqué que les participants estimaient que le contenu du cours correspondait bien à leurs activités professionnelles habituelles. Les participants étaient également satisfaits de la méthodologie et de l'organisation. Le contenu des modules de cours a été mieux apprécié, avec des scores plus élevés que ceux des cours précédents. Certains participants ont indiqué que les facilitateurs devraient éviter le dogmatisme et reconnaître l'importance du contexte propre à chaque pays. La question du respect des spécificités propres à chaque pays est pleinement reconnue. Dans le même temps, nous considérons que le débat ouvert et comparatif au sein d'un forum international stimule une réflexion originale et constitue une caractéristique essentielle du cours. Dans un contexte multiculturel, la facilitation devrait en effet toujours chercher à comprendre les sensibilités culturelles propres à chaque pays.

Le cours était organisé autour de l'élaboration de plans d'action individuels et de groupe. Ce focus sur les plans d'action a commencé il y a quelques années et, à chaque cours, a reçu une attention croissante. Nous prévoyons d'avancer dans cette voie, d'améliorer la qualité des plans d'action individuels ou collectifs à chaque fois, et de construire les 17 modules de cours autour de cette tâche principale.

2.2 Recommandations spécifiques par pays

2.2.1 Nigéria NPHCDA

Le gouvernement nigérian - avec le soutien financier de la Banque mondiale - a lancé son programme de financement basé sur les résultats en 2011, afin de tester l'approche innovante du FBR face à des indicateurs nationaux de santé médiocres. À la fin de 2018, le programme devrait couvrir environ 13 millions d'habitants. L'approche RBF a donné des résultats encourageants au Nigéria. Pourtant, il existe un certain nombre de préoccupations clés concernant la conception et sa durabilité.

Recommandations

- Pour les nouveaux États souhaitant démarrer le PBF, les participants au cours ont proposé une nouvelle organisation institutionnelle qui positionne la Cellule PBF au niveau national et au niveau de l'État, au sein du ministère de la Santé, à un niveau approprié, par exemple. sous le secrétaire général ;
- Finaliser la proposition sur le PBF communautaire pour s'assurer que d'autres incitations existent pour la communauté ;
- Les documents du projet peuvent également souligner que les établissements de santé peuvent utiliser d'autres fonds pour l'infrastructure, tandis que les subsides PBF devraient plutôt se concentrer sur de petites réhabilitations, l'amélioration de l'équipement et, en général, l'amélioration de la qualité.

2.2.2 L'État de Kano

Recommandations

- L'État de Kano, qui compte 13,8 millions d'habitants, propose une nouvelle approche de réforme, à savoir le financement basé sur la performance (PBF), dans trois LGA qui couvrent un million de personnes.
- L'objectif est d'atteindre les objectifs de développement durable (ODD) en veillant à ce que les établissements de santé fournissent des soins de qualité.
- Les structures publiques et privées seront recrutées afin de cibler la population de manière compétitive.
- Les personnes chargées de la responsabilité dans le système de santé devraient être tenues responsables de leurs performances et devraient travailler sous contrat et être rémunérées en fonction de leurs performances.
- Le budget du projet pilote devrait être d'environ 4 millions USD par habitant et par an. Avec la réforme en cours et le renforcement des services de santé, l'État a une occasion unique d'introduire et de financer le FBP par le biais de la Loi sur le Fonds Fiduciaire de Santé de Kano et du projet Saving One Million Lives.
- L'Agence de gestion des soins de santé contributive de l'État de Kano est proposée pour servir d'Agence de Contractualisation et de Vérification.
- Il existe dans l'État un réseau de personnel de santé qualifié et employable, que les établissements de santé pourraient employer à travers l'approche PBF.
- La Cellule PBF sera située au ministère de la Santé de l'État avec un Comité de Pilotage PBF et des comités de validation au niveau des Autorités Gouvernementales Locales (LGA).
- Les meilleures pratiques PBF seront appliquées autant que possible, notamment par une gestion autonome des formations sanitaires, la mise en concurrence des contrats, les partenariats public-privé et les instruments d'équité PBF.
- D'autres problèmes, tels que l'obligation de déposer de l'argent sur le Compte Unique du Trésor, le monopole de la centrale d'achat des médicaments et la loi sur les marchés publics pour les infrastructures, doivent être analysés et des solutions trouvées.

2.2.3 L'État de Jigawa

L'État vise à mettre en œuvre le FBP face à de multiples défis.

Recommandations

- Le plan d'action de l'État de Jigawa se concentrera sur la conception d'un projet pilote de financement basé sur la performance dans 3 grandes LGA : Gwaram,

Kafin Hausa et Babura, couvrant une population d'environ 1 million de personnes, soit près de 20 % de la population de l'État.

- Le fonds consolidé de 1% peut être utilisé pour financer le PBF ;
- L'existence du financement de la SOML qui pourrait être utilisé, ce qui pourrait profiter au financement futur du PBF ;
- Organiser des rencontres de création de sensibilisation avec divers intervenants au cours de la 3e semaine de juin 2018 ;
- Organiser une réunion de plaidoyer avec les membres de la chambre d'assemblée de l'État 4ème semaine de juin 2018 ;
- Organiser un voyage d'étude avec les principales parties prenantes au Rwanda en juillet 2018.

2.2.4 État de Zamfara

L'État est situé au nord-ouest du Nigeria et compte 4,8 millions d'habitants.

Recommandations

- Le ministère de la Santé de l'État propose d'adopter l'approche de financement basé sur la performance (PBF). L'approche sera ascendante et sera pilotée dans trois zones de gouvernement local (LGA) et couvrira une population d'environ un million de personnes ;
- Le score de l'analyse de faisabilité actuelle est seulement de 44% et l'équipe propose de discuter des problèmes de changement à plusieurs niveaux dans le but d'améliorer le montage de l'approche PBF, y compris l'endroit où trouver les fonds
- Un plan d'action ambitieux a été présenté dans le rapport détaillé.

2.2.5 L'État de Yobe

Yobe est dans le nord-est du Nigeria et compte 3,4 millions d'habitants. L'état de Yobe présente des indicateurs de santé inacceptables, avec un taux de mortalité maternelle de 1 200 pour 100 000. Le taux de prévalence contraceptive n'est que de 3 %. Yobe a démarré en 2017 avec le PBF, qui sera étendu en 2018 à 10 LGA. Cependant, il y a des problèmes de conception et le score de faisabilité n'est que de 64%.

Recommandations

- Mettre en place une Cellule Technique PBF de l'État sous le bureau du Ministre et établir une unité de contractualisation du FBP au bureau du Secrétaire Général pour signer des contrats avec les directions ;
- Créer des cadres juridiques et politiques pour l'autonomie des structures de santé afin d'embaucher et de licencier le personnel ;
- Décentraliser davantage les achats des inputs par les établissements de santé auprès des distributeurs opérant en concurrence ;
- Réviser les plans d'affaires pour inclure les bonus d'amélioration de la qualité ;
- Revoir la loi pour permettre au gouvernement de financer directement les établissements de santé privés et publics sur la base des principes et des meilleures pratiques du PBF ;
- Sensibiliser les décideurs à la mobilisation des ressources du PBF.

2.2.6 Le Zambia

Le ministère de la Santé de la Zambie est engagé dans le FBR depuis plusieurs années, mais aucune Cellule Technique PBF nationale n'a encore été établie. Quatre projets FBR, financés par la Banque mondiale, l'USAID, le DFID et le SIDA, sont gérés par 4 départements différents. Cela pose un défi de coordination et d'optimisation des ressources.

Cela pourrait avoir changé depuis que le gouvernement a annoncé, au début de 2018, le passage de la planification basée sur les *inputs* à celle basée sur les *outputs*. C'est sur cette base que l'équipe zambienne propose de faire pression en faveur de l'intégration et de la mise en place d'une Cellule Technique PBF, placée directement sous la responsabilité du Secrétaire Permanent, afin de mieux coordonner les différents programmes verticaux de FBR.

2.2.7 La Gambie

La Gambie est un petit pays d'Afrique de l'Ouest avec une population de 1,9 million d'habitants. Depuis 2014, la Gambie a lancé un projet pilote PBF financé par la Banque mondiale, qui couvre actuellement 40 % de la population.

Recommandations

- Promouvoir l'adhésion du MoHSW au PBF et développer une stratégie sur la manière dont l'approche PBF peut être institutionnalisée à travers une Cellule PBF au MoHSW, une Agence de Contractualisation et de la Vérification autonomes et l'application des Bonus d'Amélioration de la Qualité ;
- Demander à l'Agence NaNA son soutien pour s'engager auprès de la direction du ministère de la Santé ;
- Augmenter la portée des indicateurs de santé de Paquets d'Activités au niveau primaire et au niveau hospitalier ;
- Réduire les coûts de vérification pour le FBR communautaire ;
- Signer des contrats de performance avec les régulateurs à tous les niveaux pour la mise en œuvre des activités ;
- Permettre aux gestionnaires des établissements de santé d'utiliser les fonds générés par le recouvrement des coûts pour améliorer la qualité des services.
- Renforcer l'autonomie des formations sanitaires dans l'application des plans d'affaires et de l'outil de gestion des indices.

2.2.8 L'Éthiopie

L'Éthiopie est le deuxième pays le plus peuplé d'Afrique avec 102 millions d'habitants. Le Ministère fédéral de la Santé, dans le cadre du plan de transformation du secteur de la santé, considère la couverture maladie universelle (CSU) comme un élément clé pour garantir à toutes les personnes, sans contrainte financière, l'accès à l'ensemble des services de santé essentiels. Dans le cadre de cette stratégie globale, l'approche de financement basé sur la performance (PBF) a été adoptée comme stratégie pour assurer l'amélioration de la qualité.

Le montage institutionnel du projet pilote PBF de Cordaid, qui a donné des résultats encourageants, reste basé sur une approche « projet » et ne propose pas encore d'organisation impliquant les institutions gouvernementales ainsi que la compagnie nationale d'assurance maladie.

Recommandations

- Mettre en place une unité PBF au sein du Ministère fédéral de la Santé pour superviser l'ensemble du processus de mise en œuvre des initiatives PBF en Éthiopie.
- Pour étendre et relier le PBF au plan de transformation du secteur de la santé du pays, des preuves supplémentaires sont nécessaires. Cela peut devenir une responsabilité conjointe entre le Bureau Régional de Santé d'Oromia, le Département de Santé de la Zone de Borena et les districts (woredas). Le projet pilote plus large devrait inclure neuf districts pour couvrir une population d'environ 581 000 habitants ;
- Le bureau régional de santé d'Oromia doit approuver la mise à l'échelle financée par Cordaid et l'ambassade des Pays-Bas ;
- Le nouveau projet à grande échelle peut inclure un comité de validation pour l'orientation générale ;
- L'agence de paiement pour le projet PBF est le bureau d'Addis Abeba de Cordaid, uniquement pendant cette phase pilote. Une fois que le FBP deviendra une politique nationale à l'avenir, d'autres organismes de paiement devraient également commencer à jouer ce rôle ;
- L'agence de la contractualisation et de la vérification de la zone peut être assurée par le bureau de Cordaid dans la ville de Yabello, mais à l'avenir (proche), ce rôle pourrait être transféré à l'Agence éthiopienne d'assurance maladie (EHIA).
- Le plan d'action du groupe Mombasa comprend plusieurs ateliers pour faire progresser la mise à l'échelle, organiser des visites d'exposition et former les champions de première ligne du PBF.

3. INTRODUCTION

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

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

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

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

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

3.2 Aims and objectives of the Mombasa PBF course

General aims of the PBF course

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

Specific Objectives

- To reach a critical mass of people who want to be change agents, are looking for tools for improvement, and who – once they understand their roles – can be implementers, advocates, and guides in executing performance-based financing.
- To help participants understand the relationships between health and national economic policies, the potential for economic multiplier effects, and how performance-based financing influences them.
- To help participants master the objectives, theories, best practices, and tools relevant to implementing performance-based financing.

3.3 The May 2018 Mombasa course

The 70th group consisted of a mix of people with varied implementation experience in PBF across Africa (Zambia, Nigeria, various states and federal, Ethiopia, and The Gambia), as well as one person from the USA.

Throughout the course, the participants were assigned to develop a “business or action plan”, following a number of steps: (a) Elaboration of the country background of the particular PBF initiative; (b) Analysis of specific PBF implementation challenges through the application of the PBF feasibility scan of module 9; (c) Develop an action plan for the participants and country groups on how to tackle the various problems identified, following the logic of the PBF modules.

The updated course guidebook, “PBF in Action: Theory and Instruments,” was distributed to participants before the program started, upon confirmation of participation. The course materials (a hard copy of the course book, PDF of the latest version of the course manual, the PowerPoint presentations and country presentations, photos of the course, and articles) were distributed during the course, together with the participants’ contact details list. On Tuesday, June 5, 2018, field excursions were organized to four health facilities: Mtwapa Health Center, Kadzinuni Dispensary, Vipingo Health Center, and Kilifi County Hospital.

3.4 The final exam, adult learning, and accreditation

SINA Health issues a Certificate of Merit to those who pass the exam at the end of the course. Those who score 57% or more receive a Certificate of Participation. The exam was conducted on Friday, June 8th, from 8.30 am and consisted of 30 multiple-choice questions tailored to the main subjects covered during the course.

The average score was 70%. Participants receive distinctions for scores of 90% or more, and we also mention those with 87%.

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

With 97% - 1 mistake

Mrs Lara Tembey, NPHCDA Abuja, Nigeria

With 93% - 2 mistakes

Dr Abba Umar Zakari, Commissioner of Health for Jigawa State, Nigeria

With 90% - 3 mistakes

Dr Noel Chisaka, Senior Health Specialist, World Bank USA

3.5 Who attended the May – June 2018 PBF course?

Sixteen from Nigeria; 6 from Zambia; 5 from Ethiopia; 3 from The Gambia; and 1 from the USA.

The list of participants to the 70th PBF course of June 2018

SURNAME	Name	Position	Sex	Organisation	Country	Prov - State - Region
ABATE	Halima	MD - Senior Expert	f	Ethiopian Health Insurance Agency	Ethiopia	Addis Abeba
DEREJE	Abdissa	RHB Quality and Equity Team Leader	m	Ministry of Health	Ethiopia	Oromia
FIKREMARIAM	Gezaheng	Public Health Manager	m	Cordaid	Ethiopia	Addis Abeba
GELLA	Zenebach	Master Public Health	f	Ministry of Health	Ethiopia	Addis Abeba
KEBEDE	Mesfiu	Resource Mobilization Coordinator	m	Fed Ministry of Health	Ethiopia	Addis Abeba
DARBO	Lamin	Program Management Officer	m	NANA	Gambia	Banjul
ENSA	Jarju	Nurse - Program Man Off	m	NANA	Gambia	Banjul
NJIE	Baba	Nurse Program Man Off	m	NANA	Gambia	CRR
ALIYU	Kabir Ibrahim	MD Exec Secretary	m	Jigawa State PHCMB	Nigeria	Jigawa
ALKALI	Gaji Ali	MD - Director Planning Research and	m	Yobe State Ministry of Health	Nigeria	Yobe
BELLO A.	Anka	Director of Planning Research and Stat	m	State Ministry of Health	Nigeria	Zamfara
CHAFE	Sabit Magaji	MD - SOML State Program Manager	m	Zamfara State Ministry of Health	Nigeria	Zamfara
DANLADI SAID	Abubakar	MD - SOML State Program Manager	m	State Ministry of Health	Nigeria	Jigawa
GETSO	Kabiru Ibrahim	MD - Hon Commissioner of Health	m	Kano State Ministry of Health	Nigeria	Kano
HUSSAINI	Tijjani	MD - Director Public Health	m	Kano State Ministry of Health	Nigeria	Kano
LIMAN	Lawal	Hon Comm of Health	m	SMOH	Nigeria	Zamfara
MIJINYAWA	Halima Mohammed	MD Exec Secretary	f	Kano Contributory HC Man Agenc	Nigeria	Kano
MOHAMMED	Kabiru Ahmed	PHC Manager	m	SPHCDA Jigawa	Nigeria	Jigawa
MUHAMMAD	Usman Bala	Permanent Secretary	m	Kano State Ministry of Health	Nigeria	Kano
MUHAMMAD YELWA	Habibu	MD	m	State Ministry of Health	Nigeria	Zamfara
MUKTAR	Shettima	Director of Planning Research and Stat	m	Yobe State PHCMB	Nigeria	Yobe
MUSA	Yusuf A.	Executive Secretary	m	SPHCDB	Nigeria	Zamfara
TEMBEY	Lara	Economist - ODI Fellow	f	National PHCDA	Nigeria	Abuja
UMAR	Abba Zakari	MD - Hon Commissioner of Health	m	Jigawa State MOH	Nigeria	Jigawa
CHISAKA	Noel	Senior Health Specialist	m	World Bank	USA	Washington
CHIPASHA	Francis	Planner	m	Ministry of Health	Zambia	Lusaka
MULENGA	Grant	Adminsitrator - M&E	m	Ministry of Health	Zambia	Lusaka
MUSAKANYA	Sharon	Clinical Officer TB coordinator	f	Ministry of Health	Zambia	Kitwe
MWEENE	Confucius	Social Worker	m	Ministry of Health	Zambia	Lusaka
NGABWE	Mannix	Principal Planner - Budget	m	Ministry of Health	Zambia	Lusaka
NONDE MULENGA	Makasa M.	Accountant	f	Ministry of Health	Zambia	Lusaka

3.6 Facilitation team

The facilitation team consisted of:

1. Dr. Godelieve van Heteren, MD, Public Health Specialist with a long medical career, Member of the Dutch Parliament, Director of Cordaid, and currently working as a senior health systems and governance consultant for WHO.
2. Dr. Fanen Verinumbe, A medical doctor and PBF consultant at the National PBF Unit in Nigeria
3. Mrs Elizabeth Mago, Technical Assistant in the Gambian RBF program
4. Dr. Robert Soeters, MD, PhD, Director, SINA Health - chief course facilitator
5. Mrs Caroline Kere, Logistical Assistant from Kenya

4. DAILY EVALUATIONS BY PARTICIPANTS

4.1 Daily evaluations by participants

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

1. Methods & facilitation;
2. Participation;
3. Organization;
4. Timekeeping.

The overall average score for the four criteria combined was 83,8%. This is 0,4% above the previous 22 English-spoken courses and 4,9% above the 40 previous French-spoken courses.

Daily evaluation topics as scored for 10 days	French speaking courses (40x)	English speaking courses (22x)	Mombasa June 2018	Comparison Mombasa June 2018 / Previous English courses	Comparison Mombasa June 2018 / Previous French courses
Methodology and facilitation	84,5%	87,5%	84,9%	-2,6%	0,4%
Participation	82,0%	87,5%	87,5%	0,0%	5,5%
Organization	73,6%	86,0%	91,4%	5,4%	17,8%
Time – keeping	75,3%	72,6%	71,3%	-1,3%	-4,0%
Overall score	78,9%	83,4%	83,8%	0,4%	4,9%

Table 1: Overall daily evaluation scores of the course.

4.2 Methods and facilitation

Methods and facilitation scored 2,6 percent lower (84,9%) than the previous English courses (87,5%) and 0,4% above the average of the French-spoken courses (84,5%). Satisfaction with the methods and facilitation was lower during the first two days compared to the rest of the course.

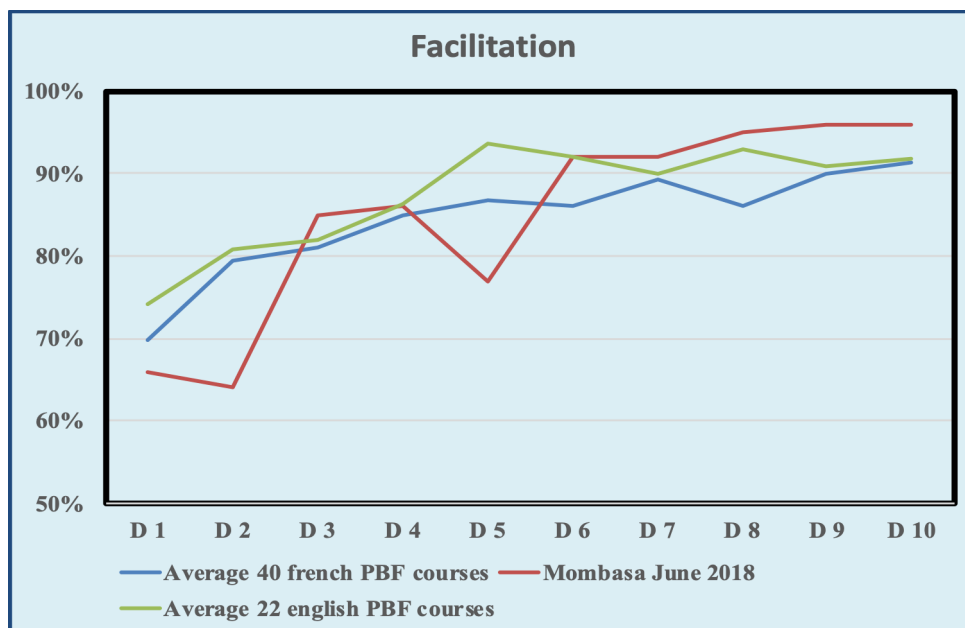


Figure 1: Evolution of the daily evaluations: *methods and facilitation*.

4.3 Participation

The satisfaction with the level of **participation** was 87,5%. This is like the previous English courses (87,5%) and 5,5 percent above the French courses (82,0%). This score is satisfactory. Satisfaction with participation was better during the second week.

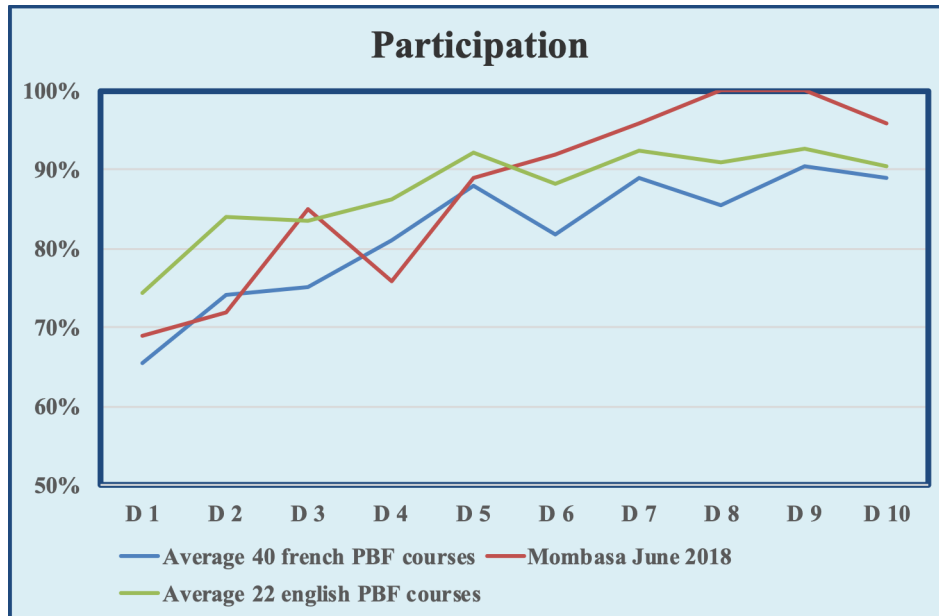


Figure 2: Evolution of the daily evaluation: *participation*.

4.4 Organization

The **course organization** in Mombasa had an average score of ‘very positive or positive’ of 91,4%, which is 5,4% *above* the average of 86,0% for previous English courses and 17,8% *above* the average of 73,6% for previous French courses.

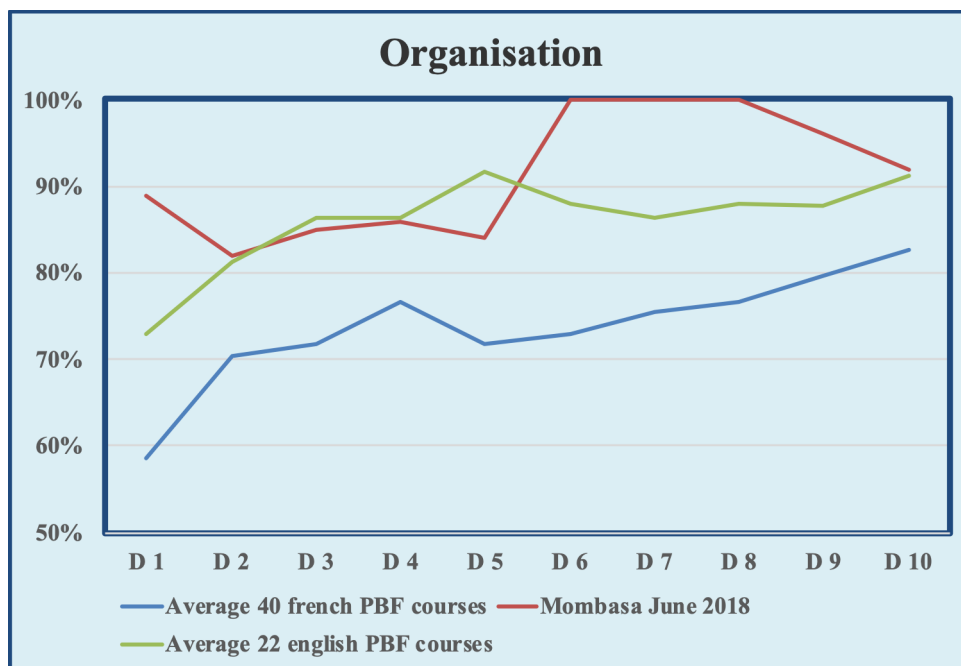


Figure 3: Evolution of the daily evaluation: *organization*.

4.5 Time keeping

Satisfaction with time keeping was 71,3%, which is 1,3% *below* the previous English courses and 4% below the French courses.

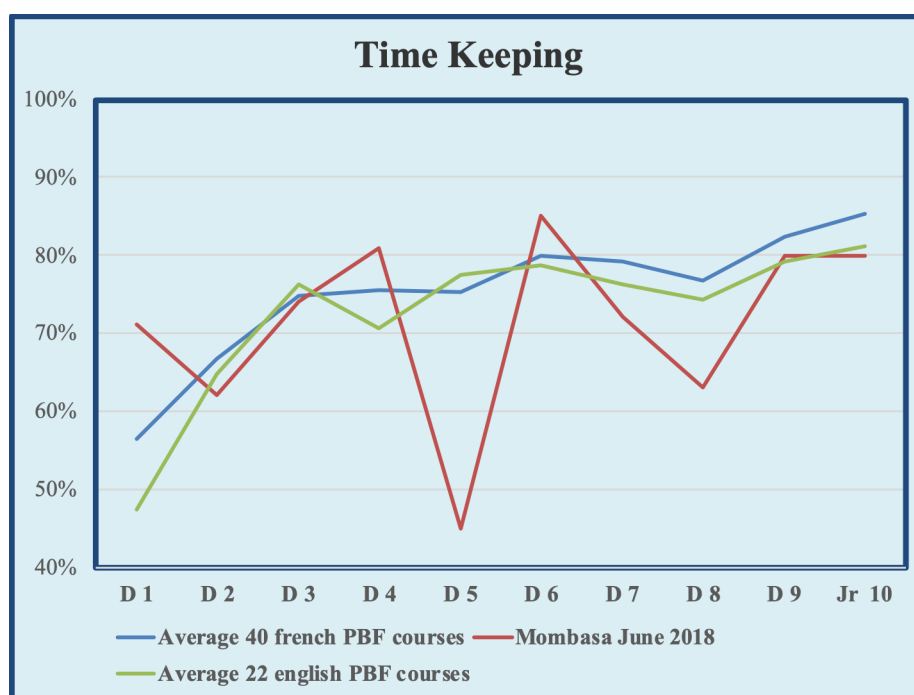


Figure 4: Evolution of the daily evaluation: *time keeping*.

5. DESCRIPTION of the COURSE

Arrival day: Sunday, May 27th, 2018

A total of 31 participants from 4 African countries (Nigeria, Ethiopia, Zambia, and The Gambia) and the USA arrived and were welcomed to the 70th International PBF course held in Mombasa, Kenya.

Participants came from various ministries of health, government parastatals, the government health insurance sector, and donor agencies. Delegates included officials from the national, state, regional, and district levels, as well as some high-level decision-makers. Most participants from the Nigerian States and the Zambia Ministry of Health (TB program) had not implemented PBF before and were considering starting new PBF programs.

Participants from some Nigerian states, Ethiopia, and The Gambia had some experience implementing PBF at different levels and needed to better understand PBF and refine their PBF designs for scale-up and increased government ownership.

The workshop began with PBF manuals distributed to participants on arrival. Pre-questionnaires were also distributed on arrival to enable facilitators to quickly understand participants' specific needs before the course began and tailor the content and discussions accordingly.

Hotel staff and facilitators welcomed participants on arrival and helped them settle in, addressing all logistical issues. During the course, participants prepared daily recaps in pairs. Participants captured, summarised, and presented key messages from the previous day each morning, with clarifications provided in response to questions.

Evening sessions with country groups were organized, allowing one-on-one dialogue with facilitators to understand country specifics, including challenges and the way forward on action plans. While the first encounter during the evening sessions aimed to understand each country's specific context and support countries in developing draft plans, the second encounter and the second week focused on refining and finalizing them. This gave more time for technical assistance to be tailor-made and provided to these plans, making the course more relevant to each participant.

Monday May 28th

At 9:00 am, Elizabeth welcomed the participants to the 70th PBF International SINA Health course. Participants introduced themselves, sharing their name, country of origin, designation, key expectations, and fears. Most participants (16) were from Nigeria, Gambia (3), Ethiopia (5), Zambia (6), and the World Bank (1).

Participant expectations ranged from being eager to learn and apply what they will learn; sharing their experience and implementation knowledge; to getting technical guidance to develop/refine their PBF frameworks. Participants' fears ranged from their ability to apply the technical knowledge when they return, to their ability to influence the 'other' decision makers to adopt PBF.

The training methodology was presented, with emphasis on adult learning techniques and the need for participants to define their 'own learning', participate, and share knowledge.

The ‘village chief’ and officials were elected to help facilitators maintain the ground rules during the workshop. The following were the Mombasa 70th village officials:

Chief: Dr. Abba Umar Zakari

Deputy Chief: Mannix Ngabwe

Timekeeper: Dr. Halima Abate

Treasurer: Ms. Makasa;

Energizers: Ensa Jarju, Dr. Baba, Mrs Sharon, Dr. Abubakar, Dr. Tijjani

The pre-test established participants' level of knowledge of PBF. Participants were then divided into working groups and sent off to their first course assignment (identifying the challenges of their health systems).

Next, Fanen presented Module 2, PBF in context: history, definition, and best practices. This generated a lot of discussion, as expected, since most participants were from the policy arena. The day ended at 16:30 with the ‘official’ crowning of the elected village chief, Dr. Abba Umar Zakari, who was also selected as the best debater of the day.

Tuesday May 29th

Day 2 started at 8:30 with the daily recap made by Dr. Halima Abate (Ethiopia) and Confucious Mweene (Zambia) of the previous day.

Module 3 on PBF best practices and change topics was presented, and the Turning Point Questions (TPQs) generated interesting discussions. Adequate time was given to these discussions, allowing participants to understand the basic principles of PBF and identify areas where they perceive the change to be “difficult”.

The day ended at 16:30 with the daily evaluation and the selection of the best debater of the day.

Wednesday May 30th

The day started at 8:30 with a recap and summary of important points from Day 2 activities, facilitated by Robert. Module 4 on PBF theories (systems analysis, public choice, contracting, decentralization and governance) was presented. Participants’ contributions centered on the extent to which governments are willing to make health facilities ‘autonomous’ in PBF, considering existing national policies that may oppose this. The rationale for autonomy, decentralization, promoting competition, and public-private partnership was explained and debated at length.

Because the PBF theory presentation generated divergent views, comments, and perceptions that required a mind-shift toward PBF thinking, each participant was tasked with drawing a picture of him/herself, typically depicting him/herself as a “change agent”. Participants revisited these pictorial drawings as the course unfolded. Some depicted themselves as bold and daring; others as good listeners and calculative; and others as peaceful and introverted.

An introduction to the microeconomics module (module 5A) then followed. Basic economic principles, as a foundation for understanding how markets operate, were presented, and the health care market was also presented. Most economic terms and principles were new to participants, so participation was low, and more time was needed to explain and clarify issues.

The session closed at 16:30 with the daily evaluation and the selection of the best debater of the day.

Thursday May 31st

Dr Aliyu Kabir (Jigawa State, Nigeria) and Lara Tembey (NPHCDA, Nigeria) presented the daily recap and summary of key points. The group completed the microeconomics module and presented the health economics module.

The group discussed how the health market differs from the “banana” market, the different failures affecting the health care market, and how economic instruments (taxes and subsidies) could be used to appropriately correct market failures in health.

Later during the day, participants were introduced to the module on the roles of various actors/stakeholders in the PBF system, starting with the role of the regulator. Participation was very high as most of these roles are part and parcel of their daily activities. Participants understood and appreciated the institutional framework depicting each actor's position, including the PBF Unit and CDV; the contractual, verification, and payment relations; and the rationale behind the framework. Using the PBF institutional arrangements model, participants began asking specific questions to help them map their approach to the health system.

Friday June 1st

Fanen provided a daily recap of the previous day's presentation. Most of Friday focused on understanding the role of another important PBF stakeholder: the Contract Development and Verification Agency (CDVA).

To understand the CDVA's role, participants were asked to prepare an application to become one of the new CDVAs in a country with a population of 4 million inhabitants. They were required to express the following in an application and present it as a 5-minute poster presentation:

1. What you understand the various roles of the CDVA to be
2. What expertise you will bring on board
3. How you will organize the work, and
4. Why your team is the best choice

Participants found this exercise very interesting and engaging.

Following the role play, a summary presentation was then made on the role of the CDV Agency. The day ended at 17:00 with daily evaluation and selection of the best debater of the day.

Saturday June 2nd

The morning started at 8:30 with a recap of the previous day's activities, facilitated by Robert. A presentation on the community's role in PBF was given. This included community-provider interactions, and participants discussed aspects and ways of community involvement in PBF.

As part of Module 9 on PBF project development feasibility, participants in their country working groups were asked to score the PBF feasibility score matrix, identify killing assumptions, and develop an advocacy plan to present in a role play (on Monday). This was followed by a comprehensive presentation of the project development feasibility scan as the backbone of the country-specific action plans. The facilitators guided participants in scoring the purity of their PBF designs, and a plenary session concluded the session.

Participants continued to work on their action plans using the results from the feasibility scan. The day ended at 13:30 hours, with daily evaluations and a selection

of the best debater of the day. Participants were then invited to enjoy a bus ride to the city of Mombasa, including the market and the famous Fort Jesus.

Sunday June 3rd

A trip to the Shimba Hills National Park was made, where some protected animals (Impala, Giraffes, Sable Antelopes, Buffalos, Warthogs, etc.) and different vegetation were seen. We took a steep 4 km walk to and from the waterfalls with a guide who explained the names and special characteristics of some vegetation, such as the dome palm, the bottom plant, lesser flamboyant, pod mahogany, and crocodile liana.

At the beautiful, serene waterfall site, some team members took a leisurely bath and took memorable pictures. Heading back to the hilltop was the most difficult phase, with some resting as often as every 10 minutes. Lunch was at the beautiful Shimba Hills Lodge within the game reserve, with a beautiful view and some squirrels.

Monday June 4th

The morning started at 8:30 with a recap of previous day activities, presented by Grant Mulenga and Halima Mijinyawa. The role plays presenting the outcome of the feasibility scans were then presented by all the groups. The role plays depicted real-life scenarios in which some groups gave course feedback to the Permanent Secretary (PS), negotiated for the establishment of the PBF Unit, secured political buy-in, and built sustainability in countries where PBF is implemented (The Gambia, Zambia). Others had more difficult tasks, such as convincing decision makers (PS and governors) to introduce PBF in the health sector (Nigeria and Ethiopia).

The module on conflict resolution and negotiation skills advocacy was then presented. The final session of the day was module 12 on the output indicators. Here, the various quantitative PBF indicators were presented, including the selection criteria and how targets for each are established.

This was interesting, as participants tried to understand the reasoning behind the target calculations, particularly. The day ended at 16:30, with the daily evaluations and selection of the best debater of the day.

Tuesday June 5th

The day started at 8:30 with the daily recap presented by Baba Njie and Fikremariam Gezahegn.

There was a brief introduction to the terms of reference for field visits by Godelieve and Robert. The groups then set out into the field to visit four Kilifi County facilities for a tour and guided interviews with the facilities' in-charges and other staff.

The facilities visited were:

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

Each team was led by one group member as facilitator. The facilities varied in size (from dispensaries/health posts to a county hospital), so groups produced different but complementary findings on financing sources, supply, and expenditures. Upon return, the groups gave feedback on the questionnaire, which helped to assess the vitality and PBF readiness of the facilities. Following feedback from the field visit, the group completed Module 12 on output indicators.

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

Wednesday June 6th

After the daily recap by Dr. Habib Yalwa and Dr. Tijjani Hussaini, the output indicators exercise was reviewed in plenary. Due to time constraints, participants did not complete this exercise in groups, but they found it interesting and useful. The module on indices management tools was then presented.

The sessions were confined to the morning. Facilitators provided hands-on support and coaching to the groups as they developed action plans to enhance the quality of this product, the main output of the course. More time was allocated in the afternoon and evening to develop the country and individual action plans. Facilitators moved around the groups to provide additional support.

In the evening, participants in their working groups presented their action plan to the facilitators, and it was commendable that at this stage, most groups had a clear sense of how they intended to proceed with PBF in their countries and states.

Thursday June 7th

The day started at 8:30 with the daily recap presented by Lamin Darbo and Dereje Abdissa.

Godelieve then presented Module 13 on business plans, after which Fanen presented the last part of Module 14 on the Indices management tools. This time, since most participants were at a conceptual level on PBF, time was not allocated to the exercise on the indices tool, which would have been more beneficial to participants already implementing PBF.

Module 11 on baseline studies and action research, Module 15 on costing, and Module 16 on PBF in emergency situations were not presented in class, but participants were advised to study them on their own.

The overall evaluation of the course was carried out before the class broke up to finalize their country action plans, and again in the afternoon for a general revision to prepare for the exam.

Friday June 8th

The exam day started at 8:30. 30 participants took the final exam, as 1 had to leave early due to official commitments. 3 participants left following the exam on Friday. In the morning, from 10:30 onwards, we reviewed the exam. This was followed by a ceremony to hand out the certificates at 16:00.

In the evening, from 20:00, we organized a dinner at the restaurant to give all participants and facilitators an opportunity to say their goodbyes.

Saturday June 9th

Most participants left on Saturday on different flights and the last few on Sunday.

6. FINAL COURSE EVALUATION BY PARTICIPANTS

6.1 General impression of the course

The score for ‘general impression of the course’ was 84.3%, 0.3% *above* the average of the 23 previous English-spoken courses. The criterion “I was sufficiently informed” scored 90%, which is 13% above the average of the previous English courses. The criterion “the program answered my expectations” scored 68% (= 18% *below* the previous courses). The criterion “the course objectives related well to participants’ professional activities” scored 95% (= 6% above the average).

Preparation	37 previous French spoken PBF courses	23 previous English spoken PBF courses	Mombasa June 2018 PBF course	Comparison Mombasa June 2018 / 23 previous English spoken PBF courses
Q1. I was sufficiently informed about the objectives of the course	88%	77%	90%	13%
Q2. The program has answered my expectations	84%	86%	68%	-18%
Q3. The objectives of the course relate well to my professional activities	89%	89%	95%	6%
Average	87.0%	84.0%	84.3%	0.3%

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

Participants’ appreciation of the methodology and content scored 94%, 6% above the average of previous English courses and 11% above the previous French courses. The criterion “content helped me to attain my objectives” scored 92%, “methodology” scored 92%, and the “balance between lectures and working groups” scored 88%. The criterion “interaction in working groups” scored 100%, and “working methods stimulated my participation” scored 96%.

Methodology and contents of the course	39 previous French spoken PBF courses	23 previous English spoken PBF courses	Mombasa June 2018 PBF course	Comparison Mombasa June 2018 / 23 previous English spoken PBF courses
The content of the PBF modules has helped me to attain my objectives	82%	90%	92%	2%
The methodology of the course	84%	87%	92%	5%
Balance between lectures and exercises	71%	78%	88%	10%
Interaction and exchanges in working groups	89%	91%	100%	9%
The working methods adopted in the course have stimulated my active participation	86%	90%	96%	6%
Average	82%	87%	94%	6%

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

6.2 Appreciating the duration of the course

For 76% of participants, the course duration was right, while 16% thought it was too short and 8% thought it was too long. This confirms that the 2-week duration of the PBF courses remains about right.

Duration of the course	37 previous French spoken PBF courses	23 previous English spoken PBF courses	Mombasa June 2018 PBF course	Comparison Mombasa June 2018 / 23 previous English spoken PBF courses
Too Short	32%	24%	16%	-8%
Fine	62%	61%	76%	15%
Too Long	6%	12%	8%	-4%

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

6.3 Comments on the organization of the course

For “organization”, the overall score of 79% was 2% *higher* than the previous 23 English courses with 77% and 9% *above* the 39 previous French courses. The conference center (88%) and the food (72%) scored 14% and 12% higher, respectively, than the previous courses. The conference hall scored 67%, and the friendliness of the staff as well as the facilitation team scored 96%.

Transportation scored 65%. The quality of the educational material scored 86%.

How do you value the organization of the training?	39 previous French spoken PBF courses	23 previous English spoken PBF courses	Mombasa June 2018 PBF course	Comparison Mombasa June 2018 / 23 previous English spoken PBF courses
Quality and distribution educational material	79%	88%	86%	-2%
The lecture room	67%	67%	67%	0%
Conference center in general	59%	74%	88%	14%
How were you received and friendliness	87%	91%	96%	5%
Food and drinks, including tea/coffee breaks	63%	60%	72%	12%
Transportation	63%	80%	65%	-15%
Average	70%	77%	79%	2%

Table 5: Evaluation of the organization of the course.

6.4 Comments on the execution of the course and the facilitators

The program execution scored an average of 81%, which was 4% above the average of the previous 23 English courses. The question of how open-minded the facilitators were scored 60%, which was 14% below the average of the previous English spoken courses. Time allocated for group work was 92%, which was 15% *above* the previous courses' scores. Time for discussion was evaluated at 92%, which was 10% above the average of the previous English courses.

Aspects related to the execution of the program and the facilitation	39 previous French spoken PBF courses	23 previous English spoken PBF courses	Mombasa June 2018 PBF course	Comparison Mombasa June 2018 / 23 previous English spoken PBF courses
The facilitators had an open mind towards contributions and criticism	80%	74%	60%	-14%
Time allocated to group work was adequate	63%	77%	92%	15%
Time for discussions was adequate	76%	82%	92%	10%
Average	73%	77%	81%	4%

Table 6: How was the facilitation?

6.5 Evaluation per module

Satisfaction per module among Mombasa participants was 97.5%. This is 8,3% above the average of the previous 23 English courses (87.6%) and 14.6% above the 39 previous French courses. Participants appreciated the completeness and the illustration provided by the facilitation team for the modules. Six modules obtained 100%, including the first-day modules, regulation, and PBF feasibility scan. Economics and the Indices Management tool also scored well this time, at 88% and 95%, respectively. The modules baseline studies and costing were not covered during the course.

Module	39 previous French spoken PBF courses	23 previous English spoken PBF courses	Mombasa June 2018 PBF course	Comparison Mombasa June 2018 / 23 previous English spoken PBF courses
Why PBF & What is PBF?	93%	92%	100%	8%
Notions of micro-economics and health economy	65%	82%	88%	6%
PBF Theories, best practices, good governance and decentralization	86%	92%	96%	4%
Baseline research – household survey launching process	77%	79%		
Output indicators in PBF interventions	87%	89%	100%	11%
CDV agency, data collection, audit	86%	89%	96%	7%
Regulator – quality assurance	82%	92%	100%	8%
Negotiation techniques and conflict resolution	88%	89%	96%	7%
Black box Business Plan	85%	88%	100%	12%
Black box Indices tool: revenues – expenditure – performance bonuses	80%	81%	96%	15%
Community voice empowerment and social marketing	81%	88%	100%	12%
PBF feasibility, killing assumptions & advocacy	87%	90%	100%	10%
Elaboration of a PBF project - costing				0%
Average for all modules	82.9%	87.6%	97.5%	8.3%

Table 7: Evaluation per module.

6.6 Written comments during the final evaluation by the participants

Pre-Course Preparations

- Please send the course outline as soon as one is available, with the course modules included

About Course methodology

- Facilitation was good;
- From the course, I gained a lot of knowledge that can support the implementation of PBF in my country. Still, I need additional support through email from facilitators, especially Robert;
- I learned the real dimensions of PBF;
- Fosters a new horizon of knowledge and experience sharing with other implementers;
- Good course and advocates especially for countries starting PBF;
- I am happy to be part of the PBF community;

- One needs to be flexible and not dogmatic on your personal principles ... context-specific issues are important;
- Very useful course, and provided great depth and insight into PBF theories and practice
- Group work exercises could have helped the PowerPoint and reduced presentations, making the course more didactic. Alternatively, have short presentations and more group work
- I am generally well satisfied ... Thanks SINA!
- Really enjoyed the course – good facilitation, content, and I learned a lot. Overall, participants came from a mix of PBF stages, which was very interesting.
- The course met my personal expectations, and the course objectives were highly related to my profession
- Some questions raised by participants were not well addressed
- Consideration should be made of the duration of the course so that content will be covered adequately
- I was impressed with the overall organization and facilitation of the course.

Course Book and Modules

- I didn't receive any material beforehand on the course objectives, though I had some prior information on some of the course content.
- The initial module on the theories could have benefitted from aligning them with the more practical modules. Subsequently, this would have provided positive reinforcement and avoided lengthy discussions, especially on the change issues
- The module on conflict resolution was not very clear
- A couple of technical modules (costing in particular) were not covered in class. Not sure if it would be possible to have courses targeting specific/different groups (or add a third course in a year).
- The course material is comprehensive; it serves as a guide when we implement it in my country

Hotel

- Initially, pork was served without proper labeling, which did not go down well with me as a Muslim
- The course environment was okay
- Food was okay but became monotonous over time. Outside catering is needed. This requires review of the conference package from full board to half board
- The quality of food was fair
- Food was sometimes not enough at the time of breaking of fast
- The taste of food is not soothing
- General organization of the course was perfectly well organized
- The lecture room was good in terms of space, equipment, layout, etc., but a little dark (not much natural light), which I think contributed to people being sleepy at times.

7. COUNTRY & TOPIC PRESENTATIONS

7.1 Nigeria Federal Level (NPHCDA)

7.1.1 General context

Because of Nigeria's high investment in health and very slow progress in improving health indices, the government adopted a new approach, in collaboration with the World Bank, to strengthen primary health care through the Nigeria State Health Investment Project (NSHIP). This results-based approach aims to improve both the quantity and quality of health services by decentralizing health facility financing, addressing structural issues, and motivating health worker performance. The project's main objective is to increase the delivery and use of high-impact maternal and child health interventions and improve care quality at selected health facilities in the participating states. In addition to improving service delivery at the health facility level, the project also aims to strengthen institutional performance at the Federal, State, and LGA levels.

The project has been implemented in Adamawa, Nasarawa, and Ondo States since December 2011. It started with a pre-pilot in 1 LGA in each state: Fufere, Wamba, and Ondo East, respectively, covering a population of 403,000. Based on encouraging pre-pilot results, the project scaled up to the remaining LGAs in the three states throughout 2014, covering a population of 5,575,000, except for two LGAs in Adamawa State affected by the insurgency. By the end of the same year, 25 LGAs were implementing Performance-based Financing (PBF), and the other 25 LGAs were implementing Decentralized Facility Financing (DFF) – another financing approach not based on performance, but solely as grants for fiscal decentralization and institutional strengthening, covering 5,372,000 inhabitants.

Based on the documented achievements of the current NSHIP and lessons learned from its implementation in Adamawa, Nasarawa, and Ondo states, additional Financing was requested and granted to the government of Nigeria to rehabilitate insurgency-ravaged healthcare infrastructure in the Northeast States of Bauchi, Borno, Gombe, Taraba, and Yobe. The Additional Financing has been adapted to the specific conditions in the NE by strengthening healthcare service delivery under Performance-Based Financing (PBF), promoting contracting with non-public sector actors, especially indigenous organizations, and applying special strategies such as mobile clinics, temporary structures for health service delivery, community nutritional rehabilitation, etc.

Currently, the AF-NSHIP operates in 3 LGAs in Bauchi and Taraba States, 1 LGA in Gombe, and 2 LGAs in Borno and Yobe, covering a total of 3,718,500 inhabitants, with plans to scale up rapidly by July 1st, 2018. As of now, 1 additional LGA in Gombe will be part of the project, along with 8 and 6 additional LGAs in Yobe and Borno, respectively, covering a total population of 7,382,000 in the Additional Financing States. In total, PBF now covers 12,956,000 in Nigeria.

7.1.2 Problem Definition

The NSHIP and AF-NSHIP have shown promising results and provide a strong foundation for PBF in Nigeria. However, as can be seen from the PBF Feasibility Scan below, there are some key concerns, particularly regarding the sustainability of the approach:

1. As project funding from the WB ends in 2020, we need strong advocacy plans to ensure the approach is adopted as national policy and does not fade away when the funds cease.
2. We also need to review the positioning of the PBF Project Implementation Unit, as it is currently too low in the structure to have strong influence.
3. Certain design elements also need to be reconsidered to ensure maximum quality and efficiency.

7.1.3 PBF Feasibility Scan

Whilst PBF has operated in Nigeria since the onset of NSHIP in 2011, it is necessary to review the project design in terms of PBF purity and identify any key problems.

Criteria to establish in how far the programme is “PBF”	Points	Score (NSHIP)	Score (AF-NSHIP)	Comments
The PBF program budget is not less than \$ 4 (simple intervention) - \$ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	0	0	Whilst the project has adequate funding from the Bank, there are high administration costs which mean that estimated less than 70% of funds reach the provider
At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	2	0	0	Currently, there no funds coming from the government currently (although a 25% commitment is expected from NSHIP States) and some States may start PBF programs with own financing (Kano, Ziguwa, Jigawa, Katsina)
The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	0	0	The National and State PBF Unit currently sits in the health financing division of the NPHCDA/within the SPHCDA and this creates serious sustainability problems for PBF to be a true transversal reform approach.
The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	0	0	No Directorates have performance contracts – limited contribution of directorates at present
The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	2	2	
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	
District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	2	2	

The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	0	2	
The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	2	2	No impact evaluation for the AF States but mapping and quality baseline assessments were done.
Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the HF are the signatories.	2	0	0	Whilst the daily managers are the signatories on the HF Bank account, the WDC Chairman (and other community representative) are also signatories which can cause issues
Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	4	4	
The project introduces the business plan that includes the Quality Improvement Bonuses	2	2	2	Investment units are provided to health facilities upon approval of their initial business plans.
The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2	2	2	Only at the level of HF
CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2		0	SPHCDA signs contract directly with managers BUT also other signatories from the community on the contract
Provider managers are allowed to influence cost sharing tariffs	2	2	2	
Provider managers have the right to hire and to fire	2	2	2	For contract staff
There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	0	2	No CDV in NSHIP (although currently in the process of being contracted) Separate CMVA and IVA in the AF-NSHIP
There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	0	2	No CDV in NSHIP (although currently in the process of being contracted)
CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	2	2	
The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	0	0	Whilst an initial investment unit is paid following competition of first BP by the facility, continuous investment units (QIBs) not part of the project
Public religious and private providers have an equal chance of obtaining a contract	2	2	2	

There are geographic and/or facility specific equity bonuses	2	2	2	
The project provides equity bonuses for vulnerable people	2	2	0	Subsidies have been increased for all indicators to make user fees nominal or zero. This creates sustainability problems
TOTAL	50	28	32	
Percentage Total	100%	56%	64%	

Threshold of 80% not reached => some criteria may be possible to improve the design to obtain higher scores, while others might be challenging.

7.1.4 Key Challenges / Killing assumptions

S/N	Issue	Risk Factor for sustainability (RAG) (1-10)	Level of difficulty for change (1-10)
1	Role of the SPHCDA as regulator and purchaser - Lack of competition for contracts - Lack of administrative penalties for poorly performing HFs	8	5
2	Inclusion of WDC chairman (and other community representative on HF bank account)	5	2
3	Inclusion of WDC chairman as signatory on purchase contract	4	2
4	Positioning of PIU at both National and State level	9	9 (for existing NSHIP/AF-NSHIP states)
5	Analysis of quality checklist scores to ensure proper weighting of the quality domains	3	1
6	Formalise process for mapping and selection of health facilities	5	2
7	CMVA and IVA – as two separate institutions which means high administrative costs	5	7
8	Infrastructure development i.e. construction not allowed within the project	8	5
9	Factoring in client satisfaction into the overall quality score of the HF	3	1
10	Lack of counter verification of quantity (different from CCSS)	6	5
11	Lack of equity bonuses for entire LGAs within States	3	6

A detailed analysis of key barriers (risk rated red) is presented below.

Role of SPHCDA as both regulator and purchaser

In the current NSHIP and AF-NSHIP design, the SPHCDA serves as both the regulator (responsible for oversight of all primary facilities in a state) and the unit that signs purchase contracts with health facilities (both primary and secondary). As a result, this violates the PBF best practice of separation of functions.

The key issue is: a. Lack of competition between the health facilities due to the almost “auto-renewal” of purchase contracts by the SPHCDA. This may be due to the position of the SPHCDA as the regulator, which also owns these facilities; b. Potential for conflicts of interest.

Therefore, the current contract management and verification agency (CMVA) should transition to a contract development and verification agency so it can develop, sign, and manage all contracts with the facility. This would not only ensure that the

SPHCDA has only a regulatory function within the setup, but also, with the CDVs overseeing the contracts, increase the competitive environment. This can be seen in the below institutional framework for a new state.

Positioning of PIU at both National and State level

One of the key features that has proved vital in the success of PBF in countries such as Burundi, Cameroon, Zimbabwe, CAR and Rwanda, which all have successfully had government buy-in to the PBF approach (and in some cases adoption as national policy), has been the positioning of the PBF Unit high up in the health system, i.e. under the Honorable Commissioner for Health or PS.

However, in the NSHIP/AF-NSHIP, this has not been the case – instead, the PBF Unit has been in the NPHCDA (national) and SPHCDA (State). For the sustainability of the PBF approach, post-World Bank funding, in the NSHIP/AF-NSHIP States, and for those states which wish to take up PBF with their own funds, this will cause issues. Instead, the PBF Unit needs to be placed higher. The institutional framework below suggests how this could look in a future state.

For the existing WB project states, the relationship between the Ministry of Health (both National and State) and the PBF PIU will need further examination to strengthen it, so the ministry has greater ownership, since it ultimately controls the health budgets.

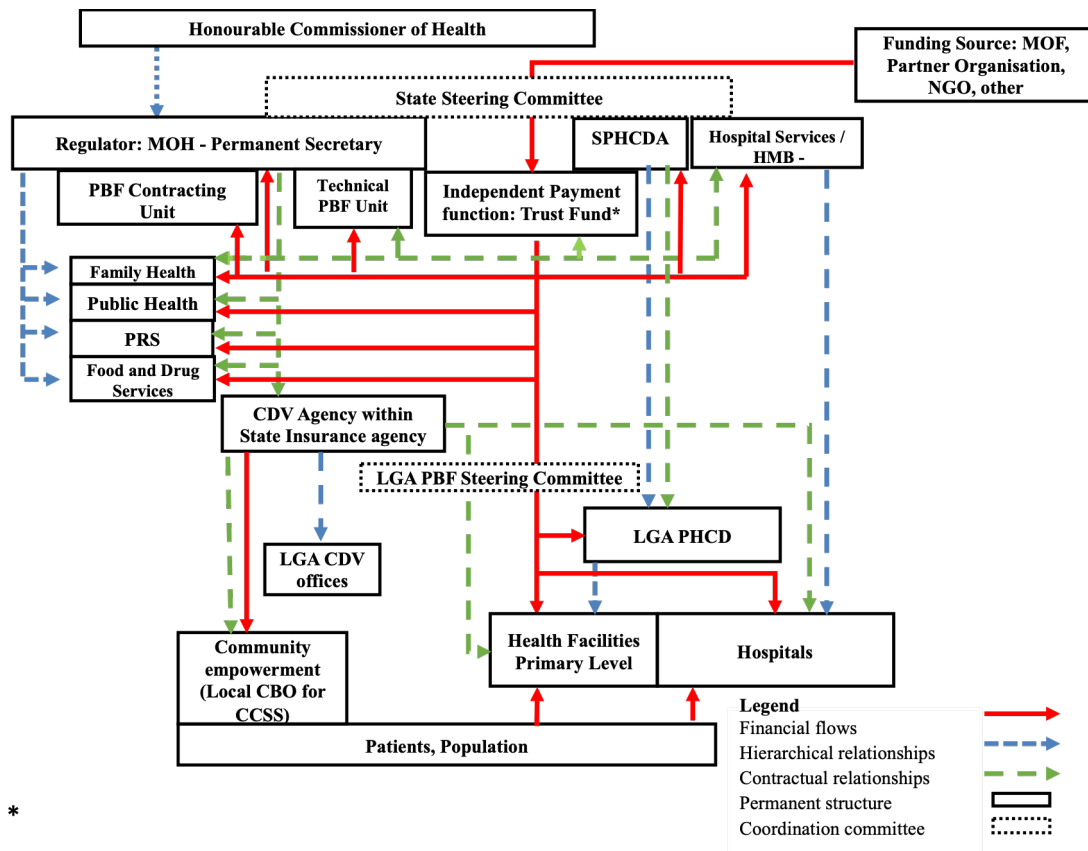
Infrastructure development within the project

Because of the current state of health facilities in the country, at the onset of the Nigerian PBF program, or following a major crisis (such as the Boko Haram insurgency), and after approval of a business plan, investment units are provided to health facilities to improve infrastructure quality. However, these improvements are limited to minor rehabilitation. Under the NSHIP/AF-NSHIP, World Bank regulations prohibit the construction of new infrastructure and major renovations using these funds. Because facilities cannot do this, they often reach a quality ceiling. Therefore, we will need to arrange a meeting with the World Bank to discuss this rule and emphasize to the project that, while they cannot use PBF subsidies to fund construction or major renovations, they can use other funds to do so. Project documents will need to be updated to reflect this. The QIB component of the NSHIP and AF-NSHIP can be improved. QIBs are not only for infrastructure but also for rehabilitation, equipment improvements, access to water and sanitation, and waste management. Moreover, QIBs may be used to accelerate recruitment of qualified staff in remote areas and restart activities in facilities affected by insurgencies. This approach does not pose procedural problems in other World Bank-supported PBF programs, such as in Cameroon and CAR.

It is also worth including a quality-improvement bonus component in the design of PBF for any new state wishing to start the approach. This will help overcome infrastructure and quality-improvement issues.

7.1.5 PBF Design Solutions

For a new State wanting to start PBF in health, below is a proposal for the institutional set-up, based on lessons learnt from the NSHIP/AF-NSHIP and PBF best practices.



*

7.1.6 Action Points

Issue	Action to be taken	Who?	Timeline
1. Role of the SPHCDA as regulator and purchaser - Lack of competition for contracts - Lack of administrative penalties for poorly performing HFs	- Advocate to National Project Coordinator for CMVAs to take on the role of signing and management of purchase contracts with health facilities rather than SPHCDA	Lara, Fanen	Q3 2018
2. Inclusion of WDC chairman (and other community representative on HF bank account)	- Finalise proposal on Community PBF to ensure that other incentives exist for the community - Removal of WDC chairman (and other community representative) from the HF bank account	Fanen, Lara	Q3 2018
3. Inclusion of WDC chairman as signatory on purchase contract	- Finalise proposal on Community PBF to ensure that other incentives exist for the community - Removal of WDC chairman (and other community representative) from the purchase contract	Fanen, Lara	Q3 2018
4. Positioning of PIU at both National and State level	- Share recommendation for institutional structure with states wanting to adopt PBF (outside of NSHIP/AF-NSHIP)	Lara, Fanen	Q3 2018

	- Further brainstorming around how to strengthen the current relationship with the MoH in the NSHIP/AF-NSHIP		
5. Analysis of quality checklist scores to ensure proper weighting of the quality domains	- Initial analysis of quality checklist weighting - Ensure follow up on weighting on a regular basis, following quarterly report development (add to TOR of reporting workstream)	Lara	Q2 2018
6. Formalise process for mapping and selection of health facilities	- Create a guideline document for selection of health facilities in scale-up LGAs - Need to include updated criteria for mapping and quality baseline exercise	Lara/Fanen	Q2/Q3 2018
7. CMVA and IVA – as two separate institutions which means high administrative costs	- Conduct cost analysis of with or without IVA once data available	NSHIP PIU	Q2 2019
8. Major infrastructure development i.e. construction not allowed within the project	- Advocate to the World Bank for changes in this rule - Amendment to project documents to emphasise that HFs can use other funds for infrastructure (just not PBF subsidies)	NPC NSHIP Lara/Fanen	Q1 2019
9. Factoring in client satisfaction into the overall quality score of the HF	- Write proposal on how to include client satisfaction (and potentially use of indice management tool) into the quality score	Lara/Fanen	Q2 2018
10. Lack of counter verification of quantity (different from CCSS)	- Write a proposal (including budget) for quarterly spot checks of quantity counter-verification by NPHCDA or SPHCDA PIU	Lara	Q3 2018
11. Lack of equity bonuses for entire LGAs within States	- Critically look at budget to see if it would be possible in the current design to include equity bonuses for entire LGAs	Lara/Fanen	Q3 2018

7.2 Nigeria – Kano State

7.2.1 General context

Kano State is one of the 36 States of the Federal Republic of Nigeria, situated in the northern part of the country, with a projected population of 13.8 million. This population is distributed across 44 local government areas and 484 political wards.

The State, like other states in Nigeria, operates the Primary Health Care Under One Roof (PHCUOR) as its main fulcrum for delivering health services to the people of Kano State. To deliver these services, Kano State has 1,163 public health care facilities, comprising 2 tertiary, 39 secondary, and 1,122 primary health care centers, plus over 300 private health facilities and thousands of patent medicine vendors that provide care to the teeming population of Kano State.

Despite years of Government efforts, delivering quality primary health care services remains a challenge in Kano State. Infrastructure remains poor; many facilities lack the required equipment or drugs to deliver basic health services; many health facilities face an acute shortage of qualified manpower and have no funds to meet their basic, day-to-day needs.

The 2016 health facility assessment conducted by the SPHCMB and UNICEF revealed that only 185 wards in Kano have a primary health care facility that meets the nationally approved standard (tidiness, open 24 hours, more than 18 hours of electricity, appropriate birth delivery services, water and sanitation facilities, etc.). Of these 185 facilities, only 10% have adequate and appropriate delivery services, only 10% have appropriate water and sanitation facilities, and only 40% have appropriate community linkages. These identified gaps in basic health care services delivery leave the community unsatisfied with the services provided (Bank, 2010)

The private health care system provides care for a substantial proportion of the population. The private sector includes tertiary, secondary, and PHC facilities, patent medicine vendors (PMVs), drug sellers, and traditional practitioners. In Kano, private health facilities are concentrated in metropolitan Kano, where over 80% are located. Private-sector services are either subsidized (e.g., faith-based health facilities) or full cost (e.g., privately owned clinics and hospitals).

7.2.2 Problem Definition

As highlighted above, most health facilities in Kano, especially primary health care centers, provide sub-optimal services, with inadequate health manpower, infrastructural gaps, and weak community linkages. Detailed results of the 2016 health facility assessment showed that only 33.2% of all wards in Kano have a facility that meets the national standard of a primary health care center.

This suboptimal functionality of health facilities in Kano is reflected in the quality of health services and various health outcomes, as shown in most national surveys. The most recent surveys, the National Health Facility Survey and the Multiple Indicator Cluster Survey (MICS), put most of Kano State indicators below the national average.

The summary of selected health indicators is provided below (Statistics, Multiple Indicator Cluster Survey, 2017):

S/No	Name of Indicator	State average	National average
1	Percentage of children 12 – 23 vaccinated with Penta 3 e	15.9	33.3
2	Infant mortality rate	112	70
3	Under five mortality rates	203	120
4	Percentage of women 15-49 with live birth in the last two years assisted by skilled provider	19.8	43.0
5	Percentage of women 15-49 with live birth in the last two years who attended ANC provided by any skilled provider	65.1	65.8
6	Percentage of women 15 – 49 years married or in union who are using modern contraception	5.7	10.8
7	Percentage of Primary Health Facilities Functional with Bag and Mask for Infant Resuscitation in the Past 3 Months	29.3	14.9
8	Proportion of Primary Health Facilities with Basic Medical Equipment by State	1.5	29.7
9	Percentage of diagnostic accuracy of in Primary Health Facilities	29.5	38.9
10	Percentage of primary health facilities that managed MNH correctly	10.1	15.5

7.2.3 PBF Design Solutions

If Kano is to make progress and meet the Sustainable Development Goals (SDG) targets, it needs to restructure health care service delivery so that health facilities, both public and private, provide basic, quality care to the target population in a competitive manner. The proposed approach is Performance-Based Financing (PBF).

The PBF mechanism is a strategy to achieve Universal Health Coverage and can help address the slow responsiveness, inefficiency, inequity, and resource leakages associated mostly with public health services. It also ensures people entrusted with certain services are held accountable to higher authorities for their performance and are compensated only based on performance.

Introducing Performance-Based Financing in Kano State

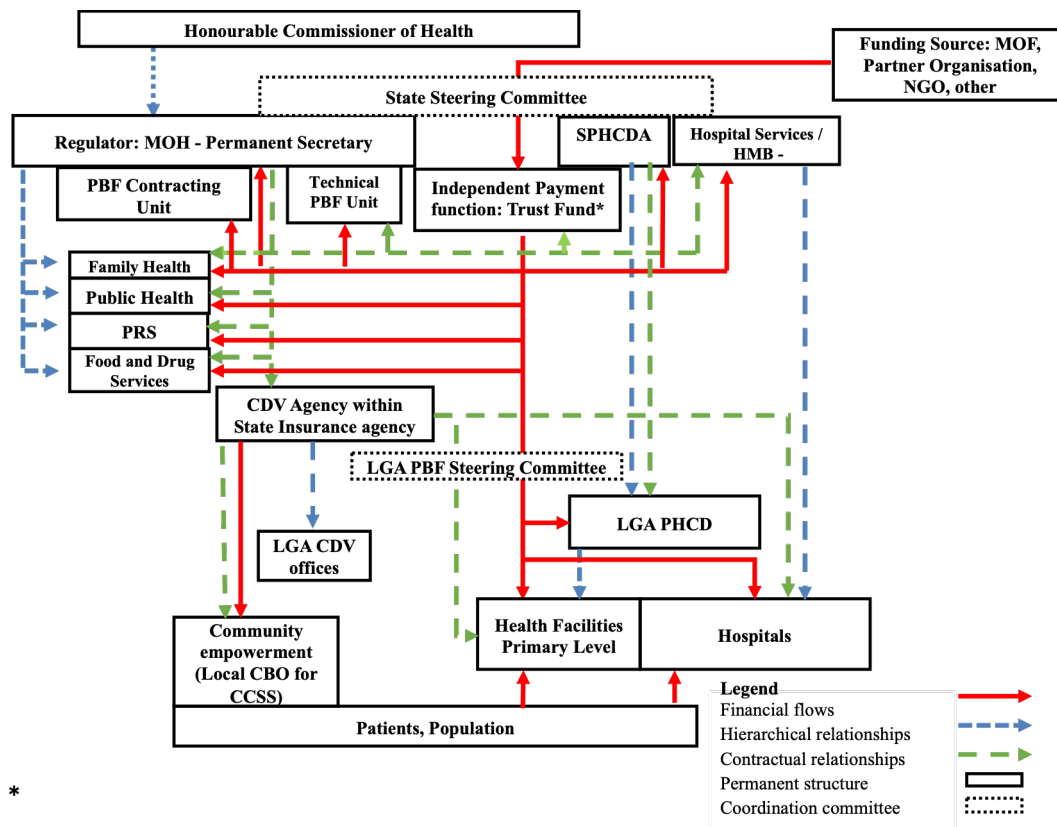
With the ongoing reform and strengthening of health services in Kano, the State has a unique opportunity to introduce and finance PBF. The opportunities that exist include:

- The existence of the Kano Health Trust Fund Law that can serve as a source of funding for PBF
- The existence of the Kano State Contributory Health Care Management Agency that can serve as a contract and verification agency
- The existence of the Saving One Million Lives Performance for Result, from which some amount can be dedicated to PBF
- The availability of health facilities both public and private health facilities that can provide quality health services
- The availability of employable health manpower that facilities can engage during PBF.

Benefits from PBF

- Increased accountability for the usage of public and private resources
- Improved efficiency
- Improved quality of the services
- Improved equity

Proposed PBF Institutional Arrangements



*

Analysis of available funding sources

Funding from the Kano Health Trust Fund (KHETFUND) is critical to the success of PBF in Kano; it provides 1% of the statutory allocation for LGAs in Kano and 5% of monthly internally generated revenue, forming the bulk of its funding. The KHETFUND law earmarks 50% of the total KHETFUND for primary and secondary health facilities in the State. Part of the realized 50% can be channeled to the PBF program, since the spirit of the law is to provide drugs and medical consumables for free maternal, newborn and child health, accident and emergency, and other related services.

If only 50% of the funds dedicated to the provision of drugs for free services are channeled to the PBF, the potential amount that can be generated for PBF using 2017 benchmark, is about four hundred million naira (NGN 400,000,000.00 approximately USD 1,2 million) per annum (total amount to be generated by KHETFUND is NGN 1,716,628,062 comprising of NGN 1,110,775,304 and NGN 605,852,7578 from 5% IGR and 1% statutory allocation respectively) This potential amount that can be generated will be sufficient to fund pilot PBF in 3 LGAs (Statistics, 2017).

Item	Amount (NGN)	Amount (USD)*
6 month Internally Generated Revenue (IGR) in 2017	11,107,753,040	30,854,869
Projected average monthly IGR	1,851,292,173	5,142,478
Projected average yearly IGR	22,215,506,080	61,709,739
Projected 5% Remittance to KHETFUND	1,110,775,304	3,085,486
Projected monthly LGA statutory allocation	5,048,772,982	14,024,369
Projected yearly LGA statutory allocation	60,585,275,784	168,292,432
Projected 1% remittance to KHETFUND	605,852,757	1,682,924
Total expected yearly in-flow to KHETFUND	1,716,628,061	4,768,411
Projected dedicated funds to Health facilities from KHETFUND	858,314,030	2,384,205
* Exchange rate is pegged at NGN 360 per USD		

Other funding sources:

The Saving One Million Lives Program for Result will contribute two hundred million naira (200,000,000.00), and an additional three hundred and eighty-one million six hundred and eighty-five thousand nine hundred and sixty-nine naira and eight kobo (NGN 381, 685,969.08) will be mobilized through the regular state input budget.

The total amount to be realized from these three sources is one billion four hundred and forty million naira (NGN 1,440,000,000.00), which is equivalent to about 4 million USD.

Population to be covered

During the pilot, the available funding is expected to finance PBF in 3 LGAs with a population of about 1 million people at 4 USD per capita per year.

Features of Kano State PBF

- The PBF Unit is to be situated at the State Ministry of Health;
- Governance and oversight are developed at various levels at the state level with a steering committee and validation committees at the state and LGA levels, respectively;
- Clear separation of functions for regulators, service provision, community empowerment, fund disbursement, etc;

- Competition among stakeholders including facilities;
- Promotion of public-private partnership;
- Sufficient autonomy of health facility management;
- Engagement of government (KSCHMA) agency as the contract and verification agency
- Communities and civil society organizations are involved in mobilization and other social marketing.
- Equity is strongly enshrined in the PBF mechanism

7.2.4 PBF Feasibility Scan (of proposed PBF design)

The feasibility scan was carried out based on the proposed design explained above.

Criteria to establish in how far the programme is "PBF"	Points	Score	Comments
1. The PBF program budget is not less than \$ 4 (simple intervention) - \$ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	4	3 less densely populated LGAs are selected for pilot site with a combined population of about 1,000,000 people and average spending of 4 USD per capita per year. The remaining budgeted will be supplemented through the SOML fund and yearly Government budget.
2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	2	2	100% of the funding will come from the State Government through 3 sources: KETHFUND, the SOML and the state budget.
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	2	Various Agencies and Departments under the Ministry will sign performance-based contract with the permanent secretary
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	2	
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	2	The output indicators will be in line with the State's priority adopting global best practices
6. The PBF program contains the community indicator "visit to household following a protocol" to be applied by all primary level principal contract holders.	2	2	
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	2	The LGA level authority will lead the quality reviews
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	2	
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	2	
10. Cost recovery revenues are spent at the point of collection (facility level) and the health facilities	2	0	Now, health because of the Treasury Single Account (TSA) all Govt.

Criteria to establish in how far the programme is "PBF"	Points	Score	Comments
have bank accounts on which the daily managers of the FOSA are the signatories.			institutions including public health facilities are not allowed to spend fund directly without remitting same to the TSA.
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	0	There is a law which stipulates that all public health facilities must procure their commodities from a central government agency, the DMCSA. This law must be reviewed to allow for more competition
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	0	Payment of improvement Bonuses to health facilities may also not apply as it is in contravention of the procurement policy of the State
13. The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2	0	Due to reason in 12 above, this will also not apply
14. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2	2	
15. Provider managers are allowed to influence cost sharing tariffs	2	2	
16. Provider managers have the right to hire and to fire	2	2	They can hire casual and contract staff
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	2	
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	2	KSHCMA will be contracted to serve as the CDV agent.
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	2	The CDV agency will work with the National Minimum Service package as the standard
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	2	
21. Public religious and private providers have an equal chance of obtaining a contract	2	2	
22. There are geographic and/or facility specific equity bonuses	2	2	
23. The project provides equity bonuses for vulnerable people	2	2	Indigent, under 5 children and pregnant women will be provided with equity bonuses
TOTAL	50	42 =	84%

7.2.5 Key Challenges / Killing assumptions

Facilities depend on central distribution for inputs (essential drugs, equipment) and have no alternative suppliers other than DMCSA. Facility managers are not allowed to spend cost recovery revenues at the point of collection

7.2.6 Action Points (Advocacy Plan)

N	Activity	Advocacy Element	Expected Output	Responsible	Time Frame
1	Debrief of Honourable Commissioner for Health	Report detailing drivable benefit of PBF	Proper contextualization of PBF	Permanent Secretary	3 rd week of June 2018
2	Scan available opportunities for implementing PBF in Kano	Source of financing	Available funding opportunities identified	Permanent Secretary	July 2018
3	Stakeholder engagements including development partner on PBF in Kano State	Explain the value-add of PBF	Stakeholders engaged to support PBF in Kano	Permanent Secretary	1 st to 4 th week of July 2018
4	Design of the PBF Units in the Ministry of Health and its relationship with the other agencies of the Ministry	Nil	PBF Designed, roles and responsibilities of various agencies and stakeholders clearly defined	Permanent Secretary	1 st week of August to 4 th week of October 2018
5	Presentation of PBF to the State Executive Council (SEC)	Benefit of PBF	Buy – in of the SEC	Honourable Commissioner	1 st week of September 2018
6	Advocacy to State House of Assembly	Benefits of PBF - Increased efficiency - Increased quality - Equity - Review of existing law (s)	Buy – in of the SEC and possible review and amendment of existing Laws	Honourable Commissioner	3 rd Week of September
7	Advocacy to the Ministry of Budget and Planning for inclusion of PBF in the Ministry of Health's budget	Benefits of PBF - Increased efficiency - Increased quality - Equity - Cost of the pilot PBF LGAs	PBF included as line item in the Ministry of Health budget	Honourable Commissioner	October 2018

7.3 Nigeria – Jigawa State

7.3.1 General context

In 2002, Jigawa State health sector stakeholders took stock of the health status of the state's people. They found that health indices were among the worst in the country. This resulted from several factors, including low investment in the sector, an ineffective health system, and poor health-seeking behavior among the populace, among others.

In response, the state undertook a radical health system reform that culminated in the establishment of the Gunduma Health System structure. Under this arrangement, primary and secondary health care were brought under one roof, effective from 2007.

Eight years after the reform, another stocktake of the health system was conducted to appraise progress and challenges. Only marginal improvements were recorded in most of the health indices. For example, the percentage of fully immunized children rose from 0% in 2008 to 3.6% (NDHS 2008, NDHS 2014), whereas IMR and U5MR were 91 and 217 and 163 and 275 in 2008 and 2013, respectively. The merging of primary and secondary care under one Board was met with mixed experiences and concerns at different levels and across the board. The principal managers of the Gunduma Health System were professionally skewed toward either primary or secondary care at any given time, but rarely both. Where the principal officer was PHC-inclined, there was a tendency to spend energy deploying PHC activities; while officers with a background in secondary care tended to spend quality time prioritizing secondary health care activities, often at the expense of primary care. It was concluded that “there is a need for urgent review of the Health Sector Reform and repositioning the sector”.

Accordingly, in compliance with the 54th National Council of Health resolution No. 29, as well as the provisions of the National Health Act, Jigawa State Government decided to establish a state primary health care agency fully reflecting the principles of Primary Health Care Under One Roof (PHCUOR) in line with the new national recommendations of consolidating PHCUOR before incorporating the secondary care at a later stage.

7.3.2 Problem Definition

Strengths

- Some level of result-based financing exists in the Free MNCH Health facilities
- Health Insurance scheme in the pipeline
- Some knowledge on PBF
- There is good experience in the health sector reform process
- N75 million/month state funding for free MNCH is available

Weaknesses

- Treasury Single Account
- Human resource management is centrally controlled
- Central procurement process (Central Medical Store-based)
- Lack of definite financing source
- Too few private health facilities
- Political playground (election year)

Opportunities

- 1% consolidated revenue fund
- In-country technical support for PBF exists
- SMOL funding
- Global partnership
- 2019 campaign

Threats

- Conflicting donor interests
- Global economic recession
- Dealing with the national concept of Primary Health Care Under One Roof

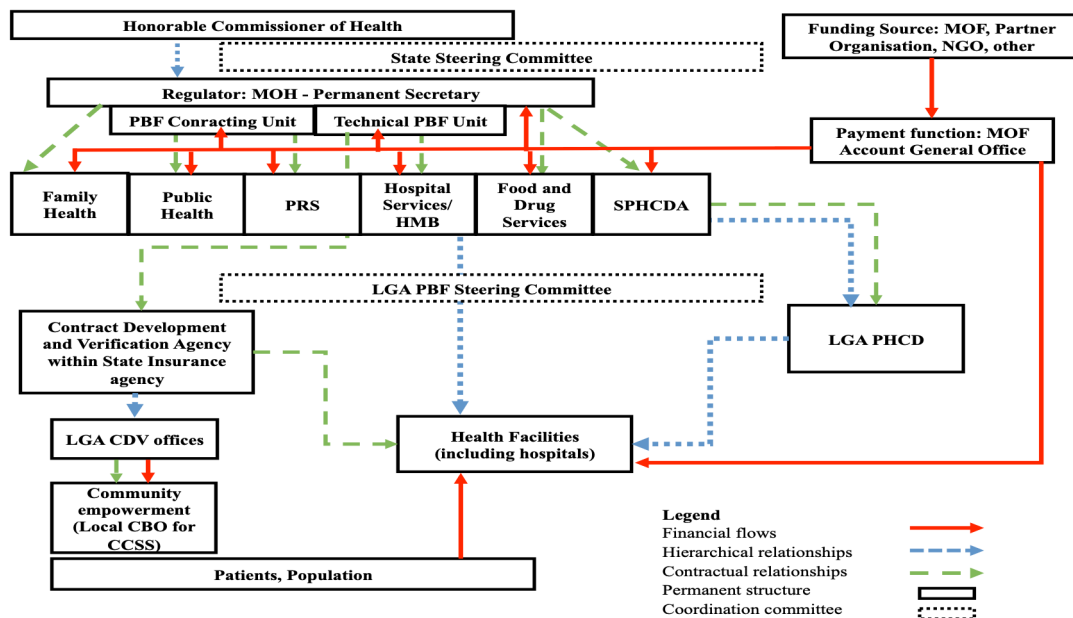
7.3.3 PBF Design Solutions

This action plan will focus on designing a Performance-Based Financing Pilot in 3 LGAs covering a population of about 1 million people.

Justification for BPF

- Dearth of human resources for health is still a reality under the PHC system
- Poor quality of care in many health facilities
- Political interference in the conduct of routine activities
- Inadequate funding
- Skewed distribution of funds in favor of secondary and tertiary health facilities
- Poor health-seeking behavior

Proposed Institutional setup for PBF



Population to be covered through PBF

The pilot is expected to cover 3 large Local Government Areas, namely Gwaram, Kafin Hausa, and Babura LGAs, representing nearly 20% of the state population. The LGAs are selected based on political and demographic characteristics.

Name of LGA	Population	No of Contracting Health Facilities	4 USD Per Capita	Total No of Health Facilities
Gwaram	374,287	11	1,497,148	56
Kafin Hausa	360,754	11	1,443,016	32
Babura	269,187	11	1,076,748	19
Total	1,004,228	33	4,016,912	107

Analysis of potential sources of funding

The total expenditure is expected to be N1,446,088,320 (4,016,912 USD) based on 4 USD per capita. This amount is also expected to be sourced from state allocation to the free MCH program (500,000 USD), SOML (300,000 USD), overhead costs provided by the government to these LGAs (USD 50,000), and the State treasury for salaries (4,933,330).

7.3.4 PBF Feasibility Scan (of proposed PBF design)

As Jigawa State has yet to commence PBF and remains at a conceptual level, the following feasibility scan was carried out based on the proposed design described in the previous section.

Criteria to establish in how far the programme is “PBF”	Points	Score	Comments
1. The PBF program budget is not less than \$ 4 (simple intervention) - \$ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	4	This will be leveraged on the existing funding sources including the potential 1% Nigeria’s National Consolidated Revenue
2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	2	2	As in 1 above
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	2	This is reflected in the organogram below
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	2	Will be based on PBF best practice
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	2	As in 4 above
6. The PBF program contains the community indicator “visit to household following a protocol” to be applied by all primary level principal contract holders.	2	2	As in 4 above
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	2	As in 4 above
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	2	As in 4 above
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	2	As in 4 above
10. Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the FOSA are the signatories.	2	0	This would be followed up with deeper stakeholder engagement

Criteria to establish in how far the programme is “PBF”	Points	Score	Comments
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	0	This would be followed up with deeper stakeholder engagement
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	2	As in 4 above
13. The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2	0	This would be followed up with deeper stakeholder engagement
14. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2	2	As in 4 above
15. Provider managers are allowed to influence cost sharing tariffs	2	0	This would be followed up with deeper stakeholder engagement
16. Provider managers have the right to hire and to fire	2	0	This would be followed up with deeper stakeholder engagement
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	2	As in 4 above
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	2	As in 4 above
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	2	As in 4 above
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	2	As in 4 above
21. Public religious and private providers have an equal chance of obtaining a contract	2	2	As in 4 above
22. There are geographic and/or facility specific equity bonuses	2	2	As in 4 above
23. The project provides equity bonuses for vulnerable people	2	2	As in 4 above
TOTAL	50	38 =	76%

7.3.5 Key Challenges / Killing assumptions

- Dealing with existing laws and guidelines (especially in human resource management)
- Inadequate funding
- Treasury Single Account, which does not allow health providers to spend cost recovery revenues at the point of collection
- Addressing the political play field
- Donor and community buy-in
- Labour Unions

7.3.6 Action Plan (Advocacy Action Plan)

Objectives

- To conduct awareness creation meetings with various stakeholders in the 3rd week of June 2018
- To conduct advocacy meeting with members of the State House of assembly 4th week of June 2018
- To conduct a study tour with key stakeholders to Rwanda in July 2018

Key stakeholders

- Directors from the MOH, JPHCDA, Hospital Managers, PHC Managers
- Members of the State House of assembly
- Office of the head of civil service
- Office of the state budget and planning
- Ministries of Finance, Women Affairs, Education
- Development partners
- Civil society organizations
- Labour leaders
- Traditional institutions
- Religious institutions

Strategies for advocacy

- Awareness creation meetings
- Debriefing His Excellency, the state governor
- Study exchange visits
- Feedback to the state executive council

Advocacy material

- Pamphlets on PBF concept
- Short videos
- Development of BPF slogans

Activity	Means of verification	Person responsible	Time frame	Remarks
Sensitization meeting with: Directors from the MOH, JPHCDA, Hospital Managers, PHC Managers	Minutes of the meeting available and shared	ES JPHCDA	1 ST week of July 2018	To be supported by the MOH
Advocacy visit to Members of the state house of assembly	PBF awareness created	HCH	2 nd week of July 2018	Targeting House Committee on Health
Advocacy visit to the Office of the Head of Jigawa state Civil service	PBF awareness created	HCH	2 nd week of July 2018	Key staff of the office of HOS in presence
Sensitization meeting with the Office of the State Budget and Economic Planning, Ministries of Finance, Women Affairs, Education	PBF awareness created	HCH	3 rd week of July 2018	
Sensitization meeting with Development Partners	PBF awareness created	SOML PM	4 th week of July 2018	MOH to support
Labour leaders	PBF awareness created	HCH	4 th week of July 2018	MOH to support

Activity	Means of verification	Person responsible	Time frame	Remarks
Sensitization meeting with Traditional institutions Religious institutions	PBF awareness created	ES JPHDA	4 th week of July 2018	MOH to support
To conduct one week Study Tour to Rwanda on PBF best practice	PBF awareness created	HCH	2 ND week of August 2018	MOH to support
To debrief the State, HE on outcome of the study Tour	PBF awareness created	ES JPHDA	4th week of July 2018	MOH to support

7.4 Nigeria – Zamfara State

7.4.1 General context

Zamfara State is in north-western Nigeria. The state was created in 1996 from the old Sokoto State. It covers 39,762 square kilometers and had a projected population of 4.8 million in 2018.

The state comprises 14 local government areas with 147 political wards. It is bordered in the North by the Republic of Niger, to the South by Kaduna State, to the East by Katsina State, and to the West by Sokoto, Kebbi, and Niger States. Zamfara has a warm tropical climate, with temperatures rising to 38C between March and May. The rainy season starts in late May and lasts until September, while the cold season, known as Harmattan, lasts from December to February. Agriculture is the most predominant and important economic occupation in the state.

The State has 693 health facilities: 2 Tertiary Hospitals, 23 General Hospitals, 668 Primary Healthcare Centers, and some Private Hospitals. The State has two health training institutions: the School of Nursing and Midwifery and the College of Health Science and Technology.

7.4.2 Problem Definition

The State's health system is fragmented, with little financial benefit to the government, service providers, or the community. Health facility autonomy is limited; there is no competition in procuring essential drugs and commodities, and there are inadequate skilled human resources for health. There is an unacceptable level of maternal, neonatal, and child mortality in the state, and there are significant challenges of human resources, limited health funding, poor utilization of services, and centralization of health care services.

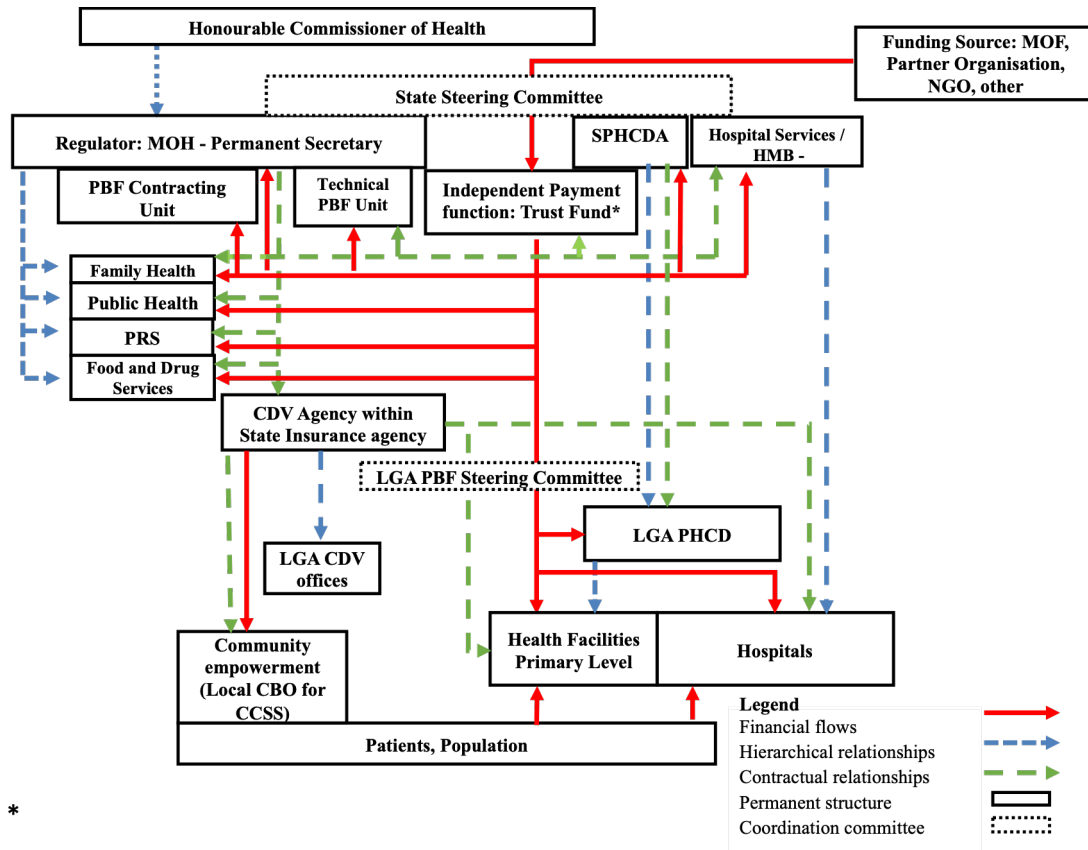
7.4.3 PBF Design Solutions

To address the current health indicators in Zamfara State, the State Ministry of Health proposes to initiate Performance-based financing (PBF). The approach will be bottom-up, piloted in three Local Government Areas across the state (one per senatorial zone), and will cover a population of about one million people. The approach fosters such principles as autonomous management, harmonization, alignment, coordination, ownership, and accountability. It also scales up services through evidence-based, cost-effective interventions and activities. This reflects the

State governments' and their citizens' aspiration to transform the health sector toward quality, efficient, and equitable health care services.

A well-designed PBF approach offers better quality health services with more qualified and relevant personnel. It also improves financial access to health services and increases the number of health package activities.

Proposed PBF Institutional setup



Population to cover

This action plan focuses on developing a PBF pilot to cover approximately 1 million inhabitants of Zamfara State.

SN	LGA	Total Population
1	Maru	425,981
2	Birnin Magaji	260,666
3	Bukkuyum	308, 844
Total		995,491

Analysis of funding requirements

1. \$ 4 per capita
2. Population to cover in three LGAs: 995,491
3. Period 2 years

Therefore, $995,491 \times 4 \text{ dollars} \times 2 \text{ years} = \$ 7,640,000$. \$ 1 is equivalent to ₦ 360

Therefore, $\$ 7,640,000 = ₦ 2.751.814.080$.

7.4.4 PBF Feasibility Scan

Since Zamfara state does not currently implement PBF and this feasibility scan is therefore based on the proposed PBF design as described above.

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

Criteria to establish in how far the programme is “PBF”	Points	Score	COMMENTS
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	0	As above
21. Public religious and private providers have an equal chance of obtaining a contract	2	2	
22. There are geographic and/or facility specific equity bonuses	2	2	
23. The project provides equity bonuses for vulnerable people	2	2	
TOTAL	50	22	=44%

7.4.5 Key Challenges / Killing assumptions

- Central Medical Store: SDSS health facility is required to purchase drugs from the State medical store. Fixed drugs supply for SDSS
- Implementation of Treasury Single Account (TSA), which does not allow health facilities to spend cost recovery revenues at the point of collection.

7.4.6 Action Points

Activity	Target	Person responsible	Time line
Mapping sources of funding for the implementation of PBF	State Government, SMOL and partners	DPRS SMOH	July 2018
Meeting and mapping of selected health facilities for PBF at LGA level	PHC Coordinators and LGA consultants	ES SPHC	July 2018
Debriefing of selected facilities and implementation status of PBF	PMOs of the Secondary facilities	DPH/DMS	July 2018
Assessment of Health Facilities	Selected Health facilities in the three LGAs	DPRS	July 2018
Development of implementation plan	Three piloting LGAs	DPRS	Sept 2018
Feedback meeting with relevant stake holders on proposed implementation of PBF in the three/four LGAs in the State	PHCB, HSMB, YBSH, MFLGA MBEP, MOF, MOJ, HC on H. FMC, MW&CA, MOI	PS	July 2018
Assessment of Health Facilities	Selected Health facilities in the three LGAs	DPRS	July 2018
Development of implementation plan	Three piloting LGAs	DPRS	Sept 2018
Advocacy meetings	Traditional and Religious institutions, policy makers	ES PHCB	Aug 2018
Training of the service providers at PHC level	CHEWs, JCHEW, and relevant personnel @ Community level	ES PHCB	Nov 2018
Training of the service providers at Secondary facility level	PMOs, Nurses and relevant personnel @ Secondary facility	DPH/DMS	Aug 2018
Formation and inauguration of PBF steering committee	PBF unit	PS MOH	Dec 2018
Accreditation of pharmaceutical vendors	Pharmaceutical vendors	DPS	Jan 2019

7.5 Nigeria – Yobe State

7.5.1 General context

Yobe State was carved out of Borno State on August 27, 1991. It derived its name from the River Yobe, which runs across the State. It is in Nigeria's northeastern region and covers about 47,153 square kilometers. Its capital city is Damaturu. The state has 17 LGAs and 178 wards, with a projected population of 3.4 million for 2017 and an annual growth rate of 3.5%. It has 14 Emirates and 105 District Heads, with about 520 village units. It shares boundaries with Borno State in the East, Borno and Gombe States in the South, Bauchi and Jigawa States in the West, and the Republic of Niger in the North. The state's location in the Sahel Savannah makes it hot and dry for most of the year, except in the southern part of the state, which has a milder climate. The major ethnic group is the Kanuri, while others include the Bade, Bolewa, Ngizim, Ngamo, Hausa, Fulani, Karekare, and Shuwa. Farming and commerce are the main occupations. Islam is the predominant religion, followed by Christianity.

About 80% of Yobe State's population are subsistence farmers, with 70% residing in rural areas and an estimated 65% living below the poverty line. Average literacy level is estimated at 35%. Demographic subsets central to health planning are children 0-1 Years (135,578), 0-5 Years (677,890), and women of childbearing age (754,680), which constitute about 4%, 20% & 22% of the population, respectively. On average, a woman gives birth to 7 children within her reproductive lifespan. The median age at first marriage is 16.3 years, accounting for the high rates of teenage pregnancy and associated health problems.

Demographic Indicator	Indicator value	Data source
Population	3,389,453 (2017)	NPC 2006 census projection
Population growth rate	3.5%	NPC 2006 census projection.
Number of LGAs	17	SMOH
Number of Political Wards	178	SMOH
Number of Health Facilities	528 (327 offer RI)	SPHCMB
Under 1 Year	135,578 (4%)	NPC 2006 census projection.
Under 5 years	745,680 (20%)	NPC2006 census projection
Pregnant women	169,743(5%)	NPC 2006 census projection
Women of Childbearing Age	745,680 (22%)	NPC2006 census projection
Median age at first marriage	16.3	NDHS 2013
Total Fertility Rate	6.6	NDHS 2013

Yobe State has very poor and unacceptable health indices. High burden of communicable diseases, high maternal mortality compared with the national average. Despite concerted efforts of Government and Development partners, the health indices of the state remain amongst the poorest in the country, with a maternal mortality rate of 1200/per 100,000 live births, infant mortality of 64 /1000 live births, and under-5 mortality of 160/1000 live births. Only 7% of children 12-23 months received full immunization, while 15% had the measles vaccine (MICS, 2016). Only 3% of women of childbearing age have access to modern contraception, and hence the Total Fertility Rate (TFR) is 6.8, which is amongst the highest in the country.

The table below summarises the key health indices.

Index	Value	Source
Maternal Mortality Ratio	1200/100,000 live births	NDHS 2013
Infant Mortality Rate	64/1000	MICS 2016
Under 5 Mortality Rate	64/1000	MICS 2016
Percentage receiving ANC from a skilled provider	33.2% (Yobe) 49.3%; (Northeast)	NDHS 2013
Proportion of pregnant women accessing SBA	10.2% (Yobe)	NDHS 2013
Contraceptive Prevalence (any modern methods)	2.7 % (Northeast); 0.5% (Yobe)	NDHS 2013
Percentage of children 12-23 month who received all basic vaccination	7% (all basic vaccine); 15% (Measles); 3.9% (Penta)	MICS 2016
Proportion of under-five (6-59 Months) children suffering from stunting	23.6% (Northeast)	NDHS 2013

7.5.2 Problem Definition

PBF is a health system approach to delivering quality health care efficiently and equitably, with clear results, as shown by evidence from several African countries. Yobe State is currently piloting PBF in 25 health facilities (2 Secondary and 23 Primary Health Facilities) in Damaturu and Potiskum local government areas. This is being scaled up to 10 additional LGAs (ongoing health facilities mapping). However, the existing legislative framework and policies need review to create an enabling environment for sustainable PBF scale-up and a system-wide sector management approach. As a regulator, the SPHCDA also serves as the contract verification and development agency, and the Ministry of Health has no central PBF coordinating unit. Therefore, effective engagement of relevant stakeholders through a carefully planned and systematic approach is crucial to bring about the required legislative and policy reviews, which are fundamental requirements. The desired return on government investment in health can therefore be better guaranteed if PBF is adopted as the standard modus operandi for ensuring a healthy and prosperous population that is socio-economically productive and on the right path to achieving universal health and sustainable development goals.

Leadership and Governance

- There is a need for review of the legal framework and policies to allow decentralization of functions regarding HRH, supplies procurement, PFM, especially at HF level, etc., to align with PBF principles and practice.
- Existing mechanisms in PFM are weak; transparency and accountability need improvement

Health Financing

- 13% of the state's total budget is allocated to health, with a mostly input-based strategy
- Over 70 % of total health expenditure is out-of-pocket, while government expenditure on health, including donor funds, amounts to no more than 30%.
- Procurement costs are high due to overpricing and over-invoicing.
- Weak financial checks and balances and accountability systems with persistent inefficiencies and low value for money.

Human Resources for Health

- Government is the sole employer of the health workforce in public health facilities through a centralized recruitment process. There is a perennial shortage of HRH in terms of quantity and quality (skill mix, competence and inequitable distribution).
- Inadequate production capacity by Health Training Institutions
- Poor motivation and reward mechanisms for health workers (low wages, poor welfare, lack of housing, limited training opportunities) leave a disenchanted workforce that cannot give its best and tends to look for opportunities to make ends meet, with corrupting tendencies, absenteeism, and poor overall performance.
- Punitive measures are difficult to enforce, which negatively impacts staff performance and the quality of service delivery.

Service Delivery

- Quality of service delivery in most health facilities, especially in rural areas where most of the population lives, is affected by HR challenges,
- Mostly not operating 24/7,
- High patronage of private health care providers, especially PMVs
- Shortage of supplies,
- Weak quality assurance systems and
- Low client satisfaction coupled with barriers to access such as cost, distance and socio-cultural factors.

Infrastructure

Mostly old and in poor condition, requiring renovation, upgrades, or reconstruction to meet minimum national standards.

HMIS

The state operates a hybrid paper and web-based DHIS system. Data quality, data demand and use, and equipment and related technology, including internet access, remain challenges.

Community Participation

- Weak systems in place for community participation in health planning and delivery
- VDCs, WDCs, FHCs and different arrangements abound; participation is voluntary, with poor incentives for participation

Health Research

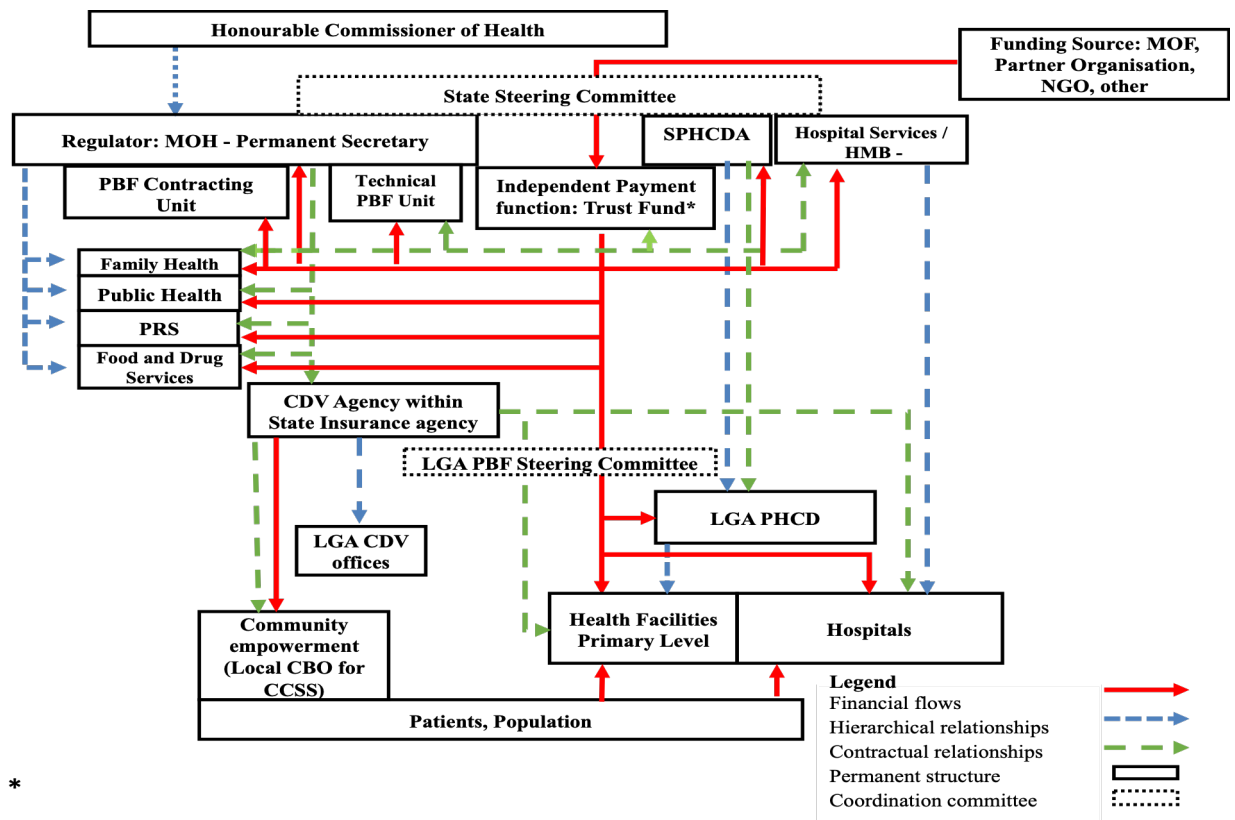
Limited capacity and weak institutionalized culture for research

7.5.3 PBF Feasibility Scan

Based on available evidence and multi-country experiences, PBF has enormous potential to help attain the targets of universal quality health coverage at an affordable cost in the long run if properly implemented. A systematic analysis of the contextual problems based on the PBF feasibility scan is summarised below:

Criteria to establish in how far the programme is “PBF”	Points	Score	Remarks
1. The PBF program budget is not less than \$ 4 (simple intervention) - \$ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	4	0	Cost at USD 3 /capita
2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	2	0	Solely funded from WB loan
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	0	No PBF coordinating unit at the SMOH
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	2	0	No contracts
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	2	Yes
6. The PBF program contains the community indicator “visit to household following a protocol” to be applied by all primary level principal contract holders.	2	2	Yes
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	2	
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	2	
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	2	0	Baseline HH survey not done
10. Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the FOSA are the signatories.	2	2	
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	4	4	
12. The project introduces the business plan that includes the Quality Improvement Bonuses	2	0	No QIB yet
13. The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2	2	
14. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	2	2	
15. Provider managers are allowed to influence cost sharing tariffs	2	2	
16. Provider managers have the right to hire and to fire	2	2	
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	2	2	NGOs play the role of the CDV
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	2	NGOs play the role of the CDV agency
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	2	2	
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	0	Yes initially but no QIB
21. Public religious and private providers have an equal chance of obtaining a contract	2	2	
22. There are geographic and/or facility specific equity bonuses	2	2	
23. The project provides equity bonuses for vulnerable people	2	0	
TOTAL	50	32	64%

7.5.4 PBF Design Solutions



7.5.5 Action Plan

Issue(S)	Activity	Approach	Target	Responsible	Timeline
Decentralise competitive procurement of supplies by HF's level	Legislative and Policy review	Policy dialogue Policy advocacy	State Assembly Health of Civil Service Judiciary EXCO Labour Unions	Health Commissioner DPRS MOH & PHCDA	Q3-Q4
Absence of legal and policy frameworks for provider autonomy to hire and fire staff	Legislative and Policy review	Policy dialogue Policy advocacy	State Assembly Health of Civil Service Judiciary EXCO Labour Unions	Health Commissioner DPRS MOH & PHCDA	Q3-Q4
Contract development and verification	Legislative and Policy review	Policy dialogue Policy advocacy	Health Commissioner MOH PS Health ES PHCDA	Health Commissioner Director of Planning	Q2/Q3
PBF business plans lacks quality improvement bonus	Revise business plans to include QIB	Regulator /CDVA Coach providers to include QIB in their business plan	CDVA Commissioner MOH PS Health ES PHCDA	Health Commissioner Director of Planning	Q2/Q3
No equity bonus for vulnerable	Revise business plans to include equity bonus	CDVA to coach providers to capture equity	CDVA Commissioner MOH PS Health ES PHCDA	Health Commissioner Director of Planning	Q2/Q3
Need to improve oversight and	Establish PBF unit under the	Advocate best practices	Health Commissioner PS Health ES PHCDA	NPHCDA PS Health DPRS MOH	Q1-Q4

Issue(S)	Activity	Approach	Target	Responsible	Timeline
coordination of PBF implementation	Office of the Hon Commissioner			DPRS PHCDA	
Review of law to allow government direct funding to private and public health facilities	Legislative and Policy review	Policy dialogue/ Policy advocacy meetings/courtesy calls	State legislative Assembly Commissioners of Health, Finance, Budget and Plan	PS Health DPRS MoH	Q1-Q4
Inadequate PBF program budget is based on less than USD 3 per capita which is below the minimum threshold of 4-6 USD/capita	High level sensitization & advocacy to mobilize more PBF resources	Advocacy meetings/courtesy calls	State legislative Assembly Commissioners of Health, Finance, Budget and Plan	PS Health DPRS MoH	Q1-Q4
PBF budget sole funded from WB funding for now	High level sensitization & advocacy to mobilize more PBF resources	Advocacy meetings/courtesy calls	State legislative Assembly Commissioners of Health, Finance, Budget and Plan	PS Health DPRS MoH	Q1-Q4
Directorates and programs of the central Ministry of Health have no performance contract	Establish PBF coordinating unit headed by at least a director under the office of the PS	Advocacy meetings/courtesy calls	Commissioner of Health PS Health Heads of PHCDA/HMB	PS Health DPRS MoH	Q1
PBF program needs to conduct baseline HH survey to establish priorities and allow impact measurement	Build capacity of PBF program officers on conduct of baseline HH survey	Include PBF work plan	PBF steering committee/ PBF program manager		
Decentralise HR management function to facility level	Legislative & Policy review	Policy dialogue/ Policy advocacy	State Legislative Assembly Commissioners of Health, Head of Civil Service	PS Health DPRS MoH DPRS SPHCDA	Q4

7.6 Zambia

7.6.1 General context

The Ministry of Health of Zambia has been engaged in RBF but has no PBF unit. However, it strives to provide quality health services effectively and efficiently. It currently has a Directorate for Performance Improvement and Quality Assurance. In the 1st quarter of 2018, the Government of the Republic of Zambia announced a shift from INPUT-based planning to OUTPUT-based planning. On this basis, we propose lobbying to integrate and establish a professional PBF Unit.

Currently, the vertical RBF projects that are running fall under 4 different departments. This creates challenges for coordination and resource optimization. Furthermore, the current system has more than one external verifier coordinating funds from different donors.

The *central-level office* at the Ministry of Health is mandated to coordinate, supervise, and pay districts' RBF funds based on the verified invoice prepared by the Clinton Health Foundation, the Ministry of Health's external verifier.

7.6.2 Problem definition

PBF principles stress the need to establish a PBF Unit, preferably at the decision-making level. PBF also emphasizes efficient and effective use of funds. However, this contrasts with the current situation in the Ministry of Health, where no unit is established, and efforts are duplicated due to vertical, fragmented project implementation.

In the current situation;

- There is *fragmentation of PBF interventions* depending on the source of funds (no resource pooling);
- *There is no standard approach to PBF;*
- *No coordination mechanism in place to maximize resource utilization.*

7.6.3 Feasibility score

Issue	Situation Current	Points avail	Score
1. The PBF program budget is not less than \$ 4 (simple intervention) - \$ 6 (more complex intervention with many equity elements) per capita per year of which at least 70% is used for provider subsidies, local NGO contracts and infrastructure input units	Not sufficient budget	4	0
2. At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency.	GRZ is implementing input-based activities that is against the PBF principles. GRZ has set up a national health insurance scheme, which will reduce donor dependence and improve the provision of quality health services.	2	0

Issue	Situation Current	Points avail	Score
3. The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	There is fragmentation in the way projects are being implemented at national level	2	0
4. The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators.	No contracts	2	0
5. The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	Fragmentation of project implementation at national level	2	0
6. The PBF program contains the community indicator “visit to household following a protocol” to be applied by all primary level principal contract holders.	Currently, the home visits are being done using different quality checklists but needs to be optimized. Donors are implementing the same at different levels, i.e., community, facility and district	2	0
7. District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	Not done systematically	2	0
8. The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	Does not exist	2	0
9. The program includes a baseline household and quality study, which establishes priorities and allow to measure the impact of the program.	Was done	2	2
10. Cost recovery revenues are spent at the point of collection (facility level) and the health facilities have bank accounts on which the daily managers of the FOSA are the signatories.	Not available	2	0
11. Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition.	No such autonomy	4	4
12. The project introduces the business plan that includes the Quality Improvement Bonuses	Does not exist	2	2
13. The project introduces the indices tool for autonomous management of	Does not exist	2	2

Issue	Situation Current	Points avail	Score
the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses			
14. CDV agencies sign contracts directly with the daily managers of the providers – not with the indirect owners such as a religious leader or private person.	There are no CDV agencies	2	2
15. Provider managers are allowed to influence cost sharing tariffs	Providers do not influence cost sharing tariffs	2	0
16. Provider managers have the right to hire and to fire	No	2	0
17. There is a CDV Agency that is independent of the local authorities with enough staff to conduct contracting, coaching and medical & community verification.	Not in place	2	0
18. There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	No	2	2
19. CDV agents accept the promotion of the full government determined packages (this in Africa mostly concerns discussions about family planning)	Yes	2	2
20. The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	Currently, 40% is used for staff incentives and 60% is used for reinvestment	2	0
21. Public religious and private providers have an equal chance of obtaining a contract	No	2	0
22. There are geographic and/or facility specific equity bonuses	No	2	0
23. The project provides equity bonuses for vulnerable people	No	2	0
TOTAL		50	16 =32 %

One tough dimension will be convincing the PS and other stakeholders to set up a coordinated funding basket run by a central PBF Unit, rather than having project implementation units run in parallel. We also anticipate resistance from various donors in establishing a common funding basket. This could create conflict at different levels, including senior management at the Ministry of Health.

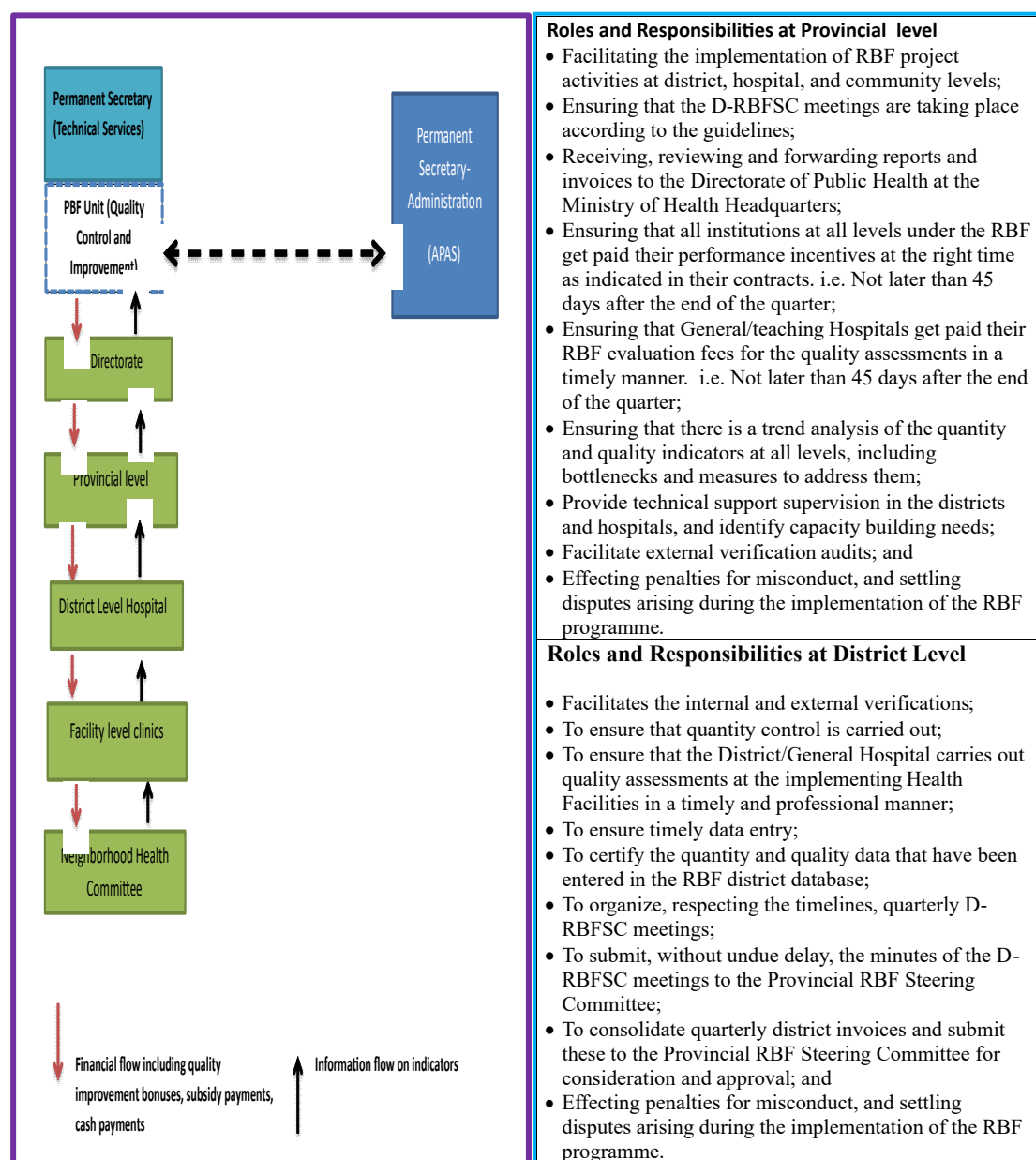
7.6.4 PBF design solutions

The absence of the PBF Unit in the Ministry is identified as a critical problem. Therefore, the team has proposed ways to address this issue. The proposal includes establishing the PBF Unit to sit directly under the Permanent Secretary's office. In addition, the team believes this design should include developing clear, articulate

messages on the potential benefits of PBF, targeting key directorates, which will be critical in addressing this concern.

The PBF solution should consider key funding sources, including the World Bank, USAID, DFID, and SIDA. This makes implementing the PBF model more advantageous for the Ministry in terms of resource availability. Moreover, the Ministry's current institutional setup is adequate to accommodate the introduction of service delivery based on the PBF approach, except that it needs strengthening, especially at the community level. Currently, different funders implement different activities at the community level in a vertical way. By using the PBF approach, the Ministry will bring these efforts together.

The figure below illustrates the setup of the PBF unit (located in the Permanent Secretary's office, Technical Services). It also depicts the flow of funds for performance and indicator information, including incentivized indicators.



7.6.5 Action Points

Activity	Dates	By Whom
Debriefing of the NTLP and Partners in the concepts of PBF	11 June 2018	Confucious and Team
Debriefing the Permanent Secretary (TS) on the concept of PBF	11 - 12 June 2018	Confucious and Team
Adapt and finalize the PBF training materials	13 – 15 June 2018	RBF team
Printing the PBF training package	18 – 29 June 2018	Gift - Procurement
Training of Trainers	18 – 22 June 2018	Confucious and Team
PBF Provincial steering committee orientation	25 – 26 June 2018	Confucious and Team
District/ Facility Orientation	27 – 29 June	Confucious and Team
Mapping of facilities and community-based organizations	25 – 29 June	Confucious/Dr. Chila
Community/Facility Orientation	2 July – 6 July	Confucious and Team
Revamping of community structures by the Health Center staff supervised by TB Coordinator	9 - 13 July, 2018	Health Center in Charge d Team
Training of community health workers	16 – 20 July 2018	Health Center in Charge and TB Coordinator
Signing of contracts (District Health Office and Health Facility)	August	MoH – policy and planning
Signing of contracts (Health Facility and Community based organization)	August	MoH – policy and planning
Contract with Hospital and DHO	August	MoH – policy and planning
Contract with MoH and Clinton Health Initiative	August	MoH – policy and planning
Monthly data audit at all levels	Last week of every month	Grant and Team

7.7 The Gambia

7.7.1 General context

PBF came to The Gambia to address the poor-performing indicators on maternal, child health, and nutrition. The Gambia is located on the West Coast of Africa and forms a narrow enclave in the Republic of Senegal except for a short seaboard on the Atlantic Coastline. It is the smallest country on mainland Africa, spanning only 11,295 km², of which about 20% is considered wetland. The country runs east to west and lies between latitudes 13° and 14° north, stretching over 360 km across Senegal. It is about 50 km wide at its widest point and level, with an altitude not exceeding 50 meters. It extends inland with widths varying from 24 to 28 kilometers along the river of the same name (River Gambia) that divides the country into two banks (North and South Banks).

According to the 2013 Population and Housing Census, The Gambia's population was 1.88 million. The average annual growth rate is 3.1%, up from 2.7% in 2003. The health and nutrition situation of women and children in The Gambia is indicated in the table below:

Maternal Health and Nutrition	Child Health and Nutrition
-------------------------------	----------------------------

	MICS 2010	DHS 2013		MICS 2010	DHS 2013
Skilled Birth Attendance	57%	57%	Neonatal Mortality Rate		22/1000
Contraceptive Prevalence Rate	13.3%	9%	Infant Mortality Rate	81/1000	34/1000
Total Fertility Rate	5.1	5.6	Under 5 Mortality Rate	109/1000	54/1000
Anaemia		60.3%	EBF Rate	33%	47%
Wasting		16.7%	Fully Immunized		76%
Overweight		22.6%	Care Seeking for Pneumonia	68.8%	68%
Maternal Mortality Ratio	730/100,000 (2000)	433/100,000	VAS Coverage	72.8%	69%
			Wasting	9.5%	12%
			Stunting	23.4%	25%
			Overweight	17.4%	16%

We found that the current PBF setup does not yet promote full sustainability and buy-in from the Ministry of Health. The Mid-Term Review results confirm this diagnosis. Based on the above and the desire to accelerate the attainment of the SDGs, the government of The Gambia has sought support from the World Bank. In 2013, the Bank agreed to provide financial support to the country. The government also decided to pilot test Performance-Based Financing as an approach to financing health services. Consequently, a five- to seven-year (2014-2021) Maternal Child Nutrition and Health Results (MCNHRP) project is being implemented, with the primary objective of increasing the uptake of community nutrition and primary maternal and child health services.

The project is currently being implemented in 5 of the 7 health regions of the country, all of which are rural. The project does not include health facilities in urban areas, nor private and faith-based health facilities. The health regions chosen have the worst health and nutrition indicators. They cover about 40% of the country's population (770 000).

There are over 80 health facilities, including hospitals (public, private, and faith-based). The project is currently being implemented in just 37 health facilities, all of which are public. The region has two hospitals, and they are included in the 37 facilities implementing the project. The project is incentivizing 15 indicators for the primary care level, while there are 6 indicators for the secondary Care level

Primary Care Indicators
New outpatient visits
Antenatal care 1st visit before 3 months
Completion of 3 other scheduled ANC visits as per the Maternity Care Guidelines
Skilled delivery
Post Natal Care (PNC) 3 visits
Number of women referred with complication received from the community, managed and a feedback provided to the VSG
Referral of mothers with complications and/or at-risk cases
Modern family planning: pills: All clients
Depo Provera: All clients
IUCD + implant
Vitamin A supplementation
Deworming

Neonates referred for complications
Successful management of severe acute malnutrition
Update of the community registers bi-annually (per child)
Secondary Care Indicators
Pregnancies with complications before and during delivery requiring interventions that have been treated
Caesarean section
Postpartum complications of mothers
Neonates treated with complications
Family planning: Tubal Ligations
Downward referral of mothers and/or newborn who after treatment at secondary care HC/hospital can be treated at primary care HC

Mid Term Review Findings

In January/February 2018, a Mid Term Review (MTR) of MCNHRP was conducted as a joint effort between the Government of The Gambia and the World Bank.

The review assessed the Project Development Objective (PDO), its relevance in the current country context and likelihood of achieving the PDO; Reviewed project design and implementation; Assessed project management and capacity building; and planned for financial sustainability.

Despite the mixed performance of indicators, with some on the increase (skilled deliveries; PNC; Family Planning-Long term; ANC 1st Visit) and some not performing well (Vitamin A, Family Planning –Short term, Other 3 ANC visit), there were key findings noted that alluded to the need to influence the project towards a stronger sustainability focus. Limited time remains to hand over the project to the ministry, compounded by the ministry's inability to respond effectively to systemic challenges inherent in the health system. So, we concluded there is a strong need to proactively own and implement RBF better as an approach to health financing and health systems improvement.

Below are the specific recommendations:

1. Decentralize and strengthen health facility autonomy in business planning
2. Engage in capacity building (transfer of skills) in RBME and data management of PBF to the Ministry of Health
3. Increase the scope of complementary maternal child, and nutrition health indicators
4. Reduce the verification costs for community RBF
5. Promote multi-sectoral collaboration and avoid fragmentation (implementation; scale-up of PBF indicators; geographical scale-up; resource mobilization)
6. Review the performance-based contracting of the regulator –to influence positive behavior (for timely implementation of recommendations, and pro-activeness, etc)

The MCNHRP Project Facilitator, who attended the 68th PBF course in Mombasa, has already successfully proposed an institutional and implementation setup to strengthen the regulator's role in coordinating PBF as a health systems reform approach. The current Gambian team could benefit from this background, coupled with the MTR findings and recommendations, and wishes to develop a clear sustainability action plan as a roadmap for institutionalizing PBF in the Ministry of Health Sector.

7.7.2 Problem Definition / PBF Feasibility Scan

Criteria to establish in how far the project is "PBF"	Points	Score	Comments
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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	4	4	Total budget \$2,710,181.28 pop 700000 in 5 Regions \$3.87 per capita per year
2	At least 20% of the PBF budget comes from the government and the PBF program has a plan to reduce donor dependency	2	0	Budget to run the current PBF program is donor funded (WB)
3	The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs.	2	0	PBF Unit not fully functional. A Focal Person for RBF identified and attached to the PHC Unit
4	The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators	2	0	Only the Regional Directorates have performance contracts At the central level is the RBF Committee
5	The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	2	0	21 indicators (15 Primary Care and 6 Secondary Care)
5	The PBF program finances the full health centre and hospital health packages and is not restricted to a limited number of vertical program indicators	2	0	Programme focused on MCHN
6	The PBF program contains the community indicator “visit to household following a protocol” to be applied by all primary level principal contract holders.	2	2	The Community indicators are contracted directly to community structures i.e. VDC and not health facilities
7	District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	2	0	
8	The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	2	2	The role of CDVA are taken up by the Regional Directorates
9	The program includes (or is part of) baseline and evaluation household and quality studies that establish priorities and allow measuring progress	2	2	
10	Cost recovery revenues are spent at the point of collection (facility level) and health facilities have bank accounts on which the daily managers of the HF are signatories	2	0	User fees are paid into a central account of the Treasury Department except for the hospitals which retain these for their own use.
11	Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition	4	4	Although there is a centrally managed supply system (CMS), health facilities have been provided with a list of accredited suppliers from whom they can procure drugs and medical supplies using their PBF funds
12	The project introduces business plans that includes the Quality Improvement Bonuses	2	0	No QIB yet
13	The project introduces the indices tool for autonomous management of the revenues, planning of the expenses and the transparent calculation of the staff performance bonuses	2	2	Management Indices tools in place
14	CDV agencies sign contracts directly with the managers of the health facilities – not with the indirect owners such as a religious leader or a Health Centre Committee member.	2	0	No CDV Agency contracted and the contract is signed by the Chairperson of the HCMC

15	Health facility managers are allowed to influence cost sharing tariffs	2	0	This is centrally determined
16	Provider managers have the right to hire and to fire	2	2	Staffs are centrally provided, however they can hire and fire on short term basis
17	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	No CDV Agency contracted and the contracts are signed by the Regional Directors and Chairperson of the HCMC
18	There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	2	0	Both the verification and payments are done by the same Agency – NaNA, however, these two functions are independently carried out by the staff of the Agency.
19	CDV agents accept the promotion of the full government determined health packages (this in Africa mostly concerns discussions about family planning)	2	2	
20	The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	2	0	Equipment and supplies are centrally provided; facilities can also procure from their subsidies
21	Public religious and private facilities have an equal chance of obtaining a contract	2	0	The project is in 5 out of 7 region contracting only public health facilities
22	There are geographic and/or facility specific equity bonuses	2	2	
23	The project provides equity bonuses for vulnerable people	2	0	The indices that are incentivized are provided free.
	TOTAL	50	22	44%

7.7.3 Key Challenges / Killing assumptions

The feasibility scan findings confirm some of the operational gaps identified by the MTR. For instance, the Ministry of Health and Social Welfare (MOHSW) is both the Regulator and the CDV, while NaNA also doubles as a fundholder and CDV. NaNA and MoH co-contract RHD, which frustrates regional personnel by limiting autonomy and complicating reporting lines. Health Facility business plans are reviewed at three levels (region, PHC –that acts as PBF Unit, and NaNA), which confuses facility staff in terms of ‘how to produce quality plans’ and delays the signing and endorsement of these documents. Therefore, although there is an attempt to separate functions, these have yet to be fully put in place.

MCNHRP is a complex project (food and nutrition security, supply, and community RBF) where multi-sectoral coordination, as a principle, needs to be strengthened. Multi-sectoral coordination through work-planning, implementation, and monitoring is critical to reduce administrative costs and promote buy-in and the sustainability of development efforts. This is coupled with MoH M & E's involvement in effectively monitoring and reporting on the progress of its health service indicators quarterly, while complementing the project's effort to produce and disseminate quarterly policy briefs for policymakers.

There is no PBF Unit in the Ministry functioning as recommended, but a Focal Person is placed at the Primary Health Care Unit to assume the functions of the PBF Coordinator. Currently, the RBF Committee at the Ministry (comprising 14 senior members, including heads of Programs and Directorates) uses performance-based contracting against a set of key output indicators to oversee the MOHSW's regular

and purchasing functions. This has created challenges, as the Ministry has failed to respond to systemic issues effectively, and the reality is that it pays for departmental performance, not individuals. For example, recommendations from health facilities on delivering quality-of-care services, joint quarterly evaluations, and Senior Management Team meetings persisted each quarter, with no central-level actions taken to respond to them.

The sustainability of the PBF approach lies in the Government's ability to reduce administrative costs. Currently, central-level health institutions are contracted for community verifications. They do not have district branches, which increases administrative costs quarterly.

The Ministry of Health has pledged its commitment, and a policy has been drafted on health financing to adopt PBF, pending validation. The bottleneck faced by health facility managers is that they cannot use funds generated from user fees. User fees are paid into a central Treasury Department account, except for hospitals, which retain them for their own use. This will require a policy change allowing health facilities to use user-fee funds to improve quality care services. Furthermore, the current RBF project implemented through PBF focuses on 21 maternal and child health services and nutrition indicators (both primary and secondary level) and may witness the scale-up of more indicators. Furthermore, to increase service utilization, health posts within the facility catchment areas (with significantly more skilled deliveries done compared to the main facility) need to be subcontracted.

SWOT analysis in developing the sustainability action-plan:

	Problem	Analysis of the problem	Way forward
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	Total budget is \$2,710,181.28 Population is 700000 (5 Regions) \$3.87 per capita per year	Strengthening the sustainability of PBF by ensuring that the necessary budget of around US\$4.00 per person per year is available. The Unit identifies financial gaps preferably one or two years in advance in order to take remedial action on time.
2	The PBF project has at least 25 output indicators for which facilities receive subsidies and a system of composite quality indicators with incentives	21 indicators (15 Primary Care and 6 Secondary Care)	Review current indicators to and adopt full set (of 25 indicators per level)
3	The National PBF Unit is integrated into the Ministry of Health at a level that allows it to coordinate all activities of the MOH with the Directorates and Programs	There is no established PBF Unit. Only a Focal Person appointment and attached to the PHC Unit	Advocate for the establishment of a PBF UNIT directly under the P/S. To lobby through the office of the Vice president
4	The Directorates and Programs of the central Ministry have performance contracts with standard output and quality indicators	Only the Regional Health Directorates have performance contracts At the Central level is the RBF Committee	Sign performance contracts with all the Directorates and Programs
5	The PBF program finances the full health centre and hospital health packages and is not restricted to a limited number of vertical program indicators	Program focused on MCHN	Financing should be cross cutting (All health indicators) Regularly revising the primary and hospital level indicators, the subsidies and monitor the costing of the budget
6	The PBF program contains the community indicator "visit to household following a protocol" to	The Community indicators are contracted directly to	All attained (PBF program contain community indicators)

	Problem	Analysis of the problem	Way forward
	be applied by all primary level principal contract holders	community structures i.e. VDC and not health facilities	
7	District regulators conduct quality reviews of at least 125 composite indicators at public and private health facilities. They also do the annual mapping of health facilities and assure the rationalization of catchment areas in units of between 6,000 and 14,000 inhabitants.	Composite indicators are less than 125, and health facility mapping have regularly not been done	Review the composite indicators and the PHC Unit should carryout health facility mapping regularly
8	The PBF program has a District Validation Committee that brings together the district regulator, the CDV Agency and one or more representatives of the providers	The role of CDVA are taken up by the Regional Directorates	Consider establishing: Regional Validation Committees or the functions to be taken up by the RHDs
9	The project includes (or is part of) baseline and evaluation household and quality studies that establish priorities and allow measuring progress	Already in place and communities are assessed quarterly through the LQAS which establishes priorities and measure progress	Continue the quarterly assessment by the contracted CBOs
10	Cost recovery revenues are spent at the point of collection (facility level)	User fees are paid into a central account of the Treasury Department except for the hospitals which retain these for their own use.	To consider using facility User fees (DRF) as a revenue for improving quality care services
11	Provider managers have the right to decide where to buy their inputs from accredited distributors operating in competition	Although there is a centrally managed supply system (CMS), health facilities have been provided with a list of accredited suppliers from whom they can procure drugs and medical supplies using their PBF funds	Maintain competition among accredited suppliers
12	The project introduces business plans that includes the Quality Improvement Bonuses	No QIB yet	Establish the necessary structures including QIB officers
13	The project introduces the indices tool for autonomous management	In place	Maintain the indices tool
14	CDV agencies sign contracts directly with the managers of the health facilities – not with the indirect owners such as a religious leader or a Health Centre Committee member.	No CDV Agency contracted and the contract is signed by the Chairperson of the HCMC	Identify and contract CDV Agencies after a merit based transparent procedures
15	Health facility managers are allowed to influence cost sharing tariffs	This is centrally determined	Advocacy for local autonomy
16	Health facility managers have the right to hire and to fire	However, they can hire and fire on short term basis	Advocacy for local autonomy for hospital CEOS and health centre managers to hire and fire staff
17	There is a CDV Agency that is independent of the local health authorities with enough staff to conduct contracting, coaching and medical & community verification	No CDV Agency contracted and the contracts are signed by the Regional Directors and Chairperson of the HCMC	Identify and contract CDV Agencies after a merit based transparent procedures
18	There is a clear separation between the contracting and verification tasks of the CDV agency and the payment function	Both the verification and payments are done by the same Agency – NaNA, however, these two functions are independently carried out by the staff of the Agency	Identify and contract CDV Agencies with clear separation of functions

	Problem	Analysis of the problem	Way forward
19	CDV agents accept the promotion of the full government determined health packages (this in Africa mostly concerns discussions about family planning)	Equipment and supplies are centrally provided; facilities can also procure from their subsidies	Maintain the status quo
20	The PBF system has infrastructure & equipment investment units, which are paid against achieved benchmarks based on agreed business plans	There are no infrastructure & equipment investment units (<i>Equipment and supplies are centrally provided, facilities can also procure from their subsidies</i>)	Establish an extended PBF system with proper infrastructure & equipment investment unit
23	The project provides equity bonuses for vulnerable people	There is no equity bonus for vulnerable people (the indices that are incentivized are provided free)	Provides equity bonuses for vulnerable people

Strengths:

- 4 US per capita per year- PBF is implemented through Ministry of Health structures (Regional Health Directorates, health facilities-hospitals, major and minor).
- Directorates actively counter-verify activities (regions, facilities, and communities) through the RBF Committee contract.
- The Ministry developed a Health Financing Policy (supporting the PBF approach). Health Financing Strategy is currently being developed (to support the policy).
- Ministry of Health supports the program.
- Champions exist (RBF Focal Person, Quality Assurance persons).

Weaknesses:

- The government did not contribute to PBF in 2018, despite contributing in 2016 and 2017.
- The ministry has no PBF Unit for coordinating and monitoring PBF activities.
- The Primary Health Care (PHC) Unit currently used to coordinate PBF activities is ineffective and not strategically located in the institutional set-up.
- User fees remitted to the central treasury account;
- Presently, political PBF champions to influence the agenda have not yet been identified. Thus, high-level training (MoHSW) is imperative.

Opportunities:

- The Ministry has been involved in PBF implementation and monitoring and is likely to be eager to take over PBF; there is also a new political environment.
- A new political environment is likely to embrace positive changes for health system delivery.
- PHC road map developed and validated.
- Global Fund is interested in buying some indicators.

Threats:

- Conflicting donor interests and vertical parallel programs. Thus, harmonizing these is a threat

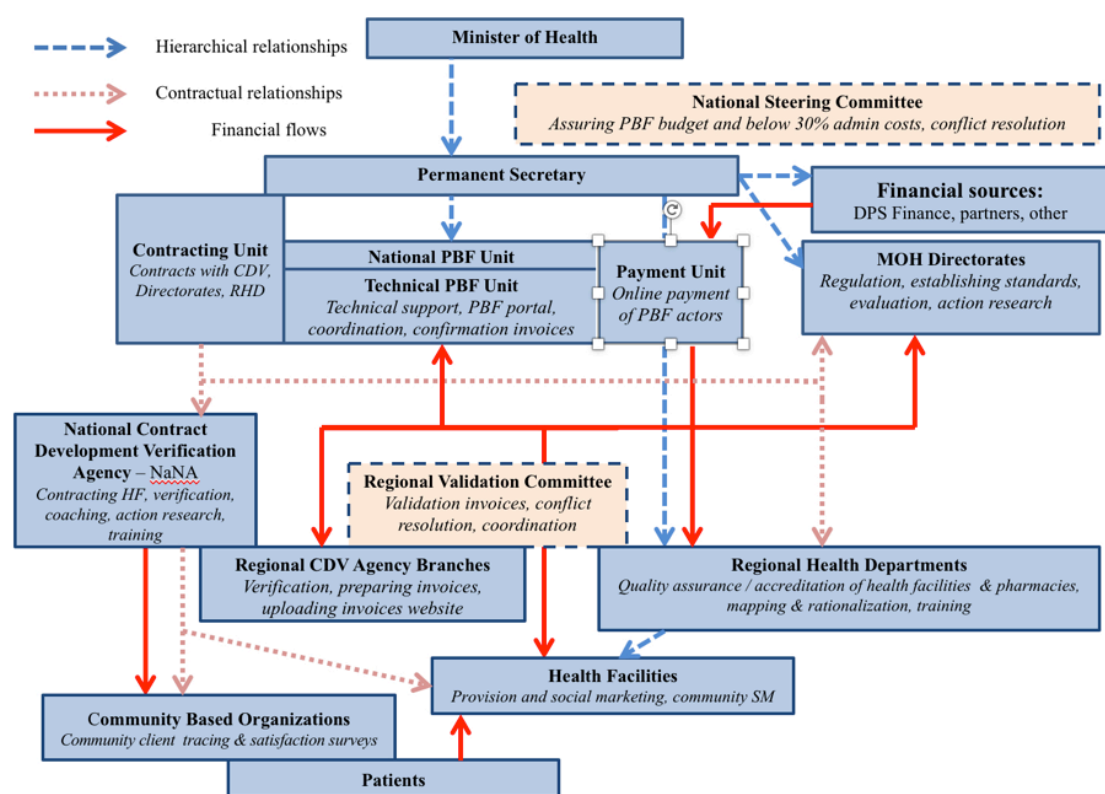
7.7.4 Can PBF help strengthen the health system?

Based on the feasibility scan of The Gambia's health system, PBF can address financing challenges, human resources, quality delivery, and the equitable distribution of scarce resources.

However, placing the PBF Unit at the highest possible level (under the Office of the Permanent Secretary for Health) may be challenging and can only be achieved through the involvement and commitment of the Minister of Health and the Permanent Secretary. Allowing health facility managers to use funds generated from user fees to improve the quality of care services will require a policy change.

7.7.5 Proposed PBF Design

Establishing the PBF unit and implementing international PBF training for identified PBF Champions is crucial for MOHSW buy-in. The proposed design below shows the PBF Unit's placement at the highest possible level to influence decisions and how it relates to other agencies to support smooth implementation of the PBF Strategy.



The design also illustrates the position of the Contract Development and Verification Agency and its relationship to other partners. In addition, as the ministry envisages adopting PBF as the health reform and financing strategy, it is proposed that the Ministry assume the role of payment agency and thus include the DPS Finance under the PS Health.

It is recommended that the PBF Unit have the following portfolios, divided into three sub-units: Contract Unit, Technical PBF Unit, and Payment Unit.

To fulfil this function, the PBF Unit should have the following minimum staff:

- Program Coordinator who will be responsible for the overall functions of the Unit, advocacy, external contracting, and ensuring adequate funding for the sustainability of the program and for the coordination of the Technical Unit

- Deputy Coordinator
- A PBF Portal Manager who will also ensure the portals are maintained.
- A Data Manager who will analyze the data.
- A Communication Officer who will coordinate all training
- Pharmacist or other managers for the regulation and reform of the pharmaceutical market
- Technical adviser
- Contract manager coordinator
- Payment Unit coordinator with administrators

7.7.6 Action Plan

Main objective: The PBF sustainability action plan serves as a roadmap to promote feedback and buy-in from the MoHSW on how to improve and institutionalize operational elements of the PBF approach from now through 2019 and beyond.

Main points

- Submit a report to the National Nutrition Agency and request their support to engage senior management at the Ministry of Health. An advocacy strategy will be outlined for the establishment of the necessary structures
- Some MTR findings noted the need to address certain operational gaps (current performance-based contracting mechanism; inadequate multi-sectoral collaboration/coordination) for improved sustainable PBF implementation
- Promote MoHSW buy-in for PBF and develop a strategy for institutionalizing elements of the PBF approach (PBF Unit, CDV Agencies, and QIB Officers).
- The PBF Unit's functionality is crucial to implementing the project and ensuring MOHSW buy-in, so they adopt PBF as a health reform strategy. As part of its health reform policy, MOHSW has committed to mainstreaming RBF into the health system. In addition, it has also committed itself to using RBF as one of the health reform mechanisms to fund health care in The Gambia.

Activity	How?	Who?	When?
Feedback on the output report (Mombasa training)	Feedback presentation meeting: 1. NaNA 2. PSC 3. RBF Committee	PMOs / RBF TA	Q 2 2018
Institutionalizing some elements of PBF 1. Contracting of health facilities - Central level MoHSW interference in approving health facility business plans reduces autonomy of facilities and regions; and delays BP approvals 2. Separating the functions of fundholder and CDV - NaNA currently doubles its role as a fundholder and CDV - RHD are dually contracted by NaNA and MoHSW which in the long run is not justifiable and sustainable	Short term solution - Move from tripartite performance contracting (RHD and Central Regulator) of facilities TO Single performance contracting (RHD) Long term solution - Advocate to the Project Implementation Committee (PIC); Project Steering Committee (PSC); and RBF Committee for a Separate CDV (proposed NaNA) for the separation of fundholding and CDV functions beyond 2019 Short term solution - Remove the CCTSS done by national Health institutions AND recruit CBOs/local members for the exercise	RBF TA and PIC RBF TA and Gambia Mombasa	Q 3 2018 Beyond 2019

3. Community verification mechanism costly - This verification (consisting of CCTSS and Lot Quality Assurance Surveys for Community PBF) is currently done by contracted external health training institutions, which has led to high administrative costs.	Long term solutions - Enact health facility household visits and include the community indicators in these quarterly assessments	RBF TA RBF TA and the PIC	Q 3 2018 Beyond 2019
Promote MoHSW ownership of PBF (now and beyond 2019) 1. Inadequate knowledge in PBF amongst MoHSW national level officials 2. Inadequate skills and appreciation in RBME and data management in PBF within MoHSW 3. Lack of proper coordination of key stakeholders (Agriculture, Livestock, community development, health departments at district/regional/national level 4. Funding government allocation for PBF (2019 budget) (USE: Health financing Policy and strategy as entry point!) 5. Review Institutional Framework **Separation of functions (CDV?? Fund holder? CBOs?) 6. Establishment of PBF Unit	- To jointly produce quarterly policy project briefs (produced by NaNA and MoH M & E Unit) AND quarterly briefing meetings with PSC and UN agencies - Identification and training of PBF champions (Mombasa Training) Short term solution - Review the RBF C contract and include indicators on data management, monitoring and reporting for M & E unit in the Ministry of Health Long term solution - Establish PBF Unit with technical skills in data management and reporting on PBF - Use performance-based contracting to contract the regional agriculture and livestock department for the Food and Nutrition Security Component - Fully functionalize the quarterly RPIC validation and coordination meetings held at RHD - Central level multi-sectorial quarterly evaluations of regional performance in the MCNHRP - And incorporate UN representatives in the PSC (Recommendations from MTR Findings) Meetings with MoF (continuous) - Ministry of Finance to commit funds for RBF - Follow up of the health financing strategy-Q3 2018 - Institute basket funding system for the MoH - Advocate to the regulator (PS/ Director of Health Services) on the proposed PBF institutional framework (beyond 2019) **NaNA: CDV. - Advocate for the establishment of PBF Unit through policy brief meetings with Senior Management Team through the office of the PS	NaNA/ MoHSW M&E Unit NaNA RBF TA PIC and RBFC RBF TA and PIC PS MoHSW Project Facilitator/ TA RBF/ Technical Working Group Project Facilitator/ TA RBF/ Technical Working Group	Continuous – quarterly Q 4 2018 Q 3 2018 Beyond 2019 Q 3 2018 Q3 - Q4 2018 Q3 2018 And continuous meetings Q3 (Now and continuous for preparation of beyond 2019)

Addressing some operational gaps Scale up of indicators (<i>now</i>) Establish sub-contracting of health posts (<i>Now</i>)	Advocate the scale up of indicators to make up to 25 indicators or more (beyond 2019)	PIC	Q3 2018
	Analyse the service utilisation of key indicators and identify facilities for sub-contracting	PIC	Q3 2018

7.8 Ethiopia

7.8.1 General context

Ethiopia is in northeastern Africa, also known as the Horn of Africa. It borders six countries: Eritrea, Djibouti, Somalia, Kenya, South Sudan, and Sudan. The country covers 1.1 million square kilometers, ranging from 4,620m above sea level at Ras Dashen Mountain to 148m below sea level at the Danakil (Dallol) Depression. More than half of the country lies above 1,500 meters above sea level. According to World Bank population projections, the country ranks thirteenth in the world and second in Africa, with a total population of 102.4 million.

The country has a predominantly rural population, with partial but rapidly expanding access to education, safe water, housing, sanitation, food, and health care. Ethiopia has made notable progress in improving health outcomes and the health service delivery system. Developing and providing quality, equitable, and accessible health services to all segments of Ethiopia's population has been a major government policy objective since the issuance of the 1993 Health Policy. In line with this, various initiatives have been undertaken to improve the delivery of quality health care services and improve citizens' health status.

Ethiopian Demographic and Health Surveys (EDHS 2000, 2005, 2011 and 2016) show improving trends for major health outcome and coverage indicators. The Inter-agency Group for Child Mortality Estimation reported that Ethiopia has achieved the child health-related MDG target (MDG-4), three years ahead of the target date. Over the past 15 years, under-five mortality (U5MR) has declined from 166 deaths per 1,000 live births in 2000 to 88 deaths per 1,000 live births in 2011, and to 67 deaths per 1,000 live births in 2016. Infant Mortality Rates (IMR) have declined from 97 deaths per 1,000 live births in 2000 to 59 deaths per 1,000 live births in 2011, and to 48 deaths per 1,000 live births in 2016. Despite improvements in childhood morbidity and mortality, nearly one in three children is chronically undernourished (38% of children are stunted, EDHS 2016).

More than one-third (36%) of married women aged 15-49 use some form of family planning; 35% use a modern method. Only 26% of births occur in a health facility, primarily in public sector facilities. Only 17% of women aged 15-49 receive a postnatal check within two days of delivery, while 81% do not receive one within 41 days. Merely 13% of newborns receive a postnatal check within two days of birth. Overall, 28% of births are assisted by a skilled provider; Ethiopia's pregnancy-related mortality ratio (PRMR) is 412 deaths per 100,000 live births over the seven-year period before the survey.

Although progress has been impressive, the needs remain huge. Ethiopia's achievements are from a low base, with absolute levels of maternal and child mortality remaining high. Achievements have also been unequal, with pastoral areas particularly lagging, and health care provision remains basic and, in many cases, poor

quality. Therefore, the next phase of improvement will require higher levels of investment as the country needs to move beyond basic-level primary care, largely provided through community-based health extension workers and health centers, to fully functional primary hospitals with skilled health care providers equipped to handle life-threatening conditions, and an effective referral mechanism.

7.8.2 Objectives

The Federal Ministry of Health (FMoH), under the Health Sector Transformation Plan (HSTP) (2015/16 to 2019/20), addresses Universal Health Coverage (UHC) as a key component, aiming to provide all essential health services to everyone without financial hardship. As part of this strategy, the document identifies Performance-Based Financing (PBF) as an approach to ensure quality improvement and assurance.

Accordingly, this document will explain how the Performance-Based Financing (PBF) approach was initiated and implemented in the country context to transform the quality, efficiency, and equity of health care. We believe that successfully expanding the showcase PBF program approach will lead to higher-quality care, increased service utilization, and ultimately a sustainable and equitable health care system, necessary to realize the Universal Health Coverage (UHC) objectives.

7.8.3 How PBF responds to the Health Sector Transformation Agenda

The PBF approach helps realize the HSTP agenda and, in doing so, strengthens the health system.

Transformation in Equity and Quality of Health Care

Improving care quality is central to PBF. Payments to health facilities are based not only on the quantity of services but also on a quarterly quality assessment carried out by district and zonal authorities, along with community verifications. These evaluations, followed by tailor-made feedback and coaching, show facilities their gaps. The quarterly subsidy enables them to make improvements.

Equity within the health system is reinforced by differentiating between facilities and paying an extra equity bonus to those centers that are more remote and face harder working conditions. All facilities are encouraged to step up outreach activities, make the needed investments, and actively engage health posts and community health workers in their work.

Information Revolution

A crucial mechanism for PBF effectiveness is monthly data verification and penalties for deviations from Health Management Information System (HMIS) data. As a result, a universal and tangible outcome of PBF is rapid improvement in data reliability: data falsification is discouraged because it costs facilities money, and understanding of data quality increases. With more reliable information available, health authorities at all levels can use data for health policy-making.

District/Woreda Transformation

District (Woreda) Health Offices actively engage in PBF in a regulatory role, as they conduct quarterly quality assessments of health centres. They also help health facilities set management priorities and develop business plans. Community voice empowerment is carried out through community satisfaction surveys and active

engagement with CBOs. This information can serve as feedback during contractual negotiations between CDV Agency and health facilities.

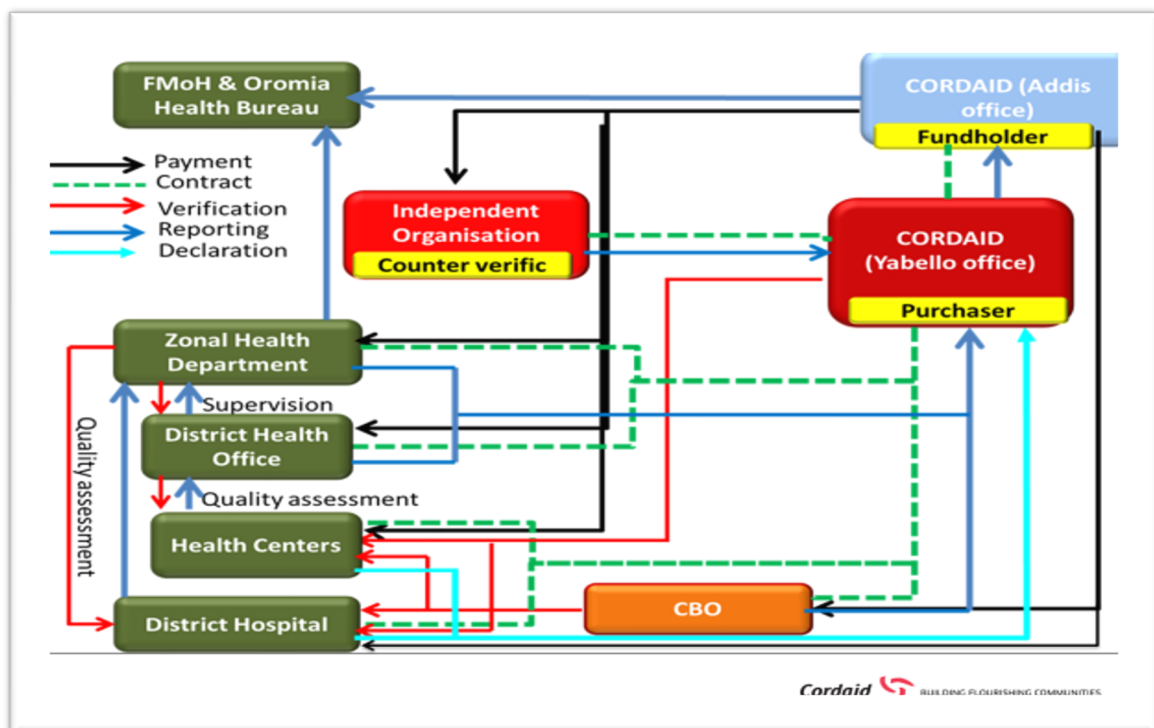
The Caring, Respectful and Compassionate Health Workforce

Finally, the PBF model encourages health staff to develop a sense of ownership regarding their own work, fostering accountability and an entrepreneurial spirit. This is achieved by involving staff in setting quality improvement priorities and turning those plans into reality through PBF incentives earned through their efforts. Experience in Borena shows that PBF increases staff motivation and gives professionals a more patient-oriented and caring attitude.

7.8.4 Status of PBF in Ethiopia: A showcase in Borena

Based on experiences elsewhere, in May 2015, Cordaid started implementing and funding a PBF pilot project in Borena Zone, within the Oromia Region. The Borena Zone is one of the 20 Zonal administrative divisions of the Oromia Region and is located 575 km south of Addis Ababa. The zone has 13 districts (woredas). The PBF project in Borena covers 4 districts: Yabello Town, Yabello Rural, Gomole, and Eliwoya. Accordingly, under the guidance of the Oromia Regional Health Bureau (ORHB) and in close cooperation with the Zonal Health Department (ZHD) and the Woreda Health Offices (WoHO), the project covers one hospital and eight health centres, with a primary catchment population of 126,000 people (substantially more for the general hospital in Yabello: 387,760). Before starting the project, the team rigorously adapted the standard PBF model to the Ethiopian context. After eight months, the project was briefly halted to further contextualize it, based on the initial experiences.

Institutional Design of the PBF pilot



The initial project incentivizes a package of 21 quantity indicators at health centre level and 18 indicators at hospital level. Indicators have been selected to represent a

broad package of essential services, with a primary focus on maternal and child healthcare. Quality assessment tools have been developed to determine a quarterly quality score for each facility. Results over the first two years were promising. Uptake of many key services has improved substantially, most notably at the primary level.

In two years, the number of verified OPD consultations in health centers increased by 138%, while verified ANC4 visits more than tripled (+238%). Average technical quality scores of health centres went up from 22% to 50%, and data inaccuracy reduced sharply, while an internal evaluation showed strongly improved staff motivation. Compared with similar projects in other countries, progress in Borena Zone has been exceptionally strong. This is even more remarkable given the area's economic, geographical, and demographic challenges. This project will expand its coverage and will continue the program from July 2018 to December 2019.

The Quarterly PBF subsidy at Health Center level

Every quarter, the quality of the health centers is assessed using an assessment tool. The quality score is composed of:

- Technical quality: measured by the district (woreda) health office: 80% of the score
- Quality perceived by the patients: measured by contracted community organizations: 20% of the score
- Moreover, health facilities can also receive a remoteness bonus (up to 20% of the quantity payment). The bonus depends on: a. Distance between population and health center; b. Availability of communication; c. Conditions of access roads to health centre; d. Availability of public transport; e. Distance to nearest referral centre

Health centre quantity indicators

21 Indicators at Health Center level	
1. Outpatient Consultations (new cases)	2. Testing for HIV/AIDS
3. OPD consultations under five (New cases)	4. Cases of STIs treated
5. Growth monitoring child < 5 years	6. Cases of TB diagnosed positive by microscope
7. Minor surgery cases	8. Cases of TB treated and cured
9. Malnutrition detected in children under five	10. Skilled Delivery
11. Referred delivery (form used)	12. Post-natal care (2)
13. Children < 1 year fully Vaccinated	14. New construction & utilization of standard latrine
15. Pregnant women who received TT2 + doses	16. 1st & repeated visit FP modern methods (LT&ST)
17. Vitamin A given to a child 6 to 59 months	18.
19. HIV+ tested pregnant women PMTCT optB+	20. Antenatal care visits (4)
21. Management newborn from HIV+ mother	22. First ANC visit within 16 weeks of pregnancy

The Quarterly PBF subsidy at Hospital level

For the hospital, 18 quantity indicators were selected, and the verification officer verified performance monthly, allowing a 10% error margin. Each indicator has its set price, based on the priority perceived by the Regulator

Hospital quantity indicators phase I of the Borena project

	18 hospital quantity indicators
1.	Outpatient Consultations (new cases)
2	Outpatient Consultations for children under five years (new cases)
3	Hospital bed days (observation/Hospitalization)
4	Major surgery cases (excluding caesarian sections)
5	Minor surgery cases
6	Blood transfusion
7	Severe Acute Malnutrition (SAM) children under five years
8	Referred delivery received from health center
9	HIV positive tested Pregnant Women put on PMTCT option B+
10	Newborn management of a baby born to an HIV positive mother.
11	New HIV/AIDS cases placed on ARV Therapy (ever started)
12	Existing patient on ART
13	Cases of TB diagnosed positive by Microscopy
14	Cases of TB treated and cured
15	Skilled Delivery (excluding caesarian section)
16	First and repeated visits for FP modern methods (short term)
17	First and repeated visits for FP modern methods (long term)
18	Caesarean sections

List of District (Woredas), Health Facilities and Catchment Population of PBF Project in Borena Zone

Name of Districts (Woredas)	Name of the Health Facilities	Catchment Population
Eliwoya	1. Adegachat health center 2. Elweye health center 3. Cari rufa health center 4. Horbate health center 5. Saba health center	12,167 15,496 5,436 10,551 3,303
Gomole	1. Surupha health center	49,926
Yabalo rural	1. Dikale health center 2. Did-yabalo health center 3. Haro Wayu health center	5,536 26,211 12,662
Yabello town	1. Yabello health center	26, 226
Arero	1. Mata gafarsa health center 2. Hallonaa health center	32,087 12,646
		186,021

Results of the PBF phase I project in Borena

Cordaid initiated an internal mid-term review to gather qualitative results from the PBF pilot project, and some results are highlighted below.

1. Results in relation to the separation of functions:

- Cordaid Borana is acting as purchaser; consistent verification, coaching, monitoring, and follow-up have been key drivers of change, encouraging health staff in the PBF facilities. This way, gaps and directions for change become clear to facilities
- Health center and hospital data have become much more accurate.

- Staff perceive regular verifications as being taken seriously and being cared for: it has stimulated a more caring attitude toward their patients
- Timely payment of the fund holder has given health facilities confidence
- Quarterly monitoring by the woreda health officers on quality shows facilities their gaps and their progress over time and is much appreciated

2. Results in relation to linking payments to results:

- There is an increase in volume on key quantity indicators and on quality
- The cycle of positive change has started: facilities receive PBF payments, prioritize, invest, receive higher payments, gain confidence, and receive positive patient feedback, resulting in pride in their work, more initiative, and improvements.
- 30% of the quarterly PBF subsidy for top-up of staff salaries is a driver for staff, also since they earned it themselves
- Improvement in data accuracy and HMIS

3. Results in relation to contracting and business plans:

- Hospital perceives the contracts with the Cordaid/purchaser as crucial
- Business plan: most HCs prioritize their key activities and investments as a team; in doing so, some of the HCs actively involve community members
- The HFs appreciate the clear agreements and directions in the contracts and Business plans: this guides them in their change and is essential for internally monitoring the change and re-planning: now we know where we are going!
- Business plans enable the HFs to focus on key shared priorities such as infection prevention.
- Examples of actions prioritized by health centers in their BPs that were implemented include fencing, medical equipment and supplies, medicine, improvements to physical structures (painting/repairs), and motorbikes.

4. Results in relation to autonomy:

- All health center staff mention that they feel more responsible for their work, the team, and the facility's performance.
- Staff enjoy their work more and, as a result, have become more creative in finding solutions and increasing patient flows.
- Autonomy in using the PBF subsidy creates entrepreneurship and gives HC and hospital staff a sense of ownership.
- Staff members have become more caring: they know this will attract more patients, resulting in a 'win-win' situation.

5. Results in relation to Community empowerment:

- Most health centers are finding ways to involve the community (building and improving health centers and providing inputs for BPs).
- HCs involve the HDA and the HPs for mobilization activities. Also, HC staff participate in campaigns
- Staff of HCs become more client-friendly and interested in what the patients would like
- The scores on the community satisfaction survey for the HFs are increasing

6. Results in relation to Equity:

PBF zonal steering committee: The steering group oversees project implementation, provides general orientation, discusses strategic issues (segregation of duties, autonomy, sustainability, integration, etc.), ensures advocacy, monitors adherence to the timeline, and arbitrates conflicts.

The PBF technical working group: The technical working group will focus more on project content, such as detailed program design, monitoring, and evaluation.

Health Care Providers: Health facilities delivering services. In the Borana project Phase II, there will be 23 public health centers and two primary hospitals.

Regulators: Phase II of the PBF Borana project will be implemented in 8 health woredas: Dubuluq woreda, El Waye woreda, Guchi woreda, Moyale woreda, Gomole woreda, Wachile woreda, Yabello town, and Yabello rural woreda. Therefore, regulators are the eight Yabello Woreda Health Offices (WHO), the Borana Zonal Health Department (ZHD), as well as the Oromia Regional Health Bureau

PBF teams: The primary hospital and the health centers involved in the project will set up a PBF team in their health facility.

The Payment Agency for the PBF project is the Addis Ababa office of Cordaid only during Phase II of the Borena project.

The Cordaid sub-office in Yabello town will serve as the Zonal Contract Development and Verification Agency during Phase II of the Borena project. In the future (this must be discussed and agreed upon by FMOH), this role may be transferred to the Ethiopian Health Insurance Agency (EHIA).

Community Based Organizations (CBOs) are contracted to undertake community verification and patient satisfaction. CDV Agency staff take samples from the patient registers. The CBO is provided with the information needed to trace patients. When the patient is traced and verified, the same patient is asked for his/her opinion on the services provided.

List of Districts (Woredas), Health Facilities and Catchment Population of Borena PBF Showcase scale-up project

Woreda/Districts and Health Facilities under PBF showcase project Phase II				
S.no	Name of the woreda	# of Health center	Name of the Health Center	Catchment population
1	Dubuluq	1	Dubuluq Health center	16.562
		2	Dhokole health center	3.808
		3	Gobso health center	3.474
		4	Bokosa health center	4.674
2	Elwaye	1	Adegalchat health center	12.167
		2	Elweye health center	15.496
		3	Cari rufa health center	5.436
		4	Horbate health center	10.551
		5	Saba health center	3.303
3	Guchi	1	irdar Health center	31.685
		2	Gofa health center	74.188
4	Moyale	1	Moyale health center	90.248
		2	Tuqa health center	10.165
		3	Afura health center	10.983
		4	Xile mado health center	35.084

		5	Mado health center	14.024
		6	<i>Moyale Hospital</i>	<i>357.192</i>
5	Gomole	1	Surupha health center	49.926
6	Waccile	1	Wachile health center	23.438
		2	Web health center	2.709
7	Yabalo woreda	1	Dikale health center	5.536
		2	Did-yabalo health center	26.211
		3	Haro Wayu health center	12.662
8	Yabello town	1	Yabello health center	26.226
		2	<i>Yabello General hospital</i>	<i>436.173</i>
	TOTAL		Without the two hospitals	488.556
Total including the two hospitals:				793,365

7.8.6 Advocacy Action Points

Activities	Responsible body	Due Date
Organizing workshops on PBF for relevant stakeholders	FMoH, Cordaid, Regional Health Bureau, EHIA	July 2018 & January 2019
Conduct exposure visit for relevant stakeholders to Borena	FMoH, Cordaid, Regional Health Bureau, EHIA	October, 2018
Training for front line champions on PBF	FMoH, Cordaid, Regional Health Bureau, EHIA	October, 2018
Intervention scale up in Borena for 18 months (Phase II Borena showcase project)	FMoH, Cordaid, Regional Health Bureau, Borena WHO's and Borena Zonal Health Department,	July, 2018

Institutional Design of a possible future national PBF design.

