

**Performance-Based Financing (PBF) within the Catholic
Organisation for Relief and Development Aid (CORDAID):**
Overview of activities, October 2009

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CORDAID has implemented performance-based programmes in several countries and different contextual situations, ranging from very fragile (Sudan and Central African Republic) to stable (Tanzania, Zambia and Indonesia). The most important characteristics and approaches of all programmes are summarized underneath.

Rwanda

CORDAID started Performance-Based Financing (PBF) in four districts in Cyangugu province in 2003. Concurrently, similar projects were started by the Belgian Technical Cooperation (BTC), Management Sciences for Health (MSH) and HealthNetTranscultural Psychosocial Organisation (TPO). PBF was adopted as a national policy in 2006. The Rwanda-approach is generally considered to be a good example of successful introduction of PBF at a national level.

The initial pilot project in Cyangugu was supervised by a steering committee, in which local communities, donor organisations and local government were represented. Priorities and contracts were negotiated at decentralized level. After scaling up PBF, the steering committee is still in place, but its role and composition have changed. While the steering committee still needs to give final approval for payments to health facilities, community organisations have less influence and the committee primarily consists of Ministry of Health (MOH) and donor representatives. Furthermore, the principle of an independent fund holder agency (FHA) was abandoned. The MOH purchases hospital care and the local district authorities are purchasing primary health care (lower level units). This means, priorities and indicators for hospitals are defined at central level. At the moment, some of the initial components of the Cyangugu set-up, like the business plans and verification by local community groups, are re-introduced in the national system.

A comprehensive verification system has been developed. The MOH at district level organizes peer evaluation at the level of district hospitals. During these evaluation sessions, the MOH officers check general health management information systems (HMIS) data and several quality indicators together with representatives from other district hospitals.

At the start of the PBF programme in 2003 CORDAID performed the role of fund holder. Since 2007, the former CORDAID office became an independent nongovernmental organization (NGO), now focussing on technical assistance related to PBF, community participation, and health insurance. The NGO, called Health Development Performance (HDP), operates in Rwanda and other Sub Saharan countries.

Democratic Republic of Congo

PBF programmes in Congo are located in South Kivu and the Kasai region. South Kivu region, which is in the eastern part of the country, is characterized by instability and the absence of formal health systems and the regulator (inspection) function. In this region, PBF is not only applied in the health system, but also in the education and infrastructure development.

In both regions (South Kivu and Kasai), independent NGOs are now operating as fund holders. Initially the fundholding tasks were performed by the diocesan health office (South Kivu) and a project unit directly funded by CORDAID (Kasai).

The Kasai fund holder, officially named EUP-FASS, is currently contracting 189 lower level units and 16 hospitals in 13 districts, with a total population of 2 million. The entire program is supervised by a provincial piloting committee, which is made up of government officials, civil society, and development organisations.

In both programmes, business plans are made at facility level, the community is directly involved through a Comité de Santé (COSA) and verification is contracted out to civil society organizations. Performance bonuses are based on a set of 15 to 20 indicators, which are determined at decentralized level.

Quality assessment is done by local health authorities, which are contracted for this purpose. Facilities receive an incentive, based on their total score on the quality checklist.

To improve access for the poor, each facility is encouraged to develop a business plan which describes how the most vulnerable people can be identified and supported in their health care expenses. If the plan is approved by the fund holder, the facility is granted an extra percentage (for the equity fund) on top of their regular budget.

Burundi

In 2006, CORDAID started an '*approche contractuelle*' to finance basic health care (both public and private service providers) in the provinces of Bubanza and Cankuzo. The approach has been adopted by the national government and is now implemented by CORDAID in seven provinces with funding from the European Union (EU) and the Global Alliance for Vaccines and Immunisation (GAVI) ().

Local FHAs have a central role in Burundi. Each FHA is responsible for contracting individual facilities, payments and verification in a specific province. Based upon performance, funds are transferred directly after verification. The FHA also contracts local community organizations for data verification and in particular to measure patient satisfaction.

Quality control is done by the "Bureau Provincial de Santé", the intermediate level of the MOH, which operates as regulator. The "Comité de Suivi et Evaluation", a steering committee organized at the level of the MOH, oversees the general implementation of the PBF and the functioning of the intermediate levels of the MOH in their regulatory role. Quality assessment and access for the most vulnerable groups is approached in a similar way as in Congo. As part of their contract with the FHA, health care providers make a business plan in which they express their strategy on how to reach the poor and most vulnerable, and for which they are remunerated.

Tanzania

For a long period of time, CORDAID has been funding health care activities executed by the Roman Catholic Church in five rural areas in Tanzania. In some cases, funding relations dated back to the early 1990-ies. Funding levels were based on the activity plans of diocesan health facilities, and there was no clear relation with output or outcome of activities.

Following positive experiences with PBF in Cambodia, Haiti and also in an African setting in Rwanda, CORDAID decided to change its funding strategy in Tanzania to a more output base approach. In this respect, there is a distinct difference with the Burundi and Congo set up: The programme was developed to support individual health facilities belonging to the Roman Catholic Church and not to support all health facilities (public and private) in one specific area.

CORDAID retained some crucial tasks at the central office in The Hague. For instance, verification is done by an external consultant, directly contracted by CORDAID. Also, incentive payments were transferred directly from the head office in The Hague. Contracting only exists between CORDAID and the diocesan health office, not with individual facilities.

The number of indicators is limited to five and focuses on utilization rather than quality. One indicator tracks the continuous availability of 10 essential drugs. Targets for the indicators and the actual indicators used were set during workshops with representatives from the diocesan health offices and

were the same for all participating facilities, irrespective of their location. Local government and MOH were informed, but not actively involved in the programme.

Following an evaluation in 2008, some changes were made to the programme. A limited number of quality indicators were added, local verification committees were established and individual facilities were also being contracted. The integration of the Faith Based Facilities into the public system remains a challenge. At the moment the public and the faith based health facility still function in parallel systems.

Zambia

Introduction of PBF in Zambia took place according to the Tanzania model: Existing funding relations were transformed from input (or activity) based to output based. The current programme operates in six hospitals and six health centres. The programme uses the same indicators as in Tanzania. Furthermore, similar strategies were used to set targets and disburse funding. As a result of the 2008 evaluation, management of the PBF programme was handed over to the Churches Health Association of Zambia (CHAZ). In addition, it was decided that the PBF approach had to be remodelled because it had many shortcomings.

Early 2009 CORDAID and the Zambian MOH decided to cooperate on the development of PBF. It was agreed that the MOH and CORDAID will pilot their approaches at the same time. To avoid duplication and/or ending up with two parallel systems, and to learn from each other, both groups involve each other as much as possible in their programs. Furthermore the intervention will build on existing systems, such as the routine planning and budgeting cycle, the performance assessment framework and the HMIS of the Zambian health care system. Both pilots are comparable to a large extent. The CORDAID pilot differs because of:

- a clear separation of responsibilities between regulator, fund holder and provider;
- an independent local fund holder;
- participation and a strong voice of the community.

Recently, the Zambian MOH started a pre-pilot project on mother and child health with PBF (called RBF: Result Based Financing) in one district. Its intention is to scale up this programme with World Bank assistance and Norwegian funding to a pilot in 9 districts and 18 control districts. It is the aim to come to one overall Zambian approach after a few years.

Cameroon

Performance-Based Financing initiatives were started in Batouri diocese in East Cameroon. The programme resembles the Burundi and Congo approach when it comes to indicators and verification methods. There is a difference in participating facilities: The programme was started only in Roman Catholic health facilities. Although the local government is involved in steering committees, there is no direct involvement as regulator or in quality assessment. Quality is assessed by organising three monthly surveys, which also serve as a verification tool. The diocese is operating as fund holder. The intention is to start a similar programme in three other Roman Catholic Dioceses in East Cameroon.

Together with the MOH, the World Bank and independent consultants, CORDAID recently developed a plan to integrate government facilities in the Batouri programme. This project will be funded by the World Bank. The project will be evaluated after 3 years and all stakeholders have expressed the intention to scale up if the project is found to be successful.

In October 2009 a two-week course on PBF was organized in Limbe. This course was attended by participants from the national MOH, local health authorities, public health facilities and church facilities. In addition, participants from the Central African Republic also attended the course.

Indonesia

The Indonesia PBF programme has only started recently. A base line survey was done in two districts of Flores Island and the results were used to determine the indicators and targets.

Initially, the intention was to channel funds through existing social insurance organisations, which would operate as fund holder. Due to gaps in its organisational capacity, it was decided not to involve them in the programme. The fund holder function is now organised at the district level, as an independent unit directly funded by CORDAID and supported by expatriate technical assistance. A steering committee, in which facilities, communities and other stakeholders are represented, will oversee the operations of the fund holder. Both public and private facilities will be contracted. The first contracts are expected to be signed by the end of 2009. Community groups will be contracted for verification and assessment of patient satisfaction.

Central African Republic (RCA)

CORDAID's emergency aid department recently started a PBF programme in one province in eastern RCA (Nana Mambere). The programme covers all health facilities in one prefecture, either through direct contracting or a subcontract. The "*agence d'achat*" operates as fundholder (FHA). The programme, including the "*agence d'achat*" is fully funded by CORDAID.

The programme will be expanded in 2010 in 2 other provinces (5 prefectures) with EU funding (5.4 million Euros). In each of the two provinces, an FHA will be established, which is responsible for contracting individual facilities, incentive payments and verification. Thus priorities are set at a decentralized level. The FHA are now fully supported (technical and financial) by CORDAID, but it is CORDAID's intention to transform them into fully autonomous NGOs in three years time.

Quality control is done by the Provincial Health Committee which operates as regulator. The programme covers a population of 1 million. Interesting characteristics of the programme are the integration with health education at community (village) level and contracting of educational services in primary schools. These mainly focus on higher enrolment and participation of girls. Important constraints in the programme are the low medical and managerial capacities across the board. This refers to health providers, government as well as civil society.

Sudan

CORDAID has two operational field offices in Sudan, one in North Sudan (South Darfur) and one in South Sudan (Northern Bahr el Gazal). Both offices are supporting primary health care programs. In 2 counties in Aweil (South Sudan), CORDAID is working together with the MOH, assisting 8 health facilities providing basic health care services to 150,000 beneficiaries. In South Darfur (North Sudan), CORDAID is working together with the MOH and SudanAid in 18 facilities, serving over 200,000 local beneficiaries and 50,000 internally displaced people. In both operational areas, CORDAID has incorporated capacity building of respectively MOH and local partner SudanAid (South Darfur).

The activities mentioned above are related to emergency aid. Apart from this, more structural assistance is provided through a community based health care programme (together with local partners) and support is given to the Christian Health Association of Sudan (CHAS). CORDAID has assessed the feasibility of PBF in the primary health care programme in Aweil County (South Sudan). It was found that conditions for PBF are not conducive, because of, for instance, the absence of a well functioning banking system and enough qualified health staff. Still, with the experience of similar PBF programmes in other countries, CORDAID intends to start implementing a PBF system together with HealthNet/TPO in the course of 2010.

The PBF-network

Many of CORDAID's partners emphasized the need for structural exchange of best practices and lessons learnt in relation to PBF. This is the reason why CORDAID has initiated the establishment of a PBF-network in Sub-Saharan Africa. This network will be operational in 2010 and, apart from sharing knowledge, it also focuses on building knowledge (through action research) and building capacities to support implementation of PBF programmes. Specific areas of attention in the 7 participating countries are:

- DRC (Congo): Introduction of PBF in HIV/AIDS activities in Bas-Congo, setting up training modules and the integration of PBF and health insurance in Sud-Kivu
- Rwanda: Research into the harmonisation of PBF and health insurance
- Burundi: National management structure for fund holding agencies and contracting community based HIV/AIDS indicators in Makamba.
- Tanzania: Training modules in English and a pilot with contracting between the local administration and church facilities in Rungwe district.
- Zambia: strengthening the voice of the community, capacity building of CHAZ in PBF, harmonisation between RBF by MOH and PBF by CHAZ/CORDAID, training for all involved in PBF and a pilot in one district;
- Cameroon: Creation and institutional strengthening of a fundholder; Training of stakeholders involved in PBF pilots; Strengthening community participation in the pilots.
- Central African Republic (CAR): Training of stakeholders; Institutional strengthening of one of the partners involved in the implementation.