Stocktaking, Reflection and Perspectives on Sustainable RBF for UHC

Session 2.4 - Reflections on PBF design, implementation, applicability in different settings

Maria Bertone
Queen Margaret University, Edinburgh
Mbertone@qmu.ac.uk

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Introduction

- Focus on PBF in fragile and conflict-affected settings (FCAS) – including humanitarian crisis settings
- Based on literature review and empirical case studies
  - Bertone MP, Falisse J-B, Russo G, Witter S (2018) Context matters (but how and why?) A hypothesis-led literature review of performance based financing in fragile and conflict-affected health systems. PLoS One, 13(4): e0195301. http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0195301
  - Bertone MP, Jacobs E, Toonen J, Akwataghibe N, Witter S (2018) Performance-based financing in three humanitarian settings: principles and pragmatism. Conflict and Health, 12: 28. https://conflictandhealth.biomedcentral.com/track/pdf/10.1186/s13031-018-0166-9

- Focus on the **context** and how it influenced **adoption** and **implementation** of PBF
- Reflect on lessons learned for FCAS as well as non-FCAS settings

- Please add in and share your experiences and views, during the discussion.

PBF and context

- Over the last few years, literature on PBF impact, theory of change, and health system linkages has been growing
- PBF modalities, implementation processes and effects are likely to be dependent on the **context** in which it is implemented
  - However, surprisingly little literature looks at how context affects PBF programmes
- By "context", we mean the socio-economic structure, political organisation, health system organisation. Because of the focus on fragile settings, we have specific interest in fault lines inherited from the conflict/crisis period
- Our question:
  - How does the context of FCAS influence the adoption, adaption, implementation and health system effects of PBF? What can we learn from this?

Why a focus on PBF in FCAS?

- The rationale for focusing on **FCAS** is based on several arguments:

  - The burden of ill-health is increasingly focused in FCAS → the role of PBF in addressing these health needs is particularly relevant to unpack
  - Many of the early PBF schemes emerged in FCAS countries (Rwanda, Burundi and DR Congo). This has been noted by many observers but there were no systematic analysis on why that might have been.
  - Conflicting argument: some argue that PBF is unlikely to be effective in fragile settings vs. others point out that precisely in situations of weak institutions there is more potential for PBF to re-align relationships and improve accountability

  - FCAS might present similar but more 'extreme' features/challenges to non-FCAS settings, which might help tease out lessons and reflections.

PBF in FCAS

- PBF adoption across **countries** (reference date: 2017)
  - 23 (43%) out of 53 FCAS countries have/had at least one PBF programme
  - 19 (56%) out of 34 PBF programmes in SSA are implemented in FCAS
- All PBF programmes in SSA implemented before 2006 are in FCAS settings (Rwanda, Burundi, DRC, Cameroon, Cote d'Ivoire)

- The first countries to have scaled-up PBF nationwide are Rwanda (2008), Burundi (2010) and Sierra Leone (2011)
- Appears to have been a successor to PBC model supported earlier by donors in FCAS (Cambodia, Haiti, Afghanistan and Liberia)
- Often multiple schemes – e.g. DRC (7) and Burundi (6) over past ten years

Afghanistan	Comoros	Guinea	Nigeria
Burundi	Congo (Republic)	Guinea Bissau	Rwanda
Cambodia	Cote d'Ivoire	Haiti	Sierra Leone
Cameroon	Djibouti	Lao PDR	Tajikistan
Central African Republic	DR Congo	Liberia	Zimbabwe
Chad	The Gambia	Mali	

Patterns of PBF adoption in FCAS

- Why was PBF introduced?
  - Link with experience of conflict and fragility rarely explicitly made

- PBF facilitating factors – some hypotheses confirmed:
  - Larger-than-usual place of **external actors**: largely externally driven adoption in both main patterns
  - Low levels of interpersonal trust and need to strengthen **accountability** and **good governance** (Mali, Burundi, Cameroon)
  - Lack of trust between donors and government and **fiduciary concerns** (DRC, Cote d'Ivoire, Zimbabwe)
  - Flexibility (or absence) of existing **institutions** (Rwanda, Burundi)
  - Less entrenched **interests** and power relations (SL)
  - Push for **decentralisation** and **facility autonomy**? Often *de facto* (inherited from conflict period) and not explicitly acknowledged, although present

Patterns of PBF implementation in FCAS

- Features of implementation – hypotheses & evidence:
  - More variation and **adaptation** of PBF in FCAS?

→ Copy-and-paste approaches after first scheme in Rwanda

→ Exception: adaptation to humanitarian and early recovery contexts (Nigeria, CAR, DRC) – empirical evidence through case studies

  - Challenges **sustaining PBF overtime**

→ start-stop(-start) approaches (SL, Chad)

→ More sustainable when linked to broader health financing/system reforms (Rwanda, Burundi)

Patterns of PBF implementation in FCAS (2)

- Health system effects of PBF in FCAS:
  - *Governance:* some evidence of PBF strengthening local level governance, but less at national level (CAR, Chad, DRC, Burundi)
  - *Health financing*:

→PBF explicitly used to replace loss user fees under FHCI (Burundi, N. Mali?)

→PBF funds may represent the only cash funding for lower-level facilities

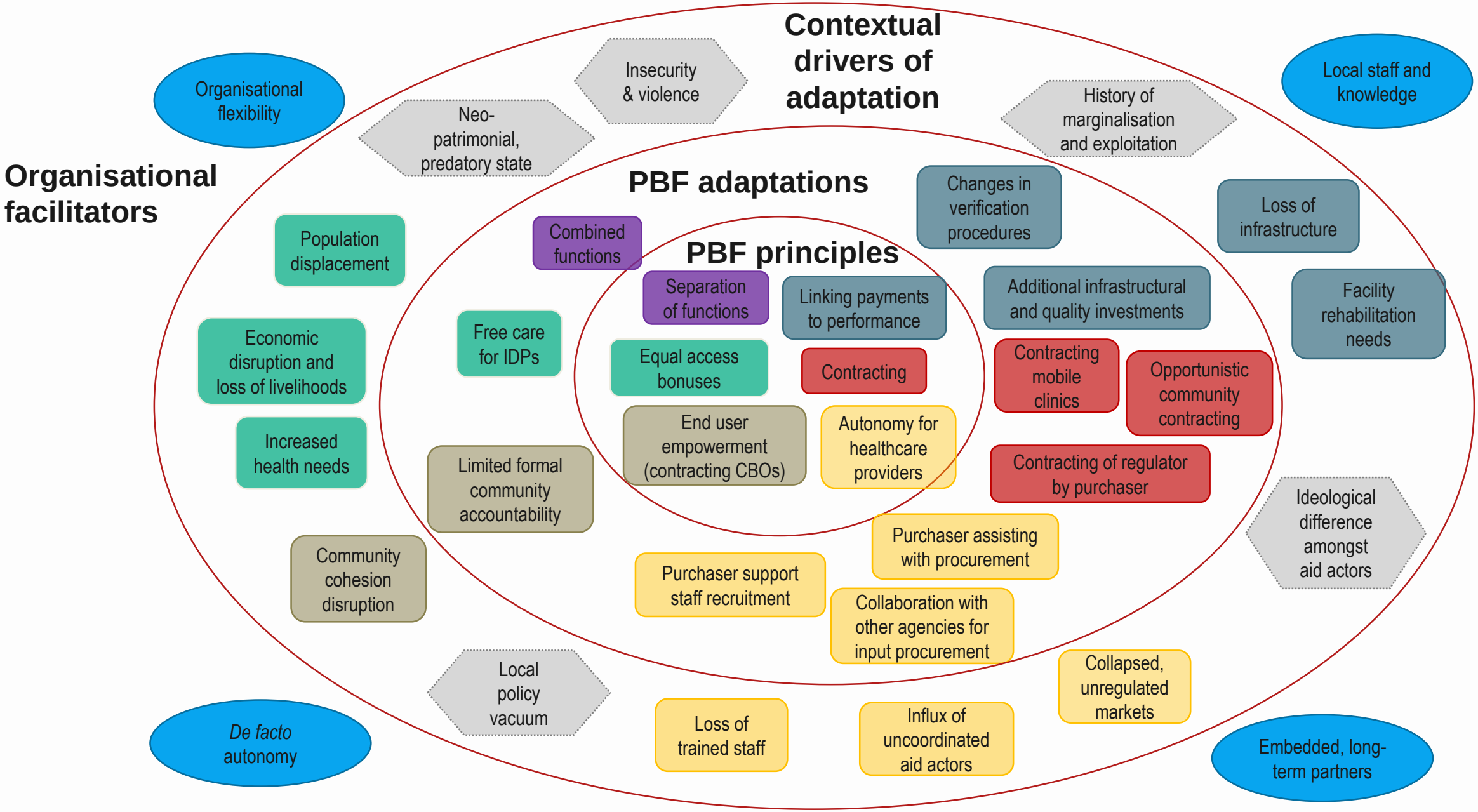
  - *HRH*: PBF may represent a higher share of income in FCAS where salaries are low/inexistent
  - *Infrastructure*: PBF does not seem sufficient to address infrastructure and equipment concerns in post-conflict settings – often coupled with non-performance based payments (CAR, Cote d'Ivoire, Adamawa State/Nigeria)

Case Studies:
PBF in humanitarian settings

Case studies: PBF in humanitarian settings

- Explore the emerging adaptations of PBF to humanitarian and early recovery settings
- Analyse how these adaptations worked and the underlying factors that sustained/hindered PBF's implementation and effectiveness in those contexts
  - Focus on South Kivu (DRC), Adamawa (Nigeria), Central African Republic (CAR)

	Central African Republic	Nigeria (Adamawa State)	DR Congo (South Kivu)
When was PBF introduced?	Since 2009	Since 2012	Since 2006
Where?	Various regions, using different models	Pilot in 3 states – focus on Adamawa State	Several pilots – focus on South Kivu
Funding	Cordaid, EU (Fonds Bekou), World Bank	World Bank	Cordaid
Implementation	Cordaid, AEDES, MoH	National Primary Health Care Development Agency and State-level Primary Health Care Development Board/ Agencies	Cordaid
Context	Depending on the areas: humanitarian and protracted crisis or early recovery	Adamawa State affected by Boko Haram's insurgency	Cycles of acute crisis and relative stability


Organisational facilitators
Contextual drivers of adaptation
Insecurity & violence
Neo-patrimonial, predatory state
History of marginalisation and exploitation
Organisational flexibility
Local staff and knowledge
PBF adaptations
PBF principles
Population displacement
Economic disruption and loss of livelihoods
Increased health needs
Community cohesion disruption
Limited formal community accountability
Free care for IDPs
Combined functions
Separation of functions
Equal access bonuses
End user empowerment (contracting CBOs)
Linking payments to performance
Contracting
Autonomy for healthcare providers
Changes in verification procedures
Additional infrastructural and quality investments
Contracting mobile clinics
Opportunistic community contracting
Contracting of regulator by purchaser
Loss of infrastructure
Facility rehabilitation needs
Ideological difference amongst aid actors
Purchaser assisting with procurement
Purchaser support staff recruitment
Collaboration with other agencies for input procurement
Collapsed, unregulated markets
Local policy vacuum
Loss of trained staff
Influx of uncoordinated aid actors
De facto autonomy
Embedded, long-term partners

Some thoughts and reflections

Thoughts and reflections

FCAS & humanitarian settings

- Some evidence that certain conditions of fragility may favour the rapid emergence of PBF
  - Role of external actors, openness to institutional reform, lower levels of trust in the public system and between donors & government
- **Pragmatic adaptation** of PBF to local context is important in FCAS/humanitarian settings for PBF to work
  - A mix of pragmatism, local intelligence and learning processes – easier said than done! Interesting to hear your experiences on this.
- What is the potential **role of the World Bank** in these settings, including advantages/ disadvantages over (I)NGOs?
  - Issues around flexibility of implementation (if NGOs are implementing partners as in CAR should be allowed sufficient decision space and margin of manoeuvre for such adaptations)
  - There are also issues around the scale of the PBF programme – small pilot vs. larger/nationwide programme

Thoughts and reflections (2)

- What can be learnt for **other (non-FCAS) settings**, for design, implementation, applicability?
  - Many patterns identified are not unique to FCAS. Some might be 'starker' in FCAS and more easy to identify

- Importance of context and of **adapting PBF design and implementation** to it
  - Pragmatism, local intelligence and learning processes are not only useful in FCAS!
  - Key question for design: **why PBF?** What specific challenge(s)/blockages would PBF address *in this context*, and how?
  - PBF is not 'well implemented': might this depend on actual context or the lack of adaptation to it? Is the design realistic?

- In order to assess applicability and tailor PBF programmes, need to **interrogate key aspects** of the broader context and of the health system
  - This includes existing institutions (for example on PFM, on decentralisation, on facility autonomy), stakeholders/power relations and health system features (levels of funding for facilities and HWs, infrastructure, drug procurement systems and quality, capacity and skills, HMIS, etc.).
  - If certain institutions cannot be radically changed, it is worth working *within/around* them (whether that is banking/IT infrastructure or institutional reform - political economy issues discussed in session 3.4)
  - Sustainability in the longer term often depends on how well integrated PBF is within the broader health system

Thank you

Group discussion

Fragile and Conflict Affected Settings

1. Alignment and coordination in FCAS

What are opportunities for improved alignment of donors around PBF in FCAS contexts? How to ensure government ownership and leadership? What role can the Bank play? How can the WB support the government's stewardship role? What are some of the challenges?

2. Agile design and implementation

How can we ensure flexible design and build in learning from implementation to adapt PBF processes in FCAS contexts? How to engage local stakeholders in this? What is the role of the Bank?

3. Humanitarian – development nexus

What is the potential role of PBF as a tool to supporting the humanitarian-development nexus? How can this best be supported, including government ownership, whether or not to fund (I)NGOs? How can (Bank) processes allow for dealing with the FACS context, including advance payments, procurement of medicines, etc. Can the project include an 'exit strategy' in the design? How to design the WB interventions to reinforce institutional capacities and establish better institutional arrangements to enhance stewardship of the government institutions?

Group discussion

Non-FCAS

4. Lessons learned from FCAS

What are some of the lessons learned from FCAS that strike you as relevant for non-FCAS settings (if any at all!)? How could they be integrated in PBF practice in non-FCAS?

5. PBF design

A key question during the design of PBF is to be explicit as to which specific, pre-existing health system challenge(s)/blockages PBF would address in this context, and how. How is the PBF complementary to other flow of funds? What are your experiences with this? How to ensure other health system bottlenecks (e.g. supply chain) are also addressed to help improve outcomes? How to support integration of PBF in the Strategic Purchasing agenda?

6. Context

What are some of the political economy (e.g. buy in) and/or structural constraints (banking system, autonomy) that hamper PBF implementation? What is your experience in navigating them and adapting or adjusting implementation to address/work around those constraints? How to support countries to maintain PBF costs and make the program more sustainable?