Health System Strengthening through Performance-Based Financing in Seven African countries – 2010-2012

Mid-Term Review
Country Report Zambia

Evaluation team

MARIA PAALMAN
ERNEST SCHOFFELEN
THEOPHIL MICHAEL SULE

NOVEMBER 2011

Table of Contents

Abbreviations

CHAZ	Churches Health Association of Zambia
CHW	Community Health Worker
DHO	District Health Office
FBO	Faith-Based Organisations
HR	Human Resources
MCH	Maternal and Child Health
MoH	Ministry of Health
MoU	Memorandum of Understanding
PBF	Performance-Based Financing
RBF	Results-Based Financing
SCCP	Samfya Community of Care Providers (NGO)
TBA	Traditional Birth Attendant
TWG	Technical working Group
UNZA	University of Zambia

1 Introduction

In July 2011 Zambia has become a low-middle income country, but traveling by car from Lusaka to the North and East for over 1500 km we saw deep poverty in the rural areas, so there must be large inequalities in income.

The new Zambian Government has committed itself to increase the percentage of government budget for health from 6% to 15% by 2015 (target set by the Heads of States of the Organisation of African Unity in the 2001 Abuja meeting). In the new budget for 2012, which was presented in November 2011, the health budget had indeed increased with 45% to just under 9% of total government spending. Responsibility and budget for health care services are not devolved in Zambia – they are decentralised by delegation. The MoH is solely responsible.

In Zambia all health services are free of charge at the point of service. User fees do not exist.

Like in other African countries the Churches own and operate many health facilities in Zambia: 16 different denominations together run 146 health facilities, among which 32 hospitals. They are organised in the Churches Health Association of Zambia (CHAZ). CHAZ is the partner organisation of Cordaid for this project. Cordaid supported CHAZ for many years, but recently decided to phase out this support due to subsidy cuts by the Dutch government. Two small PBF projects are still ongoing, one in 4 health facilities in Mpika District, funded by Cordaid's own resources, the other in 4 health facilities in Samfya District, funded by the 7-country PBF project.

Zambia's Sixth National Development Plan (2011-15) launched on 4th February 2011 mentions the country's intention to move from input-based financing to output-based financing. Recently the Ministry of Health (MoH) started a large MCH focused Results-Based Financing (RBF) programme with a budget of 17 million US dollars for two years from the Health Result Innovation Trust Fund, managed by the World Bank. The programme is set up as an impact study with three arms: 10 districts will receive performance-based financing (and some initial equipment), 10 other districts will receive approximately the same amount in input financing, and 10 districts will receive no additional funding.

2 Effectiveness

The following results as mentioned in the overall logframe are relevant for Zambia:

- Result 2c: PBF approach is harmonised between Church and State
- Result 3a: An institute, capable of PBF training, exists
- Result 3b: CHAZ is capable of independently promoting and expanding PBF experience in Zambia
- Result 4a: Client's voice is strengthened
- Additional result: PBF is piloted in church and public health facilities in one district

2.1 PBF approach is harmonised between Church and State (Result 2c)

The relationship between the Churches, represented by their Health Association (CHAZ) and by the Bishops, and the State, represented by the MoH, is good. In 2010 CHAZ and the MoH signed a

Memorandum of Understanding which formalised their working relationship. Under this MoU the government supports CHAZ health facilities by recruiting and remunerating health workers, paying 75% of operational costs and by providing essential medicines. Ten CHAZ health training institutes are also supported. The FBO health facilities remain in the ownership of the Church, who is responsible for the infrastructure. CHAZ is also fully involved in health strategies and planning exercises.

The cooperation between CHAZ and the MoH on the Cordaid and EU funded PBF projects in Mpika and Samfya was certainly facilitated by this conducive environment of true partnership. Harmonisation has been achieved on the following aspects:

- The CHAZ PBF projects include both public and church facilities (4 each)
- Quality Assessment of the CHAZ PBF projects is included in the annual plans of both District Health Offices (DHO) and are part and parcel of regular supervision visits of the DHO team to the health facilities
- The five performance indicators, which are jointly used in the PBF projects and RBF programme are defined in the same way (the PBF projects use an additional 7 indicators)
- The amounts of subsidies to be paid out per performance indicator have been aligned
- Quality assurance and verification tools have been harmonised between the PBF and the RBF projects
- Both projects use the same training institute: the University of Zambia (UNZA)
- The PBF coordinator of CHAZ is on the MoH Technical Working Group (TWG) on health care financing, where all issues related to RBF and PBF are discussed.

The main difference between the CHAZ projects and the WB RBF programme is with regard to the guidance to health facilities on how the subsidies can be used: in the RBF programme 75% of the subsidies can be used for salary bonuses, while this is maximum 50% in the PBF project; in the RBF programme the other 25% is meant to be for community health activities, while this is 10% in the PBF project; in the PBF project the remaining 40% is for investment and additional operational costs, including procurement of additional drugs. In the PBF project these percentages can be changed by the health facilities in consultation with the community.

CONCLUSION: RESULT ACHIEVED

2.2 An institute, capable of PBF training, exists (Result 3a)

The University of Zambia (UNZA) was chosen and contracted by CHAZ as PBF training institute. Two staff of UNZA attended the international 2-week SINA Health/Cordaid PBF course as a basis for their own task to train stakeholders in Zambia on PBF. Five other UNZA staff were later also trained by Management Sciences for Health, who are supporting implemention of the World Bank funded RBF project. The latter training focuses more on didactic skills, while the SINA/Cordaid training is more technical. Training sessions in the districts for the RBF programme are predominantly conducted by UNZA staff, but for UNZA to become *the* national training institute for PBF, it is necessary to keep on building up the critical mass within UNZA. This remains a challenge, as one of the two SINA Health-trained staff left UNZA in the meantime.

UNZA collaborated with CHAZ on the PBF baseline survey, the project implementation manual and training curricula for community representatives. Fourty community representatives were trained. Recently UNZA also trained the PBF purchasing agency in Samfya, contracted by CHAZ. Health Facility staff had previously been trained. In 2012 UNZA will also train local community-based organisations to do the regular community verification of health facility data, used to calculate the subsidies.

CONCLUSION: RESULT ALMOST ACHIEVED

2.3 CHAZ is capable of independently promoting and expanding PBF experience in Zambia (Result 3b)

To prepare CHAZ for setting up and coordinating the PBF projects an in-house capacity assessment was done, four staff participated in the SINA Health/Cordaid PBF course. One of them is the project Officer for PBF. CHAZ also received technical assistance through Cordaid. Trained staff in turn informed other colleagues within CHAZ on PBF.

Their capacity has further been strengthened through the 7-country project, in particular through the international exchange of experiences during the annual thematic meetings and the Steering Committee meetings.

CHAZ has promoted PBF within several government structures and coordination groups at different levels and documented design lessons. This has resulted in changes in the design of the RBF project and in other NGOs becoming interested and investing in output-based financing.

The small Cordaid/CHAZ project has had great influence on the design of the big RBF project. There is a good chance that PBF/RBF will be scaled up to the national level. If that happens the Cordaid PBF projects will have contributed to changes in the health system of Zambia, which is the overall objective of the project.

CONCLUSION: RESULT ACHIEVED

2.4 Client's voice is strengthened (Result 4a)

Health Centres have Committees made up of community representatives, many of which are also community health workers. This was already the case before the PBF projects started. Now they co-sign the PBF contracts between the health facility and the local PBF purchasing agency and they are co-signatory to the bank account of the health facility. They discuss what the PBF subsidies should be used for. They are also represented on the health facility financing committee, that decides how the PBF bonus will be divided over the staff.

In the hospital the team visited this does not work as well as in the health centres. Community members are on the Hospital Advisory Board, but this Board has not met since PBF started, as its functions (almost exclusively community concerns about the hospital) have been taken over by the Community PBF committee, which meets quarterly. Minutes are available. They make an action plan for the use of the 10% of the PBF subsidies paid to the hospital. However, the Committee is not involved in PBF management of the hospital itself, have never seen a business plan and do not know the quality score of the hospital or what exactly the hospital used the other 90% of the PBF subsidies for. Therefore they cannot assess which improvements are due to the subsidies.

Community members also participate in the District PBF Committee.

Fourty community representatives were trained on conducting client satisfaction surveys for PBF in the two areas were the projects are active. The results of these exit surveys were reported back to the eight health facilities and resulted in improvements in e.g. sanitation, waiting time, general cleanliness etc.

The involvement of the community in all the above resulted among other things in more transparency in the use of PBF subsidies by the health facilities. In 2012 CHAZ intends to evaluate the influence of community participation on utilisation and quality of health services.

Another PBF tool to strengthen the voice of the community is community verification of the utilisation data that the health facilities use to invoice the local purchasing agency, that pays out the PBF subsidies. Usually a local CBO is contracted to visit a sample of patients, to check that they actually visited the health facility, for which reason, how much they paid (if relevant) etc. This serves the purpose to detect any ghost patients, that the facility could potentially write into the registers in order to inflate the volume for which they receive subsidies. This kind of community verification is not yet taking place, but plans are in place to introduce it during 2012.

CONCLUSION: RESULT PARTLY ACHIEVED

2.5 PBF is piloted in church and public health facilities in one district (additional result, specific for Zambia)

A pilot district (Samfya) was selected and a baseline survey was done, the results of which were used to adapt the project design. Due to budget constraints only 4 health facilities were included in the pilot, two FBO hospitals and two public health centres (the latter were selected by the DHO). In another district, Mpika, a similar pilot is ongoing, funded by Cordaid from its own resources. There also 4 health facilities are included.

Staff of the health facilities included in the pilot project were trained on concepts and practicalities of PBF. The project purchases 12 indicators, which are the same for hospitals and health centres. The latter is unusual, but the reason for this,as explained by CHAZ, is that the hospitals have satellite health centres, and it is the PHC services that these satellite centres provide which are actually included in the PBF pilot and not the hospital services.

Initially CHAZ acted as purchasing agency, but has subcontracted the purchasing function now to a local NGO, the Samfya Community of Care Providers (SCCP). This NGO is now responsible for reviewing the business plans of the health facilities, preparation and signing of contracts, quantitative verification or audit of health facility utilisation data, consolidation of quantity and quality data, a narrative quarterly report, calculation of payments,feedback to the District Steering Committee, and all other coordination activities on PBF in the district. SCCP staff was internally trained in Zambia by UNZA and CHAZ for one week. However, the team learned that SCCP has very limited experience in the health sector. A similar structure (with another NGO) is in place in Mpika District. CHAZ is still the Fundholder, and pays the subsidies directly into the bank accounts of the health facilities.

The DHO is contracted by CHAZ to do the independent quality assessment of the contracted health facilities.

From the above it can be concluded that a real PBF pilot is in place, albeit on a very small scale, with ample community involvement. Interesting is that the MoH in Zambia has allowed this pilot to take place with almost full separation of functions: the DHO, as the extended arm of the MoH, is responsible for planning, guidelines and quality assurance of services; the FBO hospitals and public health centres are responsible for provision of services and an independent NGO is responsible for verification and calculation of payments. There is some overlap in functions between CHAZ as fundholder and FBO hospitals, although the latter are not owned by CHAZ; there is also overlap between the regulation (DHO) and provision by the public health centres, as both are MoH institutions. But most importantly the MoH and DHO, as well as CHAZ, have allowed an independent purchasing agency to operate.

A District PBF Steering Committee is functional, which includes as members all stakeholders, including community representatives.

Use by the health centres of PBF subsidies was as follows: 50% bonus for staff, 40% investment and operational costs, 10% for community activities. In the hospital the percentages were different: 25% for drugs, 25% for running costs, 25% for staff subcontracting (type of bonus for overtime) and 25% for savings. With the 10% community volunteers are contracted to do HIV counseling, growth monitoring of children, encourage women to deliver in a health facility, assist with DOTS for TB, give disease information, constructed a hand water pump and rubbish pit for the mother shelter at the hospital etc. They report monthly to the health centre and are also paid for performance = community PBF. According to the DHO,the PBF pilot resulted in increased utilisation and improved quality of services in all included health facilities; staff is more motivated and punctuality improved. Subsidies were used e.g. for contracting an additional clinical officer, procurement of small supplies and additional medicines, contracting CHWs, painting the health facility, buying mattresses, improving toilets, buying new uniforms etc.

Facility income has increased by 50-100% for Health Centres and 10-20% for 'hospitals' because of the PBF subsidies. Also staff income has substantially increased.

CONCLUSION: RESULT ACHIEVED

3 Efficiency

3.1 Staffing

Both the Health Programs Manager and the PBF Project Officer are members of the Steering Committee. The PBF Project Officer at CHAZ is charged with the daily oversight of both of the 7-country PBF project and the other Cordaid funded PBF project. For the first 18 months of the 7-country project he himself did all the work of the purchasing agency (see 2.5 above), as well as being the liaison with the MoH and member of the TWG Health Financing, contracting and working together with UNZA, developing tools, conducting field visits and reporting to Cordaid. Now that the

purchasing function has been contracted out, the training institute is operational and the projects are routinely running, in short, now that almost all results have been fully achieved, the PBF Project Officer will need less time for project coordination. This time can be used to focus on sustaining project achievements and benefits after the project will have come to an end and even expanding the PBF scheme to all health facilities in both districts, using governments own funds, as Samfya and Mpika are not included in the RBF programme.

The SCCP is not using their staff efficiently for verification of health facility data and invoices. They send three people to every health facility, where in PBF projects in other countries this job is done by a single person. For the time being (learning experience and very few facilities), two people could be justified, but in the future, especially when scale of PBF is increased, this should be reconsidered.

3.2 Reporting

Every 6 months CHAZ makes a narrative progress report and financial report against the EU reporting format and sends them to the Project Coordinator at Cordaid the Hague. They do receive feedback on both narrative and financial reports from Cordaid, in particular requests for clarification or more details. The narrative reports stand out for good quality descriptions of the work done and contain broader analyses, which bear witness to the understanding of PBF concepts and wider vision on health systems on the part of the partner, i.c. CHAZ.

3.3 Finances

When reporting is satisfactory disbursements are made by Cordaid directly to CHAZ. In 2010, all disbursements from CORDAID were sent timely. The 2011 disbursement was delayed by three months which resulted in the project failing to pay subsidies to the implementing health facilities on time.

According to CHAZ the budget is not sufficient for the required activities to achieve the results. For example, in the budget the funds for training for the entire project life have been exhausted half-way into the project. The project also does not have sufficient funds for technical support visits to the facilities. The concentration of funds in the budget is in the area of human resources (salaries) and allowances for consultants and there is a very thin allocation for activities in the project.

The budget for Zambia for the 7-country project was €746,570. At the mid-term €195,277 had been spent. The expenditure rate therefore was 26%.

3.4 Synergy

One of the objectives of the project was to experiment with synergistic activities. In the case of Zambia there was clear synergy between the two small PBF projects. The existing project paved the way for the 7-country project and increased the scope of the pilot. This also improved efficiency somewhat, because tool development, field visits, training etc. could be combined for the 8 facilities. However, the pilot is still very small and having two different purchasing agencies for only 8 health facilities is obviously not very efficient (albeit necessary, given the distancesinvolved).

Synergy also exists in the community PBF component, as the CHWs and TBAs are trained by the vertical programmes, while they receive financial incentives for their work from the PBF pilots.

The most important synergy is undoubtedly the effect that the small pilots have had on the much bigger RBF programme, as described above.

3.5 Support by HDP

CHAZ is in regular, albeit infrequent, contact with HDP. They requested HDP to come and assist with training, which did not happen due to conflicting time schedules. They did comment on the training materials. HDP did visit the Zambian project recently to advise on separation of functions, the problem with the Zambian Health Insurance Company (ZHIC) as intended LPA[1] and the role of CHAZ in the project. HDP also kept CHAZ focused on the results to be achieved. CHAZ is satisfied with the support of HDP.

There is a problem, that progress reports are not sent to HDP. They are sent directly to Cordaid. This means that HDP is not automatically aware of progress and problems, which hampers their coordination role. HDP do send e-mails to actively inquire about progress. CHAZ suggested to first send the progress reports to HDP, who forwards them with their comments to Cordaid.

CHAZ does not actively use the project website. The project officer did not make an account and was not able to download any resources. Only checks announcements. Once looked for a template for business plans, but could not find it. He would like more support on how to use the website.

CHAZ did not seek direct contact with other countries, but the CAR contacted them and even came to visit. They do feel part of a network, but this network could be further strengthened.

3.6 Support by Cordaid

The present 7-country project was the follow-up of an earlier P4P project in Zambia funded by Cordaid. CHAZ staff was involved in the initiation, planning and designing of the PBF 7-country project. A Cordaid consultant from ETC Crystal supported CHAZ with this.

CHAZ has regular contacts with the project coordinator at Cordaid, more frequently than with HDP. He is considered their main technical adviser.

3.7 Visibility of EU and Cordaid

CHAZ has not done any specific activities to credit the EU or Cordaid for their financial support. This was discussed and they intend to rectify this during the coming year.

4 Recommendations

1. The substantial increase in government health budget provides a window of opportunity for the District Health Offices in Samfya and Mpika to scale up PBF to whole district (together around 60 HFs) with their own funds. This warrants careful negotiations wit the District Commissioners and DMOs.
2. CHAZ should introduce community verification for PBF in the catchment areas of all 8 health facilities. This can be combined with the satisfaction surveys, but should be done in the

[1] Initially CHAZ had identified the ZHIC as local purchasing agency. However, they asked a very high price for their services and Cordaid did not give a green light. Subsequently the local NGO SCCP was contracted.

community (not on exit). Local CBOs can be contracted for this purpose. Lessons learned from other countries can provide details as to how best to implement this activity.

3. CHAZ should put pressure on the Church hospitals to allow community members to be much more involved in decision-making on PBF matters (as in the public health centres)
4. LPA staff in Samfya (and Mpika?) could go on a study tour to IADH Burundi or AAP Sud Kivu to compare ways of working and learn hands-on about their tasks. Another suggestion would be that they are supported to attend the SINA Health/Cordaid PBF course.
5. The budget for the LPA under contract (SCCP) should be re-assessed, as it does not reflect their real costs (salaries of staff are now not included. If needed CHAZ can request HDP's accountant to support them in making a realistic budget.
6. SCCP should reduce the number of verificators to two per facility visit and consider to further reduce to one in the future, if and when PBF is expanded to all health facilities in the district.
7. The project should consider to change the quality bonus from stick to carrot system, meaning that the quality score always increases the quantity bonus, instead of decreasing it. With no additional funds this means that the quantity subsidies would have to decrease, while the amount to be earned by the quality bonus would increase. While the total amount of subsidies could stay the same, the psychological effect is positive.
8. CHAZ should enable an exchange visit by CSSC/MoHSW Tanzania to discuss Church/State partnership at the highest possible level of government and churches.
9. Together with CSSC Tanzania CHAZ could produce an article about the differences in relationship between Church and State in the two countries and the effect of that for PBF.

Annex 1 People met and organizations visited Zambia

Karen Sichinga	Executive Director CHAZ
Rosemary Kabwe	Health Programs Manager CHAZ
Clement Chibanga	Project Officer PBF CHAZ
Godfrey Jzimbi	District Commissoner Samfya District
Rhoda Bulezi	Acting DMO, MoH Samfya District Office
Jonas Bwali	Chief Executive Local Purchasing Agency Samfya Community of Care Providers (SCCP)
Gilbert Mutone	Acting I/C Samfya Health Centre
Musargo Lule Ogasti	Representative health staff Samfya Health Centre
Charity Kangwa	Nurse Samfya Health Centre
Moses Chepeski	Chair Samfya Health Centre Committee
Leah Chalwe	Member Samfya Health Centre Committee
Maximore Shamende	Member Samfya Health Centre Committee
Epidius Mpundu	Member Samfya Health Centre Committee and Casual Daily Employee
Beatrice Mapulanga	Acting Administrator Lubwe Mission Hospital
Pongo Lelo	Medical Officer in charge Lubwe Mission Hospital
Judith Ngosa	Nursing Officer in charge Lubwe Mission Hospital
Daniel Sibajene	HR Officer Lubwe Mission Hospital
Judith Mapulanga	Acting Nursing Officer Lubwe Mission Hospital
Dominic Mwansa	Trustee PBF Committee (teacher)
Higgins Chipunka	Secretary PBF Committee (community development officer)

Annex 2 Presentation Feedback Workshop

MTR 7-country PBF project Zambia

Feedback workshop

24 Nov 2011, Kigali

Recent Changes/Info

- In July 2011 Zambia has become a low-middle income country (but there seem to be large inequalities in income)
- GoZ has started a large MCH focused RBF programme with funding of World Bank (impact study)
- All health services are free – no user fees
- Govt has committed to increase % of govt budget for health from 6% to 15% by 2015

Results Zambia

2c) PBF approach is harmonised between state and church

3a) PBF training institute exists

3b) There is a partner capable of independently promoting and expanding PBF experience

4a) Client's voice is strengthened

Additional result: PBF is piloted in church and public health facilities in one district

2c) PBF approach is harmonised between state and church

- In Zambia church health facilities are almost fully paid by govt: salaries, 75% of operational costs, drugs and training. Ownership and maintenance of infrastructure with church. Relationship of church and state is good.
- CHAZ PBF projects (total 8 facilities) include both public and church facilities
- CHAZ is represented on TWG - HCF
- Indicators, subsidies, QA and verification tools have been harmonised between CHAZ and RBF project; also use the same trainers (UNZA); guidance on use of subsidies differs
- CONCLUSION: RESULT ACHIEVED

3a) PBF training institute exists

- University of Zambia (UNZA) was chosen as training institute
- 5 staff of UNZA did SINA Health course (also trained by MSH for RBF project)
- UNZA collaborated with CHAZ on baseline survey, project implementation manual and training curricula for community reps (40 were trained) and trained the new purchasing agency SCCP (HF staff had already been trained by Cordaid/ETC Crystal)
- CBOs still to be trained on community verification
- CONCLUSION: RESULT ACHIEVED

3b) Partner capable of independently promoting and expanding PBF

- 4 people from CHAZ did SINA Health course
- Only PBF coordinator actively involved in PBF (no critical mass)
- CHAZ has promoted PBF within several govt structures and coordination groups at different levels and documented design lessons
- Resulted in changes in design of WB RBF project
- Resulted in other NGOs investing in output-based financing
- The small Cordaid/CHAZ project has had great influence on the design of the big RBF project (→ overall objective)
- CONCLUSION: RESULT ACHIEVED

4a) Client's voice is strengthened

- 40 community representatives were trained on conducting client satisfaction surveys for PBF in the 2 areas were project is active (exit surveys were conducted and feedback to HF took place)
- Resulted in more transparency in HF use of PBF subsidies
- HCs have Advisory Committees made up of community reps, many of which are also CHWs
- Of these 2 community reps are on the HC financing committee, that decides how the PBF bonus willo be divided over the staff
- Community verification of PBF in HFs is not yet taking place
- CONCLUSION: RESULT ALMOST ACHIEVED

PBF is piloted in church and public health facilities in one district – 1

- A baseline survey was done
- PBF pilot is conducted in 2 districts, in 4 HFs each (50/50 public and church). 1 district financed by 7-country project, 1 district by other Cordaid funds.
- Staff was trained
- Steering Committee is functional.
- 12 indicators are purchased, the same for hospitals and HCs.
- Initially CHAZ acted as purchasing agency, but has subcontracted purchasing function now to local NGO (contract and verification, calculation of payments), staff internally trained 1 week. CHAZ still Fundholder, which pays subsidies to HFs.
- DHMT is contracted to do quality assessment (together with CHAZ)

PBF is piloted in church and public health facilities in one district – 2

- Full separation of functions
- In all HFs utilisation has increased and quality improved; staff is more motivated, punctuality improved
- CHAZ decreased PBF subsidies for consultations and admissions, because utilisation increased very much
- Use of subsidies: 50% bonus for staff, 40% investment and operational costs, 10% for community activities (can be changed in consultation with community)
- Subsidies were used e.g. for contracting an additional clinical officer, procurement of small supplies and additional medicines, contracting CHWs, painting HF, buying mattresses, improving toilets, new uniforms etc.
- CONCLUSION: RESULT ACHIEVED

Recommendations

- Community verification can be combined with satisfaction surveys, but should be done in the community (not on exit)
- Hospital PBF indicators should be different from PHC indicators
- The LPA could go on a study tour to IADH Burundi or AAP Sud Kivu
- Budget for LPA should be re-assessed (salaries of staff not included) – visit HDP Alexis?
- Project should consider to change quality bonus from stick to carrot system
- The increase in health budget provides a window of opportunity for local govt in Samfya and Mpika to scale up PBF to whole district (together around 60 HFs)