Republic of ZAMBIA

Cordaid

Linking relief and development

SINA HEALTH

Report of the *first* English
Performance Based Financing Course
(and eighth if including French courses)

held in

Lusaka - Zambia

between

the 5th and the 17th of July, 2010

Version 270710
Lusaka

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF GRAPHS

1. INTRODUCTION

This is the report of the ***first*** English spoken ***performance based financing (PBF)*** course that took place between the 5th and the 17th of July, 2010 in Lusaka. However, when including the previous seven French speaking courses it was the ***eighth*** PBF course. The course was conceptualized by SINA Health with support from Gyuri Fritsche of the World Bank and was financed by Cordaid. Frank van de Looij from Cordaid was instrumental in preparing the contacts with the course participants from Tanzania, Zambia, Zanzibar and Ethiopia. Frank's active role was highly appreciated by the facilitators as well as Cordaid's financing and the support from Natascha Lacko. We further acknowledge the support of the World Bank by Monique Vledder, Cosmas Musumali, Caroline Phiri and Rosemary Sunkutu. Nancy Matambo (assisted by Kaiko Mukololo) of Kulture Consult did an excellent job concerning the travel arrangements and logistics for both participants and facilitators.

This report further describes the country representative recommendations from Zambia, Tanzania, Cameroun, Zanzibar and Ethiopia concerning PBF as well as by the facilitators.

1.1 Performance based financing (PBF), an approach in progress and its definition

Performance based financing, as a revitalized form of primary health care and the Bamako Initiative, is steadily replacing the input based centralized traditional systems which have produced such disappointing results during the last few decades. Since the late 1990s, PBF initiatives and pilots, formerly known as contracting or the contractual approach, have been developed in Asia (Cambodia) and from 2002 onwards in Rwanda, DRC, Burundi, CAR and Cameroon (all French speaking). In July 2010, it was estimated that 22 African countries plan for, or started some form of PBF pilots programs. Two countries (Rwanda and Burundi) adopted PBF as their national policy and scaled it up successfully through internal market mechanisms, while some other's such as the Central African Republic and Cameroun may soon follow.

During the PBF course in Lusaka Gyuri Fritsche and Robert Soeters proposed the following temporarily definition of PBF:

"Performance-Based Financing is a holistic approach with a result orientation defined as financing based on both quantity and quality of service outputs. This approach entails making health facilities autonomous agencies that work for the benefit of health related goals and their staff. The effectiveness can be enhanced by demand-side interventions such as conditional cash transfers, vouchers schemes, equity funds and community based health insurance programs. It is also characterized by multiple performance frameworks for the regulatory functions, the performance purchasing agency and community empowerment. Performance-Based Financing applies market forces but seeks to correct market failures to attain efficiency gains. PBF at the same time aims at cost- containment and a sustainable mix of revenues from cost-recovery, government and international contributions. PBF draws from micro- economic, systems analysis and public choice theories. PBF continuously seeks to test these theories through empirical research and rigorous impact evaluations which lead to best practices".

While receiving comments from different corners of the world (and notably from Bruno Meessen from Antwerp ITM, Petra Vergeer from the World Bank and Peter Bob Peerenboom) there seems to appear a tendency also to reformulate the term Result Based Financing more commonly used by the World Bank in such a manner that it incorporates the above definition of Performance Based Financing.

This shows that there is a quickly growing consensus around the contractual approach, RBF and PBF movement about its underlying concepts, best practices and instruments towards

achieving equitable and quality health care but without losing the elements of the efficiency of the market as well as cost-containment. The incorporation of the demand side elements of vouchers, equity funds and health insurance are conceptually welcome but they require to be tested until rigorous empirical research and impact evaluations show a demand side approach that is equally effective, efficient and equitable, and at reasonable cost.

1.2 Aims, objectives and intended result of the PBF course

Aims of the course

- To contribute to the improvement of the health status of the population by providing accessible and equitable services of good quality while respecting the free choice for public & private providers and by making rational and efficient use of limited government and household resources.
- Participants understand the superiority of market forces in distributing scarce resources but also how to address its failures by applying market instruments such as the subsidies (and taxes), regulatory tools and social marketing.

Specific Objectives

- To reach a critical mass of people who adhere and can apply performance based financing and who will gradually replace health systems based on traditional input financing.
- To provide participants with an understanding of the relationships between health and national economic policies, the potential for economic multiplier effects and how these are influenced by performance based financing.
- To master the objectives, theories, best practices and tools relevant to putting performance based financing into practice.

Expected Result

- At the end of this course, the participants should be capable to engage in performance based financing and to understand the role of the different stakeholders (communities, health centers, hospitals, regulators, fund holder organizations, community voice empowerment).
- They should understand the strength and failures of the free market economy in health care in relation to the relevant health policies.

1.3 Challenges surrounding this first English PBF course

1. It was for the *facilitators* (with the exception of Robert Soeters) *their first time* to conduct this particular PBF course. However, with the presence of Gyuri, Godelieve and Christian this challenging task was made much easier. Gyuri Fritsche is a PBF pioneer from Afghanistan and Rwanda and is now one of the leading PBF experts of the World Bank. Godelieve van Heteren is a former Dutch parliamentarian and Cordaid director with 20 years experience in adult learning and health systems research. Christian Habineza is a PBF pioneer from Rwanda and director of Kigali based NGO that supports PBF in different countries.

   During the course we also discovered the excellent abilities and willingness to play facilitating roles of Cosmas Musumali (Consultant for the World Bank) and Harrison Mkandawire (director of the World Bank financed PBF pilot project in Katete district, Zambia). We further expect that among the 30 participants more persons will be added to the critical mass of enthusiastic PBF family members who advocate and implement PBF. These may come from Zambia (UNZA, CHAZ and MOH), Tanzania (CHHC, MOH and Kilimanjaro Christian Medical Centre), Cameroun (MOH) and Zanzibar (MOH).

2. The course book developed during the previous seven French spoken courses as well as the PowerPoint presentations *needed translation for this first English PBF course*. The organizers were also not sure in how far the context of English speaking Africa could be compared to the French speaking countries and in how far the theories, PBF best practices and instruments would also be applicable and appreciated by the participants of the different countries.

   The course guide *PBF in Action : Theory and Instruments* was distributed among the participants at the start of the program, but the PowerPoint presentations could only be distributed afterwards as they were still the subject of intense scrutiny and changes during the course by the facilitators and some participants. These changes will be incorporated in the next version of the course guide before the next course by the end of November 2010. Cordaid has agreed to print this next English version while the French version was already printed in June 2010.

3. While some of the *participants* had previous experience with contracting or P4P, *none of them had experience with "pure" PBF*. This implies that participants often needed to change their ideas. The existing health systems in English speaking Africa are mainly based on traditional primary health care concepts, centralized planning, rigid cost sharing mechanisms, public monopolies (in particular for essential drugs) and community participation. PBF aims to create a paradigm shift from these traditional ideas towards autonomous health facility management, separation of functions and the market oriented approaches of competition, public – private partnerships, public choice, flexible cost sharing mechanisms to balance revenues and expenditures, social marketing, cost containment and efficiency.

   We observed that in particular during the first week some participants found it difficult to leave their comfort zones towards the PBF change environment. This made the course challenging to implement also not helped by the large group of initially 33 (and with facilitators and Cordaid employees 40). Yet, by the end, participants did not evaluate the course far below the average of the previous French speaking courses so that the facilitators apparently achieved the intended aims, objectives and results during this first English spoken course.

4. A further complicating factor was that the Zambian Ministry of Health was during the course embroiled in fiscal trouble and allegations of corruption in the press. There were also recent changes in their leading civil servants so that it was *challenging to coordinate the PBF course with the senior MOH staff*. Upcoming elections in Zambia also implies that further changes are likely to occur. All this explains the relative absence of the MOH senior decision makers during the course. However, some MOH civil servants were attending the course on a full time basis. The University of Zambia leadership were eager to enter into dialogue and we appreciate their willingness to endorse the Certificate of Merit that came with this PBF course.

1.4 The exam by the end of the course, adult learning and accreditation

Passing the exam by the end of the course yielded a Certificate of Merit, which was issued by the University of Zambia (UNZA) in collaboration with SINA Health and Cordaid. The course exam conducted at Friday the 16th of July at 14:00 consisted of 30 multiple choice questions which were tailored around the main messages of the PBF course. The test is easy to pass for those who follow the course and read the course material and all persons who took the test indeed passed. Nine participants had 90% or more and the overall average was 81%. The three participants from Cameroun had the highest country score with 88%. The eight

medical doctors in the course achieved on average a score of 89%, followed by the 14 economists and administrators with 80% and the 12 participants with other professions 76%. Dr. Pascal Nji from Cameroun obtained the 100% score which makes him to belong to the seven participants among the 240 persons ("PBFistes") who attended all eight PBF courses so far, who also achieved 100% ("centistes"). The course logistics assistant Kaiko Mukololo also successfully conducted the test.

Before the exam, some participants proposed that an "exam" does not match the spirit of adult learning, which the facilitators believe not to be correct. There was some talk of not taking the exam, but by the end everybody took the test (including the facilitators) as well as the logistics assistant (35 in total). Some of the participants who aired their concerns commented afterwards that the exam turned out to be "a major incentive" to engage with the course material in more detail. The course facilitators believe that the PBF course *without* an exam lowers the standard and would make it difficult for an academic institution such as the University of Zambia to endorse the course and sign the Certificate of Merit. The participants can now put their participation to the course in their CVs as a credible individual achievement.

We therefore propose *not* to lower the course in the future to a "Certificate of Attendance" level. This conclusion further implies that any organization wishing to conduct this PBF course and using the material are requested to be accredited by Cordaid – SINA Health by fulfilling minimum quality standards.

1.5 Who did and who did *not* attend the PBF course

There were 30 participants that uninterruptedly followed the course; 3 from Cameroun, 1 from Ethiopia, 13 from Zambia, 10 from Tanzania and 3 from Zanzibar. Among those there were 12 women and 18 men. The biggest group of 14 were administrators or economists. There were (including the facilitators) 8 medical doctors and 12 particpoants had other backgrounds.

Mr. Collins Chansa and Mr. Mubita Luwawelwa from the Zambian Ministry of Health did not finish the course and did also not take the exam. Dr Rosemary Sunkutu from the World Bank attended half of the days and did not take the exam. We may make a follow up on the reasons although it was said that this was linked to "pressing work". From Cordaid Frank van der Looij attended the first week and Natascha Lacko the second week attended the course but this was planned.

The list of all participants was made up of people with the following profiles:

Participants linked to local or national government

1 person	MOH Policy and Planning Department, Tanzania
4 persons	MOH Zambia (1 economist and chief planner, 1 principal planner MoH, 1 deputy director, who left the course after first days, and 1 financial specialist)
3 persons	Ministry of Health and Social Welfare, Zanzibar (1 secretary of health sector reform, 1 deputy, 1 head of continuous education)
1 person	Accountant provincial health office, Zambia
1 person	District health director, Zambia
1 person	Environmental health officer, Zambia
3 persons	Regional and district health administration, Cameroon (1 public health physician in centre region, 1 district medical officer, 1 regional coordinator of the HIV-AIDs program).

Participants linked to international organizations

4 persons Consultants World Bank (1 from Netherlands/Washington, 3 from Zambia, of whom1 left after first week).

Cordaid and organizations supported by Cordaid (CSSC, CHAZ, ECS)

2 persons Cordaid staff, Netherlands
3 persons CSSC, Tanzania (1 person from CSSC Financial Management, 1 PBF coordinator from CSSC, 1 zonal PBF coordinator)
4 persons CHAZ (1 chief coordinator PBF, 1 CHAZ manager, 1 HIV-AIDS coordinator, 1 advocacy specialist, Zambia
1 person Ethiopian Catholic Secretariat, Ethiopia (program manager AIDS relief)

Religious organizations

See above : Several Cordaid supported organizations are faith based organizations.

University organizations

2 persons KCMC (1 head community health department KCMC (Tanzania), 1 university lecturer public health and health promotion KCMC (Tanzania))
2 person UNZA (lecturers economics department, Zambia)

Health Care Providers

1 person Hospital administrator, Tanzania
1 person District pharmacist, Tanzania
1 person Community health service provider, Tanzania

The list of participants, their position and their email numbers is attached to this report.

2. RECOMMENDATIONS FOR FUTURE PBF COURSES

2.1 General findings, recommendations and conclusions

- *The duration of the course.* The course was considered "short" or "too short" by 52% of the 30 participants. In part, the large proportion of people, who wished a longer course, was attributed to the multi-country participation in this course as this takes more time to compare the different country experiences. Some participants also indicated that only in the second week they started to see the various connections between the subjects and the relevance for their own work and from that moment wished to engage more. This latter issue might be solved by better identifying the course objectives and by better explaining from the start the sensitive topics covered in particular in English speaking Africa.
  We may also further fine-tune the target groups per course. More time may be needed for those participants, who wish to engage deeper with the operational tools such as : (a) business plans; (b) the revenue, expenditure, performance bones "indices" tool; (c) the research methods; (d) the costing and; (e) the quantity and quality indicator development.

  Time-keeping was noted as a recurring difficulty in Lusaka.

  We propose that during future 14-day courses the hours will be extended from 08:30 to 17:30 instead of 17:00. This should also be well communicated in advance with the explanation that the course is very time consuming and that there is no time for "being on holidays".

- The original *number of participants* of 35 and with the facilitators of 40 was *too large*. The course was in high demand with over fifty people, who had applied. Some participants also suggested a smaller group size of 20 participants. This would indeed be ideal but not cost-effective considering that: (a) there is a very high demand for such courses for which there is still a limited supply and (b) it would increase the cost for the course per participant.

  In conclusion, we believe that the same number of participants per course such as in Kigali of around 26 is deemed to be better.

- The **general impression by the participants of the course** was positive and more or less on a par with the results the equivalent multi-country courses, organized in Limbé, Cameroun (October 2009) and in Kigali (June 2010). Use of time, distribution of material, lecture room and general friendliness of staff and coordinators all received a high score in Lusaka. Criticism existed regarding the conference center Cosmic Lodge mainly due to the poor internet connectivity. Lusaka scored lower than Limbé on contents, the balance between lectures, exercises & group work, interaction and participation. Due to time constraints several scheduled module exercises were indeed dropped or shortened, which in part explains this criticism. Participants expressed a desire for advance availability of the course material on USB or CD.

- A large number of comments related to the English version of the course book ***PBF in Action. Theory and Instruments***. The course book is a "work in progress" and only during the course the PowerPoint presentations were translated in English and edited.

  Participants made the following suggestions:

  a) The lack of standardization of the English, of concepts, and on the sometimes limited coordination in the course book with the flow of the module PowerPoint sheets. The flowchart in module 6 should be revisited to make it clearer and the different relationship among actors much clearer. The course book did indeed not match all Power Point presentations;

b) Objectives of some course modules are not SMART. Participants pointed out a number of repetitions, typographical errors and internal inconsistencies that should be removed. There were in addition still some French passages in the book;
c) Practical exercise on coming up with PBF project proposal (formal feedback from facilitators in exercises would be welcome). Develop a planning course in PBF;
d) Split the module of health economics from micro economics. Other participants suggested a shortening of the economics chapters and the inclusion of more pertinent exercises. They also suggested to strengthen links between all modules and with the economics concepts given in the book with PBF;
e) Better explain the health centre and hospital hierarchy,
f) Provide a detailed stakeholder mapping and analysis as an advocacy tool;
g) The presented slides should be revisited as some of the information is double. There was also the suggestion that the book should be open to further peer review and to introduce more country-specific nuances;
h) More mentioning of possible bottlenecks with experiences from other countries where PBF has been implemented *and* more on strategies for setting up PBF in traditional health systems. The facilitators believe that identifying bottlenecks is an ongoing process of adapting PBF to address them. Flexibility and learning from mistakes is (and should remain) a characteristic of PBF. Only with such flexibility PBF may continue to be as successful as it currently seems to be;
i) Show video shows or clips of practices as regards to PBF and about speeches, aspiring words by Presidents / Ministers about initiatives relating to PBF. This might be a good idea to pursue. Should be doable with the many new experiences in Africa;
j) The venue should be outside town to prevent Lusaka based participants from leaving the conference. The facilitators agree. Three Lusaka based participants left the course for various work related reasons and this disturbed the other participants.

The above comments are valid for the revision of the course book, to be finished before next course in November 2010.

- Some participants thought that the modules of business plan, black box indices, development of a PBF project and costing are their main job back at home. They therefore propose that these modules should receive more emphasis such as how the EXCEL exercises should be interpreted in different country contexts.

  Facilitators: *Courses might in the future become more tailored towards specific needs of participants. For example the PBF tools such as business plans, identification of indictors, quality assurance, costing and black box indices instruments might become part of other specific courses – probably also increasingly in the standard curricula of nursing, medical schools as well as master degree courses.*

- The course needs to be **compulsory** for university student or colleges.

  Facilitators: *Agree and when PBF becomes more accepted in a given country medical and nursing schools as well a master degree courses might become adapted to the PBF curricula. For example micro economics, health economics, public choice, systems analysis and good governance as well as PBF theories and instruments could each obtain 5-40 hours.*

- Frank speak facilitation is OK, but facilitators should always be part of the adult learning approach. Course coordinator needs to improve more the way he relates to participants otherwise his attitude towards participants developed positively throughout the duration of the programme. Dual presentation (presenter and facilitator) was counterproductive. Need for a more open minded lead facilitator to sell the PBF concept.

Facilitators' comment: *All facilitators (including Robert Soeters) are aware that the approach of confronting rather bluntly certain preconceived ideas or to correct misinterpretations by participants of the course content is a* ***high risk*** *approach and does probably not always match adult learning best practices.*

As shown above this approach was indeed not always understood or appreciated. We therefore intend to better identify in advance what are the likely sensitive topics (such as monopolized distribution of inputs, corruption due to a lack of separation of functions, accepting that health facilities should be truly autonomous, accepting that health facilities should be allowed to charge user fees in case of insufficient revenues). These should then be embedded in more advanced adult learning approaches. This approach should aim at making the course also implementable by any facilitator in such a manner that while not altering the change objectives in the perception and attitude of participants that it reduces the risk of offending certain participants.

Nevertheless, it should also be acknowledged that the change objectives of ideas and attitudes among participants inherently creates an element of opposition and even conflict during the course which can (and should) not always be prevented.

- Research methodologies need to be revised up to standard practice.

  Facilitators: *We feel PBF research standards are already rather high. However, a more detailed description of research methods such the role of focus group discussions, how to conduct household surveys, mapping of health facilities, statistics is indeed important but would exceed the available time for the course unless a separate course would be organized more specifically for PBF research methods.*

2.2 Methodological suggestions of participants *(on which facilitators do NOT agree)*

- To have more facilitation whose area of specialization is used: Presenters should be competent (not reading slides). The key facilitators should be the ones presenting and not the participants. Some were blank on the subjects and were just reading through slides. Only participants who have knowledge or have been trained before in PBF should facilitate.

  Facilitators' comment: *Concerning this comment the facilitators do not agree but intend to further refine the adult learning techniques. This also implies better identifying learning objectives, how to deal with sensitive topics and how to use more advanced methods to change certain preconceived ideas and attitudes of participants.*

- Participants to be awarded **per diems**.

  Facilitators: *On this topic the facilitators strongly disagree and – to the contrary – intend to make next courses fee paying such as was already successfully tested in Kigali. However, if sponsors wish to pay per diems this is obviously agreeable. The PBF course should advance participants careers and for this they should pay. Paying participants to attend a course seems to provide a wrong incentive signal.*

- Increase the number of facilitators.

  Facilitators: *It would become too expensive. We feel six facilitators (2-3 conceptual, 1-2 adult leaning and 1-2 for logistics) is enough.*

3. COUNTRY RECOMMENDATIONS

3.1 Recommendations by the participants of the Lusaka course

Country recommendations were read out at the closure ceremony on Saturday July 17, 2010.

Zambia

1. PBF should be institutionalized in the MOH the health care financing technical working group;
2. Promote harmonization of PBF activities with various stakeholders;
3. PBF should be incorporated in the curriculum of higher learning institutions such as UNZA, NIPA, EHC, the nursing schools and others;
4. Hospital, District and health centre grants should be treated as PBF grants;
5. The donor funds be treated as PBF funds.

Tanzania

1. Transform P4P into a "pure" PBF strategy. Discuss where to put the initiatives from CSSC and the Government of Tanzania?
2. The team trained in Lusaka will conduct advocacy at all levels;
3. Promote advocacy and lobbying for effective PBF strategy implementation ;
4. At higher ministerial level there should be joint forums to discuss issues on separation of functions for smooth PBF implementation ;
5. Review the funding mechanisms for the PBF pilots;
6. Development of Tanzanian business plans should consider the PBF principles;
7. Harmonize relationship between MOHSW and PMORALG for successful service agreements
8. Dialogue with key ministries for PBF to be spearheaded by CSSC.

Zanzibar

1. Promote lobbying to Health Sector Reform Secretariat on PBF concepts;
2. The technical working group (TWG) to reach consensus on the introduction of PBF in Zanzibar;
3. Present PBF to the Zanzibar Joint Annual Review Meeting in September 2010;
4. Work with the Ministry of Finance on which modalities to introduce.

Cameroon

1. The Cameroonian government should set the ball rolling by effectively starting PBF in the earmarked health districts before the end of this year;
2. Government should identify and grant licenses to drug suppliers at regional and district levels;
3. Government should be encouraged to use as personnel those who have been trained in PBF for the implementation phase;
4. Government should avoid moving staff from PBF pilot Regions and Districts who do not express the need to move.
5. Government grants should be paid in cash into the accounts of health facilities and health district piloting PBF, while abolishing the 'carton' system.
6. Public-private partnership in health should be encouraged at all levels of the health system.

Ethiopia

1. Involve other actors in the health care service (FBOs, CSOs) in the planning and piloting process
2. Share the assessment results and findings with other actors, to avoid duplication
3. Enhance cooperation of the public and private sectors
4. Finalize the business plan of health facilities using standard planning format
5. Identify fund holder agency, prepare contracts and memorandums of understanding (MOUs)
6. Familiarize health facilities with PBF concepts and support them to apply the principles
7. Start PBF advocacy sessions with local government authorities and public private partnerships.

3.2 Recommendations by the conceptual facilitator of the PBF Lusaka course

Zambia

It appears that the Zambian health reforms are challenging and that the MOH is somewhat paralyzed by election time and recent changes in senior civil servants. The Ministry of Health has also been affected by corruption scandals, which were widely published in the national newspapers.

The health system seems to suffer from over-centralization such as the monopolization of inputs (human resources, equipment, essential drugs and infrastructure development). There is an inadequate cost sharing policy whereby rural health facilities apply free health care and whereby existing cost-sharing revenues are not spend at the point of collection but are bureaucratized in an inefficient central system using the treasury. Health facilities do not have own bank accounts so that cash use of revenues at health facility level is hampered. There is no provincial or district equity mechanism that promotes the more isolated areas over the urban centers and human resource policy is bureaucratic and inefficient. In 2006 the Ministry of Health regained control over fund disbursement. This seems contrary to the good governance aim of separating the regulation tasks from fund disbursement tasks. It seems also to reverse the reforms from the 1990s towards health boards at central and district levels instead of further decentralizing it further and to promote the separation of functions.

All these elements together makes the conclusion justified that the Zambian health system is inefficient and lacks good governance checks and balances. Based on experiences in other countries in Africa with PBF it may be justified to say that if PBF would be introduced that two times more activities could be financed by 50% of the current budget. The current ineffective and almost unconditional use of donor money should require further analysis.. This means that reforms could be proposed whereby there are sufficient checks and balances between the public and the private sector, abandoning public monopolies, allowing more space for innovation and entrepreneurship as well as the realization that the private interests of individual civil servants should as closely match the public interest. PBF is built on such principles so that huge efficiency gains as well as cost containment improvements can be achieved.

The recent World Bank and Cordaid initiatives to expand and start new PBF pilots in Zambia therefore seem to come at a very welcome moment. For them to become successful there seems to be a need to apply the more “pure” form of PBF with true autonomy for health facilities, decentralizing human resource policies, the use of cost sharing revenues at the point of collection, the freedom for health facilities to buy their essential drugs and equipment at a good quality wholesalers of their choice instead of being dependant on inefficient monopolists and to open their own bank accounts and the separation of the regulatory and fund disbursement functions. This may be at the moment easier to achieve by the Cordaid financed pilot than the World Bank pilot unless the World Bank financed pilot would contract out the fund disbursement function to (private sector) organizations other than the Ministry of Health. This would be in line with the approach also followed in Cameroun by the World Bank.

A wider approach towards PBF in Zambia not only involving the Ministry of Health but also other ministries, academic institutions and civil society groups may be the way forward. PBF has a great potential also to initiate multi sector activities such as in education, rural development and even administration.

If requested further discussions between the course organizers, the World Bank, the MOH, CHAZ and Cordaid may advance some of the above recommendations *(to be expanded).*

Cameroun

PBF initiatives in Cameroun are in a crucial state with a relatively small PBF pilot in the Eastern Region since 2008 still collecting valuable information and experiences. In July 2010 the Littoral Region has started to recruit a fund holder team that will operate autonomously within an civil society organization called the Littoral Special Fund. In three other Regions (South West, North West and East) PBF pilots will start whereby NGOs will play the role as fund holders. These are expected to start operating before the end of the year. A baseline study may be conducted by the end of 2010.

Tanzania

While the PBF course facilitators are almost ignorant concerning the PBF pilot experiences in Tanzania it appears that the P4P initiatives are very modest in terms of size, scope and concepts. They mainly involve religious health facilities, have relatively small budgets, involve a limited number of subsidized indicators and so far no quality systems and do not apply all main PBF best practices. An external support visit by a "pure PBF consultant" might be useful for the further development of PBF *(to be expanded).*

Zanzibar

This Tanzanian province has its own autonomous Ministry of Health and also maintains direct relationships with donors such as Danida and the Global Fund. PBF is still a new phenomenon in the country but apparently there is interest. The three course participants were enthusiastic and such as shown in their recommendations above eager to advance PBF. Zanzibar is relatively small in size and population (1,1 million people) and a pilot in two of the ten districts would be relatively easy to implement and to finance. Some technical support seems appropriate in the country *(to be expanded).*

Ethiopia

The introduction of PBF met with resistance some 2 years ago when government thought it to be a bad idea to allow health facilities to handle cash money. This bottle neck has been solved and there seems to be a growing interest to start new PBF initiatives. The PBF course facilitators from Lusaka lack information and knowledge concerning Ethiopia to further comment on the state of PBF *(to be expanded).*

4. NEXT PBF COURSES in FRENCH & ENGLISH - ACCREDITION

This first English spoken PBF course in Lusaka course was financed and organized by Cordaid for which the course organizers wish to express their gratitude as this made it possible to test the first English spoken PBF course in an accommodating environment. There were around 50 applications for the 33 places that were awarded. The response from the participants as well as other stakeholders suggests that more courses should be organized. These new English spoken courses should have improved aims, objectives, course material and curriculum. The first task will therefore be to thoroughly revise the course content and to rewrite the course book and PowerPoint presentations as well as to revise the adult learning aspects.
We further need to revise the mix between: (a) presentations by the participants and the interaction with the facilitators; (b) module exercises and presentations;

We propose to organize the second English language paying course starting November the 22nd to the 4th of December 4, 2010. Tentatively this course may be organized in Nairobi as this is the best suitable and cheapest place in Africa to reach from different places of the world. It is proposed to be organized by SINA Health, Cordaid, and possibly HDP Rwanda.

Cordaid and SINA Health are further in agreement with the open source distribution of the PBF Course book and modules, but stipulates that the sources of these materials should be explicitly mentioned as **Cordaid – SINA 2010.**

An organization wishing to use the French or English course material may wish to be accredited by Cordaid - SINA Health as having achieved high quality standards.

For this they need has to fulfill the following criteria:
a) Conduct by the end of the course a test accredited by an academic institution;
b) Assure that 4-5 experienced facilitators are present with proven experience in PBF;
c) That facilitators advocate the aims, objectives, theories and best practices of PBF and;
d) Have credible experience with adult learning.

For accreditation organizations are requested to contact SINA Health.

5. DESCRIPTION OF THE PROCEEDINGS OF THE COURSE

The Lusaka PBF course took place from July 5 to July 17, 2010. The opening ceremony was held on July 5 in the presence of acting dean Dr. J.R.S. Malungo, senior lecturer of the Department of Development Studies of the University of Zambia, and of professor M. Ndulo, head of the department of economics of the University of Zambia. Mr. Frank Van de Looij delivered a speech on behalf of Cordaid, followed by the opening speech by Dr. Malungo.

After the official opening, participants articulated their personal objectives and drew their individual development maps which were publicly presented. Afterwards, the course facilitator gave a brief outline of the course and its adult learning methodology, followed by the election of the 'village chief' and his 'assistants', and the elaboration of several 'rules of the game'. In the afternoon session of the **first day,** the first program module on National Politics and PBF, was scheduled, which elaborates the connections between national and health policies and PBF. The end of the first day, the first daily evaluation took place. The course has adopted a methodology in which each subsequent day begins with a recapitulation of the previous day's course contents by two participants, followed by a presentation of the daily evaluation outcome of the previous day by two others. The course aims to have well-timed, autonomous, participatory, innovative, synthetic (TAPIS) presentations.

The whole of the **second day** was devoted to the basic notions of micro-economics and health economics, and dealings with market concepts and market failures. This was excellently facilitated by Cosmas (a consultant of the World Bank) on micro economics while Collins (from the Zambian Ministry of Health) presented the health economics part. On the basis of the comments it appears that these modules could be more concise and should be illustrated with various exercises. The intense and fruitful discussions prevented the use of the given exercises, which in itself was regrettable.

The discussions about health economics continued into **the third day**, and were followed by a part of module 3 : PBF best practices. This module includes the theories which underpin PBF (contracting, public choice theory, systems theory, black box management) and introduces the institutional set up, good governance principles and equity mechanisms in PBF.

Discussions about the subjects of module 3 spilled over into **the fourth day**, and were completed by country reports on Rwanda and Burundi. The late afternoon of this fourth day was devoted to preparing the field visits to five health institutions on Friday.

The field visits occurred on **the fifth day** and comprised Kalingalinga UHC in Lusaka, the Pendleton private clinic in Lusaka, the Kafue District Health Management Team, Kafue's District Hospital, and Kafue Mission/ZNS Regional Health Center. Since PBF has not been fully implemented in Zambia, the participants used the questionnaire for 'non-pbf settings' in the course book, which probes the PBF elements in existing health settings, and links with the experiences of the previous days of the course. In terms of participation, contents and organization, the visits scored very high.

In the morning of the **sixth day,** Saturday, participants presented and discussed their field visit findings. Module 4 was introduced by Caesar from UNZA, which dealt with research for PBF in baseline studies, household and quality reviews.

On **Sunday**, a large number of participants took the optional tour to Siavonga on the border between Zambia and Zimbabwe to see one of the largest man-made lakes in the world and the power station which services most of Zambia, Zimbabwe and parts of Tanzania with energy.

The Monday of the second week – the **seventh day** – began with the module 4 role play on the advocacy of baseline study result among the various decision makers in PBF. This was

followed by module 5 on PBF output indicators, which was further illustrated by the use of a modified Delphi technique to prioritize indicators, and to select a weighting for these indicators, including a method of using these weightings to arrive at the final unit costs, an exercise conducted by Gyuri Fritsche. This was followed by the beginning of module 6 : the role of the fund holder, and fund holder verification methods.

The **eighth day**, Tuesday July 13, was devoted to the various roles of the regulator including the quality review instruments, indicators and procedures at their disposal. Much discussion took place on what the key roles of the regulator actually are in PBF systems and how some traditional functions are separated out. In the afternoon, module 8 which deals with negotiation skills and conflict resolution was worked through. This was followed by a role play in which various axes of tension between PBF stakeholders were enacted. In the evening the Zambia, Tanzania, Cameroon, and Zanzibar delegations delivered their country presentations, followed by a debate on common challenges to introduce PBF in these various national systems.

The **ninth day**, Wednesday July 14, was fully devoted to modules 9 and 10 which cover the health facility management black box tools: (a) Business Plan and (b) the revenue – expenditure – performance bonus "indices". Group work made these tools more concrete, participants indicated they would have liked to have more time for the practical exercises which accompany these modules.

On the **tenth day**, Thursday July 15th, started with module 11 which deals with community-provider interaction, social marketing and community verification, followed by module 12 concerning drawing up a PBF memorandum of understanding, and module 13 which treats costing of a PBF project. All these modules were considered highly valuable and practical, but did receive too little time. Participants indicated they would have liked to see the module on community participation further developed and would have loved to see more time allocated to practical exercises such as the one on costing.

Friday, the **eleventh day,** 31 participants and 4 facilitators took the exam, which consisted of 30 multiple choice questions. After completing the exam, participants filled out the final evaluation forms. At 16.00 hour the representative of the Zambian Ministry of Health, Dr. Christopher Samoonga, acting director Policy and Planning, addressed the group on behalf of the Permanent Secretary. He highlighted the importance of international collaboration in improving health care for all people, and the necessity for knowledge sharing and innovation in providing access to health and improving performance.

On Saturday**,** the **twelfth day,** the main exam results were shared with the group and the exam questions discussed. One candidate from Cameroon was honored for having passed the exam with a 100 percent right answers. The course evaluation results were presented by Christian Habineza, and were discussed with the group. Dr. Malungo of the University of Zambia came to pay his respect, but left the closure ceremony to Prof. Ndulo. During this ceremony, the country recommendations were read out for Zambia, Tanzania, Zanzibar, Cameroon and Ethiopia. Natascha Lacko subsequently addressed the group on behalf of Cordaid and underscored the importance of working together in communities of change, with PBF advocates collaborating as change agents. Prof. Ndulo concluded the official speeches by expressing warm congratulations to the various participants. Together with Ms Lacko he handed out the certificates of merit to each of the participants who passed the exam. Robert Soeters gave an overview of country recommendations based on the discussions that took place during the course and which can be found in paragraph 3.2.

6. DAILY EVALUATIONS BY PARTICIPANTS

Every day, the participants gave their evaluation of the proceedings of the course on the basis of five clear assessment criteria : 1) methods and facilitation ; 2) participation ; 3) organization ; 4) time-keeping and; 5) food and drinks.

The graphs below demonstrate the development of the verdict '(very) positive'. The first graph related **to "methods and facilitation",** indicates a steady growth of the level of satisfaction with a slight topping off towards the end of the course. From experience in previous courses, it is clear that during the first three days - which abound in tougher theoretical modules - participants are often more critical about the facilitation than later in the week when the modules with more practical exercises are introduced.

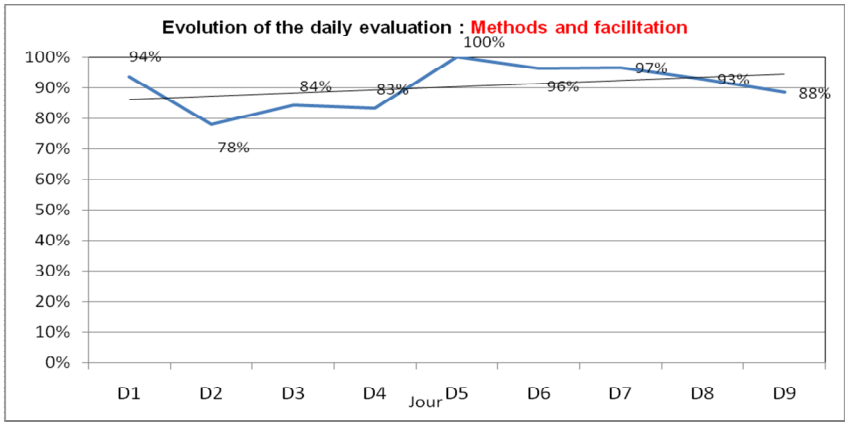

Figure 1: Evolution of the daily evaluation: *methods and facilitation.*

Compared to the average of the previous seven PBF courses (= blue line) (Bujumbura/Burundi 2x, Katana/DRC 1x, Limbé/Cameroon 1x, Munkamba-Kananga/DRC 1x, Kigali 1 x), the Lusaka course has been evaluated positively with respect to both methods and facilitation. The average score for methods and facilitation was 91%. The very positive tendency in the evaluations for the field visits and for the program in the second week are similar to the results in previous courses.

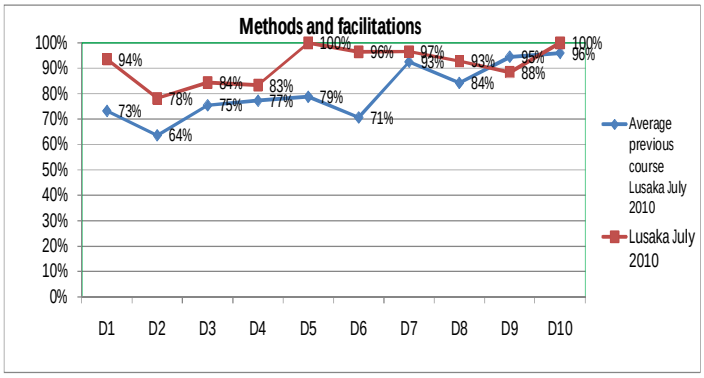

Figure 2: Comparison of the daily evaluation by the participants: *methods and facilitation.*

The satisfaction with the level of **participation** was high, with an average of 90%. Here the scores mounted from 75% at the beginning of the course to 100% towards the end. Initially, there was a lot of discussion about how to further stimulate participation and the facilitators consequently suggested improvements. The fact that almost all participants at some stage in the course had to present a module added to a better level of participation after the first week. Additional efforts should be made in future courses to allow more time for practical exercises and group work, and discussions about practical implications of PBF in concrete settings.

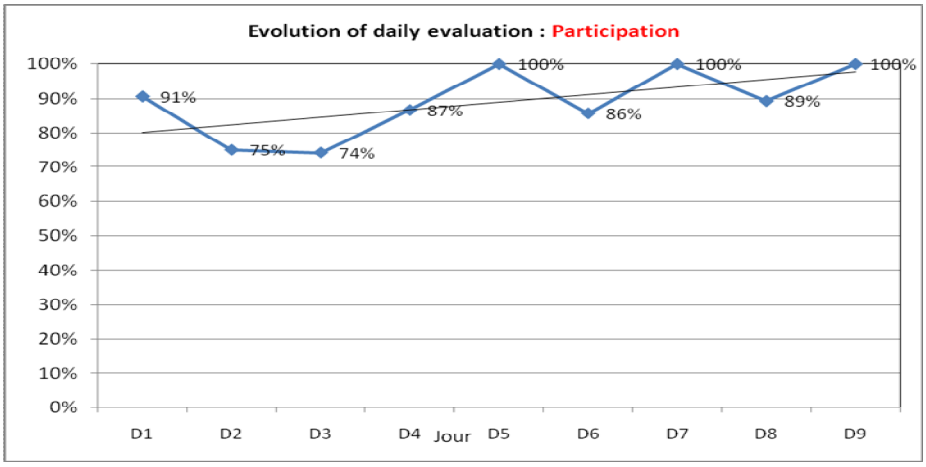

Figure 3: Evolution of the daily evaluation : *participation.*

The levels of **participation** were a little higher than in the average of the previous courses.

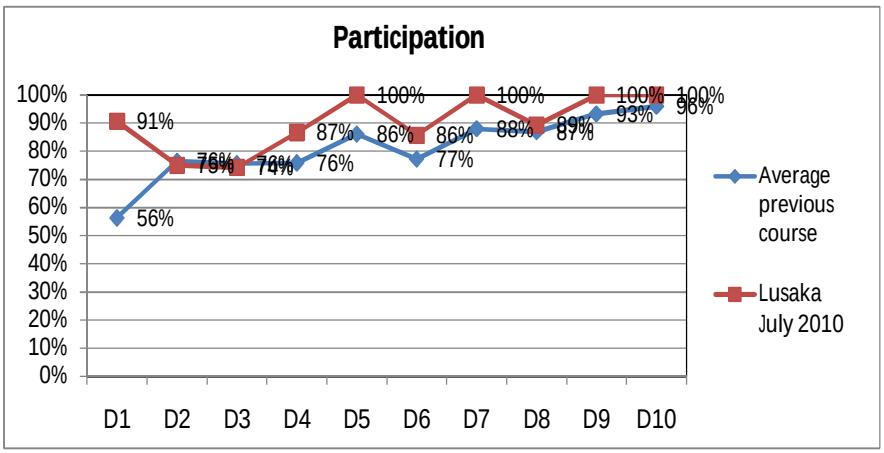

Figure 4: Comparison of the daily evaluation by the participants: *participation.*

The organization of the course in Lusaka had an average evaluation 'very positive' of 93%. Figures oscillated from day to day (see figure 5) but especially in the second week stayed above 90%.

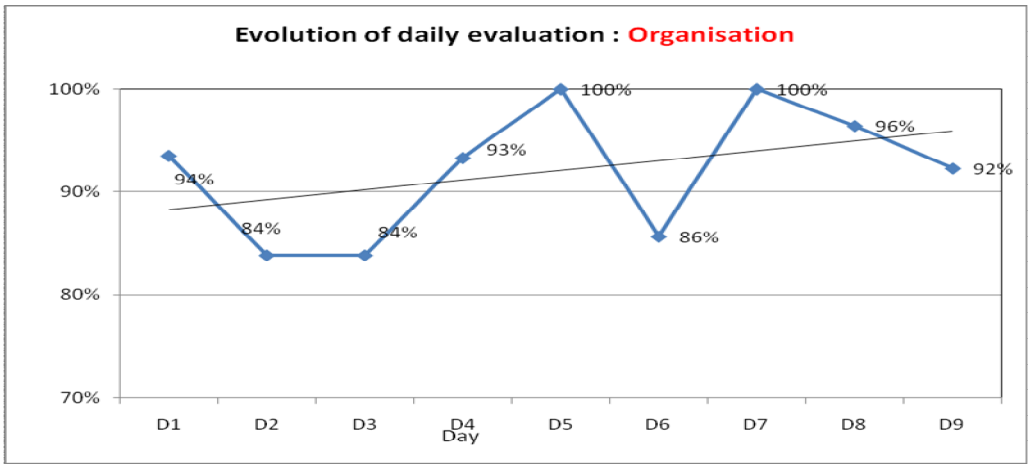

Figure 5: Evolution of the daily evaluation: *organization.*

Compared to the average of the previous seven PBF courses, the **organization** of the Lusaka course was deemed highly satisfactory by most participants (see figure 6).

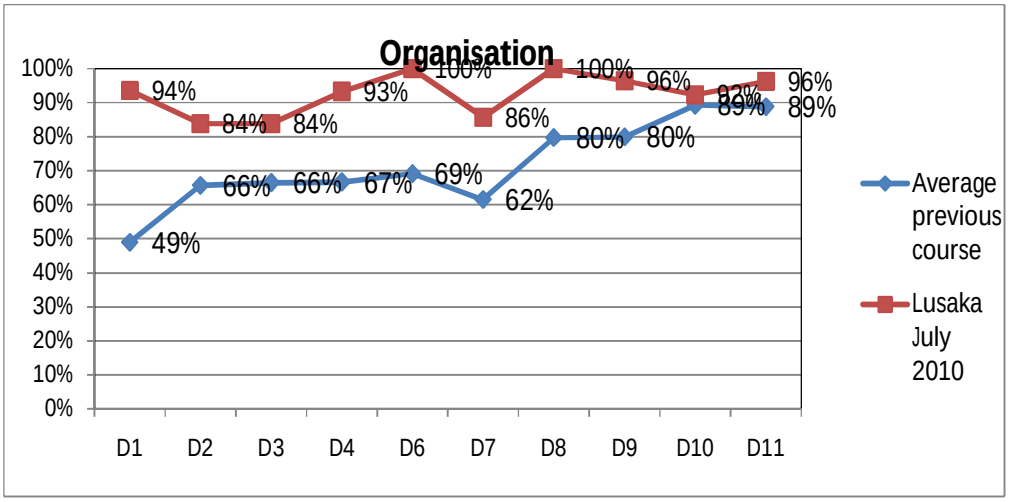

Figure 6: Comparison of the daily evaluation by the participants: organization.

The subject of **time keeping** was a recurring point of criticism. Here, the average of the positive evaluations over the two weeks was 78%, albeit with a clear improvement after the first few days. This matches earlier experience. However, the tensions between entering into a subject in detail, and managing the 13 modules equitably, remained prominent until the final day. If in future courses, more time is to be allocated to practical exercises, a revision of the other course material is necessary if one wishes to stay within the time frame of two weeks.

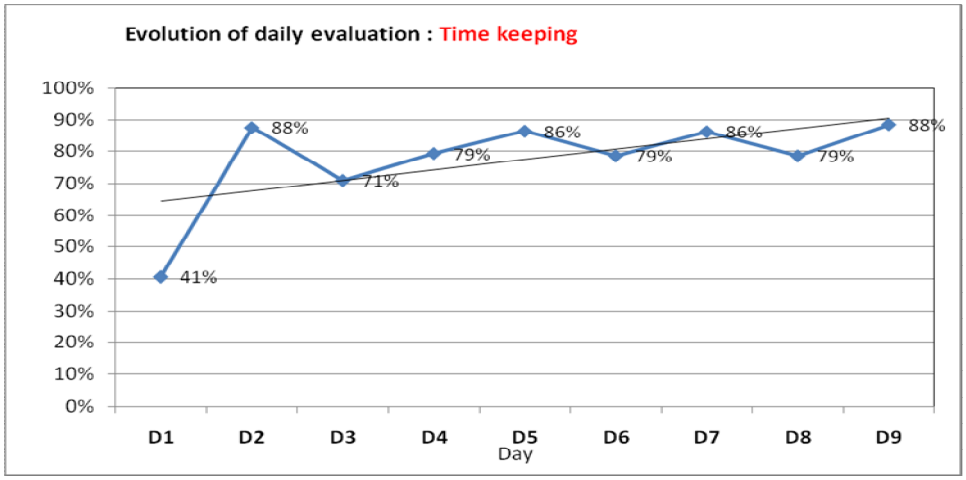

Figure 7: Evolution of the daily evaluation : *time keeping.*

It appears from figure 8 that **time keeping** has been a problem, even in earlier courses, and that the Lusaka course was not badly evaluated comparatively.

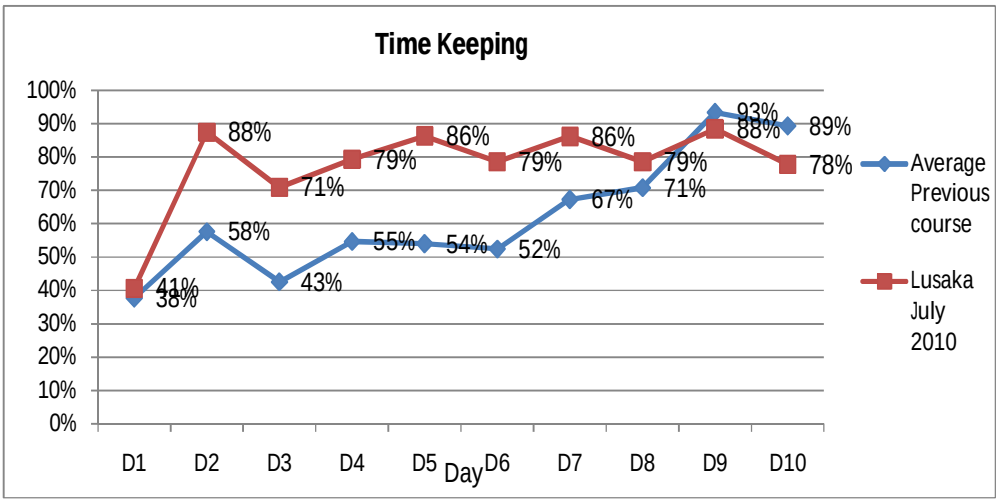

Figure 8: Comparison of the daily evaluation by the participants: time keeping.

The satisfaction with **food and drinks** remained moderate. There was a clear improved appreciation during the days the Cosmic Lodge offered Zambian meals, but complaints continued to circulate with some about the lack of 'variety' in the food that was offered. The average level of 'very positive' scores, however, was 79%.

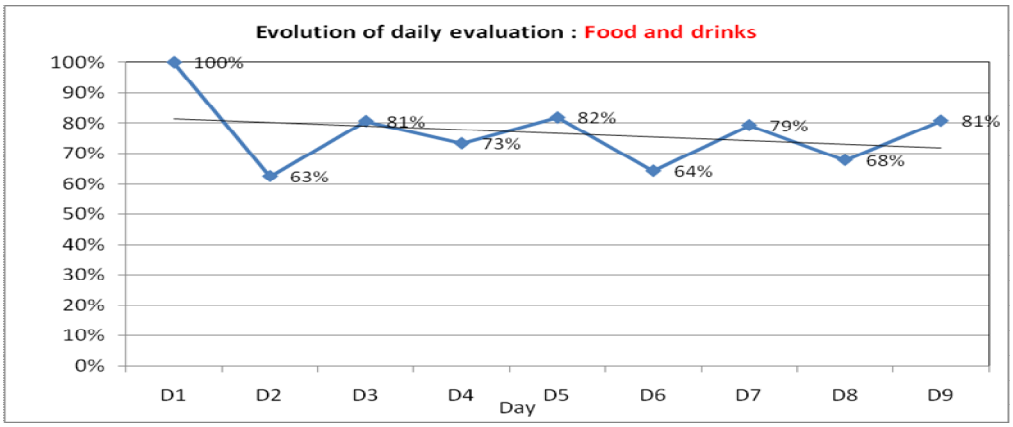

Figure 9: Evolution of the daily evaluation: food and drinks.

The scores on **food and drinks** were comparable to the average scores on the subject in previous courses (see figure 10).

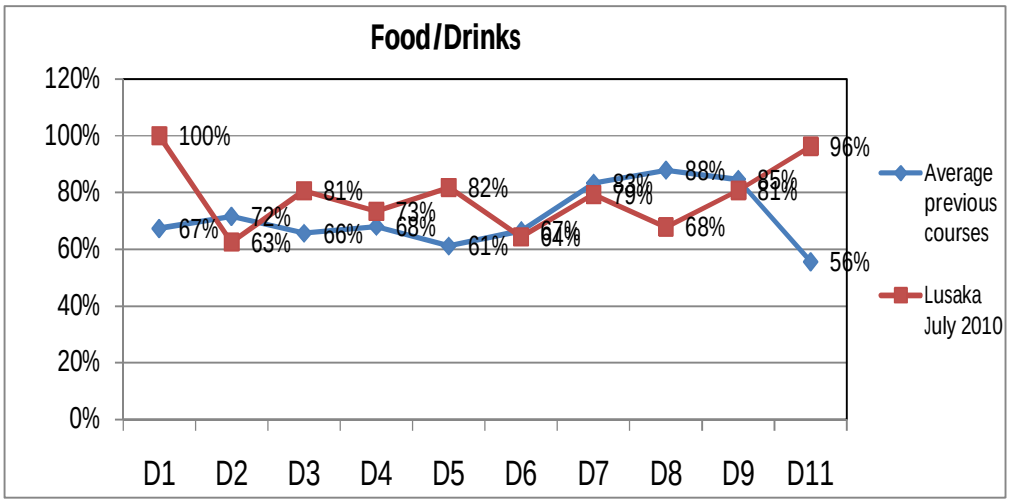

Figure 10: Comparison of the daily evaluation by the participants: food and drinks.

7. FINAL EVALUATION BY PARTICIPANTS

7.1 General impression of the course

The general participants impressions during the final evaluation of the course were as follows:

General impressions of the course	Bujum-bura Sept 2008	Bujum-bura Nov 2008	Katana Juillet 2009	Limbé Oct 2009	Mun-kamba Mai 2010	Kigali Juin 2010	Lusaka July 2010
Q1. The content of the PBF modules has helped me to attain my objectives	92%	97%	81%	86%	88%	90%	80%
Q2. The methodology of the course	85%	87%	79%	82%	98%	76%	**67%**
Q3. Balance between lectures and exercises	72%	78%	78%	77%	90%	68%	**61%**
Q4. Interaction and exchanges in working groups	79%	90%	81%	79%	97%	87%	78%
Q5. Quality of the course material	74%	85%	77%	75%	92%	58%	70%
Q6. The working methods adopted in the course have stimulated my active participation	89%	91%	86%	87%	97%	82%	76%
Average	**82%**	**88%**	**80%**	**81%**	**94%**	**77%**	**72%**

Table 1: Overview of the general impressions of participants of the different PBF courses.

From this evaluation the average score of 72% was the lowest compared to the previous 6 courses evaluated based on the same questions. The scores were lower for the methodology, balance between lectures and exercises and the active participation. Some of the explanations of this below average evaluation have been given in the previous chapters although it seems not consistent with the above average daily evaluations by the participants. This contradiction may be linked to the slightly different evaluation methods during the French and English courses (different interpretation of “satisfaisant” and “positive”).

7.2 Planning aspects of the course

Concerning the planning aspects of the course and in how far the course answered to the professional activities of the participants the Lusaka evaluation *scored above average*.

	Très satisfait? OUI ! Buja Sept 2008	Très satisfait? OUI ! Buja Nov 2008	Très satisfait? OUI! Katana Juillet 2009	Très satisfait? OUI ! Limbé Oct 2009	Very Positive? Yes! Lusaka July 2010
Q1. I was sufficiently informed about the objectives of the course	94%	93%	87%	78%	97%
Q2. The program has answered my expectations	85%	92%	81%	78%	88%
Q3. The objectives of the course relate well to my professional activities	91%	95%	81%	79%	95%
Average	**90%**	**93%**	**83%**	**78%**	**93%**

Table 2: Participants’ evaluation of the planning of the PBF course.

7.3 Appreciation of the duration of the course

52% of the participants found the course short or too short. This is partially related to the fact that some participants only felt in the second week of the course to be able to link the course materials to their own practical backgrounds. From that moment on, they were keen to develop more practical insight and would have liked to see such practical input increase. Some participants suggested to develop more targeted courses for decision-makers and operational PBF participants separately.

Duration of the course	% Katana juillet 2009	% Limbé Oct 2009	% Munkamba Mai 2010	% Kigali Juin 2010	% Lusaka July 2010
Too Short	0%	7%	5%	0%	**21%**
Short	13%	45%	20%	27%	**31%**
Fine	65%	38%	75%	65%	41%
Too Long	19%	7%	0%	4%	7%
Unclear	3%	3%	0%	4%	0%

Table 3 : Participants' evaluation of the duration of the PBF course.

7.4 Comments on the organization of the course

The participants of the Lusaka course gave **organization** an above positive evaluation of 82% related to the previous courses (between 65% and 83%). Use of time, distribution of course materials, the lecture room and the friendliness of the organizing parties scored very well with the participants. Some points of criticism existed on hotel (mainly due to the instable Internet environment which existed at the Lodge) and on transportation.

.	Très satisfait? OUI !	Très satisfait? OUI !	Très satisfait? OUI !	Très satisfait? OUI !	Très satisfait? OUI !	Très satisfait? OUI !	Very Positive? YES!
How do you value the organization of the training ?	Sept 08 Buja	Nov 08 Buja	Juil 09 Katana	Oct 09 Limbé	Mai 10 DRC	Juin 10 Kigali	July 10 Lusaka
Q1. The use of time	80%	89%	69%	70%	75%	62%	84%
Q2. Distribution of educational material	87%	92%	83%	85%	95%	58%	88%
Q3. The lecture room	56%	53%	74%	86%	60%	65%	86%
Q4. Cosmic Lodge as conference center	79%	85%	43%	87%	81%	56%	78%
Q5. How were you received and friendliness	90%	89%	71%	89%	87%	80%	95%
Q6. Food and drinks, including tea / coffee breaks	88%	89%	71%	87%	90%	79%	81%
Q7. Hotel and transportation	80%	67%	44%	78%	60%	59%	59%
Average	**80%**	**81%**	**65%**	**83%**	**78%**	**66%**	**82%**

Table 3: Participants' evaluation of the organization of the PBF course.

7.5 Comments on the execution of the course and the facilitators

The average score in Lusaka for execution of the course and facilitation was according to the final evaluation below average with 71%. This seems consistent with the earlier findings that the course was considered too short. According to 22% of the participants, there was a lack of openness of facilitators towards contributions. This aspect may indeed need more attention and will improve probably when the facilitators know better the different countries involved, the different sensitivities as well as when the English PBF course materials improve.

Aspects related to the execution of the program and the facilitation	Sept 08 Buja	Nov 08 Buja	Juil 09 Katana	Oct 09 Limbe	May 10 DRC	July 2010 Lusaka
Q1. The facilitators had an open mind towards contributions and criticism	93%	97%	91%	86%	100%	**78%**
Q2. Time allocated to the presentations was adequate	90%	95%	84%	85%	98%	**76%**
Q3. Time allocated to group work was adequate	81%	89%	83%	69%	95%	**59%**
Q4. Time for discussions was adequate	82%	85%	81%	68%	92%	**71%**
Average	**87%**	**91%**	**85%**	**77%**	**96%**	**71%**

Table 4: Participants' appreciation of the execution of the PBF course and the facilitators.

7.6 Comments on the contents of the course

The Lusaka score on **content** of 87% was average compared to the previous courses. The content was highly evaluated with 95%, it answered the participants expectations by 88% but only scored 79% on matching the participants expectations, the balance of the course was well appreciated with 88%. It seems to demonstrate that the course did answer most particpants expectations.

Contents of course : what do you think about the educational course contents?	Très satisfait? OUI ! Sept 2008 Buja	Très satisfait? OUI ! Nov 2008 Buja	Très satisfait? OUI ! Juillet 2009 Katana	Très satisfait? OUI ! Octobre 2009 Limbé	Très satisfait? OUI ! Mai 2010 DRC	Très satisfait? OUI ! Juin 2010 Kigali	Very Positive? Yes! July 2010 Lusaka
Q1. The contents of the course was	93%	97%	91%	86%	100%	88%	95%
Q2. The content has answered your expectations	90%	95%	84%	85%	98%	88%	88%
Q3. The content matches your experience	81%	89%	83%	69%	95%	83%	79%
Q4. The modules of the course are well balanced	82%	85%	81%	68%	92%	85%	88%
Average	**87%**	**91%**	**85%**	**77%**	**96%**	**86%**	**87%**

Table 5: General impression of the participants in the Lusaka PBF course.

7.7 Evaluation per module

The overall scores of satisfaction per module by the Lusaka participants is shown in the following table. It shows a slightly less favorable score in particular for national policy, PBF theories, baseline studies and research, business plan, community – provider interaction and PBF project development and advocacy. There was only one module "regulation" that scored slightly above average compared to the previous courses.

Module	Average satisfaction previous 6 courses	Satisfaction July 2010 Lusaka	Tendency
1. Introduction on national policy and PBF	93%	89%	-
2. Notions of micro-economics and health economy	89%	88%	+/-
3. PBF Theory : best practices, system analysis, public choice theory, contract theory, economics	96%	84%	-
4. Baseline research – household survey – quality reviews – stakeholder analysis, launching process	91%	86%	-
5. Output indicators in PBF interventions	88%	85%	+/-
6. Fund holder agency, data collection, audit	94%	93%	+/-
7. Regulation – quality assurance	90%	91%	+/-
8. Negotiation techniques and conflict resolution	96%	96%	+/-
9. Black box 1 – Business Plan	92%	86%	-
10. Black box 2 "Indices" tool: revenues – expenditure – performance bonuses	91%	84%	+/-
11. Community - provider interaction : community voice empowerment and social marketing	89%	77%	-
12. Development of a PBF project and advocacy	89%	84%	-
13. Elaboration of a PBF project - costing	90%	83%	+/-
Total	**91%**	**87%**	**+/-**

+/-

Table 6: Participants' appreciation of the 13 modules of the PBF course.

Compared to the previous PBF courses the participants thought that the modules needed modifications as shown in the next table.

Module	Requires modification according to 7 previous courses	Require modifications? Yes! Lusaka July 2010	Tendency
1. Introduction on national policy and PBF	41%	21%	-20%
2. Notions of micro-economics and health economy	56%	36%	-20%
3. PBF Theory : best practices, system analysis, public choice theory, contract theory, economics	26%	14%	-12%
4. Baseline research – household survey – quality reviews – stakeholder analysis, launching process	40%	31%	-9%
5. Output indicators in PBF interventions and population targets (EXCEL)	39%	22%	-17%
6. Fund holder agency, data collection, audit	27%	17%	-10%
7. Regulation – quality assurance	37%	3%	-34%
8. Negotiation techniques and conflict resolution	20%	14%	-6%
9. Black box 1 – Business Plan	42%	21%	-21%
10. Black box 2 "Indices" tool: Analysis of revenues – expenditure – performance bonuses	44%	34%	-10%
11. Community - provider interaction : community voice empowerment and social marketing	41%	54%	13%
12. Development of a PBF project and advocacy	30%	36%	6%
13. Elaboration of a PBF project - costing	32%	35%	3%
Average for 13 modules	**36%**	**26%**	**-10%**

Table 7: The need for modifications expressed by participants.

According to this evaluation the modules 11 (community interaction), module 12 (development of a PBF project and advocacy) and module 13 (costing) needs further improvement in comparison to the evaluation of the previous courses. However, according to this evaluation also module 2 (micro-economics and health economics), module 4 (baseline research) and module 10 (indices tool) requires further attention.

Supplement 1 : LIST OF PARTICIPANTS, FACILITATORS & E-MAILS

Participants for Lusaka PBF cours 5-17 July 2010 - Version 24 July 2010

	Participants & country	Position - Academic Background	Sex	Email
	Cameroun			
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	Ethiopia			
4	DEWO ROBI Zinash	ECS HIV/AIDS - BSc	f	zinu22@yahoo.com
	Tanzania			
5	ISASI Mecklina	CSSC Administrator	f	mecky.tz@gmail.com
6	KALINDU Japhet	Igogwe Hosp Administator	m	jkalindu@yahoo.com
7	KIBOPILE Patrick John	District Pharmacist	m	kibopile@yahoo.com
8	MANONGI Rachel Nathaniel	Kili Chr Med Cen, PhD	f	rmanongi@yahoo.co.uk
9	MUKULU Madina Paulo	Kili Chr Med Cen, MPH	f	madina_paul@yahoo.com
10	MUSHI Declare	Kili Chr Med Cen, PhD	m	declbety@yahoo.com
11	MZURIKWAO Godwin John	Diocese Accountant	m	gmzurikwao@yahoo.com
12	NSWILLA Anna	MOH - Policy & Planning PhD	f	answilla@yahoo.co.uk
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17	CHILESHE Lee	MOH -Planning BA statistics	m	chileshelee@yahoo.com
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20	MUSUMALI Cosmas	Economist World Bank, PhD	m	nfstltd@gmail.com
21	MUTENGWA Fides	MOH West Prov Accountant	m	chabomuntengwa@yahoo.com
22	MWAMBAZI Wesley	MOH - Planning - Economist	m	wmwambazi@yahoo.com
23	PHIRI Caroline Ntetema	MOH - WB - MPH	f	drcarolp@yahoo.com
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29	ABDULLA Mohammed Ali	MOH Zanzibar	m	abdallazone@yahoo.com
30	SALMIN Sharifa Awadh	MOH Zanzibar - M Int Health	f	salminyy@yahoo.com
	FACILITATORS			
	Netherlands			
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	Rwanda			
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