

Performance based financing in fragile and conflict affected settings: what are the opportunities and challenges?

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November 2018

Background to the work

Over the last decade, performance-based financing (PBF) has been increasingly implemented in low and middle-income countries, becoming a significant feature of the health financing landscape, including fragile and conflict-affected states (FCAS). Under PBF programmes, funds are made conditional on agreed outputs or outcomes, often with quality adjustments. While research and evidence on PBF has grown, there remain some very significant gaps in our understanding of it. The ReBUILD research programme, which has been delivering research on health system reconstruction post-conflict and in wider FCAS settings since 2011, has been examining PBF in FCAS settings to draw out lessons for policy-makers and funders.

Key messages

Performance-based financing (PBF) is particularly common in fragile and conflict-affected settings (FCAS), and some features of these settings may favour the emergence of PBF, for example:

- the greater role of external actors and donor
- a greater openness to institutional reform
- lower levels of trust within the public system and between government and donors.

However, findings are mixed regarding PBF implementation and effectiveness in FCAS settings.

Despite the 'PBF principles' codified over time (such as strict separation of functions and comprehensive verification systems), adaptation to context, flexibility in implementation and pragmatism (rather than copy-and-paste approaches) appear to be key elements to ensure the survival - and perhaps success - of PBF, especially in humanitarian settings.

When PBF is analysed as a health financing/system reform, evidence is mixed and expectations should be realistic. Foreexample, in relation to strategic purchasing, PBF remained one purchasing mechanism amongst many, with traction mostly on the services covered in its package and limited wider transformative effects. Political economy analyses highlight the drivers of PBF across settings:

- In Sierra Leone, external actors, internal divisions and the resource/capacity-strapped environment led to lack of ownership and appropriation at national level and may explain the start-stop-start story of PBF.
- In Zimbabwe, despite initial resistance, ownership later developed, with substantive changes introduced by the Ministry of Health and Child Care (MoHCC). But challenges and tensions remain - for example, in terms of longer-term funding and institutionalisation.

Key messages for donors include

- Processes for introduction of PBF in FCAS settings need to be especially sensitive and iterative, to allow local leadership to develop and continue
- There is no one model for PBF – given the range of challenges, institutional arrangements and political economy configurations, PBF must be locally adapted and flexibly implemented.
- PBF can be one mechanism for providing more flexible resources (with accountability) to frontline providers; however, it has to emerge from local situation analysis and be situated within the health system as a whole. It should not be a stand-alone measure.

All the briefing papers in this series can be accessed at <http://bit.ly/2rUPRH9>

This briefing paper series has been developed by the **ReBUILD Research Programme Consortium** to inform a number of key issues around health systems in crisis-affected settings, and draws both on ReBUILD's own work and wider sources. The issues were identified in a **research agenda-setting study** carried out by the **Health Systems in Fragile and Conflict-Affected States Thematic Working Group** of Health Systems Global.

Methods

This work includes:

1. A literature review starting from initial hypotheses about how FCAS contexts may influence the adoption, adaption, implementation and health system effects of PBF. These were interrogated through a review of available grey and published literature.¹
2. Comparative case studies from three humanitarian settings (northern Nigeria, Central African Republic and South Kivu in the Democratic Republic of Congo) examining why and how PBF has emerged and has been adapted to those unsettled and dynamic contexts, what the opportunities and challenges have been, and what lessons can be drawn.²
3. A political economy analysis of decision-making processes on PBF in Sierra Leone during the 2010-2017 period. Sierra Leone presents an interesting case because of the 'start-stop-start' trajectory of PBF.³
4. A political economy analysis of factors behind the adoption of PBF in Zimbabwe – one of the few African countries to scale up PBF nationwide - as well as of the shifts in influence and resources which PBF brought about.⁴
5. Analysis of the impact of PBF on strategic purchasing in three FCAS settings – DRC, Uganda and Zimbabwe.⁵ A more detailed case study of Zimbabwe was also produced.

Summary of findings

The **literature review**⁶ from the study confirms that PBF is more common in FCAS countries, which were often also early adopters. We find however that the programmes rarely acknowledge the FCAS context as a driver of introduction, and that analysis of whether PBF is ultimately reducing fragility or bypassing it is lacking. Two models of start-up were found – one centred on NGO pilots, later scaled up (typically, these were earlier cases), the second being larger-



scale piloting or implementation, supported by external donor with involvement of the government. As with the rapid spread of other policy ideas, the role of key individuals, implementing agencies and funders (for example, the World Bank through the Health Results Innovation Trust Fund and NGOs such as Cordaid) can be traced in the spread of PBF, often using a narrative of success (not necessarily evidence-based) from early pilots elsewhere.

The study finds that rather than emerging despite fragility, conditions of fragility may favour the rapid emergence of PBF. Factors may include the greater role of external actors and donors, a greater openness to institutional reform, and lower levels of trust within the public system and between government and donors, all of which favour more contractual approaches. However, the evidence in the literature is more mixed regarding factors supporting (or not) PBF implementation and the effectiveness of PBF in FCAS settings.

In the three-country case study of **PBF in humanitarian settings**⁷ (DRC, northern Nigeria and CAR), the analysis reveals that these challenging environments required a high degree of PBF adaptation and innovation, at times contravening the so-called 'PBF principles' that have become codified (see figure 1 overleaf). Our study points to the importance of pragmatic adaptation in PBF design and implementation to reflect the contextual specificities, and identifies elements (such as, organisational flexibility, local staff and knowledge, and embedded long-term partners) that have facilitated adaptations and innovations. The key point emerging from the analysis, which is likely to be relevant beyond humanitarian settings, is that flexibility and pragmatism (rather than copy-and-paste approaches) are essential to ensure the survival, and perhaps the success, of a complex intervention such as PBF.

In relation to **PBF's impact on strategic purchasing**,⁸ at the government level, the study finds little change to the accountability of purchasers, although PBF does mobilise additional resources to support entitlements. In relation to the population, PBF appears to bring in improvements in specifying and informing about entitlements for some services. However, the engagement and consultation with the population on their needs was found to be limited. In relation

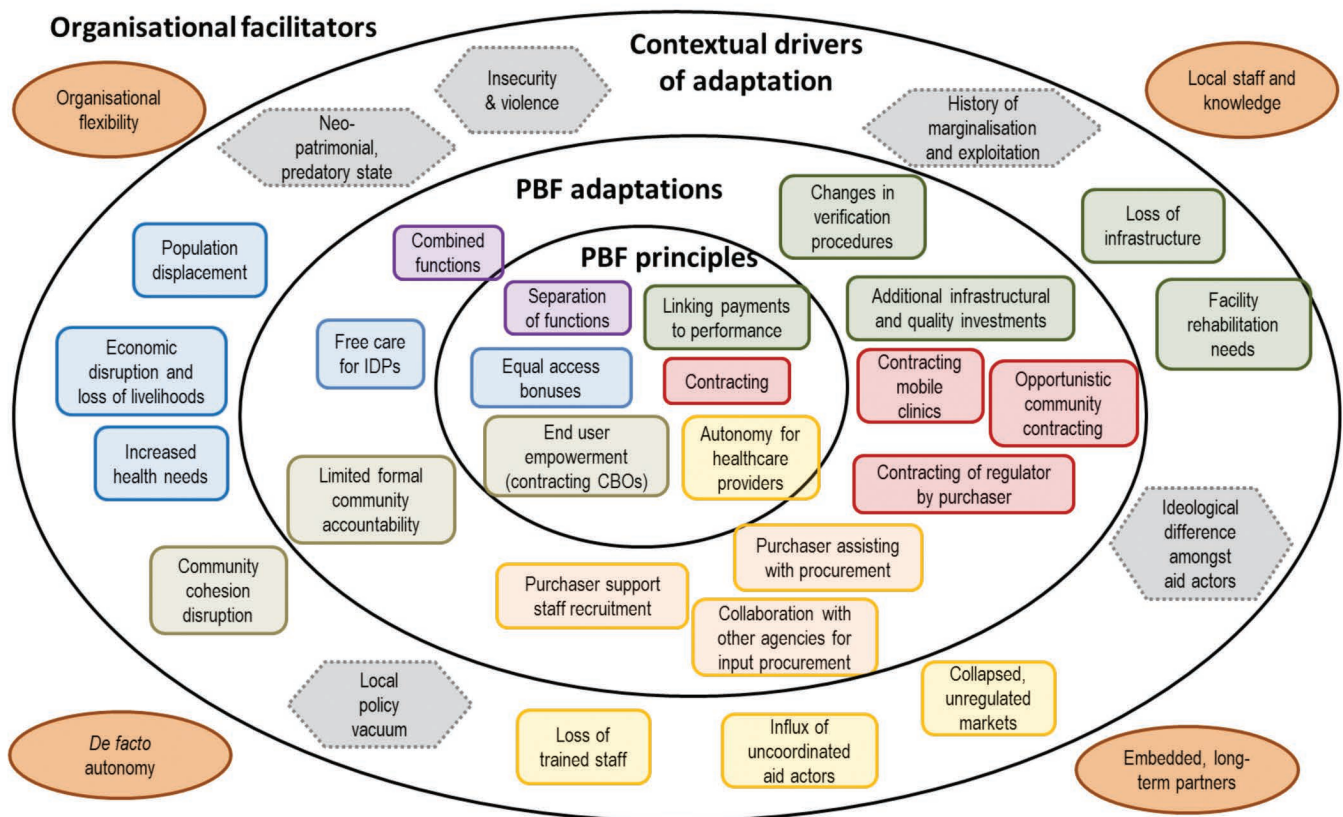


Figure 1: Adaptations of PBF in three humanitarian settings, their drivers and facilitators 7

Examples of “PBF adaptations”, and their respective “contextual drivers”, are mapped against PBF principles by using the same colour; “contextual drivers” in grey, dotted lines are general ones. “Organisational facilitators” also refer generally to all adaptations.

to providers, PBF does not impact in any major way on provider accreditation and selection, or on treatment guidelines.

However, it did introduce a more contractual relationship for some sets of providers and bring about at least partial improvements in provider payment systems, data quality, increased financial autonomy for primary providers and enforcing equitable strategies.

More generally, PBF has been a source of much-needed revenue at primary care level in under-funded health systems. The context – particularly the degree of stability and authority of government – the design of the PBF programme and its stage of development were key factors behind differences observed.

While PBF has been presented as a potential catalyst to wider health system reforms and as a tool to increase strategic purchasing, the example of **Zimbabwe** – one of the few countries in Africa to be implementing PBF on a nationwide scale and widely seen as a successful example of PBF – suggests that we should have more modest expectations.⁹ PBF in this case brought focus to specific outputs – maternal and child health services at primary level – but remained one purchasing mechanism amongst many, with limited traction over the main service delivery inputs and programmes. Its achievements included enabling some flexible resources to reach primary providers, funding supervision and emphasising the

importance of reporting. Set against that were many constraints, including high transaction costs. The legacy of system capacity pre-crisis in Zimbabwe is an important factor in its relatively swift scale-up and implementation.

In **Sierra Leone**, the **political economy analysis**¹⁰ highlights the role of external actors and the resource-strapped environment of the Ministry of Health and Sanitation (MoHS) in the start-stop-start story of PBF, along with internal divisions within the MoHS, divisions between donors, and policy processes which align with donor funding cycles in a way which is not conducive to the development of national understanding, leadership and ownership over the programme. The findings also suggest that the issues of lack of ownership and of local adaptation and appropriation are compounded by a dissonance in the framing of PBF, with many (national) actors framing PBF with a focus on motivation and additional resources for primary facilities, and some (external) actors seeing it as a critical piece of a broad health financing reform.

This is also reflected in the **political economy analysis in Zimbabwe**,¹¹ where results-based financing (RBF) was initially a means to resources for the Ministry of Health (MoH) after the political-economic crisis of the 2000s, but where genuine ownership later developed, with substantive changes introduced by the MoH to the

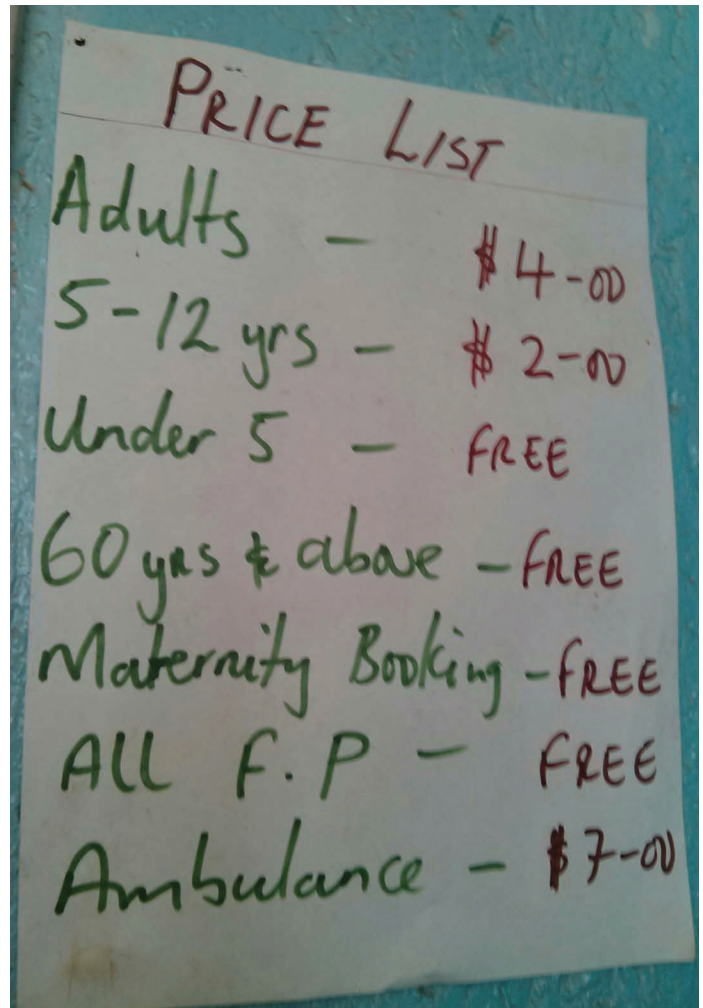
model to ensure it fitted into existing systems to the greatest extent possible. This also ensured that district level managers were not marginalised by the shift in resources.

Government ownership was also aided by the earlier policy of results-based management into which PBF could be ideologically retrofitted. The insecure financing of RBF is however a major challenge, and budget reductions are causing tensions at facility and health worker levels, while institutionalisation of the policy (which has been highly dependent on intensive intervention by contracted NGO implementers) is an outstanding challenge.

Tensions are also revealed between one strand of RBF (increasing autonomy, passing power and resources to the periphery, etc.) versus RBF as way or re-establishing control over the system (enforcing accountability, reporting, verification, sanctions, etc.).

References

1. Based on 140 documents, covering 23 PBF schemes.
2. This was based on a document review, 35 key informant interviews (KIs) and 16 focus group discussions at national and subnational level in the three settings.
3. This was based on a document review and 25 KIs with national stakeholders and international actors.
4. This was based on a review of 60 documents, and 40 KIs with district, national and international experts.
5. This was based on a review of 110 documents from 2004-2018, and 98 KIs conducted with international, national and district level stakeholders in early 2018 in the selected districts of the three countries.
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This is an output of a project funded by UK aid from the UK government. However the views expressed do not necessarily reflect the UK government's official policies.

