ADAMAWA STATE
PRIMARY HEALTH CARE DEVELOPMENT AGENCY

PBF PROGRESS REPORT:

LESSONS LEARNED AND STRATEGY FOR FUTURE IMPLEMENTATION JUNE 2020

ANADACH CONSULTING LIMITED
ANALYZE | ADVISE | ACHIEVE

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Abbreviations

ADSPHCDA	Adamawa State Primary Health Centre Development Agency
BFPHCPF	Basic Family Planning and Health Care Provision Fund
CHEWs	Community Health Extension Workers
CHOs	Community Health Officers
CMVA	Contract Management and Verification Agency
DFF	Decentralised Facility Financing
FMs	Facility Managers
FGDs	Focused Group Discussions
FGN	Federal Government of Nigeria
HMB	Health Management Board
IDIs	In-depth Interviews
IDPs	Internally Displaced Persons
IM	Intramuscular
IVA	Independent Verifier Agent
LGAs	Local Government Areas
MC	Maternal and Childcare
MDG	Millennium Development Goals
MNCH	Maternal and Neonatal Child Health
MoH	Ministry of Health
NICS	National Immunisation Coverage Survey
NDHS	National Demographic Health Survey
NPHCDA	National Primary Health Care Development Agency
NSHIP	Nigeria State Health Investment Project
PBF	Performance-Based Financing
PHA	Primary Health Agency
PHC	Primary Health Care
PHCs	Primary Health Centres
PHCDA	Primary Health Care Development Agency
PIU	Project Implementation Unit
QOC	Quality of Care
RBF	Result Based Financing
SPHCDA	State Primary Health Care Development Agencies
STD	Sexually Transmitted Diseases
TBA	Traditional Birth Attendants
UHC	Universal Health Coverage
WDCs	Ward Development Committees
WHO	World Health Organisation
WB	World Bank

Executive Summary

Despite recurring public health crisis in Nigeria, the country's health care system does not provide the level of health care services required to meet the needs of its population. Although there has been recorded progress in recent years, key indices, particularly in maternal and child health, remain poor. In 2015, according to the World Health Organisation (WHO), Nigeria accounted for 19% of global maternal deaths.

It is within this challenging context that the Nigeria government decided to intervene and strengthen its health service delivery and outcomes, especially at the primary care level. Comprehensive primary healthcare remains the bedrock of healthcare service delivery and the key to achieving Universal Health Coverage. (UHC) Specifically, the government introduced the Nigeria State Health Investment Project (NSHIP) to increase delivery and use of high impact maternal and child healthcare interventions, as well as improving the overall quality of care in the three pilot states in Nigeria, one of which is Adamawa. The project piloted a performance-based financing scheme at health facilities and sub-national administration; it also coordinated disbursement linked indicators at sub-national administration and state levels.

Our combination of qualitative and quantitative analysis of the Adamawa NSHIP project offered a complementary approach to understand the impact of policy on the quality of care provided at various PHC facilities across the state. We found that the NSHIP improved health outcomes in several dimensions; facility managers and other key stakeholders considered funding, sustainability planning and capacity building to have contributed to the remarkable achievements of the project. Beneficiaries of the scheme acknowledged that infrastructural upgrades, engagement of well-trained staff and provision of subsidised services to vulnerable groups improved performance.

However, in the absence of external funding, the sustainability of the positive changes at the facility level remains a key challenge. This was emphasised by unexpected project funding challenges in 2018, resulting in a decline in most health services. We suggest that the Adamawa State Government consider focusing on the following recommendations to build a sustainable action plan that ensures no gains are lost:

- Refine the ADSPHCDA organisational structure, inclusive of the policies and procedures based on the lessons learnt. Emphasis should be placed on improving communication channels between the health facilities.
- Facilitate financial sustainability at all levels. This can be done by encouraging a greater allocation of funds to health providers at state and local government levels; government should also leverage the BHCPF, support expansion of pooled financing/insurance that can be used at PHC level (e.g., NHIS, State Insurance Schemes) and at the facility level by encouraging the use of insurance schemes, innovation, and payment for services such as medication, which people are able/willing to pay.
- Decide whether to stay with the PBF or DFF model. It is challenging to manage both models simultaneously. While the PBF model produces superior health outcomes, it is critical to guarantee its financial sustainability. If the ASPHCDA budget for 2018 of N8.6 billion had

been fully funded, this would have catered to the “basic and complementary” health packages costed by the World Bank.

- We suggest that ASPHCDA build on the strong data culture in the PBF by leveraging electronic collection and storage of data. In addition, it should improve data analytic skills at both facility and central levels.
- Institutionalise standard operating protocols for key health interventions within the facilities.

While the Adamawa experience indicates that performance-based financing is effective at improving demand and quality for selected primary health services, the unexpected funding difficulties reveal that such improvement may be temporary. Thus, it is important to ensure that issues of financial sustainability are addressed before commencing a performance-based program elsewhere. It is also important to note that it is difficult to run two different payment schemes for employees who work in the same states, do the same jobs for a substantial amount of time, without demotivating some staff by the inconsistencies.

Unfortunately, while the Adamawa State Government grapples with the prolonged period of political upheaval and its impact on access to maternal and child health, it now must contend with the current COVID 19 pandemic, further making the necessity of an effective primary care system even more critical.

With an even more tenuous financial situation, worsened by the COVID-19 pandemic, as well as the criticisms about the sustenance of incentives and the effectiveness of the Adamawa State PBF project, the question remains: what considerations are required to promote and sustain the improved performance of primary care facilities within Adamawa State?

Acknowledgements

This document is the result of diverse contributions from many who deserve recognition. First, we thank the Adamawa State Primary Health Care Agency (ADSPHCDA) for funding the independent qualitative and quantitative assessment of the NSHIP project in Adamawa.

We are also grateful to the Honourable Commissioner of Adamawa State Ministry of Health, as well as the staff of the State Ministries of Health, Local Government, Director of Planning Research, staff of the Federal Ministry of Health and staff of the World Bank Project in Abuja and Adamawa. They all provided significant input and direction during the research.

Our heartfelt thanks go to the numerous Local Government Chairmen, Officials and Facility Managers at the DFF and RBF facilities across several local governments. We also thank the beneficiaries who were either interviewed, observed, or participated in stakeholder consultations. Their tireless efforts greatly enhanced the quality of this report.

Lastly, we are immensely grateful to all the individuals, including Anadach staff and consultants, who have contributed in one way or another to the development of this report. Though it is impossible to mention each person by name, their input was nonetheless vital to completing this work.

1.0

Introduction

Description of Specific Terms

Results-Based Financing (RBF) constitutes financial incentives for goal-oriented, quantitatively measured accomplishments. These result-based rewards are given to state and local government agencies to encourage the active engagement of lower-level government personnel in the healthcare sector and the achievement of measurable health objectives. The Nigeria State Health Investment Project (NSHIP) has provided the opportunity to test two alternative financing strategies in Adamawa, Nasarawa and Ondo states, with selected facilities operating either Performance-Based Financing (PBF) or Decentralised Facility Financing (DFF) - another financing approach based solely on grants for fiscal decentralisation and institutional strengthening.

Performance-Based Financing (PBF), a subset of RBF, is the provision of monetary incentives to health providers based on a set of measurable performance targets. It is a strategy increasingly adopted in developing countries to improve access to and quality of health services in a bid to achieve universal health coverage (UHC). The PBF is based on the rationale that health care providers exert more effort when payments are conditioned to the quantity and quality of the health services provided. Although it varies across countries, the PBF scheme has three basic pillars: a defined package of services, the performance payment method and verification mechanisms.

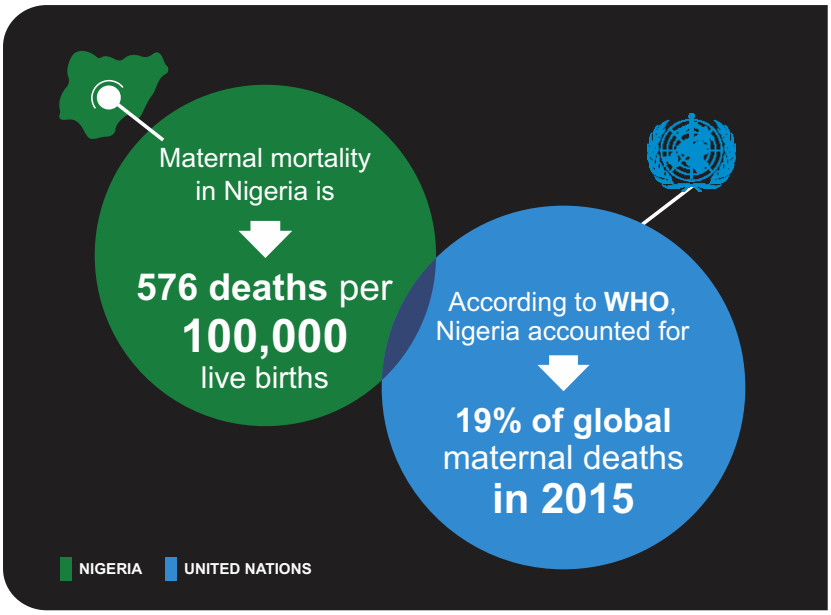
The DFF is another financing approach based solely on grants for fiscal decentralisation and institutional strengthening. It provides a fixed amount reward system for the same packages of service as the other assigned facilities, but the monetary awards to the Local Government Areas (LGAs) are distributed based on the average income from workers at their PBF facility counterparts. These monetary awards cannot be used for staff bonuses.

1.0 Introduction

1.1 Context

According to the recent Economic Recovery Growth Plan, Nigeria's healthcare system still does not provide the level of health care service required to meet the needs of its population. Currently, the average life expectancy in Nigeria is 52 years, far lower than what obtains in its peer African countries, e.g., Ghana (61 years) and South Africa (57 years). Our under-five child mortality rate has 89 deaths per 1,000 live births, a level far above the benchmark of 64 deaths per 1,000 live births set by the UN Sustainable Development Goals (SDGs).

Although there has been recorded progress in recent years, key indices, particularly in maternal and child health, remain poor. Maternal mortality in Nigeria is among the highest in the world at 576 deaths per 100,000 live births. According to WHO, Nigeria accounted for 19% of global maternal deaths in 2015. Lack of skilled healthcare workers, inadequate equipment and drug supplies contribute significantly to the poor progress in maternal and child health outcomes. Income inequality across the country also play a large part in affecting health outcomes. In 2018, the poorest 20% of people in Nigeria had child mortality rates 3 times higher than the rates afflicting the richest 20% of people.



Given the recognition of the shortcomings in its health care sector, the 2016 National Health Policy provided an implementation framework to translate the provisions of the National Health Act and the Sustainable Development Goals into the health and wellbeing of all Nigerian citizens. The tenets of Universal Health Coverage are central to the goal of National Health Policy, which is: “To strengthen Nigeria's health system, particularly the Primary Health Care sub-system, to deliver quality, effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians.” To achieve this, the National Council of Health approved the National Strategic Health Development Plan (NSHDPII) which provides the Health Sector Medium Term roadmap.

It is within this challenging context that the Nigerian government decided that the situation in the health sector required bold interventions to strengthen service delivery and improve health outcomes. Examples of result-based financing operations were piloted, some of which were the Nigerian State Health Investment Project

(Performance-based financing at a health facility and sub-national administration and disbursement linked indicators at sub-national administration and state levels); Saving One Million Lives (disbursement linked indicators at State levels), and the Accelerating Nutrition Results in Nigeria Project (Performance-based contracting with non-state providers).

Specifically, the Nigeria State Health Investment Project (NSHIP) was introduced to achieve high impact on maternal and child health interventions, as well as improving the overall quality of care in the three pilot states in Nigeria - Adamawa, Nasarawa and Ondo. It was originally a five-year programme financed by the World Bank, which employs a result-based approach to improve quality of health services by decentralising health facility financing, addressing structural issues and motivating health worker performance.

However, the prolonged period of political upheaval hindered access to maternal and child health (MNCH) services in the northeastern states, one of which was Adamawa State. Currently, preventive services such as vaccinations for school-age children are much lower in the region. The aftermath of this “missed opportunity” for vaccination in affected states impacts the health indices, especially as asymptomatic carriers, and transmitters of childhood infections (such as polio) to unprotected children may be difficult to monitor and control. During this assignment, there have been several other unexpected delays, including the ongoing Boko Haram threats in parts of Adamawa, elections at all levels of governments and subsequent transitions, and now the ongoing COVID-19 pandemic.

On December 31, 2019, pneumonia of unknown cause was detected in Wuhan, China and was first reported to the WHO Country Office in China. This was the start of the novel coronavirus, a global epidemic with impact far beyond the health sector.

According to the World Health Organisation (WHO), as of April 7, 2020, more than 1,317,139 cases of COVID-19 had been reported in over 212 countries, resulting in over 52,700 deaths. The first confirmed case in Nigeria was reported on February 27, 2020. Since then, over 6,677 cases resulting in 200 deaths have been reported across the country, with 26 recorded cases in Adamawa

and one death. (There is some concern that limited testing may be underestimating cases in Nigeria). Given the widespread nature of the COVID-19 pandemic, the impact of the health crisis could be grave, considering Nigeria's relative weak health system worsened by the global economic shut down which has triggered an economic crisis in Nigeria. Dalberg Advisors have projected a reduction of Nigeria's GDP by 4% in the moderate scenario and by up to 23% in the downside scenario, while the National Bureau of Statistics (NBS) projects that economic growth could fall by as much as 4.40% or up to 8.91%, depending on the length of the lockdown and federal government's action.

The efficiency of Nigeria's health sector is a key determinant of the country's capacity to respond to COVID-19; this is critical to salvaging the virus' public health impact and to reduce the negative consequences on the economy. In times of such crisis, the critical role of the health sector should be front and centre in discussions of economic development. Unfortunately, the current revised Federal Government 2020 budget proposal recommends a cut of over 40 % of its expenditure on health – which is far below the Abuja declaration on public health expenditure. This cut is expected to include the Basic Health Care Provision Fund (BHCPF), from which several states (including Adamawa) were expecting to draw funds for primary health care. However, there is inclusion for funding the BHCPF and various health insurance schemes in the proposed Nigeria Economic Sustainability Plan that could support primary healthcare if implemented. Therefore, it has become even more important to assess the outcome of this innovative intervention by the Nigerian Government supported by the World Bank. This report focusses on the experience in Adamawa State only.

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2.0

Technical Approach

2.0 Technical Approach

The overall aim of this report is to document the achievements of the RBF project in Adamawa state mainly from the facility and beneficiary perspectives, as well as to determine lessons learnt and identify any suggestions to support its contribution to the sustainability of the current successes of primary health care in Adamawa State. We hope that the document will not only contribute to Adamawa State health care but also encourage the adoption of key determinants of success at the primary care level which may be applicable across Nigeria and other resource-challenged health care systems.

Objectives

The specific objectives of this project were:

- To complement past evaluations of the NSHIP program, with quantitative analysis of available data, and qualitative analysis of key stakeholders of the Adamawa project.
- To directly document the implementation experience, and successes of the RBF project in Adamawa from beneficiaries, community representatives and other stakeholders in Adamawa.
- To synthesise current research findings and analysis with past evaluations resulting in a document that highlights the performance, successes, and challenges of the Adamawa State Primary Health Care Development Agency (ADSPHCDA) under the RBF initiative.
- Based on the above, identify key lessons learnt, and useful suggestions for improvement of primary care in Adamawa and elsewhere.

3.0

Methods

3.0 Methods

3.1 Study Design

In 2019, the Anadach research team conducted semi-structured quantitative and qualitative interviews of key health executives involved in making policies across the state. One of the indices of performance was the change in utilisation of maternal, neonatal and child health (MNCH) outpatient consultation and service achievements by LGAs. A proportional sampling approach was adopted across the 403-primary health centres within the LGAs. It was discovered that eleven (11) LGAs benefited from PBF while 10 LGAs operated under the DFF model. A total of 231 facilities (comprising of 216 PHCs, 8 general hospitals and 7 private facilities) were funded via the PBF model, while 125 facilities (118 PHCs and 7 general hospitals) were funded using DFF. Two PBF funded LGAs were eliminated due to insecurity. 15% of facilities funded via the PBF scheme were selected using a proportionate systematic sampling technique. Thus, a total of 34 randomly selected PBF funded facilities were selected and 10 DFF funded facilities were also randomly selected as controls.

3.2 Data Collection

Before commencing the study, the Anadach team visited relevant facilities to assess information contained in the data rooms, (stored in paper format) and develop appropriate data collection tools. The team carried out a desk review of existing project documents (including business and operational plans, annual reports, and past evaluations.) These preliminary visits served as a baseline to facilitate comparisons. Qualitative data collection tools were developed; data was collected via in-depth interviews (IDIs) and focused group discussions (FGDs) involving key stakeholders. The respondents included in the interview process were:

1. Key executive and management team members including the Executive Chairman, Secretary, Directors, Board Members and Chairmen/women of LGA.
2. Managers and staff of the selected PHC facilities in various LGA, complemented by FGDs
3. PHC beneficiaries and community representatives.
4. Other stakeholders as agreed with the Primary Health Care Development Agency (PHCDA) – including Ministry of Local Government Affairs, Ministry of Health, NPHCDA and selected secondary care FMs.

3.3 Quality of Data

The quality of the paper collected data varied according to facilities. Most facilities had missing data points, but this was particularly obvious in several of the DFF facilities - much fewer indicators were collected from DFF facilities. Also, there were several missing data points and some data periods were repeated. We had to visit the actual facility to get more information on some data points. However, the quality of data from the PBF facilities was more complete, reflecting the importance of data in qualifying for the performance bonuses. Conclusively, the DFF facilities provided insufficient data which limited our ability to analyze outcomes and detail the differences between RBF, especially around key indicators in our sample.

3.4 Data Analysis

Qualitative and quantitative analysis of data was carried out with a focus to understand the perception of the quality of health services and outcome indicators at the implemented health facilities. The qualitative analysis also sought input on suggested changes.

3.5 Description of the Study Area

Adamawa state, located in the North Eastern region of Nigeria, has an estimated population of 4.3 million across its 21 LGAs and 266 political wards. In recent years, the political upheaval has hindered access to maternal and child healthcare (MNCH), as well as preventative services such as school-age immunisation in the North Eastern States.

The primary health sector in Adamawa state consists of 994 public PHCs and 59 private PHCs in the private health sector (ASPHCDA, 2019). Following a population mapping, a pattern of a minimum population of 8,000 to 1 PHC was designed.

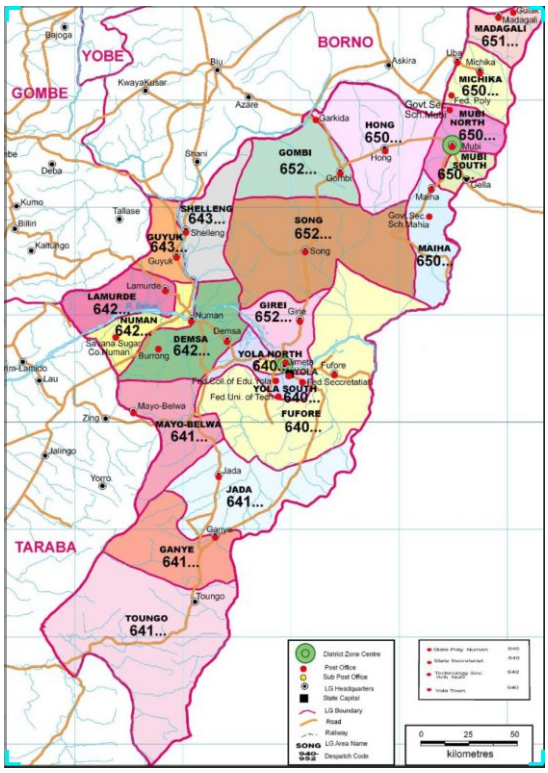
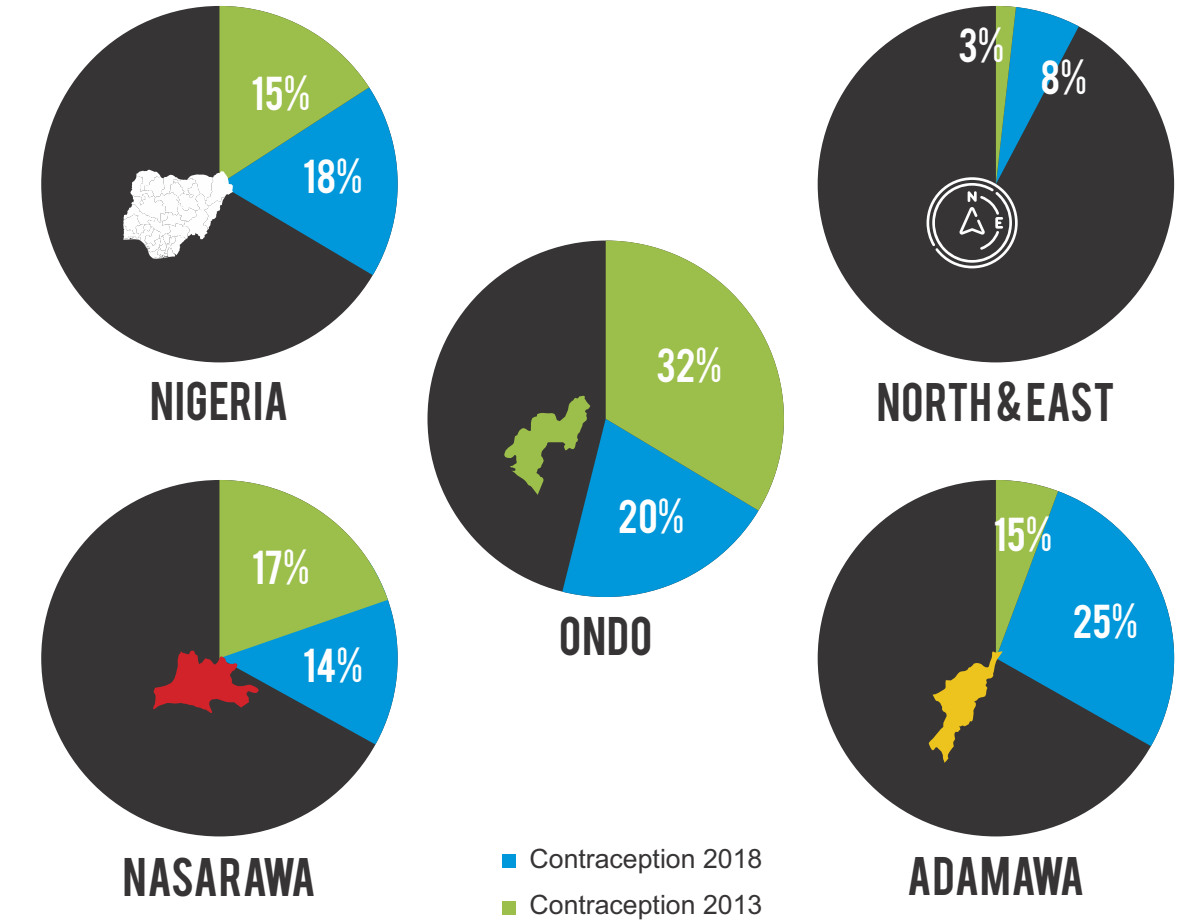


Figure 1: Map of Adamawa State showing the LG

In 2011, Adamawa State commenced the NSHIP pilot programme with 15 participating health facilities. It was subsequently scaled up to cover all PHCs in the state by the years 2014 – 2015. Further information on the NSHIP institutional arrangements is available in the annexe. The NSHIP RBF project appears to have radically transformed healthcare in the state. For example, vaccination coverage has improved significantly with an estimated increase of 54% in vaccination rate at birth within 3 years of implementation, and over 300,000 children have been completely vaccinated in the same period. There was also an increase in the use of contraception in Adamawa compared to the rest of the North East region and other project states.

Figure 2: Contraception usage in 2013 and 2018 (DHS surveys)



In 2016 and 2017, the National Health Facility Survey ranked Adamawa state as the best in the country, although it had the worst indices of the three project states at the start of the initiative. This achievement has been majorly attributed to strong political will, mentoring, autonomy, and proper task delegation. Despite significant unexpected challenges related to the loss of 7 PHCs, displaced migratory populations, destroyed infrastructure and insurgency, the NSHIP programme has been scaled up to cover all 403 PHCs in the state, including some private health centres in Yola.

3.5 ASPHDA Organisational Arrangements:

The Adamawa State Primary Health Care Development Agency (ADSPHCDA) is an autonomous arm of the Ministry of Health. It is backed by the state law (passed in 2011) with an effective and functional governance structure. All PHCs are autonomous with functional community health committees actively involved in the preparation of business proposals. The PHCs can source drugs and essential commodities in the open market (there is a list of approved vendors). Drugs supplied by vendors are assessed randomly and defaulters on quality are dropped automatically.

The agency's organogram is comprised of board members who are responsible for decision making. A population-based nomenclature is chosen over the hospital nomenclature as the heads of PHCs are referred to as “managers.” These managers are community health officers (CHOs) chosen based on pre-existing experience and qualifications. Management training is a prerequisite to empowering PHC managers on the task of communication, leadership, and planning.

The ADSPHCDA comprises of five physicians who serve as directors overseeing all activities and programmes at the agency level, but no physician provides clinical services at the PHC level. All PHC managers are either Nurses, Community Health Officers (CHOs) or Community Health Extension Workers (CHEWs) with required management training. The management committee in each PHC conducts regular internal audits of the operations and employees to assess performance and recommend employee remuneration. PHCs also have community health committees that serve as independent stakeholders and provide planning advice. Further details are available in the ASPHCDA organogram in the annexe.

4.0

Results

4.0 Results

4.1 Review of Outcome Indicators and Service Achievement

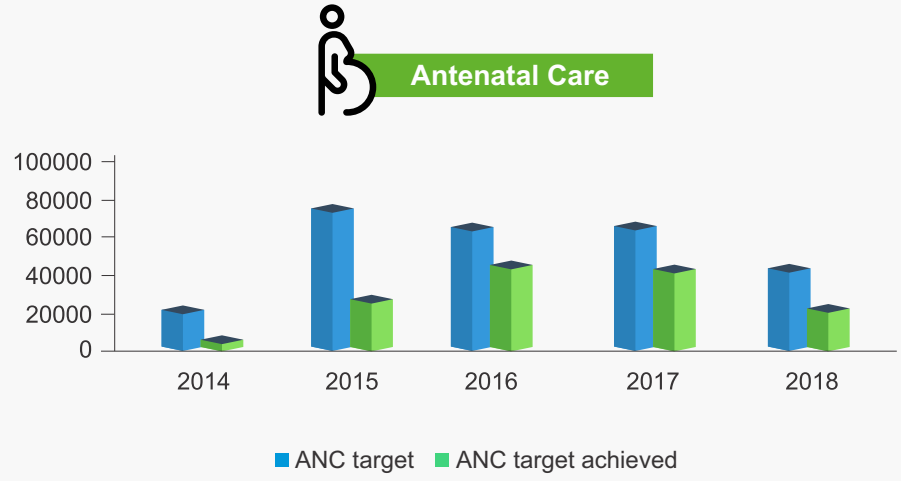
This study examined the impact of PBF on a range of structural inputs, service achievements and revenue across health facilities within selected LGAs between the periods of 2014 to 2018. It reviewed selected outcome indicators including workforce, ANC, institutional delivery, the incidence of sexually transmitted disease (STD), childhood vaccination, maternal and childcare and wellness. There was a significant positive effect of the PBF scheme on operational indexes such as patient volume, infrastructural improvement, knowledge and motivation of health workers, staff availability and commitment, data collection, record keeping, and improved quality of services. However, the corresponding analysis on the number of skilled versus unskilled workforce reveals that the PBF scheme had no significant impact on the workforce. These results strengthen the existing evidence that PBF has on improving targeted health indicators. The pairwise correlation analysis shows statistically significant numerical representation which the PBF had on several outcome indicators such as the proportion of pregnant women receiving 4 or more ANC visits and proportion of children (12-23 months) who receive Penta3. Further, health facilities participating in the PBF outperformed their counterparts enrolled in the DFF scheme across Adamawa.

While most indicators showed improvement between 2014 to 2017, in 2018, all indicators reviewed a significant decline. None of the targets for antenatal care, childhood vaccination, and institutional delivery was met, particularly when compared across all LGAs selected. Some selected examples are below.

Antenatal Care

The chart below shows a comparison between the proposed ANC target and the ANC achieved target from the year 2014 to 2018. Although the ANC target for each year was not achieved, the proportion achieved steadily rose by more than 10% between 2014 and 2015. However, in 2016, the proportion of the ANC achieved target rose to 76.6%; this proportion declined to 68.4% in 2017 with a further decline to 52.2% in 2018.

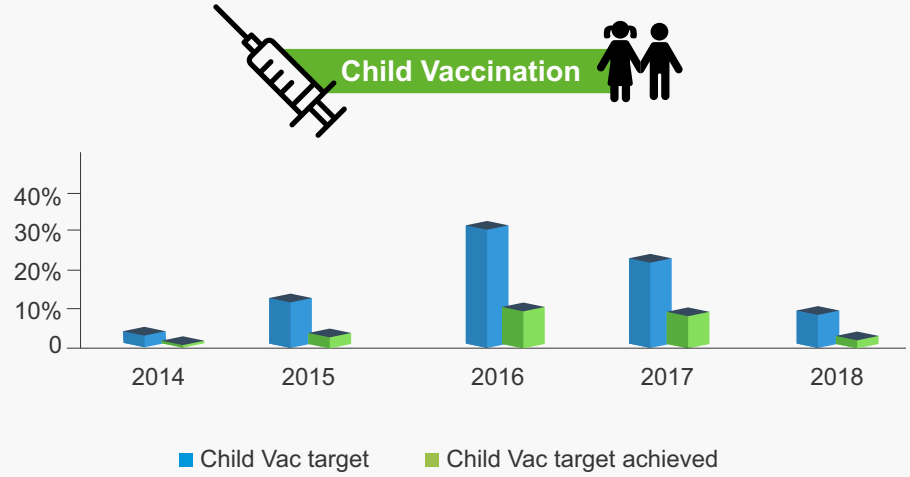
Figure 3: Services: ANC Visits at Health Facilities



Child Vaccination

Figure 8 shows the aimed childhood vaccination target compared with the achieved target between 2014 to 2018. It was less successful than the progress on ANC, even though there was a stable upward trend in the proportion of vaccination achieved yearly which peaked in 2017 (41.3%) and declined by more than half from the previous year to 27.0 % (in 2018).

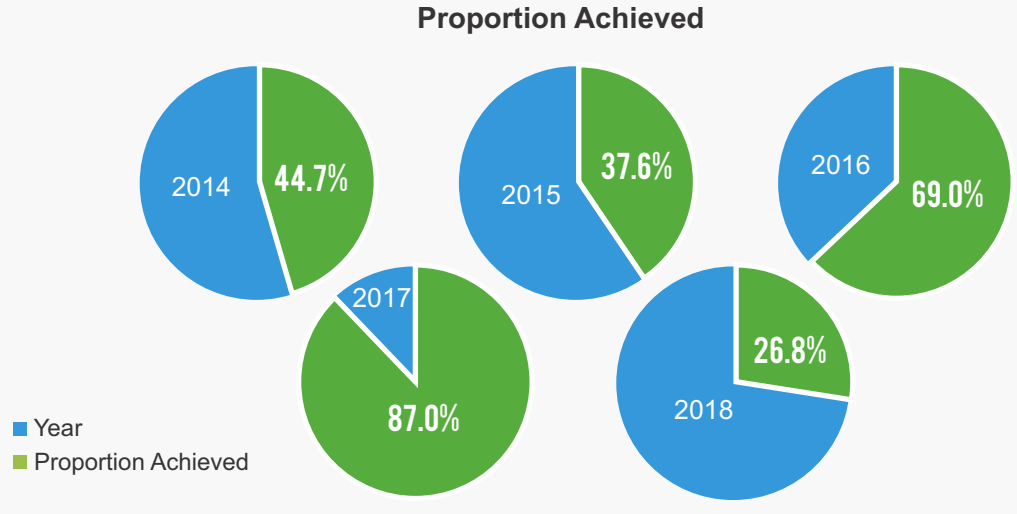
Figure 4: Performance-Based Financing: Childhood Vaccination



Institutional Delivery

Figure 10 shows a comparison between the aimed institutional delivery target versus the institutional delivery achieved target between the year 2014 and 2018. Overall, there was an upward trend in the proportion of delivery target achieved compared to the actual target aimed. This upward trend revealed an increase to 87.0% in 2017. This was followed by a decline to 26.8% in 2018.

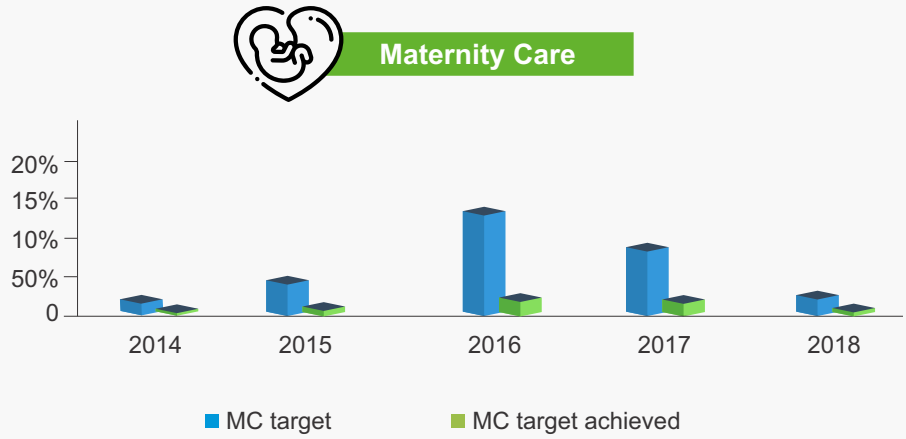
Figure 5: Proportion of Institutional Deliveries Achieved



Maternal and Child Care

Figure 12 compares the aimed maternal and child target with the achieved target from 2014 to 2018. Overall, there is a stable upward trend in the proportion achieved yearly which peaked in 2017 (25.8%) and dropped to 19.8 % in 2018.

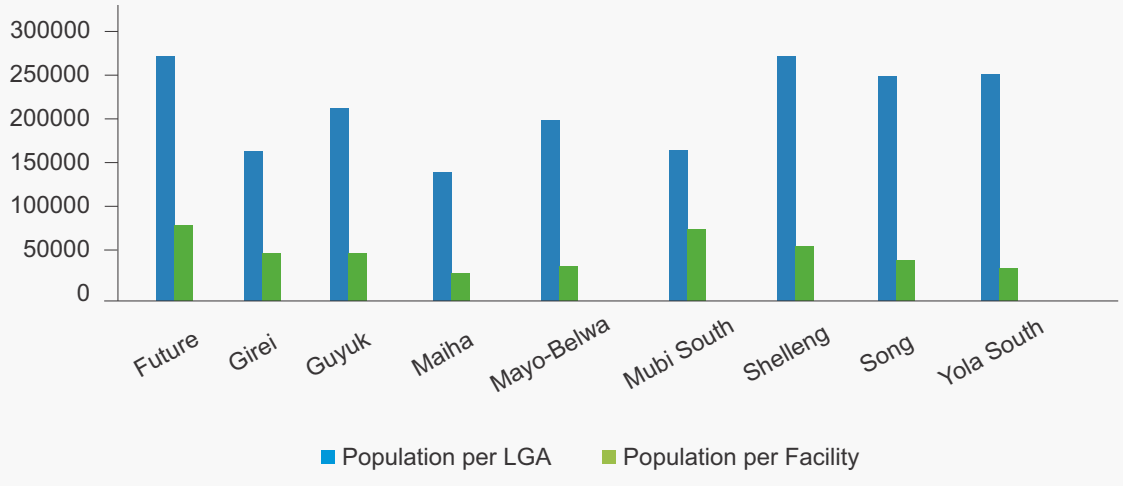
Figure 6: Performance-Based Financing: MC



4.2 Service Achievement by Local Government Areas (2014-2018)

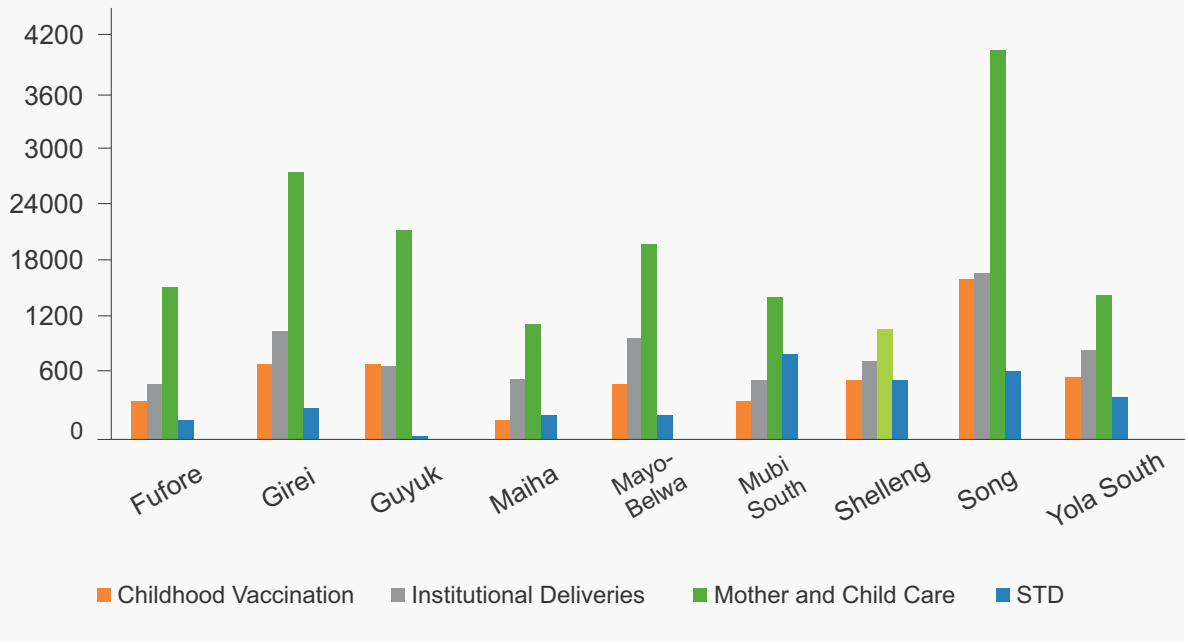
There were four major themes which provided a framework to understand the implementation impact of the RBF in Adamawa state. These included ANC utilisation, childhood vaccination, institutional delivery, and outpatient volume. There were differences in the population per LGA from Maiwa (147,200) to Fufore (279,900), and an average population per facility from Maiwa (36,800) to Fufore (93,300).

Figure 7: Comparing Population per LGA and per Facility (PBF Facilities)



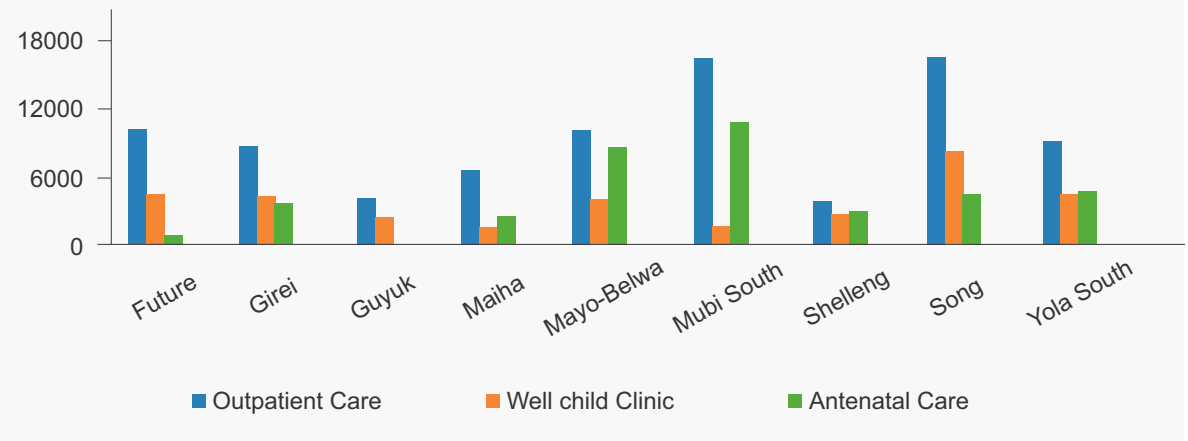
There were also differences in service achievements based on LGA facility and service. Song facilities provided the most childhood vaccinations, institutional deliveries and mother and childcare services even though it covered the fourth smallest population per facility. Mubi South had the highest number of patients receiving STD care.

Figure 8: Average Number of Patient Visits for Select Services per LGA facility



Mubi south provided the most services in terms of antenatal care (almost 11,000 visits) and outpatient care (almost 18,000). Song provided the most well-child clinic services, while Guyuk provided the least amount antenatal care despite having the median population per facility.

Figure 9: Average Number of Patient Visits for Select Services per LGA



4.3 Qualitative Analysis

A total of six categories of representatives in selected LGAs were engaged in focused group discussions or individual conversations to obtain their perspectives on the impact of RBF on primary health care in Adamawa. The general perspective across all group interviews was positive and had similar projections of the project goals and objectives. However, there were several areas for improvements identified.

4.3.1 Facility Manager Interviews

Thirty-nine facility managers of DFF and PBF schemes, across six local government areas, were interviewed in five focus group discussions and twelve in-depth interviews. The discussions spanned the following areas: work conditions, motivation, supervision, marketing, successes, unwanted/negative effects, satisfaction, and recommended changes. Overall, the facility managers reported being satisfied with the pilot until regular subsidies and bonuses got delayed. Initial assessment revealed that Ardo PHC of Mayo-Belwa LGA was the best-run facility, as it was the only facility to retain 100% of its hired employees with salaries fully paid despite funding delays. A few managers cited funding delays as their biggest reason for dissatisfaction with the NSHIP programme. However, most participants reported being very satisfied with the pilot project. Comments made by the managers include:

- "*Very, very satisfied"*
- *"I would want the NSHIP programme to*
- *continue till my retirement"*
- *"Has done greatly, we are really enjoying the*
- *support of NSHIP and has brought changes to the life of the communities"*
- *"100% satisfied"*

Work Conditions and Environment

Most facility managers identified positive changes in their work conditions and environment, enjoying their newly defined roles and increased responsibilities, as well as staffing flexibility, improved infrastructure e.g., new labour ward, shops to increase revenue and improved availability of drugs. For example, a comment from an interview was "Yes, I can hire & fire, there's full autonomy over finances." Furthermore, all the facility managers stated funding was a strong motivating factor while other motivating factors included training, improved work environment, director evaluation, positive community feedback/appreciation and the delivery of quality care.

The indicated feedback from the community, RBF and ward development committees complemented available data on priority diseases, patient socioeconomic status and funds. This data was then used to set quarterly facility targets and evaluate the effectiveness of the changes made. We employed the creation of data tools, data clerks (possible only at RBF facilities), regular (weekly and monthly) as well as data validation to ensure accuracy in data collection.

Marketing

Many of the facilities actively marketed their services through community engagement outreaches. This was achieved through dialogue, compound meetings, engaging village heads, home visits and post-natal services. Other methods employed to increase community

engagement included meetings with Ward Heads, TBAs, local chemists, youth leaders, faith-based institutions, indigent/village development committees, women mobilisers, and health talks. The provision of incentives and free amenities such as soaps and mosquito nets played a significant role in further engaging these communities. We saw "google maps" being used in a facility to help identify marketing targets. A PBF facility manager reported using financial incentives to engage/reward community members. "Community members are paid 50-100 naira for ANC referrals, and TBAs get 200 nairas for referrals." They also gave in-kind goods such as "cooked eggs-soap-towels for ANC."

Factors Encouraging Successful Outcomes

Factors Encouraging Successful Outcomes	Challenges to Successful Outcomes (and mitigations, if any, at facility level)
Mentorship	The opposition of patients to any male staff at deliveries (now only female members of staff are present).
Accurate record-keeping	Beliefs that family planning causedsterilisation and immunisation will reduce the population. Overcoming by community education, peer champions to overcome barriers to family planning and engaging religious/community headsimmunisation barriers.
Autonomy	Accessibility to remote populations tackled by initiating community outreach
A positive attitude of health workers	A decrease in ANC enrolment (noted in 2018 DHS with a decline of 3% in Adamawa) with an increase in the rate of home deliveries. Tackled by operational changes, further community engagement such as home visits, outreach services, sensitisation, incentives, and social marketing.
Support from donor agencies	Refusal of the intramuscular (IM) polio vaccination by some Fulani due to concerns that the IM injection caused musculoskeletal problems. Overcome by dialogue and education.
Community involvement	Most facilities indicated strong community involvement was present
Financing (a most important factor).	One of the health centres had purchased livestock (cows) in anticipation of the end of the pilot intending to use the livestock as a source of funding for sustainability.

Unwanted/Negative Effects Linked to PBF Bonuses

Staff at the DFF funded facilities wanted bonuses like those at the PBF facilities, but there were no peculiar challenges affecting the quality of services reported. Sometimes bonuses paid to employees in the PBF facilities led to a few, subtle negative effects. Numerous employees focused on certain incentivised services while neglecting the non-incentivised services. For example, some facility managers stated that some employees were eager to do outreach when bonuses were paid while other employees in certain facilities were not eager to deliver non-incentivised services. This unwanted effect was mitigated by regularly checking registers and conducting meetings with staff to encourage involvement with other activities. A facility manager reported that some employees had concerns with open performance evaluation. Late payment of subsidies and bonuses affected employee morale, commitment and placed pressure on the system. Overall, the consensus among the facility managers was that these challenges were surmountable.

A few comments made by the FMs include:

- "Hired staff focused more on purchased services to get more bonuses than permanent staff"
- "Record of activities used to rate performance and determine due bonuses"
- "Focus was on services with bonuses attached. Still unable to overcome this problem"
- "Staff focused on home visits over other services- meetings were held to explain why targets had to be achieved across all services"

4.3.2 Community Representatives and Beneficiaries Interviews

Common Health Conditions

Malaria was the top concern and was reported by every participant either in focus groups or individual interviews. Other conditions of concern were typhoid, maternal health, and seasonal changes in health. Some participants also stated Cholera was a common health condition. Many participants noted that the incidence of malaria re-occurrence had reduced since the inception of the NSHIP scheme.

Health Seeking Behaviour

Representatives reported that most of their communities sought care at the PHC centre, which was also reflected by FGDs with beneficiaries. Individuals also sought healthcare from chemists and traditional birth attendants (TBA). Representatives of the community stated that there has been an overall positive increase in health-seeking behaviour. Reasons for increased utilisation of care included:

- Provision of high-quality healthcare services in the centres
- Degree of professionalism displayed by the staff
- Accessibility and availability of 24-hour care services.
- Free consultations and medications offered to members of the community

Some beneficiaries stated that they started seeking more care in the PBF in the last few years because of the better infrastructure, services, and availability of drugs. They stated: "I use this facility due to better staffing" "PBF programme has motivated staff attitude, there are now shorter

waiting times" "better structure, services and care."

Participants stated that the following were important factors they considered when seeking care: staff attitudes, availability of drugs and services, proximity, clean environment, medical expertise, and short wait times. While the factors that discouraged participants from seeking care at the health centre included a lack of quality care and attention, poor attention, poor staff attitudes, dishonesty, lack of drugs and well-trained staff. Bad roads and inaccessible riverine channels were also the major obstacles to obtaining care in the facilities.

Assessment of the Health Centre

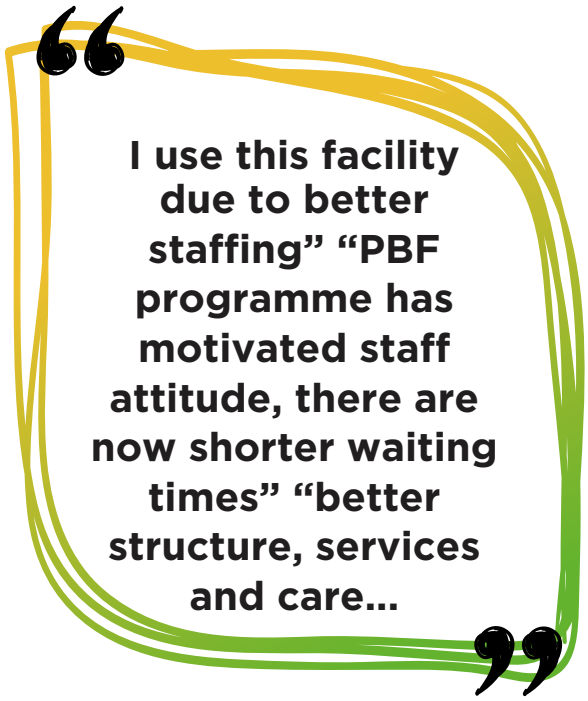
Participants appreciated the following aspects of the health centres:

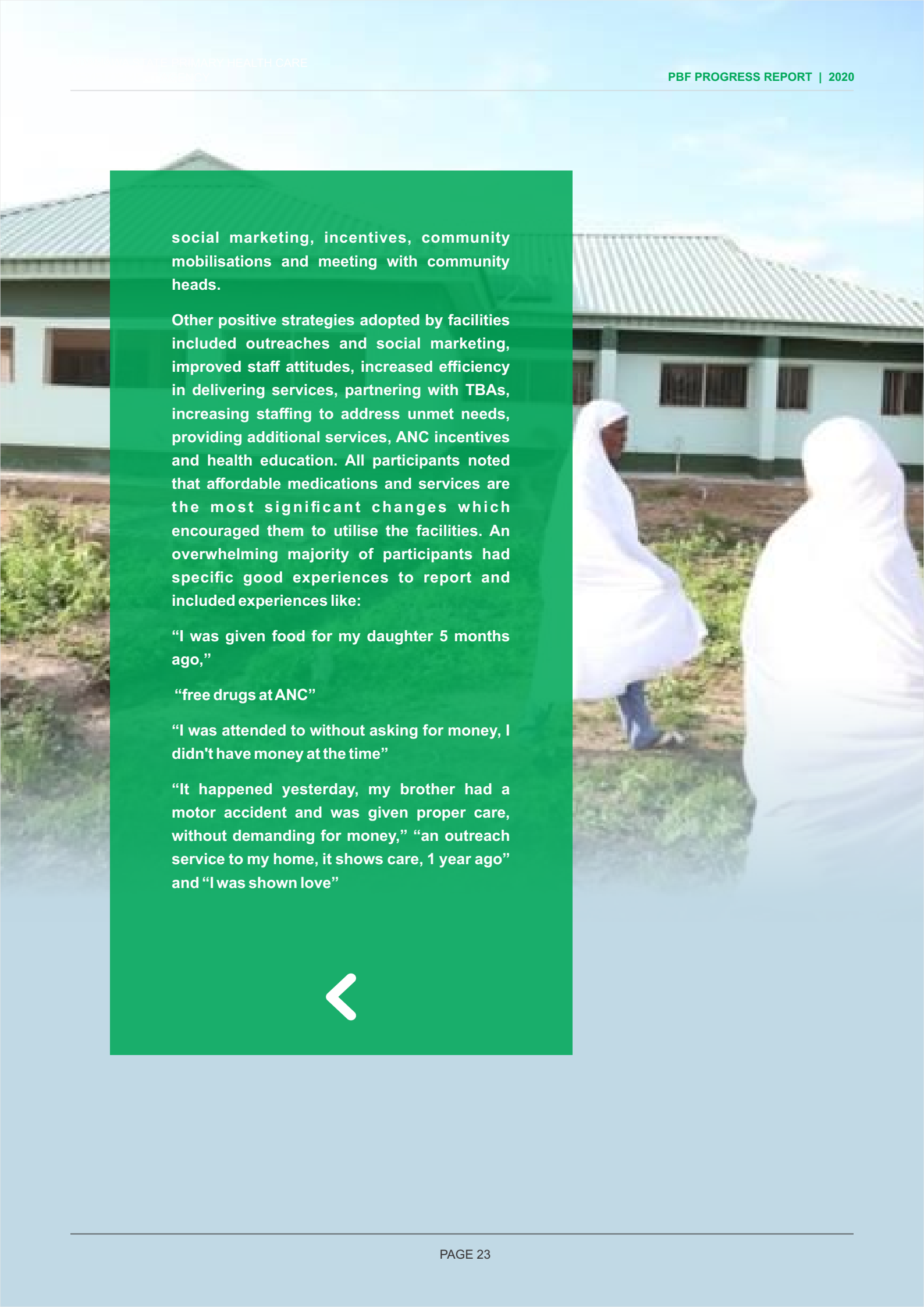
- Efficient management and incentives
- Prompt attention provided in a conducive environment
- Availability of free or subsidised drugs
- The friendly attitude of the staff
- High quality of care
- Cleanliness of the clinic
- Prompt and improved services
- Health talks
- Availability of 24-hour service

A few patients reported specific negative experiences at the health centres such as the purchase of medications outside the health facility and interaction with impolite staff who were not helpful. Over 97% of the participants stated that they were very satisfied while 3% of participants stated that they were somewhat satisfied with their health centre. The wait time at the facilities ranged from zero to three hours, but most of the participants reported wait times of less than 30 minutes. Some of the general reasons some participants did not like the facilities included insufficient infrastructure, poor staffing, difficulty accessing the facility and lengthy wait times. There did not appear to be any differences between PFF and DFF facilities.

Health Centre Changes

Beneficiaries identified the following positive changes after the pilot commenced: improved infrastructure, potable water, improved ANC, improved staff attitude, adequate staffing, 24-hour service, affordable prices, available and subsidised drugs as well as building improvements. Before NSHIP commenced, beneficiaries faced certain challenges such as shortage of staff, absenteeism, poor staff attitudes, no laboratory facilities and limited funding. Majority of the participants noted an improvement to these issues including the provision of water.





social marketing, incentives, community mobilisations and meeting with community heads.

Other positive strategies adopted by facilities included outreaches and social marketing, improved staff attitudes, increased efficiency in delivering services, partnering with TBAs, increasing staffing to address unmet needs, providing additional services, ANC incentives and health education. All participants noted that affordable medications and services are the most significant changes which encouraged them to utilise the facilities. An overwhelming majority of participants had specific good experiences to report and included experiences like:

"I was given food for my daughter 5 months ago,"

"free drugs at ANC"

"I was attended to without asking for money, I didn't have money at the time"

"It happened yesterday, my brother had a motor accident and was given proper care, without demanding for money," "an outreach service to my home, it shows care, 1 year ago" and "I was shown love"

4.3.3 Selected Adamawa-Based Stakeholder Interviews

In-depth interviews were conducted among ten participants who are selected stakeholders based in Adamawa from various institutions including MOH, APHCDA, LGAs (both PBF and DFF).

A) **Yola-Based Interviews**

Overview

These participants had a common understanding of the project and were involved in the supervision or coordination of the NSHIP project in Adamawa. All participants were sceptical at the start of the project, but this changed as the pilot ran its course. They believed that the implementation of NSHIP resulted in better work ethics, better supervision, increased staff commitment and infrastructural renovations (as adjustments were made in shifting towards an output-based system with staff and community engagement.) Majority of the participants also noted that the greatest motivating factor for the workers were the bonuses in PBF facilities, but this was now declining as the funding has become irregular. They also stated that job satisfaction was greater in employees of the PBF facilities compared to the employees in DFF facilities.

Changes

Several new institutional elements were introduced on the inception of the NSHIP including but not limited to improved supervision, performance contracts and provision made for indigent patients. The reasons for these adopted changes varied from direct funding to autonomy. The participants' responses to the question about the difference between the DFF and PBF varied from none (based on a mid-project evaluation, based on an outcome evaluation) to differences in bonuses, level of motivation among the workers, record keeping, marketing tactics, indicators being monitored, supervision, patient volumes and the level of community involvement. A participant identified staff attitudes to be different in the two different types of facilities, noting that staff in DFF facilities had worked very hard initially, erroneously hoping to be switched to the PBF financing scheme. Several participants stated the level of autonomy was the same for both financing schemes but the reasons for the differences between low and high performing facilities include motivation by the bonuses, patient inflow, population densities, and social marketing.

Implementation Challenges and Lessons

The interviewees gave mixed responses to the question surrounding whether the NSHIP was implemented true to the original World Bank design or was modified to fit the local context. Difficulties encountered during implementation included uncooperative workers, resistance from the community, and poor financial management. These problems were resolved by training, supervision, engagement tactics and using local champions. The key differences between the NSHIP and previous interventions were the sole focus on primary care, better implementation, community involvement and the NSHIP being an output-based programme.

Key insights gained during the implementation were funding, a need for sustainability planning and the import of verification. Majority of the participants stated that funding was critical for the success or failure of the NSHIP. Leadership, external support, separation of functions and governmental commitment also emerged as key success factors. Peculiarities in Adamawa state that had to be overcome included insurgency and Internally Displaced Persons (IDPs). This challenge was overcome by contracting out services in camps and host communities. A cultural barrier in Adamawa that had to be overcome was women having to seek permission before leaving their homes. This challenge was mitigated by community involvement, social marketing, indigent committee, and home visits by female staff.

Unwanted Effects/Challenges

While the NSHIP has multiple positive effects, the following unwanted effects of the NSHIP were cited by the participants:

- Overdependence of the health system on the NSHIP
- Loss of staff from DFF to PBF facilities
- A shift in attention to services that were incentivised
- Loss of motivation in workers since funding\ became irregular
- Friction between the MoH and the PHA over project oversight
- Strategies implemented to resolve these issues included the cancellation of abused services and constituting committees to address other problems.

B) **Local Government Areas Interviews**

Overview

We also interviewed participants representing both RBF and DFF facilities whose roles included quality assessment, data collation, coordination, and supervision. Half of the participants expressed doubts about the efficacy of the project at the start, but they all acknowledged that this had changed significantly. The other half of the participants expressed a positive outlook at the outset and stated that this was largely unchanged. The biggest motivating factor for workers was the bonus which worked by increasing staff commitment, punctuality and reducing absenteeism. Motivation and satisfaction were noted to be higher in PBF facilities compared to DFF facilities. However, due to recent irregularities in bonus payments, there has been a decline in staff performance and newly hired staff had resigned.

Changes

Some of the major changes reported after the inception of the NSHIP included infrastructural improvement, increased technical knowledge, increased staff commitment, availability, data collection, record keeping, and improved quality of services. Participants stated that after the inception of the NSHIP scheme the following changes occurred “Improved overall experience, programme been impactful on providers and communities”, “More elaborate experienced staff” and “PBF sustained the facilities when salaries were not regular”

Implementation Successes and Challenges

During the implementation process, participants noted that locals within the community including Traditional Birth Attendants (TBA) were used to increase uptake of the project. Key success factors of the pilot included were:

- Subsidy payments directly to facilities
- Data/record keeping and use of protocols
- Leadership
- Manpower
- Drug availability amongst others

Some difficulties which were encountered during the implementation processes such as manpower shortage, adherence to protocol, poor quality data were all successfully addressed. In contrast to previous experience with other interventions, the stakeholders noted that the NSHIP had strategic funding, facility-level autonomy and is community-based. Lessons from the pilot included the importance of management, funding, and community involvement. It was also noted that PBF worked better than the DFF scheme.

Participants stated that the major differences between DFF and PBF facilities were payment of bonuses to PBF facilities, fewer indicators monitored in DFF facilities, and "lack of supervision, coaching or mentoring of DFF facilities." The consensus was that bonuses incentivised the staff to adopt the changes required in the NSHIP. Some institutional elements introduced during the NSHIP include the use of protocols in treatment, provision of new services and quality improvement. No new institutional elements were implemented in DFF funded facilities. In response to the question about the difference between the high and low performing facilities, the participants noted that subsidies/bonuses paid to staff, capacity building, and adherence to the protocol were all major differences between high and low performing facilities.

Specific difficulties encountered include the rejection of modern family planning methods by local women, their spouses, and chemists/traditional healers who "diverted" patients. These difficulties were managed via dialogue, education, awareness programmes and encouraging patient referrals. Dialogue with religious leaders was also used as a strategy to manage cultural barriers. Mismanagement of funds at the facility level was cited as a major factor that could cause the pilot to fail.

Unwanted Effects/Challenges

Two participants expressed concerns over their perception of a lack of sustainability planning during the interview. They also acknowledged that there was a redistribution of attention to services that were contracted. This redistribution of attention was combated by adding an "error margin" of 10% to purchased services such that a value of >10% of any dataset invalidated all contracts presented leading to loss of attached bonuses.

Participants stated that after the inception of the NSHIP scheme the following changes occurred "Improved overall experience, programme been impactful on providers and communities", "More elaborate experienced staff" and "PBF sustained the facilities when salaries were not regular"

4.3.4 Executive Level Interviews

Their specific roles varied widely depending on their positions in the various organisations. The most important aspects of their roles were supervision, mentoring, capacity strengthening, ensuring agreements were upheld by facilities, getting different agencies to work together, and knowledge exchange. A variety of responses was received in response to the query of initial goals of the NSHIP, including ensuring sustainability, increasing the quality and quantity of services, and increasing delivery of high level maternal and child interventions. Majority of our participants expressed their initial doubts and scepticism of the pilot which have changed as the pilot become successful. When comparing experiences in the health sector before and after the NSHIP, the following emerged:

- Improved capacity and problem-solving skills with the NSHIP "PBF more efficient"
- Improved QOC
- Infrastructural development with the NSHIP
- Better supervision and training
- Better work experience with the NSHIP and higher staff morale
- Improved staffing

Introduction of new institutional elements like the Contract Management and Verifier Agency (CMVA) and Independent Verifier Agent (IVA), and supervisory visits to the facilities amongst other changes.

Implementation Challenges

During the implementation phase, the participants reported that the challenges experienced with stakeholder engagement were related to political challenges, autonomy, staffing, equipment shortages and sustainability. The implementation of successful strategies such as the hiring of staff, purchasing equipment, sustainability and planning mitigated these challenges during the project. These challenges were overcome by clear design, seamless engagement of stakeholders, training for stakeholders and support from the World Bank. Partnerships with locals within the communities were leveraged to increase uptake/buy-in of the pilot. The participants remarked that the NSHIP was performance-based with better management, design, increased autonomy, and more community involvement. However, the issue of financial sustainability and long-term government support remained a concern with several interviewees.

Unwanted Effects

Many of our participants noted that there was a redirection of attention to services that were incentivised. Other reported unwanted effects included:

- An overdependence on bonuses
- A drop in worker motivation when the bonuses become irregular
- Gaming of the quality verification survey
- Delays due to frequent changes in the payment system

Table 2: Suggested Changes to Improve Services and/or Ensure Sustainability from Participants by Group

SDG	FFSA
Facility Managers	DFF managers suggested switching over to a PBF scheme to enjoy the bonuses. However, one facility manager noted that she was satisfied with the DFF scheme because she did not want the accompanying responsibilities and potential problems associated with managing bonuses. Other suggestions were: ▪ Review of tariffs especially for indigent patients to encourage more private hospitals to come on board ▪ More manpower ▪ Improved motivation ▪ Regular payment of subsidies and bonuses, as well as payment of outstanding debts to providers, were put forth as suggestions for improvement. Participants also suggested that verification criteria be reviewed because the criteria were now “too strict.”
Community Representatives and Beneficiaries	▪ Provision of free drugs to pregnant women and nursing mothers ▪ Provision of ample waiting/sitting area space at the facilities ▪ Provision of regular health talks ▪ Further subsidising costs of services and medication ▪ Engagement of more trained staff ▪ Expansion of equipment and services e.g., laboratory and ultra-sound ▪ Creation of access roads. ▪ Improvement in infrastructure e.g., toilets, borehole ▪ Ensuring there is a medical doctor at the centres
Adamawa Stakeholders	▪ Changes suggested to ensure continuity of the scheme included: ▪ Regular funding ▪ Capacity building with a big emphasis on sustainability and sustainability planning ▪ Advocacy at the state level (Legislative and Executive) ▪ Get government buy-in, expose policymakers to PBF training ▪ Financial education to members of Ward Development Committee (WDCs) ▪ Modified autonomy ▪ Membership of the WDCs should be tenured (some colluded with facility managers to perpetrate fraud) ▪ Change all hospitals to PBF

SDG	FFSA
LGA Interviews	▪ Modified autonomy of facility managers, regular funding, discontinuing the “error margin,” sustainability planning and retention of staff. ▪ Suggested the following to ensure continuity of the pilot- regular funding, and continued capacity building
Executive Level	▪ Reduced autonomy of FMs ▪ Introduction of checks and controls ▪ Focus on sustainability ▪ Greater financial supervision ▪ Implementing a sliding scale for counterpart funding ▪ Implementing the similar funding mechanism across all facilities whether in the PBF or DFF ▪ The most important factors for sustainability emerged as: ▪ Regulation of financial management ▪ Community involvement ▪ Need for personnel who understand the process ▪ Greater financing e.g., Basic family planning and health care provision fund ▪ Strict adherence to the objective of the programme development

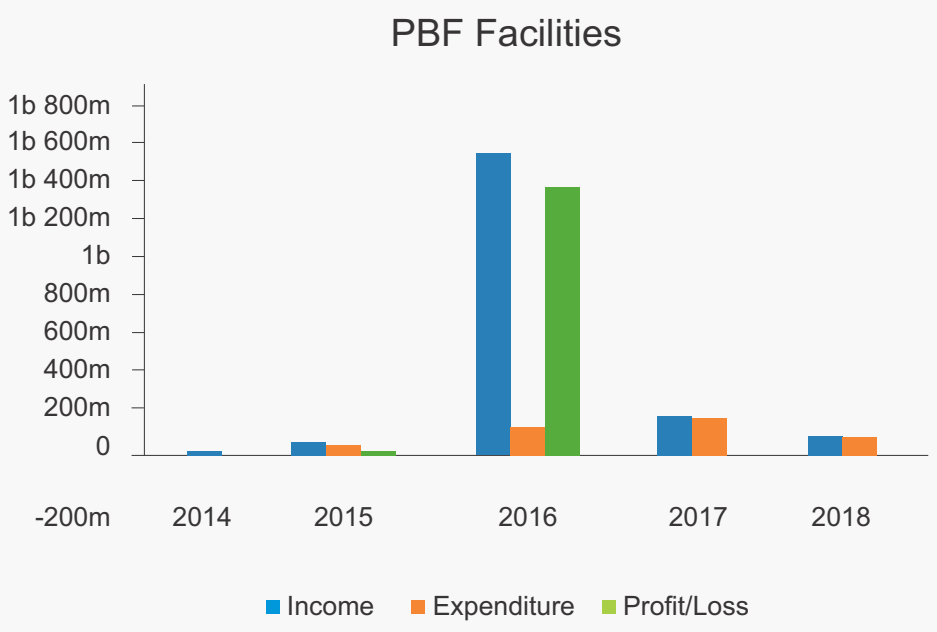
4.4 Finance

These financial reports summarized in the figures below provide yearly transaction information based on income, expenditure, profit/loss across the facilities enrolled in the PBF and DFF scheme between the years 2014 to 2018. The PBF facilities had a profit margin every year except in 2018.

In 2014, PBF facilities earned an income of approximately N22.7 million and made a profit of N10.8 million. In 2015, the profit margin increased to about N21.4 million which represents approximately 97% increase in profit growth rate.

In 2016, income further rose to N1.6 billion with a profit of approximately N1.4 billion. However, there was a record fall the following year, dropping from N1.4 billion to N217 million with a profit of N14.7 million. At the end of the project in 2018, PBF facilities had a 51% reduction in income from the previous year (possibly linked to reduced funding from the project) and incurred a loss of N4 million. The expenditure was

Figure 10: Financials for PBF Facilities



As summarised in Figure 26, income flow for DFF facilities showed some fluctuations over the years. In 2014, income was N11,000 with a net loss of approximately N2.7 million. There was no income generated in 2015 and 2016, but the facilities incurred debt and a net loss of approximately N10.1 million in 2015 and N21.8 million in 2016.
In 2017, income was N813, 905 and the expenses were N41.8 million, with a net loss of approximately N41 million. There was a further income increase in 2018 to N1.4 million. However, expenditure exceeded the income this year with a net loss of approximately N33 million.

Figure 11: Financials for DFF Facilities

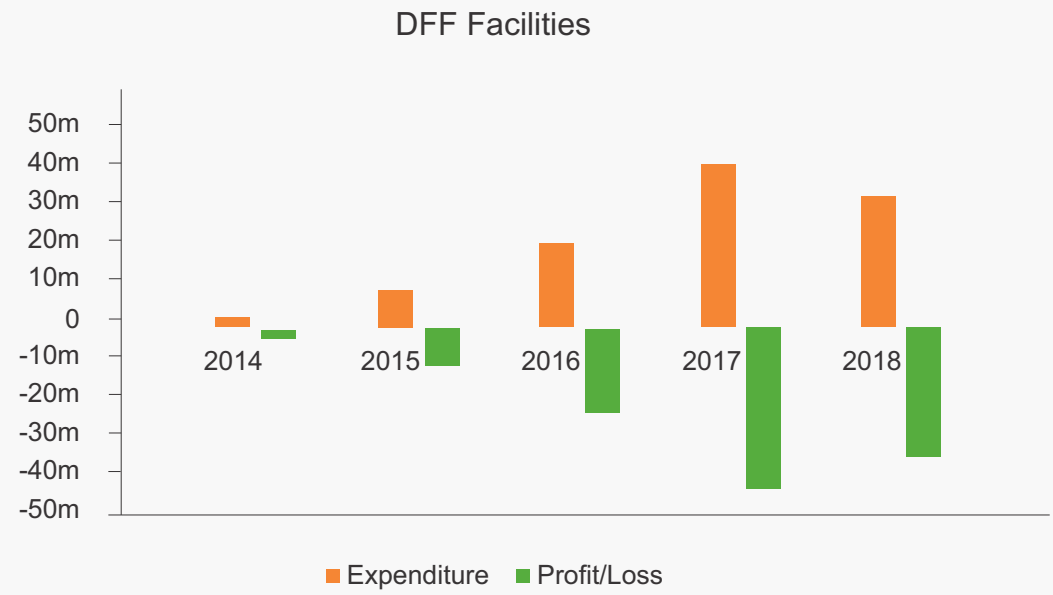


Figure 12: Financials for DFF Facilities

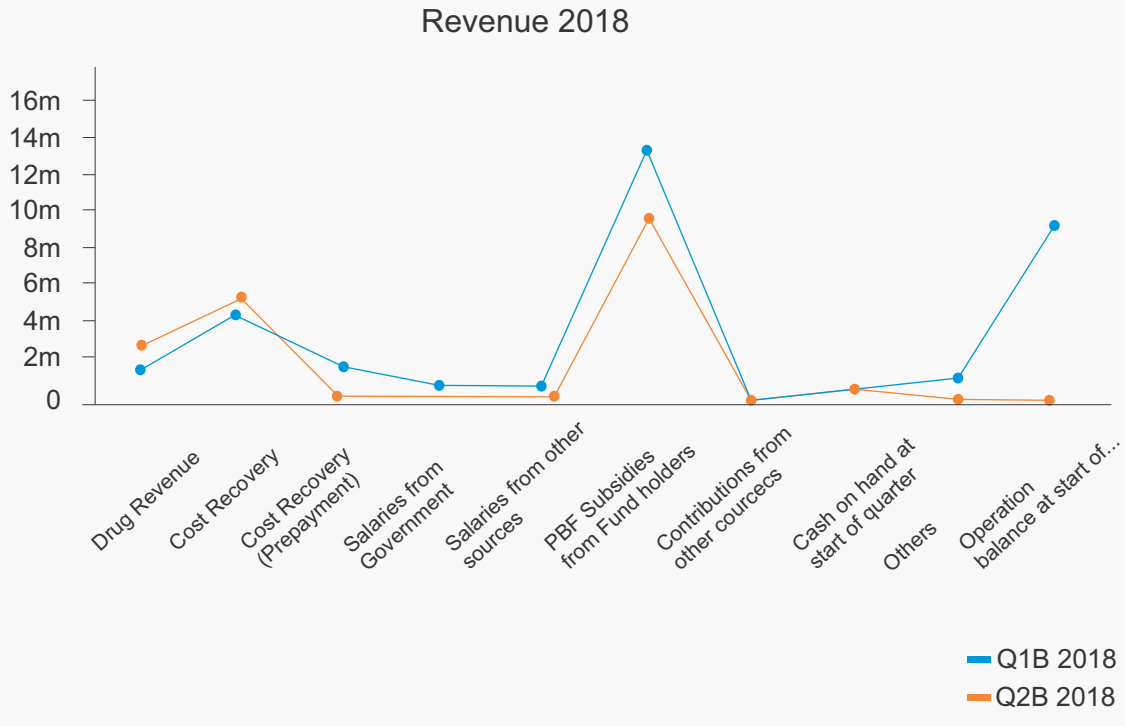
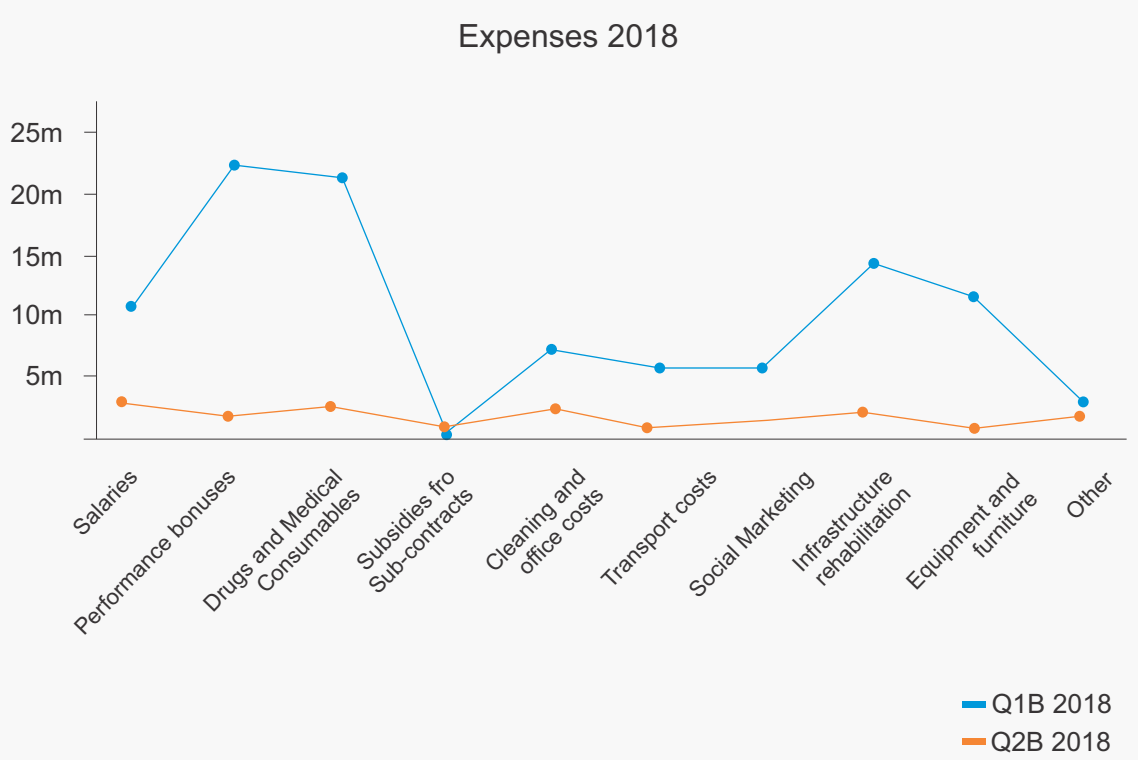


Figure 27: Financials for DFF Facilities



5.0

Key Implications

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The combination of qualitative and quantitative analysis of the Adamawa NSHIP programme offers a complementary approach to understand the policy impact on the quality of care provided at various PHC facilities across the state. The effectiveness of any health financing scheme depends on a well-designed programme and a feasible implementation plan. An efficient administration and adequate infrastructure will likely accomplish any programme's objectives as opposed to poorly designed and implemented programmes. In the case of Adamawa, it appears that the NSHIP did support improved health outcomes in several dimensions, though several targets were not met. However, the sustainability of the positive changes at the facility level, in the absence of external funding, remains a key challenge which was emphasised during the unexpected challenges within 2018. Naturally, this resulted in a decline in most health services. However, some RBF facilities had been able to develop new sources of financing; either by tapping into private health expenditure or developing alternative revenue sources including the hiring of community spaces etc.

The Adamawa NSHIP implementation sites follow the same design and model of incentivising payments with slight variations in the number of health facilities engaged per LGA. Stakeholders were initially sceptical about the project, due to difficulties in staffing and equipment. These issues were resolved by using subsidies and incentives to hire staff and buy equipment. The initial goals were focused on improving infrastructure in facilities, increasing care utilisation, improving health indices and capacity building. As the project progressed, major changes were observed such as infrastructural improvement, expansion of the agency, regular supervision at Federal/State/LGA levels, bonuses, improved staff commitment, community ownership and a coordination platform. There were notable differences between PBF and DFF facilities such as:

For instance, DFF received 50% less of what PBF received. In addition to this advantage over the DFF, the PBF also received a monthly verification of minimum package services, higher level of supervision and community involvement, better quality of care and higher patient volume and contracting of scientist for laboratory services. However, the level of autonomy was equal in both the DFF and PBF facilities. Service engagement improved because of changes from direct funding, autonomy, and access to 24-hour service. The differences between health facilities were attributed to motivation by bonuses and patient inflow/population densities into facilities - this served as the strongest motivation for the workers. It is observed that when funding stalled towards the end of the study, there was a decline in the service engagement across the various health facilities in the participating LGAs. These findings provide a platform for further discourse on the impact of various contextual and implementation factors likely to affect outcomes of RBF in the State and as a benchmark for the country.

Notable differences between PBF and DFF facilities observed were:

However, both facilities experienced the same level of autonomy. The differences between the health facilities were attributed to employee motivation from bonuses. Secondly, increased patient flow to the "renovated" PBF facilities also reflected in the increased revenues to these facilities. Employee bonuses are a strong motivating factor which was evident in the decline in the service engagement across the various health facilities. These findings provide a platform for further discourse on the impact of various contextual and implementation factors likely to affect outcomes of result-based findings (RBF) in the State and as a benchmark for the country.

Our findings show that irrespective of the level of health care available, PBF engages the health provider and improves their efforts. This supports the conclusions from our studies that show that PBF improves other dimensions of provider effort and may be a significant factor in contending with issues related to low provider effort and high absenteeism in health facilities.[2]

1 Gertler and Vermeersch 2012
2 Chaudhury et al. 2006; *Olken, 2012; Huillery and Seban, 2013.*

Key Challenges

Government partnerships are complex; they are often difficult to work through between the stakeholders involved in service delivery. As stated in the aggregate report, "the DFF facilities learnt and adopted social marketing from the PBF facilities; but community members complained about QOC when funding decreased. The result of this was that facilities were unable to pay contract staff and fund community meetings." This issue of financial sustainability is critical, and unfortunately, a path does not appear clear. In 2018, out of the N9.8 billion budgeted by ASPHCDA, only 38% was spent. The government expenditure supported only personnel (75% of planned expenditure) with no budget releases for operational expenditure, drugs, or capital expenditure. The operational expenditure of N8. 45 million came from donors/grants.

Many of the participants highlighted a redistribution of attention to services that were incentivised. Others reported unwanted effects such as overdependence on bonuses, lack of transparency, and drop in worker motivation when the bonuses became irregular. There were also issues such as gaming of the quality verification survey. These were resolved by an adjustment in national-level measures, staff training and advocacy etc.

It is important to not underrate the influence that the Federal Government of Nigeria may have in the activities at the State level; this may pose a threat to the existence of any partnership or changes proposed or implemented. For example, the recent reduction in the Federal health budget described earlier and/or potential economic stimulus could play a significant role in the health financing environment. Therefore, the mitigation plan should focus on developing an accountability-based framework focused on financial (accounting for resources and resources use) and non-financial issues (distribution of information, legal and operational rights) that may arise.

Recommendations for Adamawa and Suggested Action Plans

Our review highlighted the importance of management, funding, and community involvement as key factors in differentiating between PBF and DFF schemes. Our findings also suggest the need for further structural improvement, staff knowledge acquisition and incentives - all of which are key motivators to improving health-worker performance. Other desirable measures suggested by participants include modifying the autonomy of facility managers, regular funding, sustainability planning and retention of staff.

Furthermore, our findings suggest that ADSPHCDA focus more on developing effective partnerships with facility managers, health care professionals and relevant stakeholders to develop, implement and sustain policies. This refinement will empower, give autonomy, and reduce dependence on dwindling external resources. This recommendation aligns with the ADSPHCDA mission which “is to strengthen the state health system for effective, efficient, accessible and affordable health services in partnership with stakeholders and communities” (ADSPHCDA, 2018). Health care professionals would have a sense of commitment towards their communities if the changes suggested for improvement are implemented. Such changes include prompt subsidies and bonus payments, sustainable funding, increased staff recruitment, and strengthened community-level surveillance.

Based on the recommendation, the action plan will address six specific objectives to improve efficiency. They are as follows:

1. Refining ADSPHCDA's organisational structure, policies and procedures based on the lessons learnt. The emphasis should be focused on improving communication channels between health facilities. This should also include education of managers on the total cost of services provided (including personnel) and not just on operational and drug costs.

2. Create time-bound modalities to foster partnerships between the facility managers or other stakeholders; to achieve these goals; the policies should focus on eliminating power imbalance that could undermine efforts directed towards the change process.

3. Focus on facilitating financial sustainability at all levels by encouraging a greater allocation of resources to healthcare at the State and LGA levels, including leveraging the BHCPF, supporting the expansion of pooled financing/insurance that can be used at the PHC level (e.g., NHIS, State Insurance Schemes) and at the facility level using insurance schemes, affordability of certain services e.g., non-HIV STDs, drugs, use of common space for paid community activities etc.

4. Decide whether to stay with the PBF or DFF model. It seems challenging to manage both models simultaneously. While the PBF model produces superior health outcomes, it is important to ensure that it's financially sustainable. In 2018, the Adamawa State Government did not release any operational funds. This was coupled with the delay in the NSHIP project funding – adversely impacting outcomes of most facilities (except a couple who had earlier addressed issues of financial sustainability). If the ASPHCDA budget for 2018 of N8.6 billion had been fully funded, it would have catered to the “basic and complementary health packages costed at $2.70 per capita per year (2/3 health centre and 1/3

hospital)" costed by the World Bank. Based on the CBN official rates of N361 to US$1 and the Adamawa state population at 4.25 million people, the cost of N4.1 billion could have been covered by the budget. However, it would have been significantly higher than the actual state budget expenditure of N2.9 billion.

5. Improve the quality of data management. A significant amount of data is collected at the facility level but there appears to be data lost between each facility and the data room. As the data is collected on paper, there are gaps in organisation, storage arrangement and accessibility. This then contributes to challenges with data analysis. We suggest that ASPHCDA builds on the strong data culture in the PBF by leveraging electronic collection and storage, in addition to improving data analytic skills at both facility and central levels. This will help to facilitate the effective use of data to improve services offered to the population.

6. Provide an implementation guide and operating protocols for health interventions. A transparent governance framework should be created to ensure suitable leadership, achieve optimal operations, develop effective work relationships, and institute a suitable capacity building programme. Annual performance appraisals by an external consultant should be built in. Implementation of the action plan should include a timeline, rules of engagement and be achieved in phases.

The sustainable action plan should be verifiable and focus on structural changes such as organisational planning, human resource, workforce transition, capacity training, finance, and human resource processes. A balanced scorecard will serve as a guide for measuring the performance of the change process and/or an independent verifier agent incorporated, as well as transparency in performance outcomes. An open feedback mechanism should also be encouraged to measure quality and service performance. Finally, it is key the agency and other stakeholders take ownership of the action plan to ensure the facilities are successful.

Recommendations for Nigeria and Elsewhere

While the Adamawa experience indicates that performance-based financing is effective at improving demand and quality for selected primary health services, the unexpected funding difficulties indicated that such improvement may be transitional. Thus, it is important to ensure issues of financial sustainability are addressed before the commencement of a performance-based program.

It is also important to note that it is difficult to run two different payment schemes for employees in the same states doing the same jobs for a substantial amount of time, without demotivating some staff. In this case, anecdotal interviews indicated that DFF staff initially were motivated to work hard so they could be moved to the RBF bonus scheme.

6.0

Conclusion

6.0 Conclusion

For several years, the PBF experience in Adamawa State, financed through the NSHIP project, has provided insight into financial accountability, project design and implementation of programmes related to MCH and other health interventions in the State. Despite its achievements, the State-wide project is still grappling with organisational management and financial issues, at the same time as significant changes in leadership, During the preparation of this report, there were two Commissioners of Health, two Permanent Secretaries and three Executive Chairpersons of ASPHDA. The Adamawa NSHIP programme is faced with concerns about its continued existence and operation in the face of withdrawal or non-sustenance of funding and government changes. Over the years, the unpredictable project funding and limited government funding has contributed to inconsistencies in funds transfer to both PBF and DFF facilities. Beyond the financial challenges, the PHC still faces inefficiencies in delivering services as more infrastructure, training of staff and community mobilisation is needed. With a tenuous financial situation amid criticisms about the sustenance of incentives and the effectiveness of Adamawa State PBF project, the question remains: what considerations could promote and sustain the performance of the improved primary care facilities within Adamawa State?

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Annex

Figure 14: The Organogram for the Adamawa State Primary Health Care Development Agency

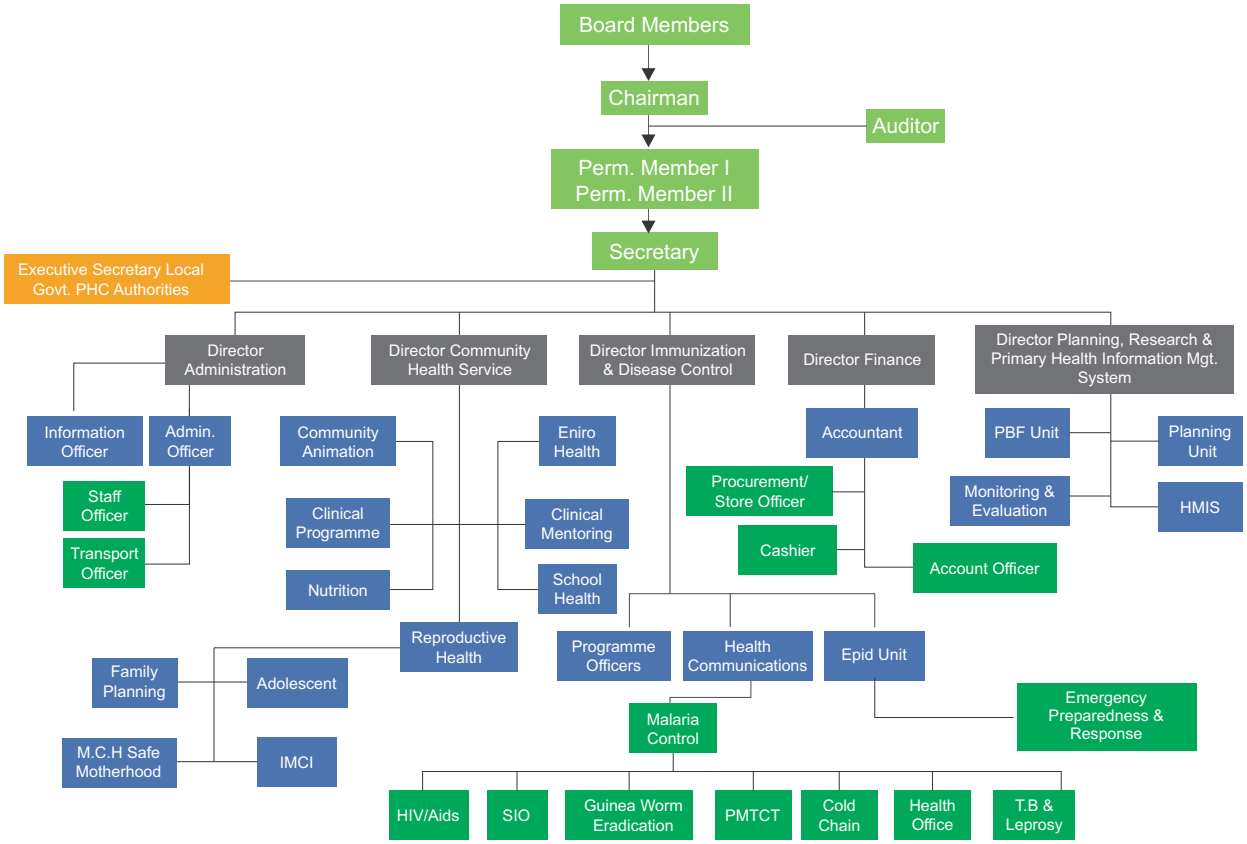


Table 3: Number of Health Facilities per Local Government Area

LGAs	Number of Facilities
Fufore	3
Girei	3
Guyuk	4
Maiha	4
Mayo Belwa	5
Mubi South	2
Shelleng	3
Song	5
Yola South	6
Total	35

Table 4: Overview of Participants by category

LGAs	Number of Participants	Role in Project
Executive Level	10 participants selected across the LGAs, NPHCDA, Ministry of Health (MoH), World Bank (WB), and the NSHIP Executive Secretary at the LGA level, as well as a team-lead at the World Bank.	Supervision, mentoring, capacity strengthening, ensuring agreements were upheld by facilities, teamwork across different agencies and knowledge exchange.
Facility Managers (FMs)	39 facility managers participated in 5 focus group discussions (FGDs) and 12 in-depth interviews (IDIs)across 6 LGAs.	Supervision of centres under either the DFF or PBF scheme.
Community Representatives	6 participated in FGD and IDIs conducted in Mayo Belwa and Girei LGAs.	
Selected stakeholders based in Adamawa: ▪ Primary Health Agency (PHA) ▪ Health Management Board (HMB) ▪ MoH ▪ LGAs	4 Participants from PHA, HBM and MoH. 6 participants from Mayo Belwa, Girei, Song and Numan LGAs.	Their roles in the NSHIP ranged from the Planning Officer to the Secretary of the steering committee, supervision, or coordination Focal Person to Director of Health Education. The most important aspects of their jobs included quality assessment, data collation, coordination, and supervision.

Table 5: Correlation Analysis | Pairwise Correlation Coefficients Table

	income	expenditure	skilled	unskilled	anc	childvac	inst-delivery	mc	outpt	std
Anc	0.6506	0.929	0.7586	0.6909						
	0.2345	0.023**	0.1371	0.1965						
childvac	0.764	0.8887	0.6309	0.6028	0.9474					
	0.1327	0.044**	0.2537	0.2819	0.014**					
inst-delivery	0.7539	0.8213	0.7369	0.7253	0.9399	0.9838				
	0.141	0.089*	0.1555	0.1655	0.018**	0.003***				
Mc	0.7614	0.9019	0.6163	0.5831	0.9503	0.9994	0.9776			
	0.1348	0.036**	0.2682	0.3021	0.013**	0.000***	0.004***			
Outpt	0.4808	0.8261	0.7663	0.7633	0.8966	0.9152	0.9367	0.9082		
	0.4123	0.085*	0.1308	0.1333	0.040**	0.030**	0.019**	0.040**		
Std	0.8212	0.8669	0.5684	0.5409	0.9226	0.9941	0.9701	0.9943	0.8691	
	0.089*	0.057*	0.3174	0.3465	0.026**	0.001***	0.006***	0.001***	0.056*	
Wellchild	0.6359	0.9238	0.592	0.5639	0.9289	0.9804	0.9515	0.9817	0.9458	0.9623
	0.2489	0.025**	0.2929	0.3222	0.023**	0.003***	0.013**	0.003**	0.015**	0.009**
Unskilled	0.3282	0.4242	0.9847							
	0.5897	0.4765	0.002***							
Skilled	0.3398	0.5143								
	0.5758	0.3753								
Expenditure	0.5101									
	0.3799									

The figures in black are the correlation coefficients and p-value in red fonts while the significant ones are in yellow.
*, ** and *** represent 10%, 5% and 1% statistical significance levels

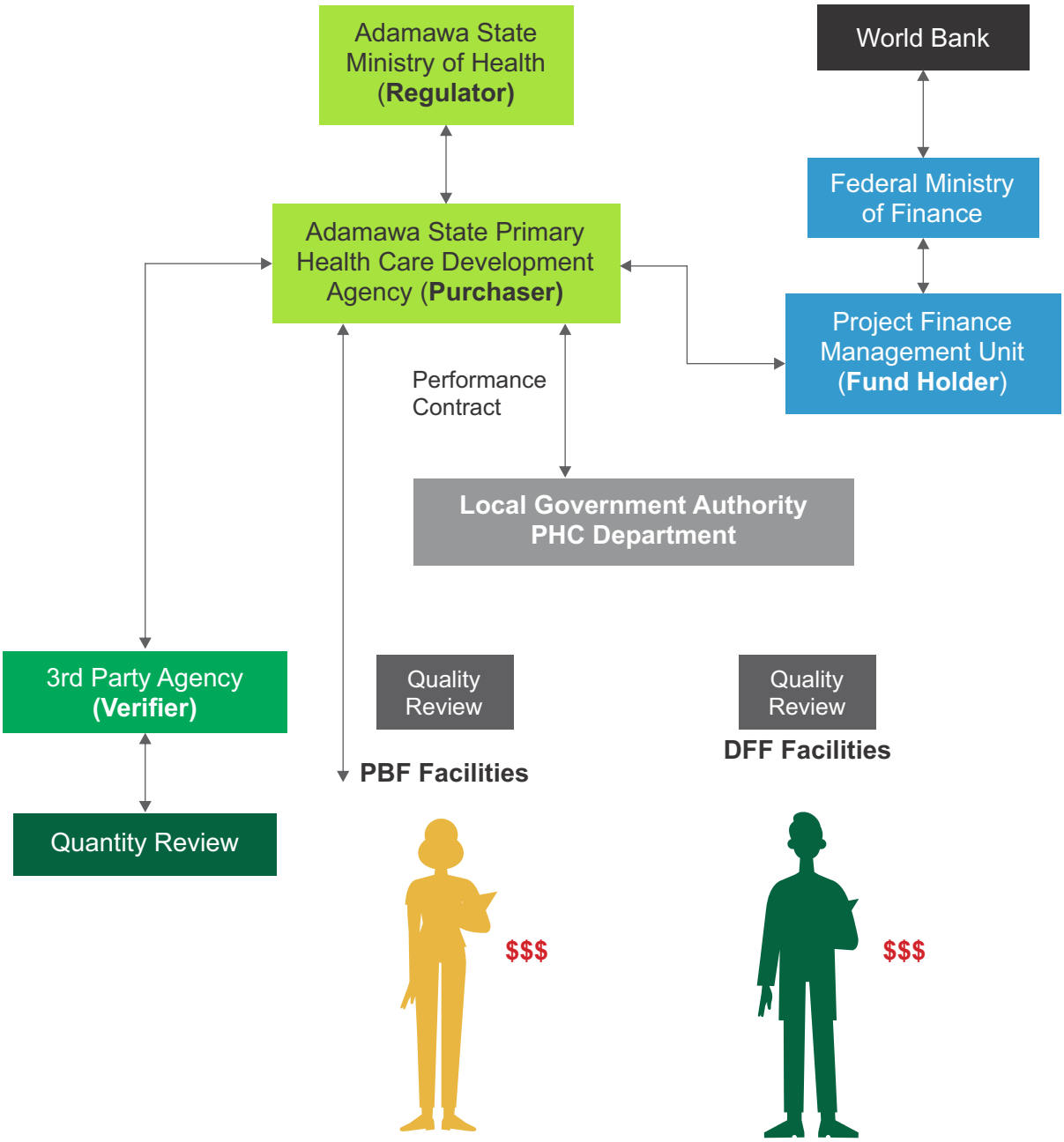
Table 6: Summary of Finance for DFF Facilities

Year	Income	Expenture	Prodit/Loss
2014	11,000	2,756,490	- 2,745,490
2015	Income	10,121,098	-10,121,098
2016	Income	21,845,130	-21,845,130
2017	813,905	41,844,711	-41,030,806
2018	1,412,567	34,588,721	-33,176,154

Table 7: Summary of Finance for PBF Facilities

Year	Income	Expenture	Prodit/Loss
2014	22,731,247.19	11,921,958.74	10,809,288.45
2015	93,461,695.07	72,083,876.47	21,377,818.60
2016	1,608,059,011.77	172,250,140.77	1,435,808,871.00
2017	216,667,472.62	202,030,808.07	14,636,664.55
2018	112,047,181.40	116,405,675.76	- 4,358,494.36

FIGURE 15: Adamawa State Institutional Arrangements for NSHIP



Appendix I

Below are the Interview guides for interviews conducted at various levels.
In-depth interview guide for Executive and Management Staff

Participant IDNO |__|__|__|__| Gender Male / Female Researcher Initials

|__|__|__|

LGA (if applicable) _____ Date |__|__/__|__/__|__|

Introduction

I am _____ from _____

- General-purpose of the study
- Aims of the interview and expected duration
- Persons involved in the process (other participants)
- Importance of participant cooperation
- Application of collected information
- General questions?
- Consent

Warm up [demographic & work history]

Can I ask for some details about you and your job?

Job Title _____

Highest Educational Grade attained ___ __ Year of graduation_____

Years worked in this job |__|__|years|__|__|months

Are you originally from this area/district (if local government chairperson?) □ Yes □ No

How old are you? □ under 30yrs □ 30-40yrs □ 41-50yrs □ 51-60yrs □ >60yrs

How long have you worked in this sector? □ 1-5 yrs □ 6-10 yrs □ 10-15 yrs □ 16-20yrs □ > 20yrs

Participant Experiences in the NSHIP Project

Domain	Topic and Probes
Role in project	What are your main roles and responsibilities in the NSHIP scheme i.e., as the executive chairman/director/board member/chairperson of LGA? **Probe:** How many facilities are under your supervision? Who do you work with? Who do you report to? How often do you or your designee visit health facilities? What is the most important aspect of your job in relation to the NSHIP project? **Probe:** What is the most critical part of your job to make sure things go smoothly? Can you compare your experiences before the introduction of the PBF and NSHIP projects to what obtains under the programme? **Probe:** What were the goals of the NSHIP when it was introduced? What are the most significant adjustments you have had to make since NSHIP?
Motivations	What were your initial feelings about the project? What were your goals at the beginning of the pilot? Has that changed through the length of the pilot? What do you think is the strongest motivating factor for the frontline workers: intrinsic (altruism, getting better at their job) vs extrinsic (bonuses)? **Probe:** What specific ways has the project affected the motivation of frontline staff? Are frontline staff more motivated with the current PBF scheme than they were before PBF? Do you think the staff are more motivated by the bonuses they get? Are your staff happier with the breadth of services the centre can provide? Have you noticed any differences in the level of motivation of workers in the DFF and PBF schemes? (for executive chairman/secretary/ director or board members only) **Probe:** What do you think is responsible for these differences in motivation. Are there any differences in the level of satisfaction of workers in the DFF and PBF schemes? (for executive chairman/secretary/director or board members only) **Probe:** What do you think is responsible for these differences in motivation?

Participant Experiences in the NSHIP Project

Domain	Topic and Probes
Implementation	**For executive chairmen only:** Was this project implemented using the World Bank Standard design or were modifications made to adapt to the context in Nigeria? Why? How was this project first received after the pre-pilot? **Prompt:** What anticipated difficulties did you encounter? How did you manage these difficulties? What unanticipated difficulties did you encounter? How did you manage them? Were local 'champions' of the project used to increase uptake? **For executive chairman/secretary/director or board members only:** Have there been prior non PBF efforts at improving primary health care in Adamawa State? What are the key differences between those efforts and PBF? Were lessons learned, if any, implemented in the administration of PBF? **For executive chairman/secretary/director or board members only:** what were the peculiarities in Adamawa state that had to be overcome to increase uptake? **Prompt:** What were the major differences between implementation in the 3 States? What cultural barriers, if any, did you encounter and how did you deal with them? How did you provide leadership in the implementation?

Participant Experiences in the NSHIP Project

Domain	Topic and Probes
Successes	What do you think is the most important factor responsible for the success or failure of the NSHIP/PBF pilot? **Prompt:** What are the most important factors responsible for the success of the programme and how would you rank them? What changes would you suggest to ensure continued success? **Prompt:** Even though you record it as a success, are there any steps in the process of implementation that you would tweak? Why?
Unwanted effects /Challenges	Please share your thoughts on the negative effects of PBF **Prompt:** Has there been an inadvertent redistribution of workers to PBF facilities at the detriment of DFF facilities? Have you noted any dissatisfaction with the bonuses/ supervision/autonomy? How have you approached these challenges? Have there been any issues with the redirection of attention to particular services at the detriment of others? **Prompt:** Did you notice that your staff started to focus too much on any particular contracted services that had bonuses attached to it at the detriment of other services? How did you perceive the challenges you come up against? **Prompt:** Did you think they were insurmountable? Did you have the required resources at your disposal to overcome these challenges? Can you give an example of a challenge and the unique approach you took to solution finding? How did you deal with unmet expectations?

Participant Experiences in the NSHIP Project

Domain	Topic and Probes
Future changes	What did not go well in the implementation? Probe: What would you do differently? Why would you do it differently? What do you think is the most important factor in the sustainability of the project?
Closing Do you have any further thoughts/comments on related issues? ▪ Summarise ▪ Thank participants ▪ Provide extra information and contacts to participants	

Appendix II

In-Depth interview guide for Facility Managers

Participant IDNO |__|__|__|__| Gender Male / Female Researcher Initials |__|__|__|

Health facility _____ Date |__|__/__|__/__|__|

Introduction

I am _____ from _____

- General-purpose of the study
- Aims of the interview and expected duration
- Persons involved in the process (other participants)
- Importance of participant cooperation
- Application of collected information
- General questions?
- Consent

Warm up [demographic & work history]

Can I ask for some details about you and your job?

Job Title _____

Highest Educational Grade attained ___ __ Year of graduation_____

Years worked in this job |__|__|years|__|__|months

Are you originally from this area/district (if local government chairperson?) □ Yes □ No

How old are you? □ under 30yrs □ 30-40yrs □ 41-50yrs □ 51-60yrs □ >60yrs

How long have you worked in this sector? □ 1-5 yrs □ 6-10 yrs □ 10-15 yrs □ 16-20yrs □ > 20yrs

Experiences as A Manager of This Facility

Domain	Topic and Probes
Work conditions	What does your typical day consist of at the health centre? **Probe:** What are the day-to-day activities that require your oversight as a facility manager? Are there any days that veer off the usual pattern e.g., end of the quarter, verification days? Important aspects of your job. **Probe:** What is the most critical part of your job as a facility manager? Can you compare your experiences before the introduction of the PBF and NSHIP projects to what currently obtains under the programme? **Probe:** What are the most significant adjustments you have had to make since NSHIP? In addition to the contracted services, what other criteria did you use to set targets for the different health services for each quarter? **Probe:** what criteria did you use to set targets for the health
Motivations	What motivates you most about the work that you do? Probes: What were your goals at the beginning of the pilot and why? Has that changed through the length of the pilot? What do you think is the strongest motivating factor for your staff- intrinsic vs extrinsic? What specific ways has the project affected the motivation of your staff? Is your staff more motivated with the current PBF scheme or before the introduction of PBF? Do you think the staff are more motivated by the bonus they get? Are your staff happier with the breadth of services the centre can provide?

Experiences as A Manager of This Facility

Domain	Topic and Probes
Supervision	What are your thoughts on the level of supervision by the steering committee? **Prompt:** Are you happy with the autonomy or lack thereof given to you? Has the level of supervision changed over the years since the PBF pilot? How did you deal with unmet expectations from above? **Prompt:** How did you handle unmet expectations with regards to financing and training? How did you ensure accountability and accuracy of data collection? **Prompt:** Did you have any challenges in this area? What challenges did you have and how did you overcome them? How did you provide leadership to your staff?
Marketing	Did you seek any input from community members on how to tailor the services you provided? **Prompt:** What methods did you use to tailor services provided by the facility, if any? How were you able to engage the community members and increase utilisation of your facility? **Prompt:** What methods did you employ to obtain public buy-in from the community? Did you have to employ designates for this purpose?

Experiences as A Manager of This Facility

Domain	Topic and Probes
Sucessess	What do you think is the most important factor in the success or failure of the NSHIP/PBF pilot? **Prompt:** In your opinion, what factors are responsible for the success and how would you rank them? What peculiarities of your centre and catchment area did you have to pay attention to? **Prompt:** Were there any specific cultural barriers you had to pay attention to? How did you overcome these barriers?
Unwanted effects/ Challenges	Have you experienced any negative effects of PBF among staff relations within your centre? **Prompt:** Have you noted any dissatisfaction with the bonuses resulting in undue friction? How have you approached friction associated with bonuses, verifications, and counter verifications? Are there any particular challenges in your centre that you had to overcome to ensure quality services all round? **Prompt:** Did you notice that your staff started to focus too much on any particular contracted services that had bonuses attached to it at the detriment of other services? How did you perceive the challenges you come up against? **Prompt:** Did you think they were insurmountable? Did you have the required resources at your disposal to overcome these challenges? Can you give an example of a challenge and the unique approach you took to solve it??

Experiences as A Manager of This Facility

Domain	Topic and Probes
Satisfaction	How satisfied are you with NSHIP/PBF pilot? **Probe:** What changes would you make and in which areas? Why?

Closing

Do you have any further thoughts/comments on related issues?

- Summarise
- Thank participants
- Provide extra information and contacts to participants

Appendix III

Focus group discussion guide: PHC beneficiaries and community representatives

Community Name: Number of participants: T. M. F. Moderator Initials

|__|__|__|

Date |__|__/__|__/__|__|

Name of closest health facility:

Type of facility:

Introduction

I am _____ from _____

- General-purpose of the study
- Aims of the interview and expected duration
- Persons involved in the process (other participants)
- Importance of participant cooperation
- Application of collected information
- General questions?
- Consent

Domain	Topic and Probes
Common Health Conditions	In your opinion, what are the common health problems in this area? Do these health problems change from time to time or remain the same?
Health Seeking Behaviour	Where do the members of your community usually seek health care? Where do you usually seek health care? Has there been a change in where and how you seek care in the past 4-5 years? If yes, why has there been a change? If no, why have things remained the same? For you, what are the most important considerations when seeking healthcare? What factors will discourage you from seeking care at a health centre or hospital?

Health Access	What problems, if any, are associated with reaching the facility i.e., condition of roads, transportation availability and costs? Have there been any changes in the past 4 years? What changes? What problems, if any, are associated with the availability of health workers, drugs, equipment, and services? Quality of services? Have there been any changes in the past four years? If so, what changes? Do you think subsidized drugs, if offered, will increase patients' use of the health centre? What problems, if any, are associated with health worker attitude/ behaviour and practices? Have there been any changes in the past 4 years? What changes? What problems, if any, are associated with the costs of health services? Have there been any changes in the past four years? If so, what changes? Has this been a factor in your utilisation of the health centre?
Assessment of the Health Centre	Can you describe in detail a good experience at the health centre that stands out in your mind? Why does it stand out? When did this occur? Can you describe a bad experience that stands out in your mind at the health centre? Why does it stand out? When did this occur? How long is the hospital wait time? What do you like the most about the health centre? Have there been any related changes in the past four years? Why? What do you like the least about the health centre? Have there been any related changes in the last four years? Why? Why do you use the health centre? How satisfied are you with the services at the health centre?
Changes in Health centre	Have there been any changes in the health centre over the last few years? If yes, what changes have you observed in the health centre? Have all these changes been positive? What efforts have been made by the health centre to get you to use the health centre? Did these efforts work?

Future changes	Are there any changes you suggest for improving services at the health centre?

Closing

Do you have any further thoughts/comments on related issues?

- Summarise
- Thank participants
- Provide extra information and contacts to participants

Appendix IV

In-depth interview guide for Selected Stakeholders

Participant IDNO |__|__|__|__| Gender: Male / Female Researcher Initials |__|__|__|

Date |__|__/__|__/__|__|

Introduction

I am _____ from _____

- General-purpose of the study
- Aims of the interview and expected duration
- Persons involved in the process (other participants)
- Importance of participant cooperation
- Application of collected information
- General questions?
- Consent

Warm up [demographic & work history]

Can I ask for some details about you and your job?

Job Title _____

Highest Educational Grade attained ___ __ Year of graduation_____

Years worked in this job |__|__|years|__|__|months

Are you originally from this area/district (if local government chairperson?) □ Yes □ No

How old are you? □ under 30yrs □ 30-40yrs □ 41-50yrs □ 51-60yrs □ >60yrs

How long have you worked in this sector? □ 1-5 yrs □ 6-10 yrs □ 10-15 yrs □ 16-20yrs □ > 20yrs

Domain	Topic and Probes
Role in project	What are your main roles and responsibilities in the NSHIP scheme? **Probe:** Who do you work with? Who do you report to? Who reports to you? Do you visit the health facilities? What is the most important aspect of your job in relation to the NSHIP project?

	Probe: What is the most critical part of your job in the smooth running of the scheme? Can you compare your experiences before the introduction of the PBF and NSHIP projects to what currently obtains under the programme? **Probe:** What were the goals of the NSHIP when it was introduced? What are the most significant adjustments you have had to make since NSHIP?
Changes	What major changes have occurred since the start of the programme? **Probes:** What are the major differences between the PBF financed facilities and the DFF facilities? Can you speak to the following processes: supervision and monitoring process, autonomy, patient volumes? community involvement? Are there new institutional elements introduced because of the project i.e., Were there any contracts based on services that were already built into the existing health framework or where new ones were created? Why have these changes occurred? **Probe:** Why do you think the PBF facilities adopted certain changes and DFF adopted other changes? What are the differences between the high and low performing facilities in both schemes? How would you explain these differences? What are the most important changes that have occurred and how would you rank them?
Motivations	What were your initial feelings about the project? What were your thoughts at the beginning of the pilot and why? Has that changed through the length of the pilot? What do you think is the strongest motivating factor for the frontline workers: intrinsic (altruism, getting better at their job) vs extrinsic (bonuses)?

	Probes: What specific ways has the project affected the motivation of staff? Are staff more motivated with the current PBF scheme or were they more motivated before PBF? Do you think the staff are more motivated by the bonuses they get? Have you noticed any differences in the level of motivation of staff in the DFF and PBF schemes? **Probes:** What do you think is responsible for these differences in motivation Are there any differences in the level of satisfaction of workers in the DFF and PBF schemes? **Probes:** What do you think is responsible for these differences in motivation?
Implementation	Was this project implemented using the World Bank Standard design or were modifications made to adapt to the context in Nigeria? Why? How was this project first received after the pre-pilot? **Prompt:** What anticipated difficulties did you encounter? How did you manage these difficulties? What unanticipated difficulties did you encounter? How did you manage them? Were local 'champions' of the project used to increase uptake? Have there been any efforts to improve primary health care in Adamawa State before the PBF? What are the key differences between those efforts and PBF? Were the lessons learned (if any) implemented in the implementation of PBF? What were the peculiarities in Adamawa state that had to be overcome to increase uptake? **Prompt:** What were the major differences between implementation in the three states? What cultural barriers, if any, did you encounter and how did you deal with them? How did you provide leadership in the implementation process?

Sucessess	What do you think is the most important factor responsible for the success or failure of the NSHIP/PBF pilot? **Prompt:** What are the most important factors you think are responsible for the success and how would you rank them? What changes would you suggest to ensure continued success? **Prompt:** Even though you record it as a success, are there any steps in the process of implementation that you would tweak? Why?
Unwanted effects/ Challenges	What are your thoughts on the negative effects of PBF? **Prompt:** Has there been an inadvertent redistribution of workers to PBF facilities at the detriment of DFF facilities? Have you noted any dissatisfaction with the bonuses/ supervision/autonomy of the staff? How have you approached these challenges? Have there been any issues with redirection of attention to particular services at the detriment of others? **Prompt:** Did you notice that your staff started to focus too much on any particular contracted services that had bonuses attached to it at the detriment of other services? How did you perceive the challenges you came up against? **Prompt:** Did you think they were insurmountable? Did you have the required resources at your disposal to overcome these challenges? Can you give an example of a challenge and the unique approach you took to solve it? How did you deal with unmet expectations?
Future changes	What did not go well in the implementation? **Probe:** What would you do differently? Why would you do it differently?

Closing

Do you have any further thoughts/comments on related issues?

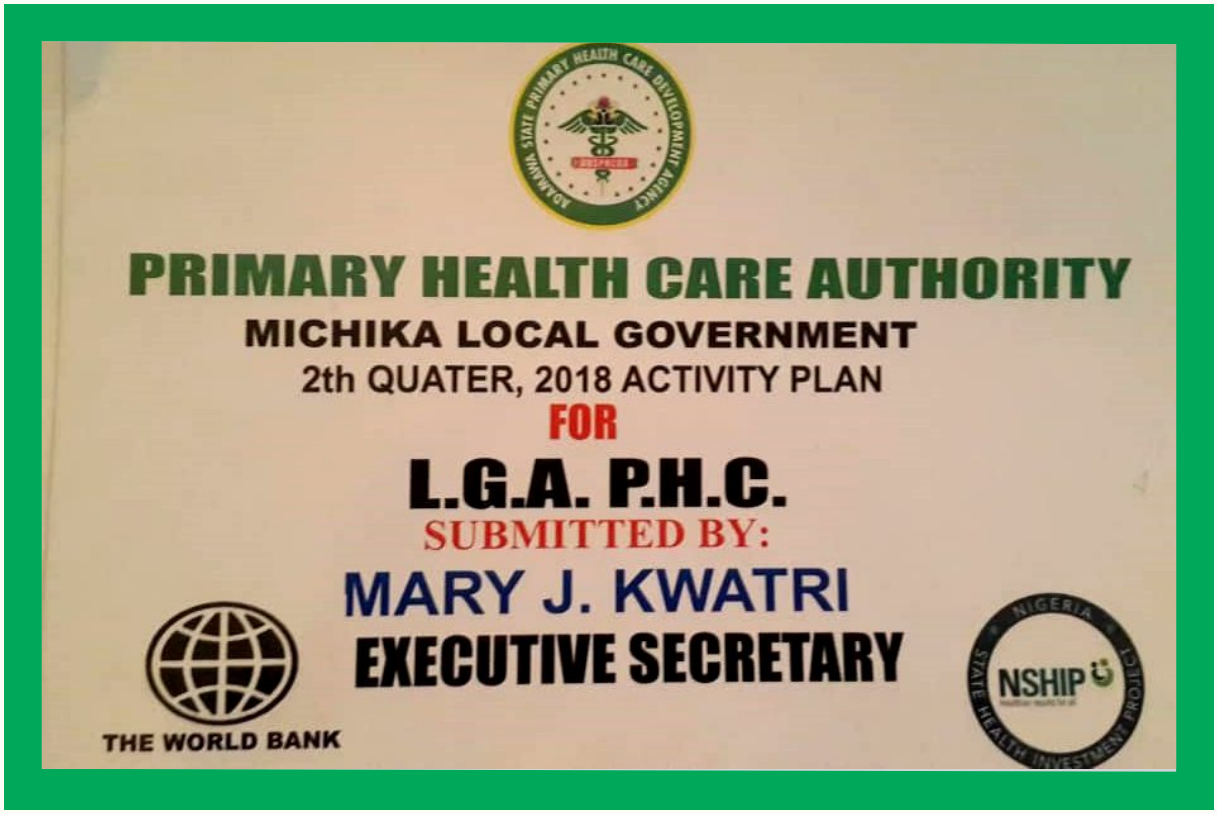
- Summarise
- Thank participants
- Provide extra information and contacts to participants

Photographs of Select Primary Facilities

PRE - NSHIP

POST - NSHIP

PHCC GUYUK



MICHIKA LG:

SOME SELECTED NSHIP INTERVENTION @ PHCCs IN ADAMAWA STATE

Gulantabal PHCC in Song LGA Before

Gulantabal PHCC After intervention

Fufore Cottage Hospital Fufore LGA Before

Fufore Cottage Hospital After

Kubursho sho PHCC Before Michika LGA

Kubursho sho PHCC After

Song Gari B PHCC Song LGA Before

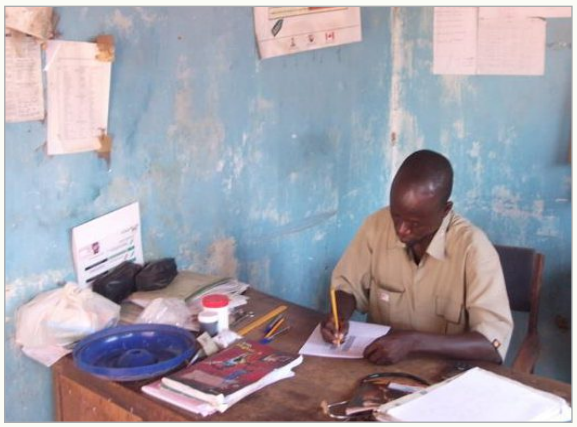
Song Gari B PHCC Song LGA After

DEDE MCH PHCC Maiha LGA Before

DEDE MCH PHCC Maiha LGA After

Sorau PHCC Mubi South LGA Before

Sorau PHCC Mubi South LGA After



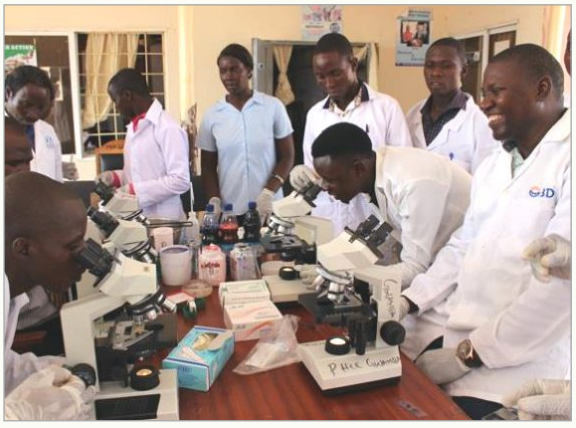
Kwabapale PHCC Michika LGA Before

Kwabapale PHCC Michika LGA After

Blashafa PHCC Michika LGA Before

Blashafa PHCC Michika LGA After

State of Microscope utilization Before



Microscope utilization for Lab Services After

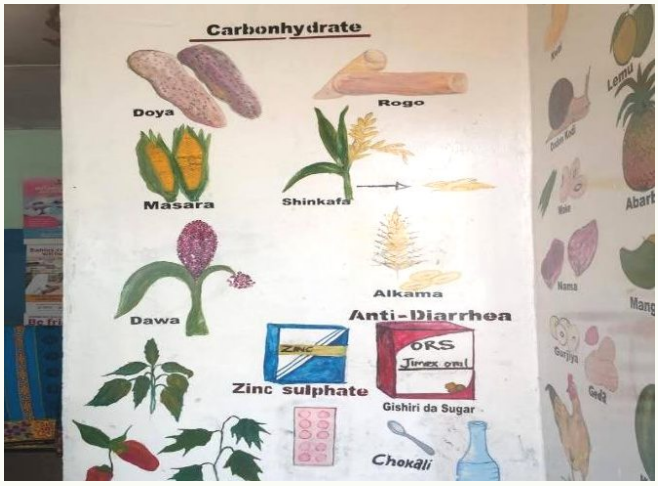
DRF drugs Shelf at an Urban PHC at Jimeta, Yola North

Stationery for health facility documentation at PHC setting (Yola North LGA)

Health facility score sheet at Child welfare unit of a PHC at Yola South

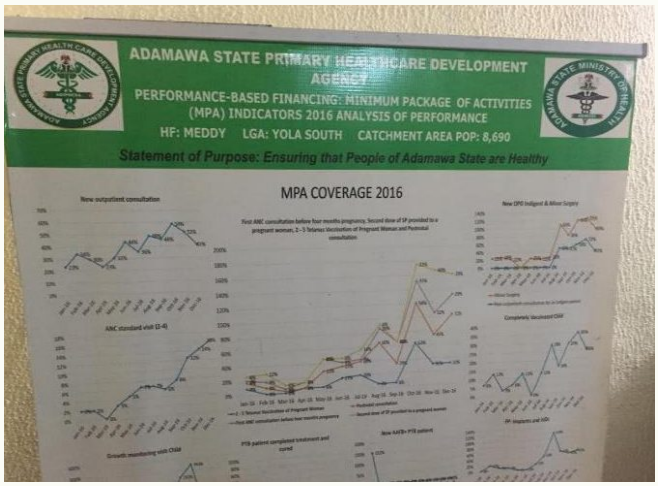
Instrument for anthropometric measurements at a Child welfare clinic at Makama Community, Yola South

A display of health education and promotion materials/posters at a Family Planning unit of a PHC, Yola South LGA



A display of health education and promotion posters maternal and child nutrition using locally grown foods/crops

Health education and promotion posters at ANC unit that depicts different classes of foods for maternal and child nutrition



A banner that depicts analysis of some key indicators in the 2016

Waiting area/reception at Gambo Jimeta PHC at Yola North

Physical files on shelf (part of the health facility Medical Records unit) at a PHC

Shelves for DRF drugs at PHC, Jimeta Yola North

Logos of various partners, institutions and NGO helping the implementation of NSHIP in Adamawa State

Line graph graphs that depict two (new outpatient consultation and fully vaccinated children) key indicators at a PHC

Maternal Health Unit at a PHC in Jimeta, Yola North

Set of equipment for cold-chain activities during immunization exercises at a PHC

Set of equipment for cold-chain activities during immunization exercises at a PHC

Kiri PHCC Shelleng LGA Before

Kiri PHCC Shelleng LGA After

Nassarawo PHCC Before

Nassarawo PHCC After

Farang PHCC Fufore LGA Exterior

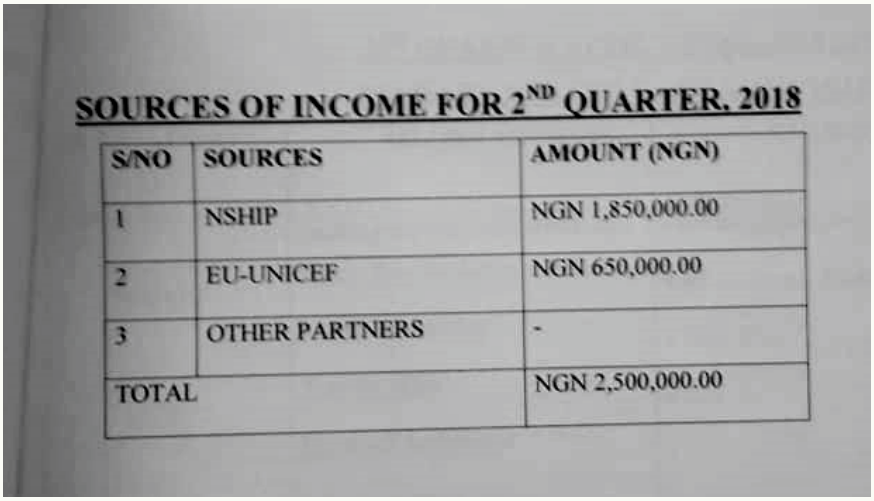
Farang PHCC Fufore LGA interior

Gunda PHCC Guyuk LGA Exterior

Gunda PHCC Guyuk LGA Interior

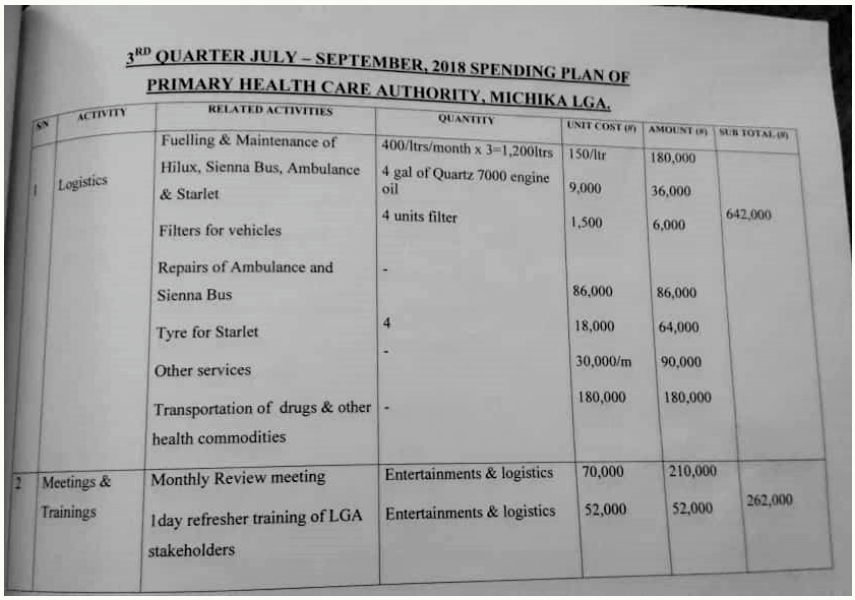
TABLE 8: SAMPLE OF INFORMATION FOR PROVIDER PAYMENT FOR PBF ON ESSENTIAL DRUGS

10	Essential Drugs Management	Yes	No
10.1	**Staff maintains stock cards for ED showing security stock levels = monthly**	**4**	**0**
10.1.1	Supply in register correspondents with physical supply random sample of three ED		
10.2	**Health facility purchases drugs, equipment and consumables from the Pharmaceutical Council of Nigeria certified distributor, approved by SMOH/SPHCDA**	**3**	**0**
10.2.1	Latest Pharmaceutical Council of Nigeria certified distribution center list for the State available		
10.2.2	Latest procurement list is shown which shows the certified distributor which sold the drugs		
10.2.3	All drugs and medical consumables are (i) NAFDAC certified and (ii) Generic		
10.3	**Main pharmacy store delivers drugs to health facility departments according torequisition**	**10**	**0**
10.3.1	All drugs and medical consumables are (i) NAFDAC certified and (ii) Generic		
10.3.2	Drugs to clients are uniquely dispensed through prescriptions. Prescriptions are stored and accessible		
10.3.3	Drugs and medical consumables prescribed are all in generic form		
10.4	**Drugs stored correctly**	**2**	**0**
10.4.1	Clean place, well ventilated with all drugs on cupboards, labelled shelves		
10.4.2	Drugs and medical consumables stored on alphabetical order, first in - first our basis		
10.5	**Absence of our of date drugs or drugs with unreasonable labels**	**1**	**0**
10.5.1	Supervisor verifies randomly three drugs and 2 consumables		
10.5.2	Out of date drugs well separated from stock		
10.5.3	Destruction protocol for out of date drugs available and applied		
	Total Points (20)	../20	xxxx



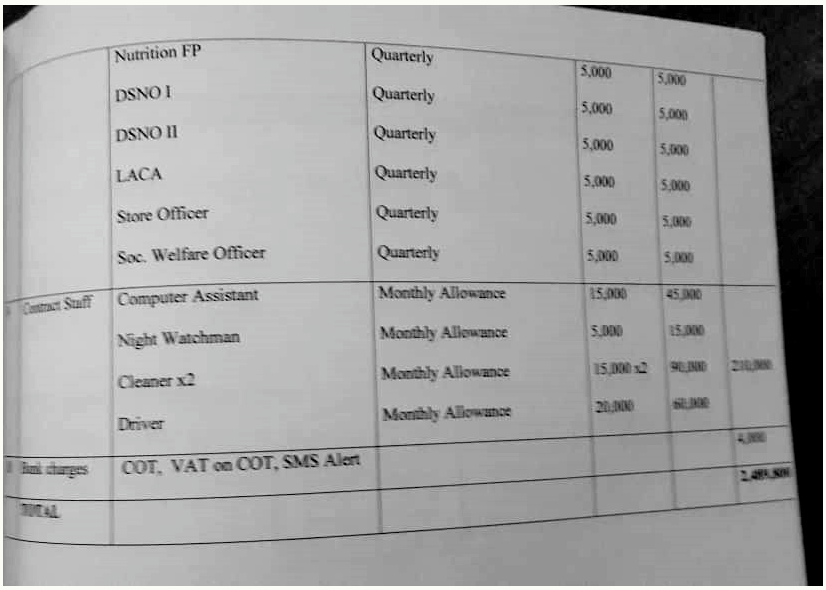
SOURCES OF INCOME FOR 2ND QUARTER, 2018

S/NO	SOURCES	AMOUNT (NGN)
1	NSHIP	NGN 1,850,000.00
2	EU-UNICEF	NGN 650,000.00
3	OTHER PARTNERS	-
TOTAL		NGN 2,500,000.00

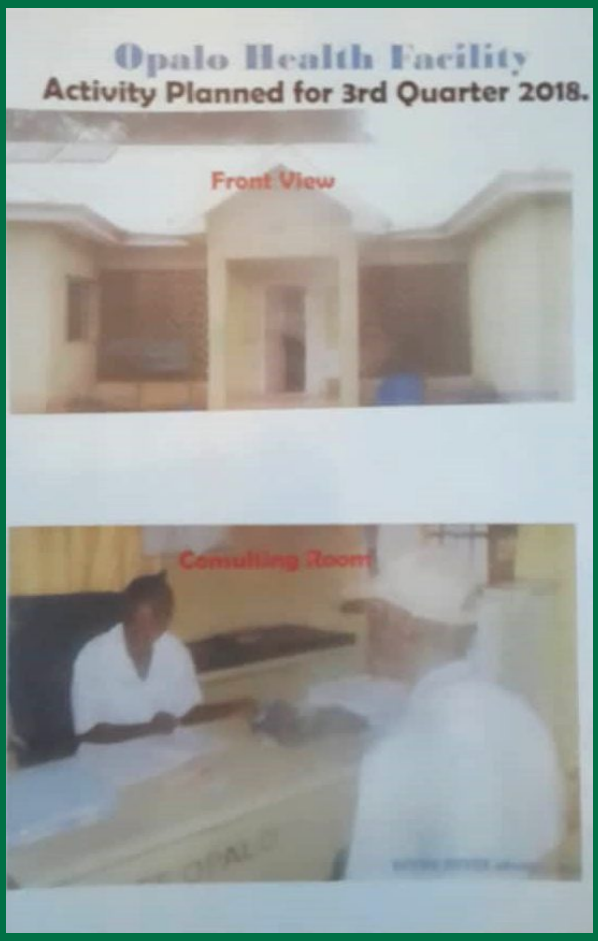


3RD QUARTER JULY – SEPTEMBER, 2018 SPENDING PLAN OF PRIMARY HEALTH CARE AUTHORITY, MICHIKA LGA.

SN	ACTIVITY	RELATED ACTIVITIES	QUANTITY	UNIT COST (₦)	AMOUNT (₦)	SUB TOTAL (₦)
1	Logistics	Fuelling & Maintenance of Hilux, Sienna Bus, Ambulance & Starlet	400/ltrs/month x 3=1,200ltrs	150/ltr	180,000	642,000
			4 gal of Quartz 7000 engine oil	9,000	36,000	
		Filters for vehicles	4 units filter	1,500	6,000	
		Repairs of Ambulance and Sienna Bus	-	86,000	86,000	
		Tyre for Starlet	4	18,000	64,000	
		Other services	-	30,000/m	90,000	
		Transportation of drugs & other health commodities	-	180,000	180,000	
2	Meetings & Trainings	Monthly Review meeting	Entertainments & logistics	70,000	210,000	262,000
		1day refresher training of LGA stakeholders	Entertainments & logistics	52,000	52,000	



	Nutrition FP	Quarterly	5,000	5,000	
	DSNO I	Quarterly	5,000	5,000	
	DSNO II	Quarterly	5,000	5,000	
	LACA	Quarterly	5,000	5,000	
	Store Officer	Quarterly	5,000	5,000	
	Soc. Welfare Officer	Quarterly	5,000	5,000	
Contract Staff	Computer Assistant	Monthly Allowance	15,000	45,000	
	Night Watchman	Monthly Allowance	5,000	15,000	
	Cleaner x2	Monthly Allowance	15,000 x2	90,000	210,000
	Driver	Monthly Allowance	20,000	60,000	
Bank charges	COT, VAT on COT, SMS Alert				4,000
TOTAL					2,489,800



OPALO HEALTH FACILITY

INCOME FOR 2ND QUARTER 2018.

INCOME

DFF Subsidy	-	N638, 894.00
Revenue on Drugs	-	N6, 000.00
ANC/OPD Card	-	N2, 000.00
Total	-	**N646, 894.00**

- Receipt of each expense should be kept with receipt number to enable the SPHCDA to match financial report and receipt.
- SPHCDA will verify the expense by matching the financial report and the receipt, and physically checking the purchased items.

Zone at: PHCA Secretariat Date: 27/03/2018

LGA PHC Executive Secretary/Coordinator

Signed

Mrs./Mr./Dr: Mary I. Kwatri

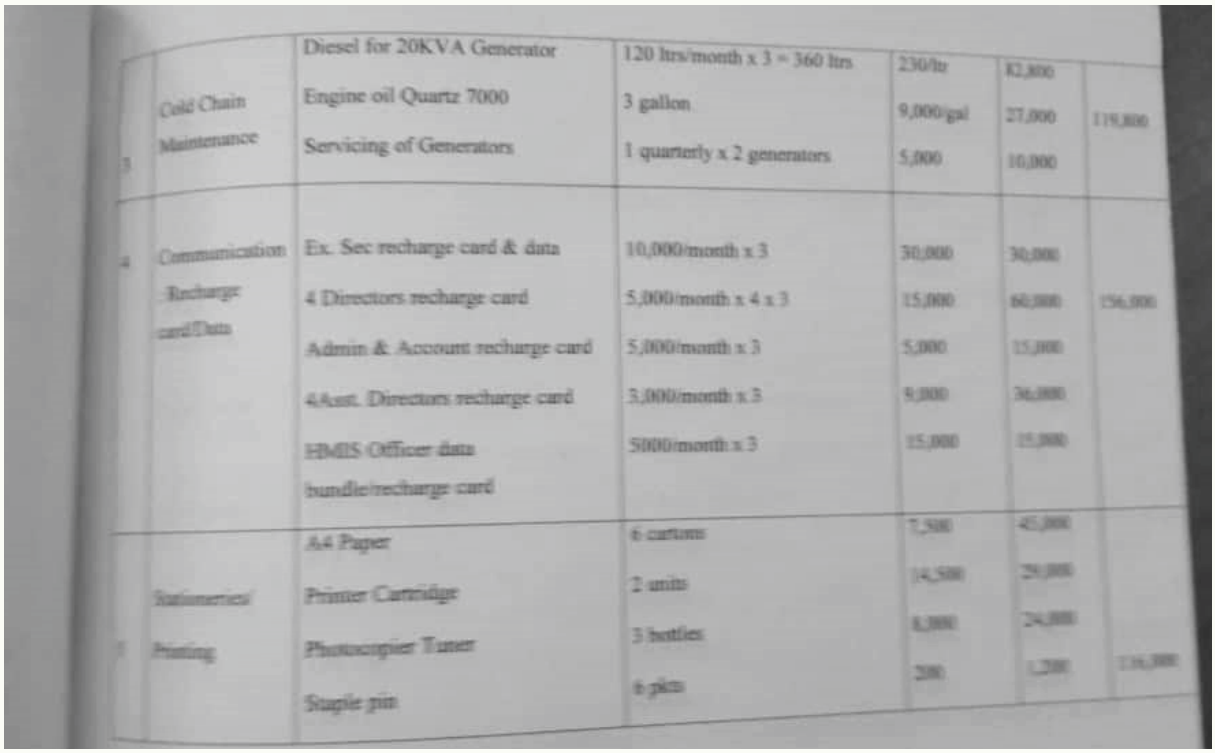
For The State Primary Health Care Development Agency

Signed

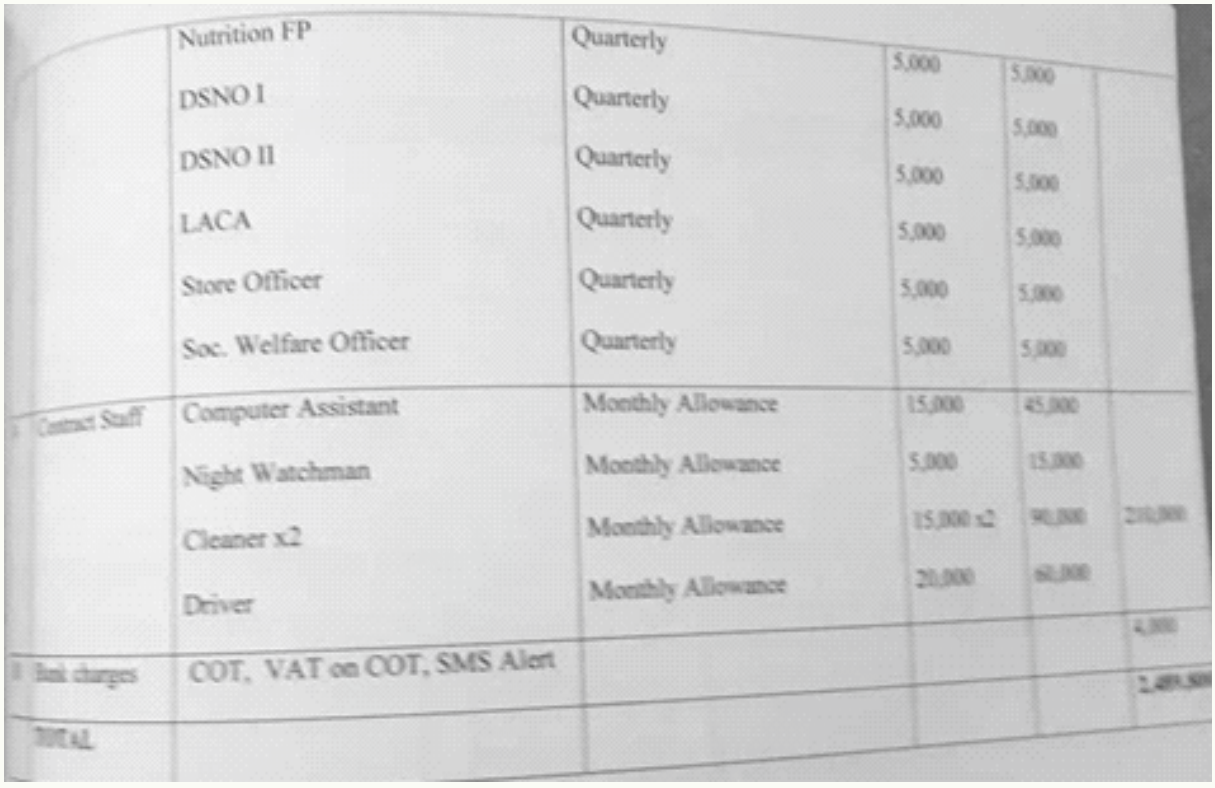
Mrs./Mr./Dr

Executive Chairman

VERIFIED BY:
HM. MAISAJE
16
SIGN.



	Cold Chain Maintenance	Diesel for 20KVA Generator	120 ltrs/month x 3 = 360 ltrs	230/ltr	82,800	
		Engine oil Quartz 7000	3 gallon	9,000/gal	27,000	119,800
		Servicing of Generators	1 quarterly x 2 generators	5,000	10,000	
	Communication Recharge card/Data	Ex. Sec recharge card & data	10,000/month x 3	30,000	30,000	
		4 Directors recharge card	5,000/month x 4 x 3	15,000	60,000	156,000
		Admin & Account recharge card	5,000/month x 3	5,000	15,000	
		4Asst. Directors recharge card	3,000/month x 3	9,000	36,000	
		HMIS Officer data bundle/recharge card	5000/month x 3	15,000	15,000	
	Stationeries/ Printing	A4 Paper	6 cartons	7,500	45,000	
		Printer Cartridge	2 units	14,500	29,000	
		Photocopier Toner	3 bottles	8,000	24,000	
		Staple pin	6 pkts	200	1,200	116,000



	Nutrition FP	Quarterly	5,000	5,000	
	DSNO I	Quarterly	5,000	5,000	
	DSNO II	Quarterly	5,000	5,000	
	LACA	Quarterly	5,000	5,000	
	Store Officer	Quarterly	5,000	5,000	
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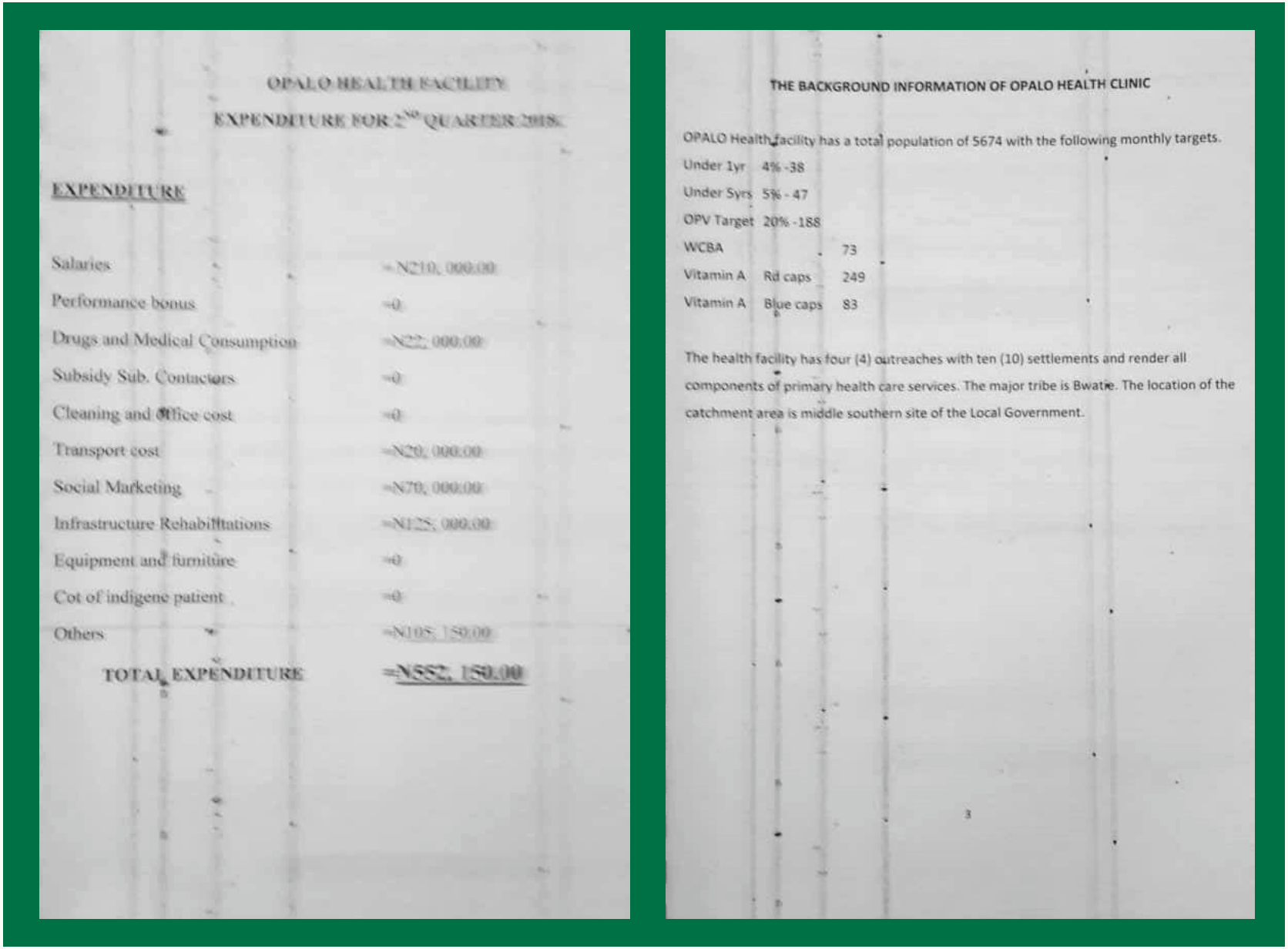
	Cleaner x2	Monthly Allowance	15,000 x2	90,000	210,000
	Driver	Monthly Allowance	20,000	60,000	
	COT, VAT on COT, SMS Alert				4,000
					2,489,800



OPALO HEALTH FACILITY

EXPENDITURE FOR 2ND QUARTER 2018.

EXPENDITURE

Salaries	=N210, 000.00
Performance bonus	=0
Drugs and Medical Consumption	=N22, 000.00
Subsidy Sub. Contactors	=0
Cleaning and Office cost	=0
Transport cost	=N20, 000.00
Social Marketing	=N70, 000.00
Infrastructure Rehabilitations	=N125, 000.00
Equipment and furniture	=0
Cot of indigene patient	=0
Others	=N105, 150.00
TOTAL EXPENDITURE	=N552, 150.00

THE BACKGROUND INFORMATION OF OPALO HEALTH CLINIC

OPALO Health facility has a total population of 5674 with the following monthly targets.

Under 1yr	4% -38	
Under 5yrs	5% - 47	
OPV Target	20% -188	
WCBA		73
Vitamin A	Rd caps	249
Vitamin A	Blue caps	83

The health facility has four (4) outreaches with ten (10) settlements and render all components of primary health care services. The major tribe is Bwatie. The location of the catchment area is middle southern site of the Local Government.

2. Spending plan:

S/N	Cost Item	Related Activity	Unit cost (Naira)	Quantity (unit)	Subtotal (Naira)
1.	Contract Staff	Skill Staff	50,000	3	150,000.00
		Security	30,000	2	60,000.00
2.	CORPS	-	50,000	-	50,000.00
3.	Construction	Cement	2,800	20	42,000.00
		Cement Blocks	140	500	70,000.00
		Iron Rods	1,500	10	15,000.00
		Water	40,000		40,000.00
		Gravels	59,000	1	59,000.00
4.	Generator/Fuel	Maintenance of Generator	20,000	-	20,000.00
5.	Social Marketing	Social Marketing	30,000	-	30,000.00
6.	Laboratory	Laboratory Maintenance	50,000	-	50,000.00
7.	Monthly Meeting	-	10,000	3	30,000.00
8.	Transportation	-	13,000	-	13,000.00
9.	Others	-	10,000	-	10,000.00
	Total				**639,000.00**

Note:

- Receipt of each expense should be kept with receipt number to enable the SPHCDAA to match the financial report and receipt.
- SPHCDA will verify the expense by matching the financial report and the receipt and physically checking the purchased items.

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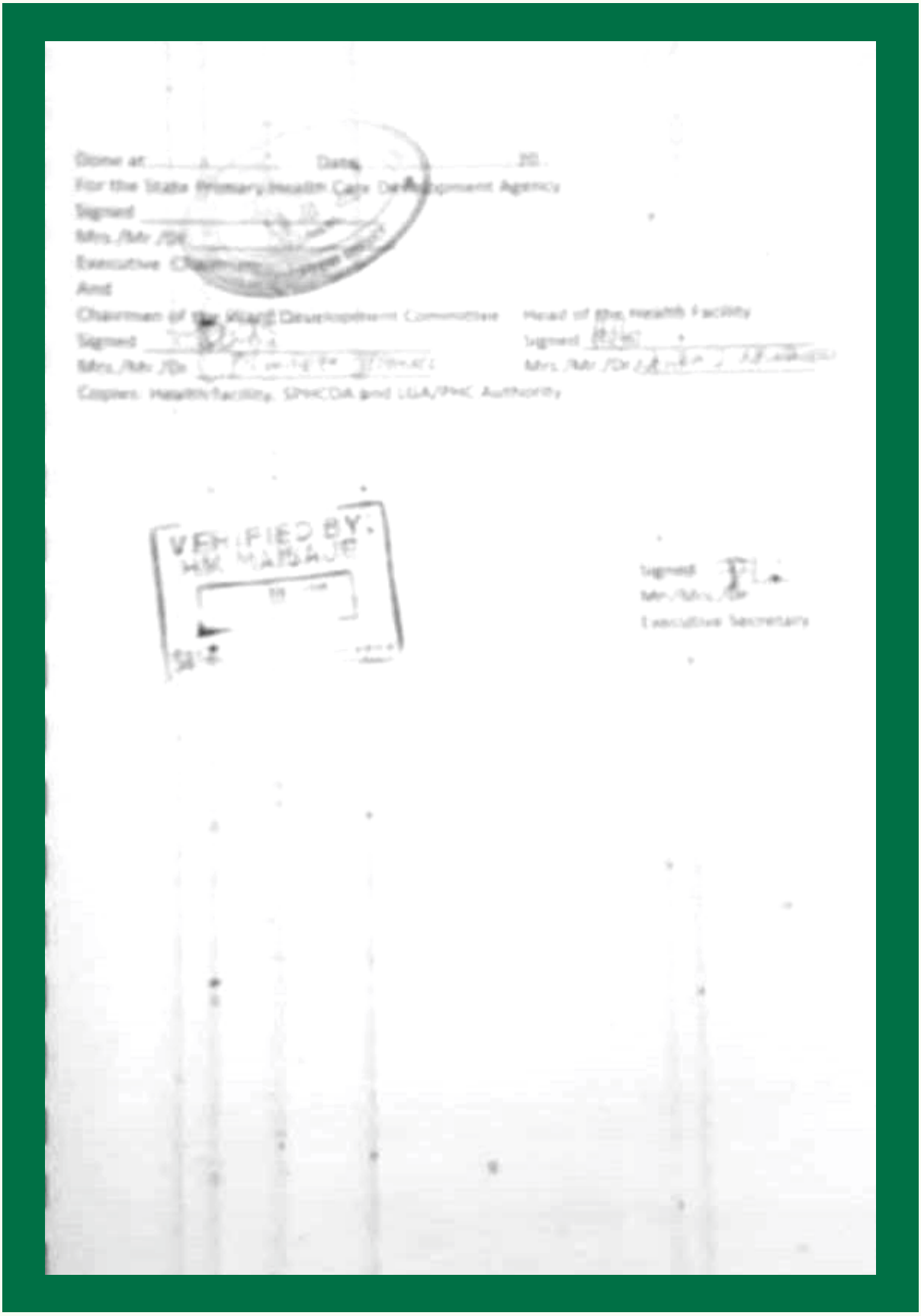
ADAMAWA STATE PRIMARY HEALTH CARE DEVELOPMENT AGENCY

ACTIVITY PLAN FOR DHS FACILITIES FROM JULY-SEPTEMBER 2018.

L.G.A: LAMURDE HEALTH CENTER: OPALO POPULATION2018:11273

1. List of activities planned for the Quarter to improve utilization and quality of the facility.

S/N	Activity	Due Date	Responsible Staff	Remarks
1.	Contract Staff	JULY-SEPT.	In-charge	Ongoing
2.	CORPS	JULY-SEPT.	In-charge	Ongoing
3.	Construction (Fencing)	JULY-SEPT.	WDC	Ongoing
4.	Generator	JULY-SEPT.	In-charge	Ongoing
5.	Social Marketing	JULY-SEPT.	In-Charge/WDC	Ongoing
6.	Laboratory	JULY-SEPT.	WDC/In-charge	Ongoing
7.	Monthly Meeting	JULY-SEPT.	In-charge/WDC	Ongoing
8.	Transportation	JULY-SEPT.	WDC/In-charge	Ongoing
9.	Others	JULY-SEPT.	WDC/In-charge	Ongoing



Done at ..... Date ..... 20..

For the State Primary Health Care Development Agency

Signed .....

Mrs./Mr./Dr. .....

Executive Chairman

And

Chairmen of the Ward Development Committee

Signed .....

Mrs./Mr./Dr. .....

Head of the Health Facility

Signed .....

Mrs./Mr./Dr. .....

Copies: Health facility, SPHCDA and LGA/PHC Authority

VERIFIED BY:
HSC MAIDUGURI

Signed .....

Mr./Mrs./Dr. .....

Executive Secretary

ADAMAWA STATE
PRIMARY HEALTH CARE DEVELOOPMENT AGENCY © 2020