



# Ensuring that target-driven funding supports and does not harm comprehensive primary health care in east and southern Africa

## Why did we explore this issue?

Primary Health Care (PHC) has inspired and galvanized action on health. PHC affirms that health is a state of complete physical, mental and social wellbeing and not merely the absence of disease and that health is a fundamental human right. Many significant achievements have been made through the participatory, community and local health service interventions in PHC. In various policies and declarations over the past 40 years, African governments have recognised PHC's contribution to improved equitable health and health care in the region and have consistently promised to accelerate efforts to implement it. Our health and health systems in east and

southern Africa have faced many domestic economic challenges and a combined burden of infectious diseases, epidemics and chronic conditions. The costs and share of external funding of our health services have grown and our health systems are increasingly influenced by global policies. In the past decade, global institutions have promoted and channeled external funds through performance based financing (PBF), as a strategy to improve service delivery and access. PBF is the transfer of money or material goods conditional upon taking a measurable action or achieving a predetermined performance target. PBF thus linked payments to facilities and health workers to the achievement of specific measurable service outcomes. For health ministries,

there were concerns over a 'one size fits all' approach and siloing of particular services and workers funded. Yet PBF was seen to bring new funds for services, health workers and information systems and potential ways to ensure and show powerful finance ministries that funds were being 'efficiently' used to improve particular health goals.

While there have been studies on whether these particular services targeted under PBF have improved, there has been little systematic evaluation of its system-wide effects, nor of its impacts on comprehensive PHC. In EQUINET, we thus saw it to be important to ask:

**How is the use of targets in PBF affecting health workers' professional roles, work and interaction with communities and their ability to deliver comprehensive PHC?**

## How did we explore this question?

We came together under the umbrella of the Regional Network for Equity in Health in East and Southern Africa (EQUINET) and with review input from our network on participatory action research (the pra4equity network) to address this question. We wanted to understand the effects of PBF on PHC from those most directly involved, the health workers at the primary care facilities and the communities and health centre committees (HCCs) in their catchment areas.

We used a participatory action research (PAR) approach where those directly affected collectively validate, analyse and act on their experience and reality to identify problems, their causes and responses for them, and to act and learn from action to produce new knowledge. As PBF is being implemented in many ESA countries, we implemented this PAR online, to enable the sharing of experience and analysis at regional level. Training and Research Support Centre and Maldaba developed an online platform for a protocol

for this PAR, piloting it as an innovation. We called the process *PARonline*.

**In 2018-2019 the PAR involved 21 online participants from seven sites in five ESA countries, including health workers from primary health centres, community members in HCCs and country site facilitators from seven national health civil society organisations in the region, referred to in this brief collectively as the 'online participants'. We also included offline local discussions with an average of 19 community members and 15 health workers per site.**

PAR seeks to understand and improve the world by changing it. We thus made proposals for changes to address problems or strengthen positive features and engaged with facility managers, district and national health authorities covering these primary care sites on the feasibility and uptake of these proposals. We applied the ethical principles for PAR adopted by EQUINET and obtained authority from the health ministries and consent of those involved.

## What are the local experiences of PBF and PHC?

The online participants valued having local PHC services close to the community and particularly saw prevention, promotion, early



*Community nutrition activities like this one in Tanzania do not usually get target funding in the region. Source: M Pixel, undated, creative commons*

detection and continuing care services as important. Health issues in the sites were seen to demand outreach, involving community health workers (CHWs) and cooperation with other sectors. However we also noted that local health services mainly focus on facility-based and curative care and face shortages of health workers and supplies.

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“Lack of adequate health workers...drug stock-outs, compounded by power-black-outs, water-shortages, long distances to health facilities, all these hamper PHC. We have a long way to go.”

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All the PARonline sites had a form of PBF. Across all, the targets were mainly for facility-based treatment and care for reproductive health, HIV, maternal and child health and tuberculosis. These are common conditions. However, there were few or no targets for equally common chronic conditions, or for service outreach and community level prevention, for community and CHW roles, or for the competencies and supplies for these services. Areas that don't have targets were seen to be underfunded or ignored, especially when PBF is a large share of total facility funding. This underestimates their importance in PHC. Pooled domestic funding could cover these areas, yet it was noted to be falling. It was also felt that not everything that is important, like trust or meaningful participation, can be put into a numerical target.

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“Service areas that do not have funding linked to targets are neglected by health workers and this can lead to complications in patients”

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For health workers, the increased funding and income was appreciated, as was the training and strengthened service monitoring in PBF. Personnel directly benefiting from incentives were happier, but laboratory, pharmacy, clerical and ground staff and HCC members who did not benefit were not. When the distribution of PBF benefits was seen to be unfair, such as junior personnel getting lower incentives despite longer working hours, it affected working relations. Communities reported having more information on and resources in services from PBF. However, the services not included in PBF were costly, as people had to purchase them privately and having some services funded and some not caused confusion. The pressure on achieving numbers was observed to reduce health worker-patient time. Local health workers and HCCs reported having little role in setting targets and that there was no flexibility to address local priorities. There was concern over 'glueing' health worker motivation to incentives, over exclusion of key service areas and over the sustainability of the external funding for PBF.

Communities and local health workers felt that if they had more say, they would fund prevention and management of chronic conditions; health education and environmental interventions, resources for village health teams, CHWs and community outreach; promotion of adolescent health, BCG/OPV vaccination of newborns, nutrition promotion and interventions on gender-based violence.

While our contexts and some dimensions of the way PBF is applied may vary, we were struck by how common our experiences and issues have been relating to PBF and PHC. We identified actions to address the positive and negative impacts that we saw to be most important for comprehensive PHC. We then discussed our proposed actions with local health workers, communities, CHWs, HCCs and health facility managers, with district health authorities and national health officials in our respective countries.



Communities and health workers would want to see more funding for health education programmes like this YDF health education for youth in Lusaka. Source: S Blume, 2012, creative commons

These constituencies generally welcomed the proposals. While the positive features and coverage improvements were noted, there were shared concerns on the short term focus on PBF and that incentives can send incorrect signals to health workers and make services too supply driven. Inadequate domestic funding was seen to pose challenges for harmonising PBF and other separate funding streams with national system goals and strategies, including for PHC.

“ Government has the obligation to fulfil people’s right to health and not external funders. ”

## What can we do to address these impacts of PBF on PHC?

The way PBF is being implemented does not deliver comprehensive PHC. While aiming to strengthen bottom-up accountability in services, neither health workers nor community members felt empowered by PBF, feeling their views and evidence to

be disregarded and seeing themselves as implementers of targets defined at higher levels.

There were real trade-offs between PBF and the way comprehensive PHC is funded and delivered. Being selective can be efficient, but can also leave gaps in the system. Unless domestic and external funders - including from PBF resources - fund the wider collective inputs for facilities and include promotion and prevention in the community, we will not improve population health. This calls for improved domestic funding for PHC, including to address any gaps. It also implies that PBF, as a significant funding stream, integrate resources and measures for these system inputs and for more holistic health services.

We thus identified **four major areas of action and ten proposals** within them for PBF to enable and not detract from PHC.

The proposals are summarised here and the full details can be found in our report [‘How does target-driven funding affect comprehensive primary health care in east and southern Africa?’](#)

## 1: PBF should enable and not impede health services being person-centred, integrated and holistic

For sustained improvements to health we need to apply a people-centred, rights-based approach, reaching into community settings for health promotion and prevention, defining and resourcing all the essential PHC services. PBF should enable this.

It should be aligned to PHC and to the national health strategy. For community and primary care services to be an effective and accessible entry point for the health system, the funding and provision of services supported by PBF should align to and be harmonized with all services, included those not funded by PBF, so that frontline services respond to all major health burdens.

This also means funding, including from PBF related resources, areas that have been neglected and locally identified priorities. These include prevention, early detection and care of non-communicable diseases, disease surveillance, prevention and management of outbreaks, together with health sector roles in community health and in addressing social determinants of health, like gender-based violence.

“ It’s good that we are at least addressing these health problems at health centres but we need to do better than this by taking it to the people. We need to focus more on the promotive and preventive ... which should be done in and with the communities through outreach. ”



Matero compound, Zambia, Idah Zulu, 2009

## 2: Improve domestic financing for PHC and reduce dependency on external funding

We should ensure sustainable, equitable domestic health financing of all PHC services at community and primary care level and not rely on external funding for this. This calls for evidence to cost and support negotiations on funding these services equitably.

The resources are there within the total health spending in our countries. We need to mobilise them using progressive and earmarked taxes and mandatory insurance, and our finance ministries should meet the Abuja commitment on 15% government budgets to health.

Where we use performance funding, the facilities need to be resourced to address

“ PHC is all essential and should have constant funding. All PHC services whether preventive or curative should be funded domestically, including for sustainability. ”

gaps and meet the service needs and inputs to achieve these goals. Payments to facilities and personnel should be done in good time, paid fairly to all in line with their work, with continuous review of any financial and non-financial incentive measures.

We should put in place measures to avoid unpredictable funding and where external funding is applied, ensure continuity when it stops.



Primary care health centre, Uganda. Source: R Namukisa, 2019

### 3: Ensure earlier and more meaningful consultation of the local level of health systems and their involvement in decisions, including on PBF

While HCCs have been involved in PBF, they should be formally recognized in law, with resource and training for HCCs, CHW and community roles in PHC, including from the resources for PBF. HCCs and CHWs can provide valuable input to and should be involved in health facility review meetings.

Where performance targets are used, don't impose the targets! Involve and listen to health workers, communities and local managers when planning, budgeting, setting and regularly reviewing decisions on these targets, and give some flexibility in funding for local priorities.



Community health workers in Malawi. Source: USAID, 2009, creative commons

Strengthen information and accountability not just on targets, but on what funds have been received, what has been achieved with the funds and what measures are in place to sustain key services.

“ The funds for CHWs need to come from the state. If an external funder feels like giving money to the CHWs it should be as additional incentives. CHWs are vital in the health sector as they are the ones with people at the doorsteps. They are the ones who do all the donkey work of the information flow between the community and the facilities.”

### 4: Ensure training and capacity support for PHC

Delivering accessible, effective and relevant PHC and taking advantage of the primary care and community services and personnel that are close to communities calls for investment in those people who produce the change. This means ensuring regular training, supervision and support for all health personnel, CHWs and HCCs and non-financial incentives that show they are valued as people and help them to do their work, like decent accommodation, leave days and insurance.

PBF funding should, with other resources, include support for this and for the necessary resources for professional roles, including scholarships and information links for career development and the medicines, equipment, supplies, information technology, energy supplies and supportive supervision and processes for quality improvement of all services at local facilities.

## What next? What can you do?

Our PARonline research showed that those directly affected by international policies that are being applied across our countries can generate evidence, learning and proposals for change, and we are reviewing how we can improve and use it in the future. We have discussed the findings and proposals on PBF and PHC outlined in this brief with the communities, facility personnel and managers, district and national health authorities covered by the research and integrated their feedback. We are following up with them.



*Discussing next steps at the August regional meeting, TARSC, 2019*

As **district and national health authorities and funders**, in addition to the general proposals raised in this brief, you could:

- a. Use needs and workload assessments and population evidence to advocate for funding needs and for equitable resource allocation, and show the costs of poor domestic financing.
- b. Adequately fund PHC services from progressive and earmarked taxes and mandatory insurance as pre-payments based on ability to pay, complemented by private sector payments and community labour and material contributions.
- c. Ensure external funding complements and does not substitute domestic financing, avoid unpredictable funding and plan measures for sustainability when external funders stop.
- d. Ensure that PBF is aligned to PHC, to the national health strategy and to demand-driven programmes. Annually review PBF targets and include facility investments in PBF.
- e. Set and implement guidelines to harmonise or integrate PBF with other funding and services, with flexibility to respond to local conditions. Inform health workers, HCCs and communities on funds disbursed to facilities and on measures for sustaining key services when external funding stops or is reduced.
- f. Promote legal and policy recognition and train and support HCCs and CHWs.
- g. Conduct regular training for health personnel; fairly distribute incentives between all at facilities in line with workloads; promote team work and improve supportive supervision for facilities in line with a clear service package and standards.

To read the full report this brief is based on please see "How does target-driven funding affect comprehensive primary health care in east and southern Africa? EQUINET" at [www.equinet africa.org/sites/default/files/uploads/documents/PARonline%20Report%20September2019.pdf](http://www.equinet africa.org/sites/default/files/uploads/documents/PARonline%20Report%20September2019.pdf)

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