How does target-driven funding affect comprehensive primary health care in east and southern Africa?

Report of online participatory action research

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Table of Contents

Summary…… **3**

1. Background: The emergence of online PAR **5**

2. Methods: The protocol and online process **6**

The protocol 7
The web design 9
Ethical procedures 10

3. Initiating the PAROnline process **10**

4. Systematising our experience of PHC and PBF **11**

Understanding and sharing views on primary health care 11
Sharing experience on target driven approaches 14
How do targets link to resources? 16

5. Analysing experiences of PBF **19**

Health worker experience of target driven approaches 19
Impact of target driven approaches 21

6. Actions to address the impacts of PBF **23**

Prioritising impacts of target driven funding / PBF 23
Identifying actions for the priority impacts of PBF 25
Common issues across the groups 29

7. Implementing and reviewing engagement on our findings **31**

Reviewing the feedback on our proposals from the local and district level 31
Reviewing the feedback on our proposals from the national level 33

8. Our proposals on PBF and comprehensive PHC **35**

A: PBF should enable person-centred, integrated and holistic services 35
B: Improve domestic financing for PHC and reduce dependency on external funding 36
C: Ensure earlier and more meaningful involvement of the local level of health systems 36
D: Ensure training and capacity support for PHC 37

9. Our reflections and learning from doing PAR online **38**

The positive experiences and reflections 38
The challenges 39
Suggestions on next steps 40

Appendix 1: Proposed actions to engage on the findings **41**
Appendix 2: Features of PHC **49**
Appendix 3: Targets relative to PHC features **50**
Appendix 4: Impacts of PBF on PHC **52**
Appendix 5: Progress markers on our actions **54**

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Acknowledgements and roles

The EQUINET online participatory action research (PAR) on how health targets affect comprehensive primary health care in east and southern Africa has involved many people at different stages. We acknowledge and thank all!

1. The initial idea was framed by Rene Loewenson, TARSC in October 2014.
2. An online search was implemented of whether any other web platforms met the criteria for the full features of participatory action research (PAR) (none were found that did this in full) and the findings and initial ideas, suggestions of how to connect with the existing pra4equity network in EQUINET and suitable theme areas were discussed at an EQUINET meeting in December 2014 and with the east and southern African participants in the pra4equity network, together with the health equity research questions that would have relevance across countries in the region for TARSC to develop a draft PAR protocol.
3. At the same time extensive discussions were held in 2015 between Rene and Lorenzo Gordon, Maldaba on how a PAR protocol could be realised online, bringing together the two different worlds of PAR and its intense collective dialogue with the precise innovative world of web design for PARonline. Rene and Lorenzo jointly developed a proposal for putting this online PAR protocol into practice.
4. We engaged with colleagues at OSF and OSIEA, particularly Dhananjay Kakde, Sharmila Mhatre, Aggrey Aluso and Emmanuel Kamonyo and were supported by a grant from OSF and OSIEA, with further resources committed by TARSC, Maldaba, and all the individuals and organisations involved.
5. TARSC worked on the protocol, facilitator guide, and made text, design and review input to the online website, led by Rene with review input from Barbara Kaim and colleagues in the pra4equity network and artwork from Adam Kirby. The Maldaba team- Lorenzo, Mark Clements and Karen Ximenes - worked on the site. Rene and Lorenzo interacted intensively over a year to June 2018 to prepare the site, with the site testing by Rene, the Maldaba team, Barbara, Mevice Makandwa and Pelagia Nziramwoyo.
6. Rene liaised with the sites to prepare their teams, ethical clearances and gather background information to input to the work. The country site facilitators provided able engagement on this: Caleb Thole Global Hope Mobilisation, (GHP) Malawi; Wilson Asibu, Country Minders for Peoples Development, (CMPD) Malawi; Greysmo Mutashobya, Health Promotion Tanzania (HDT), Pelagia Nziramwoyo, Centre for Youth Driven Development Initiative (CYDDI), Uganda; Francis Serunjogi, Center for Health Human Rights and Development (CEHURD), Uganda, Idah Zulu, Lusaka District Health Office (LDHO), Zambia; Edgar Mutasa, Community Working Group on Health (CWGH), Zimbabwe. We acknowledge the leadership of the organisations they work in.

7. A regional EQUINET workshop in January 2018 was held with support from OSEA/OSF to introduce the PAR process and research, test the website design and discuss feedback on both.
8. The PAR online process was implemented from July –December 2018. The facilitators were Rene and Barbara at TARSC. The participants were from Malawi: Caleb Thole, GHM, Anastazia Mercy Moyo. Kochilira Health Centre, Thoko Kabango, Kochililira Health Centre Committee, Wilson Asibu, CMPD, Peter Kalolo, Monkey-Bay Community Health Centre, Nduzayani Machilika, Health Action Committee Monkey-Bay; from Tanzania: Greysmo Mutashobya, HDT, Bakari Kijuu. Mataya dispensary, Bagamoyo, Kivuli Omary Abdallah, facility health committee, Bagamoyo; from Uganda: Pelagia Nziramwoyo. CYDDI; Josephine Nassanga . Kasangati HC IV Wakiso, Sarah Nampewo. health unit management committee, Kasaganti HC IV; Francis Serunjogi, CEHURD, Rita Namukisa, Buikwe Health Center III, Florence Nakamya, resident Buikwe District; from Zambia: Idah Zulu, LDHO, Angelina Chiwala, Chawama Level 1 Hospital, Conwel Mwakoi. health centre committee Chawama Level 1 Hospital, Lusaka; from Zimbabwe: Edgar Mutasa, CWGH, Itayi Katsande, Mashambanhaka clinic, Headman Tendai Madzukwa, health centre committee, Mashambanhaka. Each site also held four rounds of local discussion with health workers and community members on findings from the online work.
9. This report was prepared as a draft by Rene and reviewed by all involved in the online PAR, including at a review meeting in August 2019, and the review feedback provided integrated in the final report.

Summary

PAR seeks to understand and improve the world by changing it, where those affected collectively validate experience and analysis, act and learn from action to produce new knowledge. While transformative, it is often local in nature. With African health systems influenced by global policies and funds, EQUINET sought to use the internet to implement PAR in multiple countries in east and southern Africa (ESA), as PARonline. Performance based financing (PBF) is one such global process. It is the transfer of money or material goods conditional upon taking a measurable action or achieving a predetermined performance target. There has been little systematic evaluation of the system-wide effects of PBF, nor of its impacts on comprehensive primary health care (PHC). Given the longstanding policy commitment to PHC in the region, our PARonline research thus asked: **How is the use of health targets in PBF affecting health workers professional roles, work and interaction with communities and their ability to deliver comprehensive PHC?**

We involved 21 online participants from seven sites in five ESA countries, including health workers from primary health centres, community members in health centre committees (HCCs) and country site facilitators from national health civil society. We also included offline local discussions with an average of 19 community members and 15 health workers per site.

Participants valued having local PHC services close to the community, noting that they mainly focus on curative care. Participants also prioritised prevention, promotion, early detection and continuing care, involving outreach, community health workers (CHWs) and cooperation with other sectors. Local PHC services were reported to face shortages of health workers, essential medicines and supplies.

All the sites in the PARonline had a form of PBF, with the targets mainly for facility-based treatment and care services relating to SRH, HIV, TB and maternal and child health. These are common conditions, prioritised by government and international funders. We found, however, few or no targets for the chronic conditions, for service outreach and community level prevention, for community and CHW roles and for service competencies, medicines and supplies prioritised in PHC. 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 role in delivery on PHC and on service targets and quality. Pooled domestic funding could cover these areas, yet was noted to be falling.

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 with them. Those who did not benefit, such as laboratory, pharmacy, clerical and ground staff and HCC members, were not. Inequality in the distribution of PBF benefits, where seen to be unfair, was reported to have affected working relations, such as when junior personnel get lower incentives, despite longer working hours. This was not found in facilities which included all workers in target-funded activities.

Communities reported having more information on and resources in services from PBF. They also noted sometimes unaffordable costs for services not included in PBF and some confusion on who benefits when some services are funded and some not. The pressure on achieving numbers was observed to worsen health worker-patient time. Local health workers and HCCs reported having a weak role in setting targets and that targets were inflexible to address local priorities. There was concern over 'glueing' health worker motivation to incentives, over exclusion of key service areas, over the external funder driven nature of PBF and over the sustainability of the funding.

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 child and adolescent health, BCG/OPV vaccination of newborns, nutrition promotion and interventions on gender-based violence.

We identified actions to address the prioritised positive and negative impacts of PBF on comprehensive PHC. We then discussed our proposed actions with local health workers, communities, CHWs, HCCs and health facility managers, with district health authorities and the national ministry of health. The proposals were generally welcomed. While noting the identified positive features of and coverage improvements from PBF, it was seen to have a short term focus and to not always be aligned to national systems and strategies. Difficulties were noted in harmonising differently funded programmes in a context of inadequate domestic funding. There was concern that incentives do not replace fair pay, can send incorrect signals to health workers and can make services too supply driven. While our contexts may vary, we have been struck by how common our experiences and issues have been relating to PBF in our local facilities. We identified four major areas of action and ten proposals within them for PBF to enable and not detract from comprehensive PHC, ***as detailed in pages 35-37.***

A: PBF should enable and not impede health services being person-centred, integrated and holistic. For this, we propose that we:

A1. Apply a people-centred, rights-based approach, reaching into community settings for health promotion and prevention, defining and resourcing all the essential PHC services.

A2. Ensure that PBF is aligned to PHC and to the national health strategy, harmonise and integrate the funding and provision of PBF and non PBF services, and

A3. Fund, included in PBF, neglected areas and locally identified priorities, including non-communicable diseases, management of outbreaks, disease surveillance and health sector roles in social determinants like gender-based violence.

B: We should improve domestic financing for PHC and reduce dependency on external funding. For this, we propose that we:

B1. Provide evidence to negotiate and ensure sustainable, equitable domestic health financing of all PHC services, using progressive and earmarked taxes and mandatory insurance, meeting the Abuja commitment, with external funders not substituting national funding.

B2. Resource facilities to meet PBF service needs, addressing gaps, avoiding unpredictable funding and ensuring continuity when external funding stops, and

B3. Make adequate payments in good time, pay incentives to all in line with their work and carry out continuous review of incentive measures.

C: We should ensure earlier and more meaningful consultation of the local level of health systems and their involvement in decisions, including on PBF. For this, we propose that we:

C1. Formally recognize, resource and capacitate HCC, CHW and community roles in PHC and PBF and involve HCCs and CHWs in health facility review meetings.

C2. Don't impose targets! Involve and listen to HWs, communities and local managers in planning, budgeting and setting decisions on PBF targets, with flexibility for local priorities.

C3. Strengthen information and accountability on funds received, what has been achieved with the funds; and on measures for sustaining key services.

D: We should ensure training and capacity support for PHC. For this, we propose providing regular training, non-financial incentives, supervision and support for health workers, CHWs and HCCs and provide from PBF or other funds, the necessary resources, supportive supervision and processes for quality improvement of all services at local facilities.

The current application of PBF falls short on comprehensive PHC. While aiming to strengthen bottom-up accountability in services, neither HWs 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. We observed 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 PBF funds the wider collective inputs for facilities and includes promotion, prevention in the community, we will not improve population health. This calls for improved domestic funding to meet gaps in PHC. 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 have reviewed our pilot and how we can improve and use it in the future. This pilot has shown that it is possible to generate useful learning across countries in an online PAR, opening new possibilities for using PAR in and beyond our region, to transform our health and wellbeing.

1. Background: The emergence of online PAR

In PAR those most directly affected by conditions actively participate in data gathering, analysis, in debating policy reforms and monitoring their implementation. It involves developing, implementing, and reflecting on actions as part of the research process to build new knowledge, through a spiral of repeated cycles of the systematic steps. PAR seeks to understand and improve the world by changing it, where those affected by problems collectively act and learn from action to produce new knowledge. The Regional Network for Equity in Health in East and Southern Africa (EQUINET) has since 2005 built a learning network on PAR in east and southern Africa (ESA), and a pra4equity mailing list for this network. This PAR work has generated equity oriented changes and transferable insights. The findings are, however, often limited by their locally specific nature. This can be problematic in a context where African health and health systems are increasingly affected by global policies and processes. The internet offers an opportunity to overcome this local specificity. Crowdsourcing has been used to draw local evidence into global processes and online courses to disseminate information globally. However, these processes do not facilitate the collective analysis, action and review by affected communities. Current e-platforms include some PAR processes, but not include all.

As EQUINET, we proposed to use the internet to implement PAR regionally, to build evidence, analysis and learning from action on global processes that affect our health and wellbeing across ESA countries. In 2014 and 2015 we discussed this in various regional forums and in the pra4equity network, to identify an area of focus that is relevant to many ESA countries, to local health workers and communities. We identified performance based financing (PBF), also called results based funding.

PBF is “the transfer of money or material goods conditional upon taking a measurable action or achieving a predetermined performance target.” There are two types of target-linked funding:

- Type 1: Narrow targets based on payment for services or outcomes
- Type 2: Targets based on broader health system indicators or outcomes

Many ESA countries and external funders implement Type 1 targets (eg number of deliveries) as Type 2 targets (such as retention or continuity of care) are more difficult to measure.

ESA countries face a demand to address resource constraints in their health services, especially in the face of a double burden of communicable and non-communicable diseases. As found in a systematic review by Witter et al., 2012, PBF has been proposed as one strategy to respond to these demands and improve service delivery. This research does not intend to systematically explain the motivations for the adoption of PBF. However, PBF did come with substantial financial support from external funders bringing new resources for health facilities, especially at primary care level. This, with the strengthening of information systems for monitoring the use of the funds, aligned to ministry of health goals for improved health care, while the use of type 1 targets aligned to ministry of finance concerns to show efficient use of funds.

Research in EQUINET and reviews such as that by Eijkenaar et al., 2013 suggest that on the positive side, PBF has curbed corruption, supported innovation, focused attention on certain issues to support delivery of global development goals and put money into services. It has led to better monitoring and has given local health centre committees (HCCs) a means to hold services accountable on delivery. On the negative side, it has been noted to be top-down, bureaucratic, ‘one size fits all’, with no flexibility for local issues. There is, however, little systematic evaluation of the system-wide effects of PBF, nor of its impacts on comprehensive primary health care (PHC), despite the longstanding policy commitment to PHC in the region.

EQUINET and the pra4equity network thus proposed implementing PAR online across ESA countries, with the research question below to explore the impact of PBF on PHC.

How is the use of health targets in performance-based financing affecting health workers professional roles, work and interaction with communities and their ability to deliver comprehensive primary health care?

Specifically we would ask:

a. What is the experience of local health workers and communities with PBF?
b. How has it impacted on professional roles, working conditions and team work in primary care?
c. How has it affected the relationship between health workers, the community and HCCs?
d. How has it affected the ability of both to deliver comprehensive PHC?
e. What has been the response to these issues from health workers, communities and HCCs?

We proposed to apply PAR online to add new evidence and learning from the lived experience of local level health workers and communities. We aimed to do this in a way that would link analysis, action and learning *by those directly affected* in ESA countries. We also aimed to collectively involve primary care health workers, HCCs and communities in multiple countries in the region in one multi-country PAR process using a web platform. This first round thus piloted ‘PARonline’ as an innovation in information technology. We deliberately did this within our pra4equity network in ESA, as a regional network with shared values of equity and social justice and PAR capacities to deliver on these values.

EQUINET took this forward in 2017 to 2019. TARSC, working with colleagues in the pra4equity network, designed a PAR process to address these questions and to learn from engaging on the findings. TARSC worked with Maldaba UK to develop a web platform to implement this PAR process online, together with offline local discussions. The earlier *Acknowledgement and roles* section details the individuals and institutions involved in this and what they did.

This report provides the evidence from this first use of PAROnline. It is a resource from which we are drawing information for other briefs and media we are preparing to engage on the work. It provides the methods, findings, key proposals and reflections on implementing PAR online.

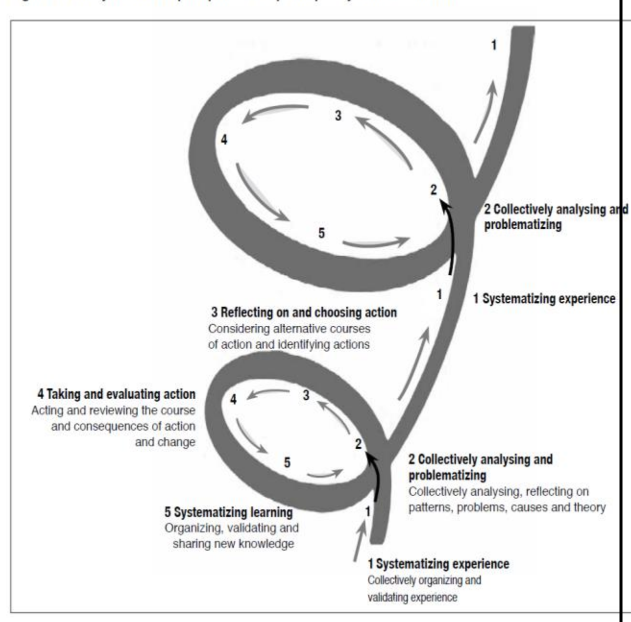
2. Methods: The protocol and online process

PAR has several key features: Those who directly experience a problem are the main source of information, are the lead actors in producing knowledge and using it for action and change, with a trusted facilitator. It involves developing, implementing, and reflecting on actions as part of the process of building new knowledge. PAR seeks to understand and improve the world by changing it, where those affected collectively act and learn from action to produce new knowledge. PAR is transformative.

PAR does this is through a spiral of repeated cycles, where each round of learning from experience and action becomes the input to a new round of collective inquiry. The PAR process follows steps to:

1. Systematize local experience, to organize people’s lived experience and situation.
2. Collectively analyse this experience and identify problems and their causes.
3. Reflect on the experiences and views of problems and their causes to choose actions that will address the problems.

Figure 1: The cyclical and spiral process of participatory action research



Source: Loewenson et al., 2014

4. Take action, and review the changes produced to learn from the actions.
5. Use the learning to produce new knowledge.

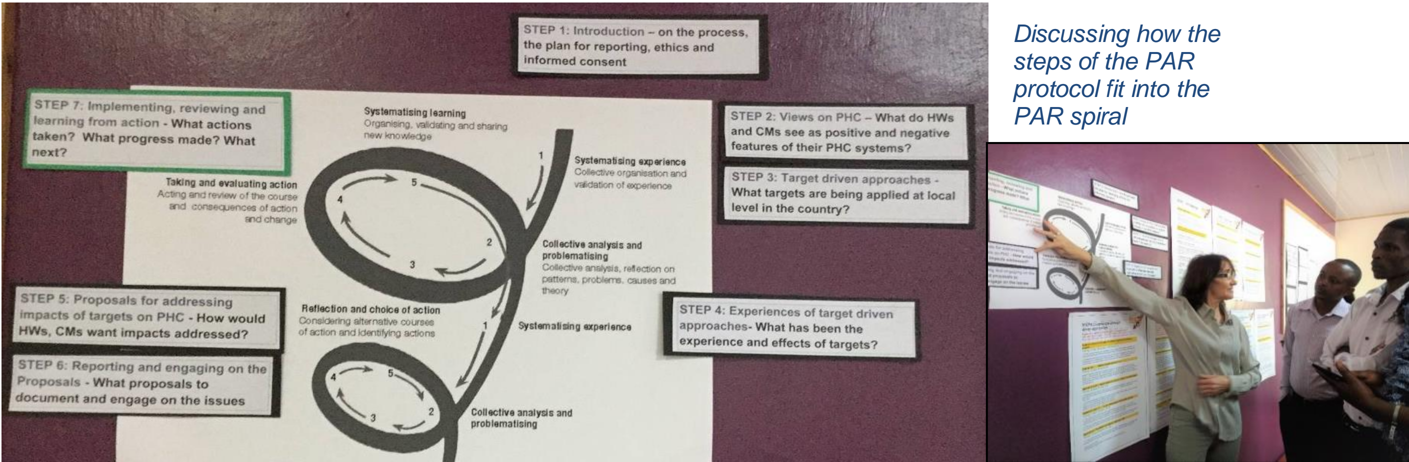
For more detail on PAR please read the Methods Reader on PAR in Health System Research and the toolkit on Organising Peoples Power For Health and hyperlinks in the text to other resources.

The protocol

The protocol was developed by TARSC and reviewed with facilitators and site teams and then with Maldaba for what was feasible online. The final protocol is summarized in *Table 1* overleaf. The steps in the research match the stages in the PAR spiral, as shown in *Table 2* below. The PAR tools included: market place; ranking and scoring; card sorting; smiley ratings, plenary and group discussions.

Table 2: Research steps in relation to stages of the PAR spiral

Stage of the PAR spiral	PAR protocol step
Preparation	Step 1: Introduction
Stage 1: Systematising experience	Step 2: Views on PHC, Step 3: Target driven approaches
Stage 2: Collectively analysing	Step 4: Experiences of target driven approaches
Stage 3: Reflecting and choosing action	STEP 5: Proposals for addressing impacts of targets on PHC STEP 6: Reporting and engaging on the proposals
Stage 4: Taking and evaluating action	STEP 7: Implementing, reviewing and learning from action
Stage 5: Systematising learning	STEP 8 Online review and August 2019 meeting



Discussing how the steps of the PAR protocol fit into the PAR spiral

The process involved as *online participants*:

1. **Health workers from a primary health centre.** In each site one health worker participated online and communicated offline with other health workers in their health centre.
2. **Community members (in HCCs) from the primary care centre.** In each site one community member in the HCC or having good links with the community participated online and communicated offline with other community members in the health centre catchment.
3. **Country site facilitators** from national health civil society who participated online and also supported the participation of the health worker and community participants in their site.

There were 21 online participants from seven sites in five ESA countries (see *Table 3)*. Offline local discussions involved an average of 19 community members and 15 health workers per site.

Table 3: The sites and organisations for the PARonline

Country, lead organisation and site
MALAWI Global Hope Mobilization, Kochilira health centre, Mchinji District
MALAWI Country Minders for Peoples Development, Monkey-Bay Health Centre, Monkey-Bay, Mangochi
TANZANIA Health Promotion Tanzania (HDT), Mataya Dispensary Pwani Region, Bagamoyo District
UGANDA Centre For Youth Driven Development Initiative, Kasangati HC1V Kasangati Town Council
UGANDA Center for Health Human Rights and development Buikwe Health Center III
ZAMBIA Lusaka District Health Office, Chamwa level 1 hospital, Lusaka urban
ZIMBABWE Community Working Group on Health, Mashambanhaka clinic, UMP district

Table 1: The PAROnline protocol

TIMING	STEP AND QUESTION	SESSION AND METHOD	FACILI-TATOR
2018			
July 12-27	**STEP 1 Introduction**	1.Introductions 2. Information on the project aims 3. The PAR process; 4. Reporting the work 5. Summary of the ethical principles in PAR. 6. Discussion and sign off on informed consent	RL
July 28-30	**STEP 2: Views on PHC:** Health worker, HCC views on features of their PHC systems	1.Introduction on comprehensive PHC	RL
Jul 31-Aug 13		2. Local discussion: features of own PHC services	RL
		3. Features of PHC: inputs to charts	BK
Aug 14-16		4. Ranking positive and negative features (x 2)	BK
Aug 17-21		5. Facilitator summary and sign off	BK
Aug 22-28	**STEP 3: Target driven approaches** What target driven approaches are being applied at local level in the country?	1. **Explanation of 'performance targets'** 2. Cards documenting targets being applied 3. **Targets vs PHC -** cards on PHC features x 3	RL
Aug 29- Sep 4		4. Plenary on services covered (dots) Collective results on funder/community targets	RL
Sep 5-18		5. Plenary discussion on services covered: Q1. Which areas are / are not linked to funding? Q2. Which areas do communities have a say over? Q3. What exceptions, flexibilities for local contexts,?	BK BK
Sep 19-25		6. Facilitator summary of main points, sign off	RL
Sep 26-Oct 1	**STEP 4: Experiences of target driven approaches** What has been the experience of target driven approaches?	1: How is PHC affected by funder targets? 2. Health workers affected by targets- listing (x4)	BK
Oct 2-4		3. Health worker feeling on targets - smiley ratings	BK
Oct 5-9		4. Summary and discussion on smiley ratings 5. Market place intro: target impacts	BK
Oct 10-18		6. Local discussion on the 3 questions 7. Delegates fill 3 market place charts on impacts	BK
Oct 19-21		8. Facilitator sorting, summary of impacts, sign off	BK
Oct 22	**STEP 5: Proposals for addressing impacts of targets on PHC** by health workers (HWs), community (CMs)/ HCCs	1. Introduction; Comprehensive PHC and targets	RL
Oct 23-25		2. Ranking and scoring of +ve and –ve target impacts on HW, CMs and PHC	RL
Oct 26-Nov 5		3. 3 groups discussing impacts on HW,CMs,PHC 4. Local discussions on impacts	RL
Nov 6-12		5. Group work on impacts on HWs, CMs and PHC	RL
Nov 13-20		6. Plenary discussion 7. Facilitator summary, sign off	RL
Nov 21-29	**STEP 6: Reporting and engaging on the Proposals** What analysis and proposals to report the work and raise it locally nationally, regionally and internationally	1. Introducing progress markers, action table. 2. Intro Actions to report, engage on findings, proposals: 2 groups, (local/district and reg/ global 3. Group work: Completing action planning table	RL
Nov 30-Dec 5		4. Plenary feedback and review x 3 groups 5. Facilitator summary of plans and proposals	RL
Dec 6-14		6. Local discussion on action plans	RL and BK
Dec 15-20		7. Feedback from local discussions x 3 levels 8. Facilitator summary of plans and sign off	RL and BK

TIMING	STEP AND QUESTION	SESSION AND METHOD	FACILI-TATOR
2019			
Dec21-Mar 14	**STEP 7 Implementing, reviewing and learning from action** What actions have been taken? What progress against the progress markers? What next?	1. Introduction: Intro to review meeting and progress markers at 3 levels	RL and BK
March 15-22		2a. Meeting 1 on progress on actions 3a. Action and progress marker review	BK
		4a. Market place intro on enablers/barriers 5a. Participant input in market place x 2 charts 6a. Plenary discussion: charts, progress markers	RL
Mar 23-May 13		7a. Local discussions on progress and questions 2b. Intro Meeting 2 on progress	BK and RL RL
May 13-28		3b. Action and progress marker review	BK
		4b. Market place intro on enablers/barriers 5b. Participant input to market place x 2 6b. Summary and plenary discussion 7b. Facilitator summary	RL
May 29-June 14 2019		8. Review of the PAR journey, experience of the PARonline, summary and sign off	RL

The web design

In an interactive process, regular interactions were held between TARSC and Maldaba to explain PAR, the protocol and the expectations for the web design and to review the design, using artwork provided by TARSC. The Maldaba team developed elements that would exist across the site, such as the facilitator summaries, discussion spaces, mechanisms for logging in and tracking steps in the process and for facilitator monitoring of participant input. A draft was designed of selected online elements that was tested by TARSC (RL and BK) and used in a hands-on demonstration with site teams in the 2018 regional meeting. For a further 6 months Maldaba worked with TARSC to develop, review, test and revise the full site content, with two points of review by a country site facilitator and a colleague exposed to the site for the first time to test its accessibility.

Lorenzo Gordon, Maldaba, Introducing the platform

After the 2018 meeting, Maldaba with TARSC input addressed further cross cutting issues, including: how participants would enter, catch up on any activities missed and enter the current activity; options for the regional facilitator to pause discussions or share comments; ways to visit and download proceedings from previous sessions; and to monitor participant participation in sessions. An option was provided for the process administrator (RL) to enter or revise text on the site; to impersonate a participant should this be needed to assist participants with their input; and to assign participants to groups and chairs for online group discussions. The final site was then moved to its permanent location on the EQUINET server and the whole process re-tested by TARSC and Maldaba a further time. The online site was launched with participants on July 12 2018.

TARSC (RL and BK) facilitated the online PAR process as regional online facilitators. **The** Maldaba team provided maintenance support of the site and addressed problems experienced by participants in dialogue with TARSC (RL). TARSC monitored and documented the experience of implementing the process. All discussions and the content of all collective rankings, tables, market place and other tools were captured in full (and are held in a more detailed document). Summaries were prepared by the facilitators at the end of each session. Any obstacles to participation and issues with site functioning were addressed during the process. *Section 9* presents the collective reflections from our online discussions and 2019 regional meeting on the strengths and weaknesses of the protocol and the online process and how we addressed them.

Ethical procedures

Prior to the start of the work TARSC liaised with sites to provide formal documents for them to procure health authority consent for the work, to find out their computer and website capacities and operating systems, to explore further the features of their primary care targets and to explain the ethical procedures for informed consent for the online participants and participants in local discussion. The ethical principles for PAR processes adopted by EQUINET (Loewenson et al., 2014) were reviewed with participants and applied during project implementation. A consent form was signed by *all online* participants and a further informed consent form was developed for verbal consent in all local discussion meetings. These consent forms indicated the purpose and features of the PAR work, that any personal information would be held securely on the online platform and voluntarily provided, and that participation is completely voluntary and can stop any time. It also made clear that reporting will be in an agreed public domain form at local and regional level. For all it was noted that written reports would not contain any personally identifiable information unless with explicit permission. Country site facilitator and TARSC contacts were provided for any complaint.

3. Initiating the PAROnline process

In the first session participants introduced themselves, with their photographs and brief biographies provided online. The regional facilitator (RF) introduced the research aims and questions and explained the PAR features, the online PAR process and the participant and country site facilitator roles. In the discussion, participants raised how they understood PAR and their experiences of using it. Participants saw PAR as being different from other types of research, in that people use their analysis to identify and learn from actions.

> *PAR differs from other research because it goes beyond identifying problems, we identify and act and review how far they have brought the desired change.*

Some things were said that are not PAR features: It is not usually done across countries. It is usually done locally. It hasn't been done online before!

Some participants described positive experiences of using PAR:

> *My experience with PAR is that in the end has helped improvement of relationships between health workers and communities as they understand each other. I have seen these two parties working together to address the shortfalls, have joint programmes, review progress together and assist in the clarification of each stakeholders roles and responsibilities....because sometimes the problem stem from lack of understanding of each others roles and responsibilities.*

Participants gave strong support to the research questions as being relevant to their services and work.

> *PBF has a major impact in the overall health service delivery and already affects health workers professional roles… because instead of looking at the people as our bosses, we tend to look at funders as our bosses.... But it has also improved performance of health workers as it is a motivational boost...*

The RF and participants applied the 7 steps of the research outlined in *Table 2* to the stages of the PAR spiral, fitting each with the relevant stage (as in the graphic on page 6). We discussed initial ideas for reporting the work, as well as the ethical principles and informed consent procedures discussed earlier. Participants confirmed their agreement with this information and 'signed off' by ticking a box online to indicate their consent. There was a 100% response rate to this.

4. Systematising our experience of PHC and PBF

We need to know how the use of targets …are affecting our work as health workers and services in the communities…In some circumstances they have become the main thrust in health financing

Understanding and sharing views on primary health care

We introduced the eight key features of primary health care (PHC) as set in the 1978 Alma Ata declaration, shown in the graphic, with an option to read detail on each PHC element (in full in *Appendix 2)* by clicking on the feature. We heard participant views of the positive and negative features of their own PHC systems.

Participants observed that for them, PHC means receiving the correct, earliest health intervention and services in the most accessible way, regardless of people's social, economic and political status. It was seen as the first contact point for health care, a basic level of care close to communities and an entry point for referral to higher level services. PHC was seen as taking health care services closer to the "door step" of households, with active participation and empowerment of communities.

> *PHC is relevant to my country... It's only PHC which can coordinate the various sectors such that supportive systems can be strengthened and then work towards health for all. PHC promotes self-reliance and community participation which can also help to sustain health programs.*

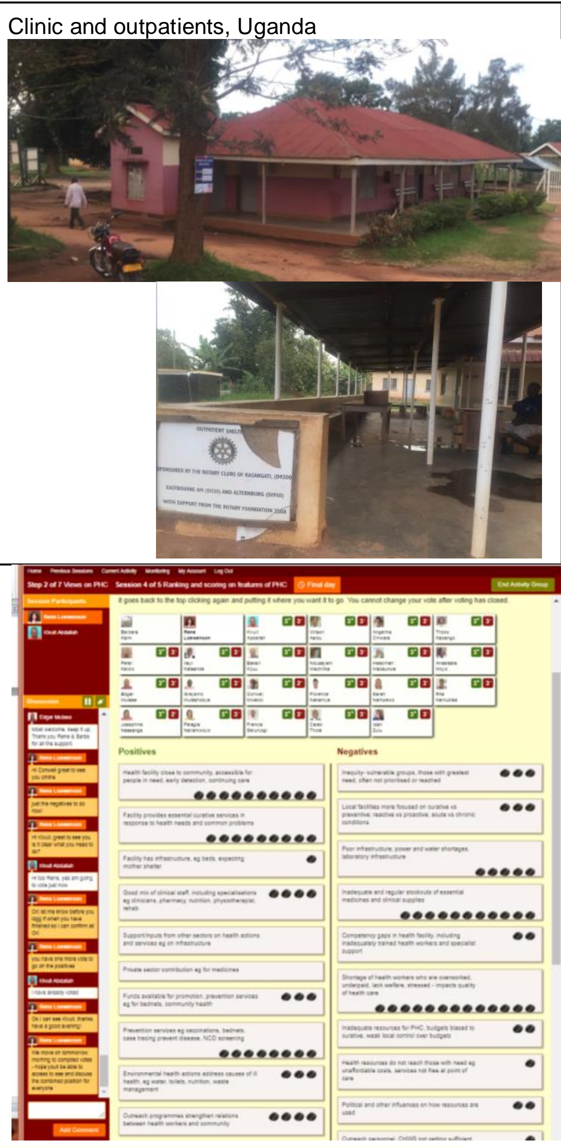
In relation to their current services, participants saw that they mainly address curative services (FEATURE 1) where people come in as patients already ill. Preventive and promotive services (FEATURE 2 and 3) and the work with other sectors (FEATURE 4) were felt to be important but to have less focus due to inadequate resources, due to the way funders, politicians direct resources, due to the lack of relevant health workers, essential medicines and commodities and the fact that these issues are decided at higher levels, (in a 'push system') that do not take local priorities into account.

> *Answering to the question whether we are doing all features of PHC in our context, it is absolutely easy to say that we are far from it.*
>
> *Resource allocation to the health sector remains a challenge...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.*

There was agreement that our current systems do not actively address the causes of ill health. There is some co-operation with other sectors, but we mainly focus on curative measures and haven't yet mainstreamed health in all sectors. While communities actively participate in services like antenatal care and immunization, they are not involved in decisions on the organisation of, or resourcing of services, so they have only the power to *act,* not to *decide*. While there is an intention to provide services to those with greatest need, these problems can mean that they are left behind.

> *We seem to be far from the imaginations of the PHC of those that agreed and drafted the Alma Ata declaration.*

All thought that PHC is relevant as it focuses on strengthening *local* health systems and empowers communities, which is seen to be essential for health. It responds to the high burden of ill health; does not only treat diseases but prevents the many conditions caused by socio-political, economic and other causes and in brings together all sectors to act on health.



Clinic and outpatients, Uganda

Offline local discussions held with community members and health workers on their views of the positive and negative features of their PHC systems further confirmed and added to these views. The discussions were interesting!
It was so amazing what health workers had to say about PHC.
The findings were entered online on cards on a chart, first individually and then in plenary with the combined results, consolidated and organised by the RF.

We ranked what we felt *collectively* to be the most important positive and negative features of our PHC services, using the 'ranking and scoring' method. Participants had two separate rounds of voting, one for the positive features and one for the negative features, with 3 'electronic stones' each, one stone for one vote. Each person placed stones on the features they ranked highest, with options to use all stones on one feature or to distribute them across different features. Each person voted individually. When the session time ended, the collective rankings were shown. A summary of the votes for each of the two lists was automatically produced by the system, showing the 'stones' and the number next to them (as shown adjacent). The RF ordered the votes by frequency in each list and facilitated discussion on the findings.

The lists are shown below showing the total votes for each feature, ranked top to bottom for each list.

List and ranking of positive features of local PHC services

Feature	Votes
1. Health facility close to community, accessible for people in need, early detection, continuing care -	10
2. Facility provides essential curative services in response to health needs and common problems –	9
3. Prevention services eg vaccinations, bednets, case tracing prevent disease, NCD screening -	8
4. Health promotion in the community supports socio-economic and health improvement -	5
5. Outreach programmes strengthen relations between health workers and community -	4
6. Good mix of clinical staff, including specialisations eg clinicians, pharmacy, nutrition, physio, rehab-	4
7. Community health workers and volunteers promote participation and reduce clinical workloads-	3
8. Community participation promotes ownership, sustainability of services and health actions-	3
9. Facility has essential medicines and clinical equipment for services-	3
10. Environmental health actions address causes of ill health, eg water, toilets, nutrition, waste -	3
11. Funds available for promotion, prevention services eg for bednets, community health-	3
12. Referral system, ambulances for referring people with complications to higher levels -	2
13. Funds available for curative services eg: from government and external funders -	2
14. Facility works with other sectors, NGOs in community health -	2
15. Health Centre Committes support community demands for responsive, accountable services -	1
16. Facility has infrastructure, eg beds, expecting mother shelter -	1
17. Support/inputs from other sectors on health actions and services eg on infrastructure -	0
18. Private sector contribution eg for medicines -	0
19. External partners assist in research on health at facility and in community-	0

The **positive features of local PHC services** were identified to be their proximity and accessibility to the community, as well as the essential services, supplies and personnel they provide close to the community to respond to common problems. Prevention and outreach activities were identified to be important as they address causes of ill health and strengthen relations between health workers and the community. Having health workers living in and part of the community enables them to easily see people's problems and their causes, to go into the community as teams with different skills and work with community health workers (CHWs) and others in the community. Prevention and health promotion were seen to be the core of what we do in health - they take place inside the community, they are more cost effective and they address health issues at the source. The diverse resources in the community were also seen to be an asset for health and health services. This includes the CHWs, retired health and other workers. These capacities need to be recognized and involved in decision- making.

> *CHWs are important because they stay in the community, understand the community health problems and they can quickly respond to community issues without waiting for the hospital***.**

> *The whole PHC is about them, right. So why are those most affected the least heard and given least space regarding their health?*

Non-government organisations (NGOs) and other sectors are also seen to play a key role in promotion and prevention and in linking communities to services.

> *Multisectoral collaboration improves quality of service delivery and also bridges gaps between the health facility and the community. This is because the NGOs spend most of their time in the community and better assess the needs of the community than the health workers who spend most of the time at the health facility.*

For the **negative features,** below, those ranked highest pointed to the need for better treatment of health workers and for improved supplies, but also for greater community involvement in planning.

List and ranking of negative features of local PHC services

Feature	Rank
1. Inadequate overworked, underpaid, stressed health workers, lack welfare- impacts quality of care-	13
2. Inadequate and regular stockouts of essential medicines and clinical supplies -	11
3. Community members not involved in planning community health activities, only in implementation -	6
4. Weak referral system, eg ambulances/ transport to take patients to higher level services -	5
5. Poor infrastructure; power and water shortages, laboratory infrastructure-	5
6. Inequity- vulnerable groups, those with greatest need, often not prioritised or reached-	3
7. Local facilities more focused on curative vs preventive; reactive vs proactive; acute vs chronic -	3
8. Policies supporting comprehensive PHC poorly prioritised, implemented or monitored -	2
9. Competency gaps in health facility, including inadequate training and specialist support -	2
10. Political and other influences on how resources are used -	2
11. Community participation through HCCs not effective eg due to weak legal status, capacities -	2
12. Inadequate resources for PHC, budgets biased to curative, weak local control over budgets -	2
13. Outreach personnel, CHWS not getting sufficient training, resources, support -	1
14. Economics, political factors generating ill health eg poverty, hunger, stress, violence -	1
15. Health resources not reaching those in need eg unaffordable costs, service fees -	1
16. Outreach programmes limited by budgetary constraints and short term, irregular funding -	1
17. Inadequate coordination. cooperation with other sectors, traditional providers, NGOs, researchers -	1
18. Limited funds for, difficult to evaluate, show direct immediate impact of comprehensive approaches -	1
19. Community members not involved in planning health services at facility -	0

Frontline health workers, CHWs *and* community members do not appear to be adequately valued for their role in the health system, yet are core for effective health services and for comprehensive PHC. *In reality if you want a good service you must invest in the person who delivers that service.*
*S*hortages of health workers and medicines may be due to inadequate funds, but also due to how funds are allocated and used and the inadequate allocation of resources for prevention and promotion. This is seen to be due in part to the lack of control that the local level has over health system resources, the political factors directing resources and the lack of respect for the views of local communities or frontline health workers in resource allocation, despite their understanding of what is needed.

We saw that those with greatest need were often not reached and that our local facilities were more focused on curative than preventive services, more reactive than proactive and focused more on acute than chronic conditions. Some of these weaknesses were seen to relate to shortfalls in resources, trained health workers and specialist support, with budgets biased towards curative services. Health workers said they were overstretched, that there were limited resources for CHWs and outreach, limited transport for referrals and weak co-operation with other sectors and providers: *At times the client numbers are overwhelming leading to a burnout. So a patient coming in is considered as a burden.*

Communities found some charges to be unaffordable and their HCCs to lack support. Community members said that they were not involved in planning services or community health activities, only in their implementation: *If services are to improve, the community should be involved in planning being that they are the end users.* Some participants also noted that the significant resources in their areas, such as from mining and other economic activities, could make a greater contribution to health.

From the discussion we summarised our prioritised three POSITIVE features of PHC as:

1. Having a health facility close to the community, accessible for people in need, for prevention, promotion, early detection and continuing care, involving team outreach, CHWs and cooperation with other sectors.
2. Investing in and providing prevention and health promotion services in the community to support health, social and economic improvement.
3. Having a facility that provides adequately resourced essential curative and referral services in response to health needs and common problems

The top three NEGATIVE features of PHC that we want to address were summarized as:

1. The shortage and under-valuing of health workers in the facility and in the community, with overwork, underpay, lack of welfare, stress and poor control over resources harming motivation, team approaches, community relations and the quality of health services.
2. Inadequate and regular stockouts of essential medicines and supplies for curative, prevention and promotion activities, compounded by top down systems and limited local control.
3. Community members, especially disadvantaged groups, not being involved in planning services and community health activities, and not being respected for the talents and capacities they bring.

We were struck by how similar our situations were in our different countries: *we face the same challenges despite being in different countries*. We observed at various points how similar our situations were in the different countries and how exciting it was to share common experiences across countries. As one participant said "like being in the same room together!". *I can't Believe our issues are cross cutting, God bless us as we come up with possible solutions.* We also saw that for many challenges in the negative features, there were often opportunities in the positive features.

Sharing experience on target driven approaches

We explored how PBF is being applied in the local primary care and PHC systems in our sites. PBF was defined as raised earlier. The sites use various terms for PBF: performance-based funding or financing or contracting; pay for performance; and results-based funding or financing. The resources transferred are usually financial payments, but in-kind transfers are also used. Participants wrote on 'cards' the performance targets applied in their local service and assigned each to the features of PHC the target best fitted with. The RF organised the cards. The white squares on the PHC graphic (as adjacent) indicated how many targets are applied to that PHC feature. Clicking on the feature showed the specific targets. The full list of targets is shown in *Appendix 3. Table 4* shows the number of different PBF targets by PHC feature for all the sites combined.

Table 4: Number of PBF targets related to the different PHC elements

PHC element	Number of targets
Feature 1: Addressing common health problems	17
Feature 2: Promotes health	10
Feature 3: Addresses causes of ill health	6
Feature 4: Health in all sectors	0
Feature 5: Promotes community power and participation	3
Feature 6: Prioritises those with greatest needs	4
Feature 7: Ensures relevant competences	3
Feature 8: Co-ordinates with other levels of care	5
Feature 9: Other (medicines and supplies)	2

Most current targets were found to be focused on PHC Feature 1 'Addressing common health problems', particularly for SRH, HIV, TB and maternal and child health. The targets were for facility based services, mainly treatment and care, prioritised by government and international funders. We observed that chronic conditions do not generally have targets, despite being a growing problem, with poor attention given to them by funders and a perception that they are costly to treat. The second largest number of targets was for preventive and promotive services (Feature 2), again largely for facility-based prevention services like antenatal care and immunization, where people have to visit facilities to access the services, rather than their reaching into communities. Yet prevention of problems like cholera, typhoid and chronic conditions demand services that go into the community and work with other sectors, especially to reach more disadvantaged groups.

> *It's good that we are at least addressing these health problems at health centre but we need to do better than this by taking it to the people. We need to focus more on the promotive and preventive but according to the list, we see less of the promotive and preventive services, which should be done in and to the communities through outreach.*

While targets can raise attention to new services, like HPV vaccination for adolescents, they were generally reported to be top-down and fixed, sometimes for many years. This, together with centrally administered 'push' systems for supplies may be slow to reflect changing disease burdens or differences between areas and gives no space for local flexibility to respond to what is identified locally.

> *We have a reactive and not a proactive kind of PHC. We focus more on curative and not much on prevention. We also focus more on diseases and not much on general health...we consider health as just the absence of disease.*

Relevant staff competencies, medicines and supplies had few targets. Yet these capacities and supplies need to be in place for the other targets to be delivered on (also termed 'service readiness'). These key inputs and co-ordination with different levels of care also affect the *quality* of services. Quality is less easy to measure, however, than the quantity of services provided, especially as we do not have regular satisfaction surveys, exit interviews or community monitoring for this.

The gap in working inside the community was seen to be the reason for fewer targets being applied to addressing the *causes* of ill health. Food inspectors and various community and environmental health workers play a role in addressing health determinants, but do not always get adequate support, especially in the face of more immediate demands for treatment. That zero targets relate to "health in all sectors" was seen to reflect a real gap in PHC involvement in schools, agriculture, environments and other sectors that play a role in keeping people healthy.

Equally, there were fewer targets relating to "community power and participation".

> *Targets promoting community power and participation are often not very effective because of lack of clear guidelines, poor or absent legal frameworks, capacity, resources and training for CHWs, HCCs. There are no real incentives for these CHWs and HCCs and HSAs.*

A lack of clear definition, laws and guidelines on what community power and participation actually mean in our services was observed to be one reason for lack of clear targets in this area.

Meetings are not empowering enough, ideally it's important that targets set should be able to assess increased knowledge and capacity and give a chance for active participation at all levels. Meaningful participation is much more than a number of meetings or a structure.

In exploring the reasons for this distribution of targets in relation to PHC, we noted that:

- The targets are set or influenced by government or international funders for actions that can produce quick results with limited resources.
- The targets are generally technical, facility-based and set top-down.
- Other areas of activity on health, such as working in communities, collaborating with school and youth programmes, building community capacities or organising nutrition gardens may be taking place, but are not reflected in targets as they may be seen as less easy to measure.

The distribution of targets across PHC features was thus felt to reflect what *is* happening in our PHC services, but not always what *should* be happening. The targets *do* reflect and may reinforce the accessibility of prevention and care at facilities. However, they *do not* adequately reflect other priorities, particularly health promotion in and outreach to the community, or work with other sectors.

The areas given less attention by targets are also those that were ranked as the worst performing features of our PHC systems, that is: the shortage of and poor conditions for health workers; inadequate and regular stock-outs of essential medicines and supplies; top down systems and limited local control and community members not being meaningfully involved in planning services. Not everything that is important for PHC can be measured, including the relationships and trust in team work and community participation, yet performance targets send a signal that something is valued, can motivate health workers and can be monitored. Those things that aren't put into targets could get left behind, underfunded or ignored.

Not everything important can have a target. Trust is vital but can't be measured...

Community nutrition activities like this one in Tanzania do not usually get target funding in the region

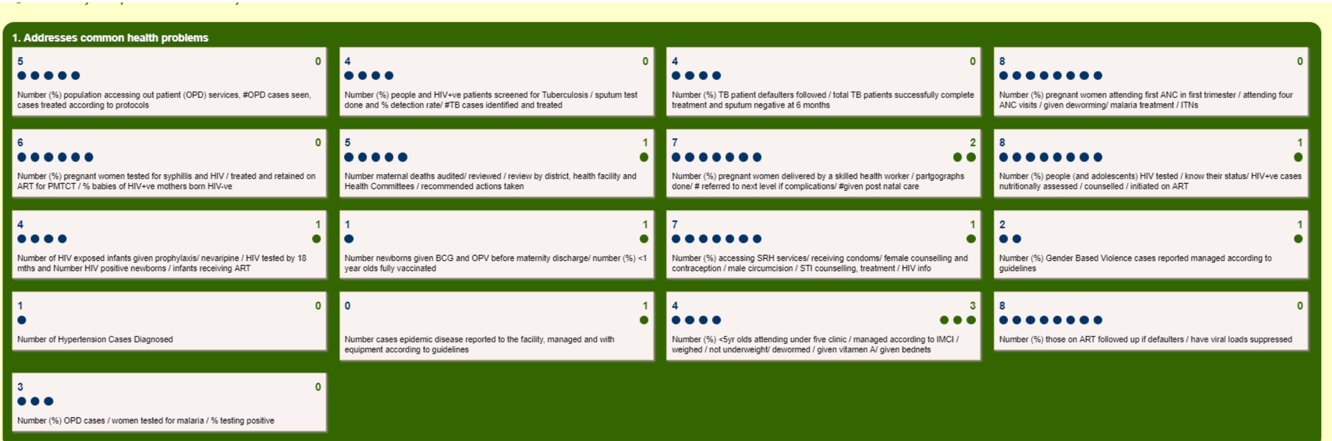
Source: M Pixel, undated, creative commons

Targets are like a bell ring in your ears reminding you that you have not achieved your goal

How do targets link to resources?

Participants individually showed the targets that were linked to funding using a blue dot and those introduced as a local decision using a green dot. The collective results were then shown and discussed, (a sample is shown below).

- 39 targets received blue dots (linked to funding), and targets with blue dots commonly had many dots, as shown for example in the extract below.
- 25 targets received green dots (locally decided), and targets with green dots had few dots.



Targets were reported across sites to be generally funded from government and international agency decisions rather than locally decided plans. They were seen to be inflexible and to leave gaps in issues that health workers and communities saw as local priorities, whether for specific groups such as elderly people, or specific problems, such as asthma or water related diseases. Target funding for maternal, reproductive health, communicable disease and HIV services was seen to be relevant. It was, however, a concern that chronic conditions and promotive and preventive services are not well funded through performance targets, despite their importance. Services that have no funded targets were also seen to be given less attention, including outreach, community based services like postnatal care and epidemic control. They may be ignored, especially when funding for targets is a large share of total facility funding. In one site it was observed that this funding gap has led to services charging for care of chronic conditions. This may discourage people from using services and lead to more severe diseases.

> *Service areas that do not have funding linked to targets are neglected by health workers and this can lead to complications in patients. Some health workers can even ignore some services once the funding is phased out.*

Even for maternal health, some areas where targets may be useful to motivate improvements, such as maternal death audits, do not have funding attached to them. There was a question of how far the approach to target funding is building processes for service improvements, given that a top-down mode of target setting can be viewed as blaming workers for poor performance. Key processes like audits that improve services, and particularly service quality, need to be supported by health workers and used for problem solving, or they may demotivate or be resisted.

There are other funds- PHC grants, local government funds, central government disbursements- that also fund facilities, staff, medicine, equipment and other inputs. In some sites some performance funding can be used by the facility for such inputs, with examples of PBF used in Uganda for facility inputs, in Tanzania for supervision by regional and district level health managers and for CHWs when referring or accompanying pregnant women to the facility for maternal health care. Performance funding can also be used to lever other funding. The extent to which a facility receives funding from other sources, such as from tax funding, to finance the system and other areas enables some of these shortfalls to be addressed. Governments were seen to use their performance on targets to show how well health services are doing, as a lever for international and domestic funding. But for a facility, what government provides for these system inputs may be critical to achieve even the targets in PBF. With decisions on general budgets and PBF both made by central government or external funders, the facility is left with very limited choice on how to manage resources.

> *I think we should pay attention to both those aspects with targets and those that are important but may not have targets.*

While effectively implemented PBF can build trust of funders, many issues that affect trust are beyond the control of the local level. Problems with macro-economic difficulties or corruption leading to withdrawal of external funders (the example of “cashgate” in Malawi was cited) arise at higher levels, but the local facilities are the ones that then take the major burden of the loss

In most sites the funds are disbursed to facilities and then payment is made from this to local health workers by the ‘in charge’. The shares vary across countries and the health ‘in charge’ in some countries has a say in how the facility funds are used locally. Which health workers get paid in most sites is ‘in line with the work effort for the service’ or which health workers are identified as being ‘involved’ in that service. There is some variation in this. In Uganda, some allowances are given not only to health workers but also the Village health teams for their participation in community mobilization. There was concern that if the incentive funds stop, this may demotivate health workers, reduce their living standards and lead them to stop or to reduce the extra time they put into these services, reducing delivery or quality of these services. It may also lead managers and supervisors to pay less attention to them. A phase out / reduction of PBF in two sites (in Uganda, Zimbabwe) was noted to have had signs of such effects in demotivation and reduced working hours.

> *If the current direct payments to health workers for achieving particular targets phases out or stops, then PHC can seriously be compromised and we could realize poor service delivery, and health workers can be highly demotivated and thus affect their performance.*

One participant noted that health workers are rarely tempted to inflate numbers to improve payments, but may do this is when the targets are hard to achieve and yet they are being pressurised by funders to reach them. As noted in one site: *It is being whispered that some providers do attract clients out of the catchment areas to come for services especially those falling in this category of targets.*

> *That temptation of inflating numbers is rare but it normally comes when the targets are hard to achieve and yet the funders are pressurizing them.*

The findings indicated that local health workers and communities do not have much say on what is funded, and local community members do not know what targets are funded. The few targets that were decided locally were related to HCC meetings held or action points implemented and selected outreach indicators for integrated management of childhood illness (weighing, deworming, vitamin A or bednet distribution). The areas where there may be local involvement taking place, such as environmental health activities or addressing gender-based violence, do not have targets.

Further even where targets are locally decided, they are generally set by health workers. HCCs were reported to not have the power to bind facilities to decisions that they make and to not access information. Some did not feel valued for their input, with a perception of a power imbalance between HCC members and facility managers. PBF procedures were reported to reduce the control the local level has over prioritised health projects and interventions, and to demand a lot of time spent getting quotes or with administration for any use of the funds for local priorities.

> *In our own situation most of the money from donors is spent on either obtaining quotations for purchases and bus fares as quotes need them for even a nail to be purchased…Suppose we want to buy tiles for mother 's shelter, we obtain 3 quotations for this, and travelling for this is expensive. Those who approve any purchase to be made may be difficult to access as they often work out of offices causing delays in purchasing. This may invalidate the already acquired quotations. This discourages community participation and ownership of the facilities*

Nevertheless, local community members and health workers reported accepting targets even if they don't decide them, as they bring facility funding and can substitute user fees for the services funded.

Communities and local health workers felt that if they had more say they would fund some areas that had less funding, but that could reduce outpatient burdens, including:

- Prevention and management of chronic conditions;
- Health education, environmental interventions (water, sanitation and waste disposal), medicines, commodities and payments for village health teams and CHWs for outreach work, home visits and community outreach to prevent common conditions and outbreaks;
- Promotion of child health, BCG/OPV vaccination of newborns, and nutrition promotion;
- Interventions to address gender-based violence, community level testing (HIV, malaria) and health promotion with adolescents.

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

The ability to fund these priorities and to build synergies between locally and centrally decided targets, between targets for chronic and acute conditions, facility and community based interventions was seen to call for a pooling of different funding sources, domestic and external and for sustainable financing. Yet, several sites noted that domestic financing has fallen, weakening the possibility of doing this.

As a summary of our experience of the current relationship between priorities in PBF and those in PHC we found that:

The targets in our local health services mainly focus on facility-based treatment and care services relating to SRH, HIV, TB and maternal and child health. These are common conditions and are prioritised by government and international funders. However, we were concerned about the lack of targets for chronic conditions, as these are a growing problem, and that the top-down nature of target setting may poorly reflect changing disease burdens or differences between areas. There were few targets relating to competencies, medicines and supplies, underestimating the role that these inputs play in delivery on other service targets and in processes for improving service *quality*.

It was positive that there were more common targets for preventive care, but these are largely for facility-based services, like ANC and immunization. In contrast, problems like cholera, typhoid, chronic and other conditions demand that services go into the community and work with other sectors. Facilities can miss a lot of health issues and people who need services when they wait for people to come to the facility. We saw few targets for work in the community addressing the *causes* of ill health, such as for the work of food inspectors, CHWs and environmental health workers and for “community power and participation”. or “health in all sectors”, despite their importance for PHC.

The distribution of targets across features was felt to be a fair reflection of what is happening in practice in our PHC services, but not always what *should* be happening. While not everything that is important for PHC can be measured, such as relationships and trust, performance targets send a signal that something is valued, monitored and used to motivate health workers. Those things that don’t have targets could be underfunded or ignored, especially when PBF is a large share of total facility funding. It is thus important that pooled funding from other sources, particularly from the government budget, cover these areas. Yet domestic financing was noted to be falling in many sites.

We were concerned that local health workers and HCCs have such a weak role in setting targets and that targets are so inflexible to health priorities that may arise in specific local / district settings. Where target funding is raising significant administrative demands on HCC members, this was felt to reduce, not increase their participation in services. While effective implementation of PBF may encourage additional funding, many factors that undermine funder trust lie at higher levels, yet it is the local facilities that feel the major burden when funding is withdrawn.

Communities and local health workers felt that if they had more say they would fund some areas that currently are not covered by PBF but could reduce outpatient burdens, including: prevention and management of chronic conditions; health education, environmental interventions (water, sanitation and waste disposal), medicines, commodities and payments for village health teams and CHWs for outreach work, home visits and community outreach to prevent common conditions and outbreaks; promotion of child and adolescent health, BCG/OPV vaccination of newborns, and nutrition promotion; and interventions to address gender-based violence, and community level testing for HIV and malaria.

5. Analysing experiences of PBF

Health worker experience of target driven approaches

We explored how health workers are experiencing PBF in the health system, in terms of its effect on their professional roles, working conditions, team work and the relationship with the community. We identified the range of workers in local health services. The generic list shown in the graphic overleaf was generated from the combined responses. Participants individually used ‘smiley to sad faces’ (from very happy to very unhappy) to indicate how each of the workers in their own local primary care service feel about targets.

Once individuals completed their inputs, the online system automatically calculated and showed for each type of health worker the totals and distribution of the smiley, neutral and sad faces, with the total number of votes, the total for each level of perception and the average 'face', as shown in the adjacent graphic.

Healthcare workers	Perception of target 1	2	3	4	5
1. Medical Superintendent / Medical Doctor / Clinician - votes: 10	1	5	3		1
2. Clinical officer in charge / OPD in charge / nurse in charge - votes: 17	3	7		6	1
3. Nursing officer / nurse / senior nurse / TB nurse / ART nurse - votes: 15	2	8		2	3
4. Clinical officer - votes: 14		8	1	2	3
5. Midwife - votes: 16	3	7	1	3	2
6. Public health nurse - votes: 7	3	2		1	1
7. Nurse aid / attendant - votes: 14	4	5	1	4	
8. Counselor / physiotherapist / nutritionist - votes: 11	1	4	1	2	3
9. Pharmacy technician / laboratory technician / radiographer - votes: 11		4	2	3	2
10. Data, records clerk / clerk / health information officer / computer operator - votes: 16	1	3	4	4	4
11. Security guard / ground staff / labourer / porter / maid - votes: 15	2	1	6	2	4
12. Environmental health officer / health inspector / health surveillance assistant - votes: 12	3	4	3	1	1
13. CHW / community based distributor / community coordinator - votes: 14	5	2	5		2
14. HCC / HUMC / VHT - votes: 14	2	1	7	2	2
15. Local government leaders / committees: village / neighbourhood / ward committee / chairpersons - votes: 14	3	5	3	1	2
16. Community volunteers / supporters / peer educators / task force members / care givers - votes: 14	3	5	3	2	1

The collective results indicated that:

- The medical superintendent, nursing officer, clinical officer (for some sites), public health nurse, nurse aid and midwife at the facility and EHT, CHW, local government leaders and community volunteers are happier with or more positively affected by the funded targets.
- The clinical officer (for others), laboratory, pharmacy, clerical and ground staff and HCC members were more 'unhappy'.

Many reasons were raised for these results. Satisfaction related to which health workers receive allowances – both financial and in kind; how far they have a say in how benefits are distributed; and how fair the funds received are perceived to be. A number of sites pointed out, for example, that junior personnel feel that they get less money, despite working long hours to meet targets. In only one site were pharmacy and laboratory technicians reported included in the allowances. HCCs and ground/clerical staff were also excluded in many sites and felt that they were not recognised for their role. CHWs and community volunteers varied in their views, depending on how far they were directly involved in the funded activities, training or allowances. In some cases, they receive benefits such as educational grants for their children or food supplements for their families. In one country (Malawi) Health Surveillance Assistants (local CHWs) have been factored into the RBF for their outreach work in immunizations, sexual and reproductive health. Yet many CHWs do not receive direct allowances for their role.

> *The fact that most of the health workers who are in the community if not all do not get any incentives from the so called RBF makes them neutral to whatever happens to it.*

Beyond the allowances themselves, PBF incentives included training; improved working conditions; social mobilisation and quality of service delivery. However, participants noted that other factors beyond these incentives were responsible for service improvements, such as health workers' desire to reach people with services. There was thus a caution on simply linking work outputs and pay:

> *The idea of saying the more you work the more you get sometimes compromises quality, especially when "workers cheat on the patients in pursuit of incentives.*

Inequality in the distribution of benefits linked to PBF was reported to have sometimes affected working relations and created jealousy between those who get paid more and those who don't, with a perception that those working harder are paid less. In contrast, teamwork was not negatively affected in facilities which consciously tried to include all workers in target-funded activities. Some participants also noted that some health workers may spend less time with patients to improve the numbers, negatively affecting their interaction with patients. For health workers at all levels to not be involved in any decisions on the targets and how they should be implemented was seen to be demotivating and disempowering. In some instances, health workers had tried to complain to the funders about the challenges they face and how hard they need to work to meet the targets – said that but funders do not listen, *instead they insist that all they want is that the targets are achieved.*

> *For the issue of not being involved in planning and decision making, yes this demotivates the health workers but once the targets are set, they realize that they can't win them but only to join them by implementing the program. Because of poverty they choose to work.*

The local discussions with health workers and community members raised similar frustrations over the limited influence local health workers and communities on what is funded in PBF and on its administrative demands. They too suggested that if they had a greater say, they would also pay attention to prevention and management of chronic conditions; to health education, environmental interventions, CHWs; nutrition promotion; interventions to address gender-based violence, community level screening and health promotion with adolescents.

Impact of target driven approaches

We explored, using a market place approach, the experience and perceptions of the impacts of targets on health worker professional roles and team work; on the relationship between services and the community and HCC roles; and on local primary health care services. The full set of impacts with the frequency they were raised is shown in *Appendix 4*. In the discussion on the charts:

For health workers, we found that the incentives and increased funding from PBF improved pay, income, morale, hard work and professionalism and provided facility and training resources for them to better do their jobs. At the same time delayed, low or even halted PBF payments (and payments eroded by inflation), including those to support the facility improvements, reduces health worker morale and undermines their work. Unfunded areas (NCDs) are seen to frustrate workers, biasing services towards target areas not comprehensive care or effective referral. Increased demands from PBF, with work overload, stress and burnout were seen to negatively affect health workers. Links with communities through HCCs and community knowledge and participation in identifying problems and implementing services, was seen to enable work at the facility, improving planning and accountability.

> *In my facility some health workers who don't feel happy say that when they try to complain to the funders about the challenges that they face in implementation sometimes they don't listen. Instead they insist that all they want are the targets achieved.*

For community members and HCCs, while PBF was seen to enhance uptake of targeted services, the limited resources for and neglect of non-targeted services was seen to result in fee charges and use of private providers for these areas of care and to community confusion on who benefits and who doesn't. While recognition of community roles and HCCs was noted, HCCs are not yet being empowered, supported, trained or funded. They are side-lined or not involved in important decisions and so are being diverted to managing funds. Sustainability concerns were seen to be very important by many people, especially when funds stop or are cut and the community is not informed, despite ultimately suffering from these cuts.

Community members attending the launch of the phase 2 of RBF in Zimbabwe

Source: World Bank, 2013, creative commons

I've discovered that much of the funds we receive is not used to save our community but to fulfil the wishes of the givers… This discourages community participation and ownership.

For comprehensive PHC, the improved resources for key inputs and skills was seen to have potential to improve outreach, coverage and quality, while noting that the resources may still not be adequate to meet all costs or demand. However, these gains were not seen to be comprehensively achieved. There was concern that health worker motivation and skills was being 'glued' to incentives and on targeted, often curative services. This left other areas of comprehensive PHC (prevention, health promotion, NCDs, OPD) not supported, despite high disease burdens, weakening the comprehensiveness and continuity of health care.

Community involvement was noted to contribute to improved services and avoidance of corruption and misuse of funds, especially if people are informed by good monitoring and evaluation.
The external funder driven nature of PBF was seen to be decreasing government's responsibility for targeted activities, with concerns over the sustainability and adequacy to meet demand and on the negative impact of limited local involvement in decisions made centrally or by funders.

A summary of the findings is shown below.

Impacts of PBF on health worker roles, community relations and PHC

For health workers,

- The major **positive impacts** related to the increased funding for facilities, with incentives improving incomes and morale and improved resources, infrastructure, medicines and training promoting heath worker capacities and performance. Health workers appreciated the training that accompanies PBF for increasing their skills and professional advancement. In some sites CHWs are included in the training and clinic work, while in others, CHWs receive incentives from PBF as part of service outreach. Monitoring and evaluation of practice was seen to improve service quality, reduce corruption and improve health worker accountability.
- The major **negative impacts** were delayed and low health worker payments, with increased demand leading to work overload, stress and burnout. Inadequate service inputs and unfunded service areas such as for NCDs affected service quality and morale. Not all health workers were happy: Laboratory, pharmacy and non-clinical personnel did not always receive the incentives and junior personnel felt their lower payments did not reflect their relative workload. Competition for targets was seen to undermine team work and to generate a burden of reporting, without involvement in setting or deciding how targets should be implemented. There was also insecurity over the sustainability of external funding.

For community relations and HCCs,

- The major **positive impacts** related to improved service uptake and HCC promotion of target areas. Communities were perceived to be more informed and aware of services and it was observed that there is greater respect between health workers and community groups.
- The major **negative impacts** were seen to be that non-targeted services were neglected and received less funds and supplies. Fee and medicine charges or use of private providers for these services were seen to make them unaffordable, discouraging people from using services until their conditions are more severe. Community members reported some confusion on who benefits when some services are funded and some not. Like health workers, they were worried about sustainability of funding and of services funded by PBF. The pressure on achieving numbers was also observed to worsen service quality and health worker-patient time. It was felt that there was inadequate training and support for HCC roles and that administrative demands for upward accountability to managers made HCCs feel less empowered.

For PHC services,

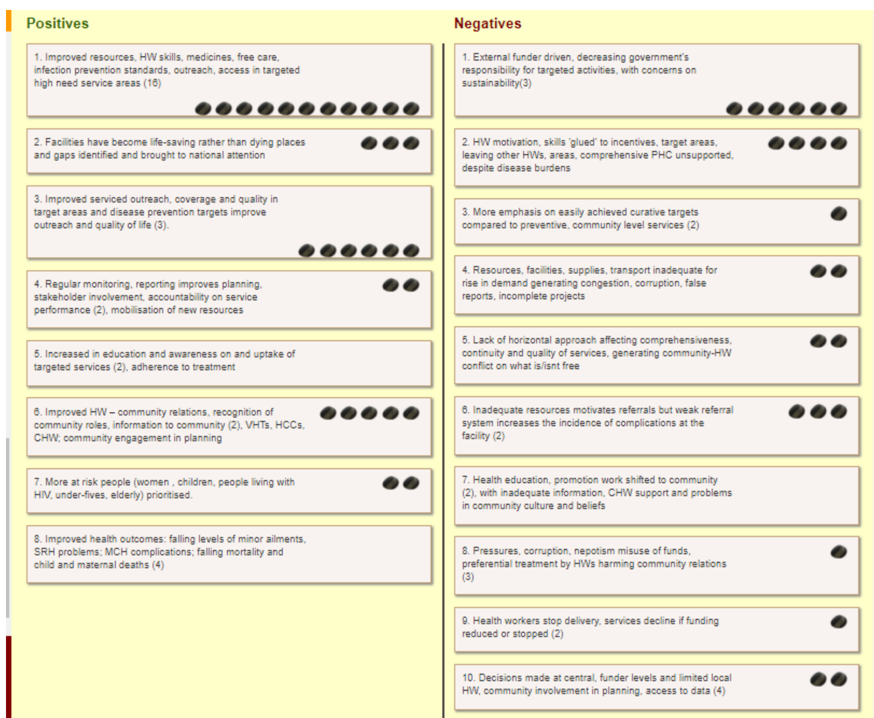
- The major **positive impacts** related to improved resources, health worker skills and services in targeted service areas. Regular monitoring and reporting were seen to improve planning and community and stakeholder involvement in planning to have improved service accountability.
- The major **negative impacts** were in 'glueing' health worker motivation to incentives and target areas, leaving other health workers and service areas not supported, despite their relevance. We observed that decisions were being made at central, funder levels, with limited local health worker and community involvement in planning. The external funder driven nature of PBF was felt to reduce government's responsibility for the targeted activities, with concerns on sustainability of funding. A mismatch between expectations on service delivery and the service resources and inputs to achieve them was seen to be generating stress and harming relations with the community.

One observation made was that across the three areas of impact there were more negative than positive impacts: *According to me there are more negatives than positives raised, yet I expected it would have been the vice-versa!* The longer list of negatives was a signal of the challenges perceived and faced at local level in making PBF work for PHC.

6. Actions to address the impacts of PBF

Prioritising impacts of target driven funding / PBF

We explored what actions health workers and HCCs would want to see to address the impacts identified in the previous session. This included actions to make PBF more useful for building comprehensive PHC, more supportive of health worker roles and of relations between communities and health workers/ services.



After a reminder of the major features of comprehensive PHC and of our findings on the impacts of PBF on PHC, we used ranking and scoring to separately rank the impacts (positive and negative combined) on (i) health workers, (ii) community relations and HCCs and (iii) on PHC in three rounds of voting. Each participant voted individually and once the voting was completed, a summary of the votes was shown for each area, with the number of votes and ranking of each feature, as in the extract in the adjacent graphic.

The combined rankings for each of the three areas are shown in *Table 5* overleaf, with the highest in each area in bold.

Table 5: Ranking of impacts of PBF

Positive impact	'Votes'	Negative impact	'Votes'
On health workers			
Positive impact	**'Votes'**	**Negative impact**	**'Votes'**
Increased funding, improved HW income	9	**Delayed & low HW payments**	6
Improved resources, infrastructure, training	7	**Unfunded areas, bias for target areas**	6
Team work targets, new approaches	0	**Increased demand, work overload, stress**	6
Information, monitoring, reporting	4	Time bound targets raise pressure for multitasking, falsifying numbers	2
Better links with communities	4	Brain drain, low morale,	0
Improved health outcomes	1	Competition for targets undermine team work	3
		HWs dont sustain services after targets reached or funding stops	2
		Too much clerical work on information needs, limited patient feedback	1
On community relations and HCCs			
Positive impact	**'Votes'**	**Negative impact**	**'Votes'**
Funding issues: Community contributions replaced by performance financing	3	Funding raising expectations and service demand, but late payments	2
Improved targeted services for communities	5	**Limited funds for, neglect of non-targeted services**	6
Free targeted services	3	**Sustainability concerns when funds stop**	5
Improved community service uptake	5	Demand, pressure on numbers worsen quality	3
Improved relations collaboration, respect between HWs and community groups	2	Poor access to services with poor transport, and increased referrals.	3
Improved recognition of community roles; community information, health, rights	3	Worsening HW-community relations, collaboration	2
Strengthened HCC establishment	0	Communities overburdened, disempowered,	0
Improved health outcomes: falling levels of minor ailments	0	Communities not participating in decisions on targets	4
		HCCs not well supported, trained; funded	5
		Negative health outcomes	0
On PHC services			
Positive impact	**'Votes'**	**Negative impact**	**'Votes'**
Improved resources, HW skills, medicines	11	**External funder driven, decreasing government's responsibility**	6
Facilities improved, gaps identified	3	**HW motivation, skills 'glued' to incentives**	4
Improved serviced outreach, coverage, quality in target areas	6	More emphasis on easily achieved curative targets vs preventive, community services	1
Regular monitoring and reporting improves planning, stakeholder involvement	2	Resources, facilities, supplies, transport not adequate for rise in demand	2
Increased awareness, uptake of target services	0	Lack of horizontal approach affecting comprehensiveness, continuity and quality	2
Improved HW – community relations	5	Inadequate resources motivate referrals but weak referral system	3
More at risk people prioritised.	2	Promotion work shifted to community groups	0
Improved health outcomes	0	Corruption, nepotism misuse of funds	1
		Health workers stop delivery, services decline if funding reduced or stopped	1
		Decisions made at central, funder levels and limited local HW, community involvement	2

From the ranking and scoring exercise we identified the top three impacts of PBF that we felt we should focus on in setting actions to strengthen our PHC systems. These are shown in the box below:

In relation to ***health workers*** the prioritised impacts for actions were:

1. **Adequacy, predictability and continuity of PBF funding, for HW incentives and for facilities, HCCs and training**, to improve health worker (HW) income, morale and professionalism and to enable team approaches and HCC support, noting that delayed, low or even halted PBF payments for HWs and facilities undermines these outcomes.
2. **Unfunded areas, such as for NCDs, neglected by and frustrating HWs**; biasing services towards particular target areas rather than comprehensive care and effective referral.
3. **Increased demand, work overload, stress, burnout in HWs and competition for targets** between HWs, with clients from outside the catchment area adding to queues.

In relation to ***communities and HCCs*** the prioritised impacts for actions were:

1. **Strengthening HCC and community roles** and enhancing information to communities, given that HCCs are not yet being empowered, supported, trained or funded in PBF; are side-lined or not involved in important decisions, and are diverted to managing funds and driven by payments.
2. I**nadequate or no funding, facility supplies for services not covered by targets** (such as for chronic conditions) leading to fee charges and use of private providers for these areas of care and community confusion on who benefits and who doesn't.
3. **Sustainability of funding,** with the community not being informed when funding stops or is cut or inadequate, despite being the ones to suffer the poor quality, waiting times and rising diseases.

In relation to ***impacts of PBF on PHC*** those prioritised were:

1. **Enhancing the improvement from PBF in resources and HW skills for services and support for community roles** to maintain outreach, coverage and access gains and to overcome resource shortfalls that lead to congestion, poor service and false reporting.
2. **HW motivation and skills and attention 'glued' by PBF to targeted, often curative services, leaving other areas, (prevention, health promotion, NCDs, OPD) for comprehensive PHC not supported,** despite high disease burdens, weakening the comprehensiveness and continuity of care for people.
3. **The external funder driven nature of PBF, decreasing government's responsibility for targeted services, limiting local involvement in decisions** made centrally or by funders, and raising **concerns about sustainability** and adequacy to meet demand

Identifying actions for the priority impacts of PBF

We divided into three groups in separate 'chat rooms', with community members discussing actions for impacts on the community and HCCS; health workers discussing actions for impacts on health workers and their professional roles and country site facilitators discussing actions for impacts on comprehensive PHC, each group reporting their findings in an online table that was shared in a subsequent plenary.

Group members also brought input from local 'offline' discussions held with community members and health workers to the group discussions. The results are shown in *Table 6.*

Table 6: Actions proposed to address the impacts of PBF

Impacts on comprehensive PHC	ACTIONS / CHANGES
IMPACT 1. Enhancing the improvement from PBF in resources and HW skills for services and support for community roles to maintain the gains made in outreach, coverage and access, and to overcome resource shortfalls that lead to congestion, poor service and false reporting	PLAN AND BUDGET FOR FACILITY NEEDS TO MEET NEEDS AND TARGETS: The National level (political, MoH) and MoFinance) and funders to link planning and budgeting to strengthen the public health system, and to ensure services and HW skills and staffing level improvements go together with performance targets and funding. Use pooled procurement for medicines at regional level to reduce prices, use technologies and IT to support HW work and allocate resources according to health needs and workloads.
	REDUCE THE DEPENDENCY ON EXTERNAL FUNDS FOR PHC: Improve domestic financing, reduce the dependency on external funds and meet the Abuja commitment of 15% domestic government budget to the health sector (and 5% of GDP) and introduce dedicated taxes for health so countries are not overly reliant on PBF funding for PHC and ensure funding for priority health issues such as maternal health. Show evidence to Ministry of Finance from community and primary care level of the real costs of poor domestic financing.
	INVOLVE LOCAL HWS, HCC AND COMMUNITY EARLY IN BUDGET PROCESSES: National level to involve frontline workers and community from inception (and not late) in planning and district levels to Improve the health centre committee capacities to add community voice on what is important for them in services.
	STRENGTHEN SUPERVISION AND ACCOUNTABILITY: Improve supportive supervision at facilities and from higher levels in line with national standards (clear service package), encourage review of services to improve approaches and involve HCCs in monitoring service delivery,
IMPACT 2: HW motivation and skills and attention 'glued' by PBF to targeted, often curative services, leaving other areas, (prevention, health promotion, NCDs, OPD) for comprehensive PHC not supported, despite high disease burdens, weakening the comprehensiveness and continuity of care for people.	ADVOCATE FOR IMPROVED PUBLIC BUDGETS AND MORE INVESTMENT IN PREVENTION: National level advocacy by CSOs, HWs and communities aimed to policy and decision makers (Minister of Health, WHO) to improve national health budgets, create community trusts and do far more to promote health and prevent diseases in schools, in training HWs and other health providers and in laws, management and MoH roles.
	REGISTER AND REACH INTO COMMUNITY SETTINGS FOR PROMOTION/ PREVENTION: Register the catchment population and organise health teams to do outreach in schools, markets, and in families and communities and train and work with CHWs to ensure proactive prevention of health risks before they become severe, with incentive funding for these activities.
	APPLY A PEOPLE CENTRED, RIGHTS BASED APPROACH: Use a the Human Rights Based Approach in health services to focus on people and thus both prevention and cure and build the capacity of duty bearers (HWs) to deliver a people and rights centred approach and communities to be involved in planning and improving their health and services. Recognise that primary care services are pro-poor and should not have cost barriers.
	DONT OVER-RELY ON FINANCIAL INCENTIVES: MoH and facilities to identify with HWs other ways of boosting motivation than relying on allowances, such as training, decent accommodation, leave days, promotion and career paths.
IMPACT 3: The external funder driven nature of PBF, decreasing government's responsibility for targeted services, limiting local involvement in decisions made centrally or by funders, and raising concerns about sustainability and adequacy to meet demand	ADVOCATE FOR DOMESTIC FUNDING OF ALL PHC: Civil society to advocate nationally and raise domestic financing for health and especially for ALL PHC services as a right and a duty of government. Do this by adequately taxing wealth, improving the national health budget and earmarking a guaranteed proportion of revenue collected for PHC to improve predictability of long term funding and to address shortfalls when external funders stop
	'VOICE FOR CHANGE' FOR MORE DIRECT EXCHANGES: Civil society to start a local Voice for Change Initiative of bringing direct voices (Hws and Communities) through ground level panels to facilitate a ` direct talk` between HWs, communities, funders and policy makers rather than relying only on representational advocacy-
	ENSURE EXTERNAL FUNDERS COMPLEMENT AND DO NOT SUBSTITUTE NATIONAL FUNDING AND LISTEN TO NATIONAL VOICE: Government should meet its duty to fund PHC and negotiate with external funders on their role to complement this and external funders and government MUST embrace community participation. including consultation meetings with local HWs and residents on what to give priority to and not think on their behalf.

Impacts on Health workers	ACTIONS / CHANGES
IMPACT 1. Adequacy, predictability and continuity of PBF funding, for HW incentives and for facilities, HCCs and training, so that it improves HW pay, income, morale and professionalism, and enables team approaches and HCC support, noting that delayed, low or even halted PBF payments for HWs and facilities undermines these outcomes	INCREASE FUNDING TO LOCAL FACILITIES: National level to increase PBF and general domestic health funding, moving away from reliance on external funding, to adequately cater for HW incentives, long service awards, pay and to cover resources for facilities and HCC capacity building, based on catchment populations and health needs. This calls for advocacy from the district health team and political wing to the national level parliament and MoH.
	PAY INCENTIVES ADEQUATELY, IN GOOD TIME AND TO ALL IN LINE WITH THEIR WORK: Make a deliberate policy that ensures timely and adequately reward of best performers that have achieved targets, and improve ALL HW and staff incomes in line with their level and the work they do with timely PBF payments by national level, funders and district health office.
	INVOLVE HWS IN FUNDING PROCESSES AND BE TRANSPARENT: Use a participatory approach to PBF target setting to include the views of all concerned parties and accommodate HW experience involving local level, end users, HWs , community. The district health office, funders and facility managers should be transparent on funds received and for what, and local HWs included in delegations to global meetings. When funders work through civil society organisations(CSOs), before implementing hold a joint meeting at the local level(i. e the district health team, the funders, CSOs and HWs) to agree on payment terms so that CSOs are transparent with the money.
	PROVIDE TRAINING AND OTHER NON FINANCIAL INCENTIVES: Conduct regular training for HWs and HCCs at local or facility level so than new employees understand their roles - by the district health office and funders- and provide scholarships, bursaries and training as a non-financial incentive. Provide a dedicated fund for HCC support
	BE FAIR, EFFECTIVE AND ACCOUNTABLE: At national level, the government to stick to what has been prioritized by MoH and avoid diverting funds meant for health services, ensure the private sector is involved and covered for uniformity of services and transparency, avoid politicians interfering in local allocations and look for options to pool procurement or collaborate on training to be more cost effective
IMPACT 2: Unfunded areas, such as for NCDs, neglected by and frustrating HWs; biasing services towards particular target areas rather than comprehensive care and effective referral.	IMPROVE DOMESTIC FUNDING OF ALL NECESSARY HEALTH SERVICES: Develop clear and alternative mechanisms to adequately fund non-PBF areas so that they are not neglected, using domestic financing (Community funds, tax, national health insurance) attracting external funds and basket funds so all health care services are funded according to health need MoH, MoFinance and funders
	HARMONISE AND INTEGRATE SERVICES TO BE PERSON CENTRED , INCLUDING: HEALTH PROMOTION: MoH to set clear guidelines to harmonise and integrate funding and provision of PBF and non-PBF programmes and services to avoid neglect of non-PBF areas so that patients go through the same basic procedures, with clear referral procedures, in a person centred approach that manage the different health problems clients come with. MoH and districts to enhance prevention services and health promotion services, including immunisation, water and sanitation, health literacy and forming community health promotion clubs and groups.
	LISTEN TO LOCAL HWS AND COMMUNITIES IN SETTING PRIORITIES: Apply the "pull" system's and not the" push system" where the district health office , the HWs and the community assess the services needed and inform the MoH to look for revenue to fund and ensure inputs and supplies for these areas, including neglected areas like NCDs. Engage also the community on revenue sources and involve communities in monitoring expenditures and client satisfaction with services (such as through local surveys) to make sure resources are applied in line with need, and discuss the findings in facility meetings. WHO (global) should establish committees with representatives of districts to show the picture of what HWs need.
	REVIEW AND ADDRESS SERVICE NEEDS, GAPS AND CONTINUITY: District to lobby parliament and national MoH for funding of all important diseases and MoH to negotiate with external funders before signing agreements, to avoid duplication and gaps in services and to ensure in agreements government funding takes over after external funders stop. Review and update targets regularly and change them where needed and also provide management emphasis to non-target areas. Provide an equity allocation to facilities in poorer districts with high needs.
	LEVER PRIVATE SECTOR RESOURCES: Government to have an MoU with pharmaceutical companies and private laboratories to provide services on areas where public services have gaps

IMPACT 3: Increased demand, work overload, stress, burnout in HWs and competition for targets between HWs, with clients from outside the catchment area adding to queues	FUND AND STAFF ALL FACILITIES TO MEET LOCAL SERVICE NEEDS: MoH to have a staffing needs assessment, improve conditions of service, employ more staff, ensure adequate numbers of facilities for the catchment population and reinforce client-focused HW practice. MoH and MoFinance to increase the budget allocation to health to meet the increasing demand of delivering comprehensive PHC and with district health offices and facilities improve the quality of services provided in each health facility so that clients do seek better care elsewhere.
	BASE TARGETS REALISTICALLY ON CATCHMENT POPULATIONS: MoH and district health teams to set clear, proper and timely incentives for HWs, allocate work that is manageable; base PBF funding on the catchment area(target population) and not on the quantity of clients attended to reduce competition. Hold continuous review meetings between management and staff to review and improve services.

Impacts on Communities	**ACTIONS / CHANGES**
IMPACT 1. Strengthening HCC and community roles given that HCCs are not yet being empowered, supported, trained or funded in PBF; are sidelined or not involved in important decisions, and so are being diverted to managing funds and driven by payments, and a need to enhance information to communities.	RECOGNISE HCCS AND SET THE COMMUNITY AND HCC ROLES IN PBF: Ministries of health to formally recognise HCCs in their structures and to integrate HCC and community roles in health, including in PBF with clear targets and resources for these roles by central government. Provide policy guidelines on election of HCC members by the community, adequate allowances for HCCs and improved working conditions of community volunteers. HCC members to consult communities before feeding in priorities and to get information on budgets, supplies etc, report regularly back to communities and meet regularly with facility in charge.
	SUPPORT HCC AND CHW SKILLS FOR THEIR ROLES WITHIN ALL PROGRAMMES: Give adequate training for HCC members and Community Health Workers for their roles in health planning, promotion, prevention and care work and to support service uptake and accountability, with operations manuals and guidelines by central and local government. Set up an organisation at national level to support and monitor HCC functions and reports.
	INVOLVE HCCS IN DECISIONS ON AND REVIEWS OF PBF: MoH to involve HCCs in district budget planning, in central and district decisions on targets set for PBF, and on its implementation. Carry out surveys of health needs and client satisfaction with services and involve HCC members in required PBF quarterly review meetings. Ensure members of parliament engage with community representatives before finalising PBF agreements.
	EMPOWER HCC HEALTH ACTIONS IN THE COMMUNITY: Empower HCCs to run independent projects that can help the community, supported by funders, government and private sector to add to funding for services and strengthen PHC
IMPACT 2: Inadequate or no funding, facility supplies for services not covered by targets (such as for chronic conditions) leading to fee charges and use of private providers for these areas of care and community confusion on who benefits and who doesn't.	BROADEN PBF! INCLUDE NEGLECTED AREAS AND RESPOND TO LOCALLY IDENTIFIED PRIORITIES: National level (MoH) to respond to growing levels of chronic conditions, to include neglected diseases, including chronic illness and all key burdens in PBF . The district level to work with HCC and community reps in identifying disease outbreaks and other health needs. Local and national advocacy groups to be formed to advocate for funding improvements.
	IMPROVE PBF FUNDING FOR CORE INPUTS (EQUIPMENT, LABS MEDICINES): Central government to provide additional funding and resources (medicines/ reagents, equipment) to improve quality of all services for local facilities and facilities to use other sources.of income (eg community health fund)
	STRENGTHEN AND USE DISTRICT REPORTING AS EVIDENCE FOR RAISING FUNDS: District to routinely report on their population disease profile to ensure all areas are funded and attract funding for unfunded areas. HCC to monitor who in the community and what services are benefiting from PBF and who / what is not;
	STRENGTHEN DOMESTIC FUNDING OF ALL NECESSARY SERVICES: Governments and public to improve domestic funding for health (progressive taxes or mandatory insurance): Create a tax to fund chronic diseases, the young, the old and the vulnerable as a duty of every citizen; collect pre-payments from people with ability to pay, ensure, incentivise and publicise private sector contributions (and violations) and fund community health funds to complement and support community labour and material contributions to PHC.

IMPACT 3: Sustainability of funding, with the community not being informed when funding stops or is cut or inadequate, despite being the ones to suffer the poor quality, waiting times and rising diseases.	ENSURE BRIDGING FUNDS FOR WHEN EXTERNAL FUNDS STOP AND KEEP COMMUNITIES INFORMED: Set national and international policy to include HCCs and community in PBF decision-making and budget processes national to district levels, and ensure HCCs hold regular meetings with the community to hear their views (See actions on impact 2 on improved domestic financing also relevant here). Inform HCCs and community when funding stops, is cut or reduced. MoH, facility management and HCC to ensure planned transitions and hold bridging funds for continuity when external funds stop.
	INVOLVE AND CONSULT HCCS AND COMMUNITY ON FUNDING SITUATION AND PLANS: Include HCC and community in designing work plans, implementing and monitoring PBF activities at the local and national level and share HCC reports and work plans at national level for their follow up at national and local level. Central government /MoH to publicise information on PBF funding through TV, radio, posters, to inform the public, to hold community meetings and take local public input on PBF funding plans.

Common issues across the groups

There were a number of issues that were common across all three groups that we discussed in plenary.

1. All groups identified that ***health services should be more person-centred, integrated and holistic*****,** addressing all the problems people come to services with, integrating prevention and health promotion and involving the community to deliver comprehensive PHC. It was also noted that any funding mechanisms and funding overall should deliver on this and that PBF falls short on it. To take this forward, the comprehensive PHC services at community and primary care level that respond to the major population health burdens and needs need to be defined, including those for promoting health and preventing ill health. These are identified as essential services and as a social right and government duty. There needs to be clear messages and information outreach on these services and the competencies and resources to deliver them.

   Communities should speak out their needs and priorities. This can be done by doing a community needs assessment. The moment they own the problem, they will start finding solutions for it.

   We proposed that PBF funding be widened to appropriately resource CHWs and key prevention services. Communities and health workers need to be sensitised on what PBF is (and is not), what services are funded by PBF (and what is not), and how other key services in comprehensive PHC are to be funded to ensure ALL essential PHC services are funded based on health need. This was seen to call for strengthened community monitoring and reporting of delivery on comprehensive PHC, with review meetings and dialogue with service providers on progress and gaps in delivery and public perceptions of services and issues to address.

   Community health workers in Malawi

   Source: USAID, 2009, creative commons

   I suggest that the targets must be reviewed regularly at least to provide room for switching from a group of indicators to others especially those which were not included in the previous list. This will holistically bring a balance of performance among health indicators

   We also noted that there are real trade-offs between PBF and the way comprehensive PHC is funded. By being selective it can be efficient, but it can also leave gaps in the system. Unless PBF funds the wider collective inputs (equipment, supplies, system needs) for facilities to respond to multi-morbidity (people coming with more than one health problem) and wider needs, it undermines health worker ability to manage clients holistically, or to manage their referral for other services when they need it.

2. We all said that we need to ***improve domestic financing of PHC and reduce dependency on external funds to address a range of negative impacts.*** This should come from taxes and mandatory insurance, so that it is prepaid and not paid at point of care when people are ill. Government needs to meet its Abuja commitment of 15% of the government budget going to the health sector. All PHC services – promotion, prevention, treatment and care - at community and primary care level are seen to be essential and should have consistent domestic funding as a government duty and social right. External funders should complement and not substitute this.
   Government has the obligation to fulfill people's right to health and not external funders.

   We saw that if people are engaged on services and have evidence from the ground, on how services are affected by inadequate funding and over dependence on external funders, this can be used to engage ministries of health and finance at central level on their need to properly fund PHC.
   The ministry of finance can be motivated to increase domestic resources for health if evidence generated from the ground shows how services are affected by over dependence on donors.

   This does not rule out community ownership of and role in supporting their facilities. Communities already contribute through taxes and in some countries insurance. This contribution should be according to ability to pay and as prepayments. While there were contrasting views, most of us felt there shouldn't be charges at public primary care level services, as this is the entry point for the health system and most people using these services are the poorer in society. Tax and insurance finances should be equitably and fairly allocated back to areas based on health needs and workloads. Communities also contribute through participating in health promoting activities and through labour, materials or contributions to community projects that they themselves agree on.
   I suggest that a deliberate policy is formulated by the government which will ensure that a higher percentage of money is allocated to lesser rich district …. an equity allocation.

3. While each group raised some specific ways to improve the performance, reliability, timeliness and fairness of PBF, we all identified advocacy and engagement on ***earlier, more meaningful consultation with local health workers and managers, communities and HCCs in setting targets, funding budgets in PBF***. More generally, this was seen to call for more responsiveness to and flexibility for local priorities, in a pull and not a push system. This included taking local inputs into account in setting targets and funding, with communities represented through HCCs. Together with annual strategic review of PBF programmes, targets and funding, there should also be some flexibility for PBF funds and targets to be applied in a way that is relevant to local health needs and priorities. We suggested that there be an equity allocation within PBF facility grants for weaker districts to improve their capabilities and activities

4. Finally we saw that ***all these processes need training.*** While there has been training on how to achieve targets, there is need for wider skills building, for health workers, HCCs and communities to understand and think critically about their systems and roles, to use information for planning, budgeting and reviewing services and for service communication with different social groups, clients and with authorities.

We collectively reviewed our proposals for action and participants confirmed their agreement with the final set. These are proposals we are making as a region on PBF that we will report and engage on at local, national, regional and global levels. *The list is pregnant with good ideas. I'm satisfied with the list. I know with the passage of time more constructive experiences and ideas are going to shared*

The next section, *Section 7,* briefly discusses the actions we took between January and June 2019 to engage and get feedback from on these proposals in *Table 6* from the local, district and national level in all the sites. We wrote them as ten action points in the form of a more user friendly brief, described in the next section.

We integrated the learning from the engagement we describe in *Section 7* and from our August 2019 review meeting to prepare the final version of the proposals presented in this report in *Section 8.*

7. Implementing and reviewing engagement on our findings

To discuss and engage on these proposals we held group and plenary discussions online to develop an action plan to report and engage on the findings with progress markers of the changes we expected as a result of these planned actions. The actions we developed focused on reporting, engaging on and getting feedback on our findings and proposals at local, district, national, regional and global level. In local offline discussions we discussed the planned actions with health workers and community members in the sites to get their input. *The general consensus in our discussions is that the plans are well drafted in view that the communities are being included in the plan. The community are suggesting involving other structures such as support groups and community based organizations in the actions.* The actions are shown in *Appendix 1, Table A1.*

To support the engagement TARSC with input from all participants, drafted a collective brief on who we are, our PAR process and our findings and proposals for change. This brief was shared with the local facility management, health workers, HCCs and CHWs and with the district and national health management, prior to meeting with them. TARSC worked on a communication strategy for taking the work to regional and global level that was discussed in the August 2019 review meeting. We also distributed relevant EQUINET policy briefs on health financing and HCCs. The action plan reflected a bottom up process:

- In the first round (January-March 2019) we reported back to and engaged with the local facility and district level.
- In the second round (March to May 2019) we took the local feedback into account and engaged with the national level, while preparing input for discussion in August on the international level engagement.

How does target-driven funding affect comprehensive primary health care in east and southern Africa?

BRIEF of findings from online Participatory action research

by R Loewenson, B Kaim, C Thole, A Moyo, T Kabango, W Asibu, P Kalolo, N Machilika, G Mutashobya, B Kijuu, K Abdallah, P Nziramwoyo, J Nassanga, S Nampewo, F Serunjogi, R Namukisa, F Nakamya, I Zulu, A Chiwala, C Mwakoi, E Mutasa, I Katsande, H Madzukwa and L Gordon

Training and Research Support Centre (TARSC)
With Global Hope Mobilization, Country Minders for Peoples Development, Health Promotion Tanzania, Centre for Youth Driven Development Initiative, Center for Health Human Rights and Development, Lusaka District Health Office, Community working group on Health and Maldaba

In the
Regional Network for Equity in Health in East and Southern Africa (EQUINET)

Version January 2019

With support from OSEA and OSF

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We agreed that we would do whatever was feasible within the time and resources available, working within existing processes and forums. We agreed to keep each other informed, with our collective voice leading our action.

> *The chairperson of the WDC said that he was very happy to have met in such a manner because such meetings are rarely called for in the community and said that he was going to table the issues raised from our research with concerns discussed in the meeting to the office of the area MP.*

Reviewing the feedback on our proposals from the local and district level

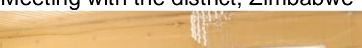
We reviewed the feedback in online meetings in March and May 2019, with progress markers for both meetings shown in *Appendix 5.* We faced a number of challenges in holding the meetings! Zimbabwe was affected by a cholera epidemic in February and Mozambique, Zimbabwe and Malawi were affected by Cyclone Idai in late March, disrupting communications and services. However, by mid-March meetings had been held with the local CHWs, local council office and leader in the area and with the facility management and district health management on the findings. There was interest in the findings and positive feedback on and contributions to the proposals at these levels.

> *We have genuine interest from health workers well as participating community members in the project. This is very encouraging and not to be taken for granted.*

> *We had two successful meetings- with health workers at the facility, with CHWs and the HCC. Participants in both meetings made commitments to improving access, quality and planning for PHC. They identified gaps in the RBF scheme and put in place a way forward for addressing them*

From others we heard:

- *Our local facility management marvelled at the findings and proposals, which made me think that they were not expecting anything worthwhile from us at first. We proved to them that we were worth listening to*
- *Actually the district already asked us to a dissemination meeting for the findings after the whole exercise is finalized and they are looking at a big meeting which will include the DHMT, all in Health charges in the district and all RBF focal persons per health unit.*
- *It was so great meeting with the teams/ leaders. They had a lot to say and comment about the questions we posed to them and what we had come up with during the online sessions, I enjoyed their views especially the DHT members.*


Meeting with the district, Zimbabwe

Source: E Mutasa, 2019

Health workers, CHWs and HCCs strongly agreed with the proposals and encouraged adoption of the suggested options that they felt would make an improvement. They added further experiences to reinforce their support for the proposals:

> *In the meeting with CHWs and HCCs, one member expressed the pain she had about the limited resources we have at the health facility. She told a story of a woman who was complaining of an illness which could not be diagnosed at the public health facility. She was referred to another facility but did not go there due to financial constraints and she ended up losing her life. They commented that there should be a way through which views can be taken up to the higher level so that their concerns are heard and reacted on basing on their needs.*

The district level also agreed with and took the findings seriously, often point by point.

> *The authorities were open to discuss our issues and comment on our findings. They also found them relevant. The other thing we also experienced was that this was somewhat an eye-opener to them on the need to assess the impact, shortfalls and successes of the PBF. There were many gaps they themselves saw needed critical analysis and requisite action to address them.*

In some settings the district was more cautious, primarily as they felt that funding was a big constraint to implementing changes, and as the authorities for the proposed changes lay at higher level.

> *One officer at District level said that our research was like opening the Pandora box in that there are many gaps in the PBF that are not critically analyzed and addressed and most officers have not been able to query for many reasons.*

The inputs from the discussions are integrated in the proposals in *Section 8*.

As a summary of the inputs made at local and district level, the proposals were generally welcomed by all. The proposals with strongest support were to fund chronic conditions and community outreach for prevention and health promotion; to harmonise PBF and non PBF services; to provide communities with information on PHC and PBF and to provide CHWs and health workers with regular in service training; to use both financial and non-financial incentives to motivate all in teams in line with their work, including CHWs and HCCs; and to have adequate support, supervision and communication from the district. There was support for improved communication at all levels, for regular meetings; quality improvement sessions and interaction with communities with updated registers of catchment populations. There was also support for improved transparency and consultation on PBF funding, on achievement of targets and on changes in funding and shared concern on sustainability of PBF funding.

Various challenges were noted at local and district levels in implementing the proposals, particularly in how to fund services for neglected conditions, community assessments, salaries, HCC costs, CHW allowances, training and other inputs. This was especially the case for inputs controlled at national level. The districts raised challenges of delayed disbursements and lack of information from national level and from facilities. While there was agreement that targets were too limited, they noted that external funders have significant influence in setting targets, that there are interests around specific programmes and that if locally set they may be susceptible to political influence. There was some concern that publishing funding information may raise unfair demands on facility managers unless the information is well understood. They also raised some additional proposals, such as establishing health posts in the community and doing active health screening in and by the community.

In discussing the feedback, we saw that we need to ensure that all those we are engaging with understand the principles and elements of PHC, including health managers. We also saw that many challenges can be addressed with improved communication with communities, local health workers and managers, giving people involved a sense of ownership rather than imposing on them. A lot of challenges arise when this is not happening. As higher level officials (district and national) who make decisions don't live in and have weak contact with local levels, we need to have more consistent ways of engaging them from the local level.

Decentralising management authority and capacities to local level could also assist to overcome some bottlenecks, but this needs measures and capacities for transparency and accountability and improved literacy on PBF and PHC in communities, CHWs and HCCs; as well as laptops and software for data analysis in the facilities; and HCC capacities to monitor use of funds. The CHWs and HCCs were seen as key for embedding PBF in PHC, but need to be recognized in law, with budget resources for their training and functions.

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

The discussions again called for improved domestic financing for facilities. There was concern of PBF's reliance on external funding and concern on what happens when external funders pull out.

> *The community I live in is blessed with natural resources varying from minerals to wildlife whose value is sufficient for its population for years and years. But …nothing is being ploughed back, even for building roads, schools or clinics.*

Reviewing the feedback on our proposals from the national level

By May, participants had met with national level ministry of health officials to obtain their feedback on the proposals. Here too there was excitement in a number of countries with the PAR process and the fact that the evidence was coming from community and facility level. They wished it could be expanded to reach other areas. One medical officer said: *I wish this research covered many sites……because we have similar challenges in the rest of the districts.* A number were keen to learn about the PARONLINE approach.

> *When the Ministry sees that community facility are involved from inception they have confidence in the program*

National officials were open to discussing the findings, saying that they found them to be valid. They welcomed the proposals and appreciated the feedback. There was strong interest in the PAR approach as it gives bottom-up voice. They called for the final PAROnlne report to be disseminated widely at all levels, nationally, regionally and internationally, with suggestions of report at stakeholders meetings with ministries of health and other ministries, including finance and development partners, CSOs and EQUINET. One ministry saw that regional findings help to show common features across countries, but wanted to know more about the variation between countries, such as in how far the PBF is supply or demand driven. This was not a focus for the PAR but can be explored in further processes. Decision

makers at all levels pledged to implementation of proposals that they supported. In some countries, the research findings were seen to come at a good time, as the ministries were developing policy, guidelines, training materials or strategies on HCCs, CHWs and community based health systems.

In particular, national officials supported proposals to invest in and strengthen promotion and prevention services and people-centred PHC approaches, including as a basis for multi-sectoral collaboration and community engagement; for integrating NCDs and all major health burdens in PBF; for overcoming biases in PBF towards better performing districts; and for formally recognising, resourcing, training in local languages and supporting HCC, CHW and community roles, including in PBF.

> *There is need for the HCCs to be provided with support and guidance for their duties to avoid friction between them and health workers, and to properly represent their communities.*

While PBF was seen to have merits, it was also seen to have a short term focus and to not always be aligned to national systems and strategies. There was agreement that incentives of different types be for all those providing the service, including CHWs and HCCs, with training and processes for quality improvements. Ministry stakeholders agreed on the need to facilitate dialogue between health workers, communities, HCCs, external funders and policy makers on PBF and on the planning, budgeting, implementation and assessment of the services at local level. As specific operational issues, national officials agreed on the need to take the catchment area and target population into account when allocating PBF; to strengthen quality improvement processes and include service quality and clients satisfaction with facilities in monitoring and to provide clear tools or guidelines on for supervision. They agreed that CHW should be part of the facility finance meetings to support social accountability.

Many of the areas people did not agree with in PBF are things we also disagreed with, including political interference in PBF; the gap in information flow especially to local levels; the dependency of PBF on external funding and the fact that incentives don't replace fair pay for all. In discussing political roles, we felt that politicians should not be involved in budget disbursements, but that their support for programmes is important: *Depending on country context, it is very important to engage politicians. Politicians are decision makers…The technocrats like medical officers are key on the technical role but for whatever they design they need the approval by politicians. … they have both power and influence. I'd suggest that we better explore best ways of engaging them rather than leaving them behind.*

Officials raised concern that incentives send the wrong signal to health workers who are already paid and doing their jobs, and that this can lead to 'gaming' for money, brain drain in those not covered and can make services too supply driven. It was agreed that incentives need regular review, and shared concern that too much staff time is spent on inflexible procurement procedures. *On incentive issues …what remains key is to ensure consensus among providers – what they see as fair and justifiable.*

The national meetings pointed to operational difficulties with implementing the proposals, such as harmonising different programmes when they are funded separately; and the lack of domestic funding to broaden service areas or provide new facilities and meetings, even though they may be agreed to.

The feedback on the proposals from these meetings was discussed online and at our regional review meeting in August 2019. We appreciated the firm commitments to act on some of the findings in different levels, where the mandate exists at that level, while also noting that many actions will take time. In our August meeting we discussed strategies for further following up on the proposals at local, national, regional and global level, noting the introduction of PBF into a region in which the PHC approach has been a longstanding policy commitment across all countries of the region.

The feedback we received from local, district and national has been integrated in our proposals in *Section 8*.

August 2019 Regional PAROnline review meeting

Source: TARSC, 2019

8. Our proposals on PBF and comprehensive PHC

From our research with health workers and communities in seven primary care sites in five countries and our follow up engagement with local, district and national health authorities in those countries, we have identified four major areas of action and ten proposals within them so that PBF enables and does not detract from comprehensive PHC. Using different names, PBF has been applied in all of our countries. While our contexts and some specific features may vary, we have been struck in this research by how common our experiences and issues have been relating to PBF in our local facilities. We make these proposals at regional level based on our shared analysis, for PBF to enable and not detract from our longstanding policy commitment in our region to comprehensive PHC. Countries already applying any of these measures can share useful experience on this in the region.

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

For this, we propose that we

A1. Apply a people-centred, rights-based approach, reaching into community settings for promotion and prevention.

A2. Harmonise and integrate services and broaden the scope of PBF, and

A3. Include neglected areas and locally identified priorities in PBF.

Community health activities, Lusaka, Zambia

Source: A Zulu, 2011

This implies specific actions within our health systems to:

a. Register or update registration of catchment populations to plan and deliver services, noting that this is difficult for nomadic people.
b. Ensure that PBF is aligned to PHC, to the national health strategy, to demand-driven programmes and to community health strategies and programmes.
c. Define, ensure resources and competencies for and provide public information on the essential PHC services that respond to major population health burdens, including for promoting health and preventing ill health, as both a social right and a government duty.
d. Fund, including from PBF, capacities, supplies and services for growing levels of chronic conditions and non-communicable diseases, for management of outbreaks, disease surveillance and for health sector roles in social determinants like gender-based violence.
e. Provide an equity allocation to facilities in poorer districts with high needs.
f. Focus on person-centred prevention and care as a right, making clear how *all* PHC services are to be funded for *all* parts of the community, including funding for key preventive and health promotion services in PBF.
g. Set and apply guidelines to harmonise the funding and provision of PBF and non-PBF services, so that clients go through the same procedures in a person-centred approach. Provide public and health worker (HW) information on PHC, on PBF.
h. Enforce public health laws and enhance prevention and health promotion, including health literacy and clubs, immunisation, water, sanitation and waste management.
i. Both from government budgets and PBF, train and fund HCCs and CHWs and the transport, supplies and other resources they need for their health promotion, community health literacy, social organisation roles, as well as health team outreach in schools, markets, religious settings and in communities.
j. Share and use evidence to review and report on performance quarterly, comparing local and national performance, and to update targets regularly, changing them where needed.

B: We should improve domestic financing for PHC and reduce dependency on external funding

For this, we propose that we

Primary care health centre, Uganda

Source: R Namukisa, 2019

B1. Strengthen domestic funding of all PHC services, with external funders not substituting national funding and voice.

B2. Resource facilities to meet PBF service needs, addressing gaps and ensuring continuity, and

B3. Make adequate payments in good time, and pay incentives to all in line with their work.

This implies actions at different levels and by funders to:

a. Provide credible evidence to support negotiations for sustainable domestic health financing, including staffing needs and workload assessments, and report and use population evidence, disease profiles and workloads in districts to advocate for funding needs and for equitable resource allocation.
b. Show evidence to Ministry of Finance from community and primary care level of the real costs of poor domestic financing.
c. Improve the national health budget, meeting the Abuja commitment of 15% domestic government budget to the health sector and 5% of GDP.
d. Provide domestic financing for all PHC services using progressive and earmarked taxes and mandatory insurance as pre-payments based on ability to pay, complementing private sector payments and community labour and material contributions; and adequately fund non-PBF PHC services domestically.
e. Earmark a guaranteed proportion of revenue collected for PHC, for prevention, for managing chronic conditions and for vulnerable groups, to improve predictability and equity of funding.
f. Publicise subsidies to the private sector and lever private contributions for health.
g. Ensure external funders complement and do not substitute government funding.
h. Avoid unpredictable funding flows, plan with local managers and HCCs on measures to ensure sustainability of funding when external funders stop, including holding bridging funds.
i. Apply an equity allocation within budgets and PBF facility grants, taking capacities, the catchment area and the target population into account, and ensure timely disbursements.
j. Fairly allocate work, set clear incentives, allocate work that is manageable and ensure adequate reward for achievement of goals and targets for ***all*** staff in line with their level and the work they do and carry out continuous review of incentive measures.

C: We should ensure earlier, more meaningful consultation of the local level of health systems and their involvement in decisions

For this, we propose that we

C1. Formally recognise HCCs and community roles in PHC and PBF.

C2. Don't impose targets! Involve and listen to HWs, communities and local managers in planning, budgeting and setting priorities, and

C3. Strengthen information and accountability on health systems.

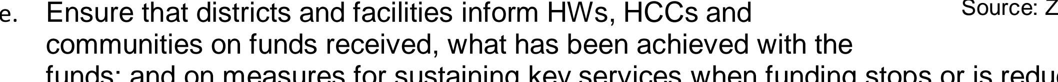
This implies specific actions within our health systems and by funders to:

a. Recognise HCCs in law, with guidelines and resources for their election by the community, term of office, functioning and training and reduce burdens that discourage participation.
b. Train for and resource HCC, CHW and community roles in PHC and in PBF funding, for health literacy and for community diagnosis on health needs and priorities.

Health Centre Committee discussing policy on HCCs, South Africa

Source: Z Sofayiya 2014

c. Involve HCCs and CHWs in community and health facility review meetings; and HCCs in district budget planning, in decisions on PBF targets and in evaluating PBF performance.
d. Include the inputs of HWs, community, HCC, local managers on PBF targets *before* implementation, including through community assessments of service priorities, include have some flexibility on PBF for targets relevant to local needs and priorities and facilitate HCC monitoring of PBF and client satisfaction with services for dialogue with facilities.



e. Ensure that districts and facilities inform HWs, HCCs and communities on funds received, what has been achieved with the funds; and on measures for sustaining key services when funding stops or is reduced.
f. Review services at facility level with HWs and HCCs to improve services and approaches, and with HCCs avoid funds meant for health services being diverted to other purposes.
g. Set up a national forum to review HCC functions and include HCC and local health worker representation in national planning and in global meetings, including on external funding.

D: We should ensure training and capacity support for PHC

For this, we propose that we

D1. Provide training, non-financial incentives, supervision and support for health workers and HCCs

This implies specific actions within our health systems to:

a. Conduct regular training for HWs through on the job training or mentorship.
b. Train and support HCCs, CHWs and other community structures for roles in health planning, promotion, prevention and care, in patient rights and in ensuring service accountability.
c. Identify with all HWs non-financial incentives for boosting motivation such as training, decent accommodation, leave days, career paths, scholarships, bursaries, training and insurance.
d. Provide, whether from PBF or other funds, the necessary resources (medicines/ equipment, supplies/ IT) and processes for quality improvement of all services at local facilities.
e. Use bulk procurement for medicines and collaborative training to reduce costs.
f. Improve supportive supervision for facilities in line with a clear service package and standards.

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

Common to all our proposals we identify that health funding and the mechanisms used should deliver person-centred, integrated, holistic services, that involve the community, that include health promotion and that prevent and address all common health problems.

The current application of PBF falls short on comprehensive PHC. We observed 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 PBF funds the wider collective inputs (equipment, supplies, system needs) for facilities and includes promotion, prevention in the community, we will not improve population health. This calls for improved domestic funding to meet the gaps in PHC services. It also implies that PBF as a significant funding stream integrate resources and measures for these system inputs and for more holistic health services.

PBF aims to strengthen bottom-up accountability in service planning and delivery. HWs and community members appreciated the improved resourcing of targeted services and facility HWs were motivated by improved incomes from the incentives. However, neither felt empowered by PBF. Local HWs and HCCs appreciate the evidence-led improvements, but feel that their views and evidence are disregarded. They see themselves largely as implementers of targets defined at higher levels and of administrative measures for upward accountability to higher levels and to external funders.

9. Our reflections and learning from doing PAR online

In walking through the PAR 'journey' from the beginning, we compared how in our research we had moved through the stages of the PAR spiral, concluding that we had achieved all stages, while recognising that we continue to act, evaluate and learn from action. We discussed the process so far, what we found positive, what difficulties we faced and our perceptions of doing PAR online. Regional facilitators used both manual and online tracking of participation, including to solve problems. *Table 7* below shows participation levels across the steps.

Table 7: Participation levels in the sessions

Step	Total participant sessions (*)	Total participated in	% Total participated	% Signed Off
STEP 1	126	100	79.4	100.0
STEP 2	105	70	66.7	76.2
STEP 3	126	96	76.2	76.2
STEP 4	161	139	86.3	42.9
STEP 5	105	83	79.1	81.0
STEP 6	168	134	79.8	71.4
STEP 7	210	139	66.2	90.5

(*) *Total Participant Sessions* = total participants x total sessions (excludes introductory sessions where there was no discussion). *Total Participated In* = total sessions x participants who participated / total participant sessions

All steps had a participation level two thirds or above. The highest level of participation (>80% participating) was in the sessions below (see the protocol in *Table 1* for session detail)

- Step 1 sessions 1,3,6 and sign off
- Step 2 sessions 3 and 4
- Step 3 sessions 2,3,4,5 and 6
- Step 4 sessions 3,4,5,6 and 7
- Step 5 sessions 2,5 and 7
- Step 6 sessions 3,5 and 7
- Step 7 sessions 1a, 5a, 7b and 8

While sessions with high participation were generally those involving individual inputs, such as on charts or voting, the variation in participation did not always relate to the session type. There were other factors unique to the site (cyclone effect, internet problems, study issues). There was no obvious trend in participation. It rose and fell at different times and in different steps and sessions. The above two thirds participation in all steps and 91% final sign off reflects a sustained commitment to the process.

The positive experiences and reflections

In our various online discussions and at the August 2019 review meeting, people raised that the programme was *ground breaking, so interesting and educative.* We saw how similar our situations were in different countries and how exciting it was to share common experiences *….like being in the same room together!* Some key steps were taken before the online process started, including the dialogue in the pra4equity list on the protocol; testing the site to ensure it was 'user-friendly'; preparation by TARSC of a Regional Facilitators Guide; and a regional meeting to orient on PBF, the research questions, the steps in the PARonline and for people to use a model of the web-platform. The regional meeting as a face-to–face process helped to build confidence and links before we met on line.

> *Had we not dedicated first to meet in Nairobi and build our 'PARonline relationship' participants might not have been comfortable sharing their experiences and developing subsequent actions.*

When the online process came alive, it generated energy as we experienced the exchanges! *The excitement I have with PAR is that it put in me a unique sense of responsibility where by it keeps ringing in my mind that each day I have to visit the PAR platform.* The site was easy to use. Any terms and tools that were initially difficult and demanded facilitator guidance became easier to work with over time: *At first when I was not used to it … but with the passage of time I grew to love it and never wanted to miss it.* Good co-ordination, timely reminders and supportive country and regional facilitators helped

in overcoming challenges and in enabling participation, building links in the dialogue: *The process was well coordinated! Thanks to our regional facilitators for tirelessly making it possible, making sure no one is left behind. This built my confidence to carry on.*

Having teams of three people for each site worked well. When actively supported by their country facilitators, people were regularly online, managed issues with greater ease and worked together in overcoming difficulties and facilitating off line meetings. When this was weaker, the regional facilitators played a greater role. We had to work well as a regional team for the process to work.

> *This PAR research project so far is filled with highs and lows, late nights and early mornings, hahaha. However, my commitment to learn and personal vision to be part of a team to produce quality PAR research findings …all contributes to my determination to accomplish its goals. I am and continue to be passionate about the unique research topic and methodology.*

The four offline local discussions in each site deepened and included experience and views from community members and health workers in the sites and validated findings at key stages: *Respondents participating directly in the research is also amazing. PAR actually saves alot of time and energy because data collection and analysis is all done during the research by the respondents themselves.*

The PAR tools were accessible and enabled us to see common experiences and issues across countries and to develop shared solutions. Individually filling tools before discussing them and having prompting questions and summaries helped to focus discussions. The steps were seen to flow and to advance from simpler to more complex levels in an organised way: *The easy part was that the steps were just flowing in a systemic manner. I could easily link the previous topic to the on-going while shaping up the following step.* The online site enabled live discussions between us 'on one platform' in a friendly, free and unbiased way: *I had time to talk my mind out without fear or even threats.* When many people were online and discussions flowed, we shared ideas and experience, enabling collective validation: *It was an interesting experience to tease out ideas online…easier with more people online.*

Participants pointed to the 'spiral PAR process as 'an amazing journey' that helped to follow a logical and process of discovery: *PARONLINE is the longest forum that I have stayed connect to with active interaction with colleagues across the region.* It was done over a year, allowing *time to reflect, learn, act and give feedback*. Participants commented that this pace of contributions gave time to *review whatever has been discussed when am off line and catch up with others.*

Participants valued the structured sharing of experience and analysis across countries: *To me what I found new is having a research done in many countries at the same time…From this research I learnt that African countries share the same challenges. I did not know that we had the same health issues.* It took people out of their local settings and made links across countries, building a sense of what is regional and common and the relevance to each country. We were able to share local experience across the region, to build understanding of our differences, to identify ignored issues and to build shared proposals for progress.

The challenges

We also experienced challenges in doing PAR online. *Internet problems, including having poor internet access or a disrupted network*, were the most commonly reported problems. While access to internet was a criterion for participation, access was inconsistent. Slow internet affected how well certain site features worked and made the discussion space less easy to use. *We* generally solved technical problems quite quickly and extended timings for a few sessions if problems or discussion demanded it, the session records assisted people to catch up as did emailed summaries from the facilitators.

Some faced difficulties with *finding time to come online* and unexpected events like cyclones! People came online at all hours and had different possibilities for staying online. This made facilitation sometimes nearly a 24 hour process! Very brief online time did not enable exchanges between participants. *Collective validation* worked well in the structured tools. However, having few people online at a time and a narrow discussion space made discussions less feasible for collective validation:

The difficult bit was that it was not easy at all for all the group members to be in the discussion room at the same time. This is different from the face to face discussion…. where I can keep people engaged. Having summaries and explicit requests for delegates to indicate agreement on questions and summaries helped. While we could 'talk' across many kilometres, we missed the faces, laughter or sighs or the noise of an excited discussion of face-to-face discussions.

The discussions faced a challenge in the design of a very narrow space for it. Participants did not always to 'listen' to what others said unless prompted, and found it difficult to follow a discussion when only able to see a few 'inches' of what had happened before. Scrolling up and down was possible, but difficult when internet was slow, leading to discontinuity and repetition. *Face to face has no network and power interruption. More ideas are easily generated via facial expressions and gestures. Some questions get immediate responses. Views and visions can be easily shared.* Facilitating the process was demanding, sometimes simultaneously in three chatrooms and was not as easy as face-face facilitation. It was, however, invigorating when the conversations flowed, when interesting ideas and collective results emerged and people generated new knowledge.

Despite the challenges, people overcame hurdles in an impressive way that showed great commitment! Most didn't give up. For example: *During the discussions, one of my team participants enrolled for a course but still made a huge effort to contribute… at one point she did not have a house helper home to stay with her children as she goes to work, but...she also managed to continue to participate online. I can't visualize that being possible within the traditional face- to -face group setting. So amazing!*

Suggestions on next steps

This process has changed us all personally - *I think this research has woken up some people to do what they are supposed to do for the community in order to full fill their rights to health , it has built our self-reflection, collective knowledge and learning and also built us as a "team" and a PAROnline family.*

We made proposals for improving the process in our final session and in the August 2019 meeting. We suggested we may have more people online if we implement the PAR at collectively agreed times, such as set times on weekends. We suggested future versions be smartphone compatible and send prompts to absent participants. We could use audio and video options and emojis for interactions, to lessen the challenges of not being face-to-face. The discussion space needs to be made more accessible for seeing full conversations. We agreed to continue to engage on our findings at all levels and to consolidate the improved relationships built between communities and health workers.

Discussing next steps at the August regional meeting

Source: TARSC 2019

Many agreed that it would be useful to do the same research questions and online process, but with a wider group of people in the region: *First and foremost, this PAR online is a great innovation… Being a pilot we could scale up to other catchment areas within our regions.* This may be done in three weekends with everyone online at scheduled times, connecting new groups with ongoing engagement.

Ideas were raised for relevant future online research, including mental health for youth, the urban health divide, monitoring other global funding; and the commodification of food and living conditions. In the August meeting we proposed a research question on: How can we improve the health and well-being of young people in urban and peri-urban areas in our region, with a particular focus on their mental health? as a way also to include new actors in the PAR.

From the initial idea mooted in 2014, through the many processes and people's inputs thereafter and with the support of partners, we have successfully demonstrated in our region that it is possible to do and generate useful learning from a systematic PAR process across countries online. We have tested an innovation and in doing so we have opened new possibilities for using PAR to transform our health and wellbeing.

Appendix 1: Proposed actions to engage on the findings

Table A1: Proposed actions to report and engage on the findings

(KEY: HW = health worker HCC = health centre committee CM = community members CSF = country site facilitator MoH = Ministry of health CHW=community health worker)

1. AT LOCAL, DISTRICT AND NATIONAL LEVEL

AREA PROPOSED	ACTION	BY WHOM	WHEN	PROGRESS MARKER
1. APPLY A PEOPLE CENTRED, RIGHTS BASED APPROACH, REACHING INTO COMMUNITY SETTINGS FOR PROMOTION/ PREVENTION: a. (District) Focus on people and their comprehensive service needs (prevention and care) as a right and the capacity of HWs and services as duty bearers to deliver this b. (Facility) Register the catchment population and organise health teams to do outreach in schools, markets, and in families and communities c. (District) Train and work with and fund CHWs to ensure prevention of health risks. d. (District) Recognise that primary care is pro-poor and should not have cost barriers. e. (District; facility) Empower HCCs to run community health activities and mobilise support for services and PHC f. (District; facility) Widen public and HW information on PBF, what it funds and make clear how other services are to be funded to ensure funding of ALL essential PHC services.	1. HWs and HCCS will propose to, discuss and agree with facility management a comprehensive plan for promotion and prevention services that is evaluated and reviewed every three years 2. HWs and HCCs locally to meet with the ward and other local leaders to present and discuss these proposals with them for them to take the views up at higher levels 3. Provide HCCs a working space in the facility for members to meet, including with HWs and community members and higher levels	1. Health workers and HCCS talking to facility management 2. HWs and HCCs (with CMs) meeting with the local (ward) and community leaders 3. HCCs and HWs talking with facility management	1. Propose the idea by March 2019 2. Hold the meeting before March 2019 3. Raise with facility management by March 2019	1. Health workers, HCCs and facility management have met and agreed to prepare a facility plan for health promotion and prevention March 2019 2. A plan for health promotion and prevention is in place after 1 year and evaluated and reviewed after 3 years 3. Local leaders know and support the findings and proposals of our work 4. HCCs have a working space at the clinic
	Provide anonymised stories of the negative consequences of not funding PHC and the supplies etc for it at primary care and community level to be used in advocacy work	CMs and / or HWs co-ordinated by country facilitators (note who does this will be voluntary and will vary by site)	Discuss and identify stories by March 2019	Stories of the negative consequences of not funding PHC at primary care and community level written and shared
	1. Discuss the findings with the local CHWs to get their views and inputs on how they see their role in prevention how to improve this 2. Include this input in the general discussions with facilities and district (as below) 3. Discuss with CHWs their views on how to strengthen their role and identify strategies, including possibly forming an association of CHWs	HCCs	By March 2019	Discussion held with CHWs

AREA PROPOSED	ACTION	BY WHOM	WHEN	PROGRESS MARKER
2. DON'T IMPOSE TARGETS! INVOLVE EARLY AND LISTEN TO HWS, COMMUNITIES AND LOCAL MANAGERS IN PLANNING, BUDGETING AND SETTING PRIORITIES: a. Use participatory approaches to PBF funding and target setting to include the views and experience of HWs, community, HCC, local managers BEFORE implementation. Use community and local assessments of service priorities in a "pull" not the" push system". b. (District) Routinely report on population disease profiles to advocate for funding needs. c. (District health office, funders and facility managers) Be transparent with HWs and community on funds received and their purpose. d. (HCCs) Hold regular meetings with facility HWs, mangers and community on their views. e. (Communities, HCCs) Monitor expenditures, who is and is not benefitting from PBF and client satisfaction with services and discuss the findings in facility meetings. f. (Facility, district, MoH) Include some flexibility on PBF funds and targets so they can be applied in a way that is relevant to local health needs and priorities. g. (District) Inform HCCs and community when funding stops, is cut or reduced. h. (Civil society) Start a local Voice for Change Initiative of bringing direct voices through panels to facilitate ` direct talk` between HWs, communities, funders and policy makers i. (Local level) Show evidence to Ministry of Finance from community and primary care level of the real costs of poor domestic financing.	HWs and HCCs locally to meet with the ward and other local leaders to present and discuss these proposals with them for them to take the views up at higher levels, to both MoH and funders	HWs and HCCs meeting with the local (ward) and community leaders	Before March 2019	Local leaders know and support the findings and proposals of our work Local leaders take up agreed proposals to higher levels (MoH and funders)
3. PAY INCENTIVES ADEQUATELY, IN GOOD TIME AND TO ALL IN LINE WITH THEIR WORK: Make a deliberate policy that ensures timely and adequately reward of best performers that have achieved targets, and improve ALL HW and staff incomes in line with their level and the work they do with timely PBF payments by national level, funders and district health office.	Health workers and HCCs to collectively discuss, agree and propose how incentives should be distributed between all at the facility to fairly recognise workloads and skills and promote team work, and discuss their proposal with facility and district managers.	Health workers and HCCs talking with facility managers and then district managers	Internal discussion between HWs, HCCs and facility managers by March 2019	1. Health workers, HCCs and facility management have met and agreed on a proposal for fair diistribution of incentives

AREA PROPOSED	ACTION	BY WHOM	WHEN	PROGRESS MARKER
4. PROVIDE TRAINING AND NON-FINANCIAL INCENTIVES for HWs AND HCCS: a. (Districts, funders) Conduct regular training for HWs in continuous professional development through on the job training or mentorship. b. (District, MoH) Train and support HCCs and Community health workers on their roles in health planning, promotion, prevention and care and service accountability, with dedicated funding and operational guidelines and manuals for their support. c. (MoH; facilities) Identify with HWs other ways of boosting motivation such as training, decent accommodation, leave days, promotion and career paths, scholarships, bursaries, as non-financial incentives	Health workers and HCCs to meet with the district to discuss and organise 3 monthly on the job training for HWs and induction training for all HCC members	Health workers and HCCs talking with district managers (as relevant with CF present)	HWs and HCCs meeting held with district managers on training plans by March 2019 Dates and training agreed and initiated before March 2019	Health workers, HCCs and district management have met, discussed and identified a plan for HW and HCC training
	HW, HCC and facility managers to conduct quality improvement meetings quarterly to see how they are performing on various indicators and close up gaps.	HWs and HCC talking with facility managers	By March 2019	HW, HCC and facility managers have held quality improvement meetings with follow up actions identified
5. STRENGTHEN SUPERVISION AND ACCOUNTABILITY: a. (District, MoH) Improve supportive supervision at facilities and from higher levels in line with national standards (clear service package). b. (Facilities) Review services with HWs and HCCs to improve services and approaches. c. (District, managers) Emphasise all services and client-focused HW practice as management, including for services not covered by PBF/targets. d. (District, facilities, HCCs) Avoid funds meant for health services being diverted and interference by politicians in local health service/ PBF allocations.	1. Health workers, HCCs to meet with the facility management to identify concrete options for involvement of HCCs, HWs, community members and local Health CSOs in service review and feedback at the facility, including through HCC interaction with communities	Health workers, HCCs and community members talking with facility managers and communities	Discussion between HWs, HCCs and facility managers by March 2019	1. A joint meeting held with facility management on options for involving HCCs, HWs and CMs in service review and feedback at the facility 2. Options for involving HCCs, HWs, CMs and local health CSOs in service review and feedback at the facility
	HW and facility managers conduct self quality assessments (SQA)quarterly so that they can rate themselves with their performance and what their standards In the SQA are and make improvements to try and reach the standards set.	HWs and facility managers	Discussion between HWs, and facility managers and tool set up for SQA by March 2019	HW and their facility managers have met and understood on how to use the SQA tool for self assessment

2. AT NATIONAL, REGIONAL AND GLOBAL LEVEL

AREA PROPOSED	ACTION	BY WHOM	WHEN	PROGRESS MARKER
GENERAL , CROSSCUTTING POINTS and a note that we will do whatever we can as feasible within the time frames we have, the resources we have and whereever possible	Produce a collective brief on who we are and how we came up with the proposed areas of change in the PAROnline process and the key features of comprehensive PHC	Brief drafted by TARSC for input by all as a short interim document of selected information to support the initial engagement on the findings).	By March 2019	A draft produced, the group's input obtained and the brief finalised

AREA PROPOSED	ACTION	BY WHOM	WHEN	PROGRESS MARKER
within the existing processes and forums we are involved in and working with other organisations we work with and that we will keep all informed at all levels	Develop a communication strategy for taking the work to regional and global level, identify the key organisations to target, what their positions are, who are allies and who would disagree and where and with what information to communicate for review by the full team in the August 2019 meeting	Draft by TARSC/ EQUINET with input on specific areas by country facilitator organisations	By May 2019	A draft strategy produced for review by the August 2019 meeting
	1. Set up a live question and answer document on questions, opposing views likely to be heard / heard ion taking up our proposals with answers on how they can be addressed that can be updated as we go	A HW/CM/CF from each team to act as focal point for providing the questions / objections and how they answered them. A volunteer from the full team to facilitate	Ongoing with inputs By March 2019 and May 2019	A Q and A document that is being shared with nd used by all teams
	For the FINAL report being reviewed in August 2019 use it to prepare suitable briefs for different audiences (different format for community, HWs, district managers, national managers, funders) in face to face meetings	TARSC to prepare a draft full report of the work for input by all as a collective product. Discussion on the policy briefs for specific audiences in the review meeting	Review of the draft report and audience specific briefs in August 2019. Targets suggested in May 2019	Full Report of the PAROnline produced Report used for audience specific briefs produced
	1. Set up a live question and answer document on questions, opposing views likely to be heard / heard ion taking up our proposals with answers on how they can be addressed that can be updated as we go 2. Within country liaise (in person or by email/etc) between the CSF, CM and HW on implementation	1. A HW/CM/CF from each team to act as focal point for providing the questions / objections and how they answered them. A volunteer from the full team to facilitate 2. CSF, HW and CM	To be discussed in August 2019	External global funders engaged on the key issues on PBF and PHC arising from the PAR
	Build and share learning and insights on the value of, challenges and potentials in using an Online platform for PAR on issues affecting local sites across countries in the region	TARSC/EQUINET and PAROnline community	Identify learning from experience for discussion by May 2019. Discuss in August 2019, output by end 2019.	Experiences of online PAR shared Insights from experience of PAROnline reviewed and learning reviewed....and documented.
6. HARMONISE AND INTEGRATE SERVICES TO BE PERSON CENTRED , BROADEN PBF AND PROMOTE HEALTH: a. (MoH) Establish the specific PHC services that respond to the major population health burdens and needs, including for promoting health and preventing ill health, as essential,	Make clear and widen awareness of the features of comprehensive PHC as articulated at Alma Ata and adopted in policy in the region, and how our proposals on PBF deliver on this	HWs, CMs, CSF organisations in PAROnline talking/ engaging in a range of ways with CMs, HWs at facilities (and with CSOs and HW organisations nationally) and other national organisations with support from TARSC/EQUINET	By May 2019	Increased understanding and support by key target groups of features of comprehensive PHC and how the proposals on PBF strengthen its delivery by May 2019

AREA PROPOSED	ACTION	BY WHOM	WHEN	PROGRESS MARKER
as a social right and a government duty. b. (MoH) Provide clear information to the public and HWs on the comprehensive PHC services that should be provided at community and primary care level, and the competencies and resources to deliver these services. c. (MoH; Int) Set clear guidelines to harmonise and integrate funding and provision of PBF and non-PBF programmes and services so that patients go through the same procedures, in a person centred approach for the health problems clients come with. d. (MoH, districts) Enhance prevention and health promotion services, including immunisation, water and sanitation, health literacy and forming community health promotion clubs and groups.	Engage facility managers at the primary care services, the district level and national level MoH to set clear guidelines to harmonise and integrate funding and provision of PBF and non-PBF programmes and services so that patients go through the same procedures	HWs, HCCs and country facilitator organisations	By May 2019	1.HWs, HCCs and facility management have met, agreed to have facility guidelines to harmonise and integrate funding and provision of PBF and non-PBF programmes and services and raised this with the district 2. CSF organisations have met MoH and agreed to have facility guidelines to harmonise and integrate funding and provision of PBF and non-PBF programmes and services 2. Facility guidelines to harmonise and integrate funding and provision of PBF and non-PBF programmes and services have been prepared
	Identify legal resources for litigation (court action) on health issues and violations of health rights and law where relevant	Country facilitator organisations	By May 2019	Legal resources for litigation on health issues and violations identified
7. BROADEN PBF! INCLUDE NEGLECTED AREAS AND RESPOND TO LOCALLY IDENTIFIED PRIORITIES: a. (MoH, Int) Respond to growing levels of chronic conditions, to include neglected diseases, including chronic illness, disease outbreak management in PBF . b. (MoH) In PBF, fund appropriately CHWs and resources for their health promotion, prevention, community health literacy, social organisation roles, and prevention services,	1. Identify the “neglected” conditions and services for each country involved and hold meetings with district and national MoH, the minister in charge of PHC, (the parliament committee), the officials the views of HWs and communities to have them prioritized 2. CFs with the local HWs and community members to put together case study stories using anonymous cases of what happens to people when neglected diseases are not included (worsening conditions, costly private care, stress for HWs etc) to back the discussions	Country facilitators (CFs) in dialogue with and with input from health workers and community members	1. List of neglected diseases and stories by March 2019 2. Meeting with MoH by May 2019	1. Neglected diseases list and "stories of consequences" compiled 2. Meeting held with Ministry officials on addressing the neglected conditions

AREA PROPOSED	ACTION	BY WHOM	WHEN	PROGRESS MARKER
including immunisation, safe water supply and sanitation and health literacy. c. (MoH; district) Review and update targets regularly and change them where needed. d. (MoH) Provide an equity allocation to facilities in poorer districts with high needs.	HWs to discuss with facility and district managers a process for reviewing the target data quarterly and taking up with MoH nationally annual review of targets to reset new target levels or new target areas as needed taking district inputs into account	HWs with facility and district managers and then country facilitators with MoH	Meeting with facility and district by March 2019 Meeting with MoH by May 2019	1. Meeting held with facility and district on review of targets 2. Meeting held with MoH 3. Guidance on target review process drafted
8. STRENGTHEN DOMESTIC FUNDING OF ALL PHC WITH EXTERNAL FUNDERS NOT SUBSTITUTING NATIONAL FUNDING: a. (MoH, MoFinance) Meet the duty to fund all PHC services, by progressive taxes, mandatory insurance and earmarked taxes; as pre-payments from those with ability to pay, complementing community labour and material contributions to PHC. b. (Govt, parliament) Improve the national health budget, meet the Abuja commitment of 15% domestic government budget to the health sector (and 5% of GDP) and earmark a guaranteed proportion of revenue collected for PHC, for prevention, for managing chronic conditions and for vulnerable groups, to improve predictability and equity and address shortfalls when external funders stop. c. (Govt) Lever and publicise private sector contributions (and violations); including as MoUs with pharmaceutical companies and private laboratories to provide services on areas where public services have gaps d. (External funders) Complement govt funding, not substitute it, with priorities set through consultation with local HWs, CMs. e. (MoH, MoFinance) Adequately fund non-PBF PHC services domestically and use this to lever additional external funds so all health services are funded according to health need.	1. Hold meetings with the MoH planning department, the Ministry of Finance and parliament to meet the Abuja commitment of 15% government budget to health excluding international funds. 2. Put together information for each country on the trend in the percent allocation to health over the last 10 years and the shortfall between the cost of the essential health benefit /services and the budget as one input to the discussion 3. Identify organisations for and build an advocacy coalition on domestic health financing	Country facilitator organisations and other CSOs	Depends on budget process in countries Between March and by May 2019	1. A document on health budget trends vs Abuja and the cost of services has been compiled in each country by May 2019 2. A meeting has been held with MoH, Ministry of finance, Parliament and feedback obtained on the commitment to implement the Abuja declaration 3. An advocacy coalition has been set up. 4. The new budget reflects an increase towards or achieves the Abuja commitment
	Develop a shared regional policy on health financing that can inform country policies	EQUINET proposal for dialogue to be held across organisations, civil society, parliaments, officials in the region on domestic health financing	end 2019	Health financing policy principles discussed regionally
9. RESOURCE FACILITIES TO MEET PBF SERVICE NEEDS, ADDRESS GAPS AND ENSURE CONTINUITY: a. (MoH) Use staffing needs assessments,	Country facilitator organisations to discuss with MoH to do a needs assessment (capacity and gap assessment) against population health needs and essential services for them to identify facility needs to use for budget	Country facilitator organisations	1. Meeting with MoH by May 2019 2. Needs	1. A meeting held and MoH feedback obtained on doing a needs and capacity assessment to

AREA PROPOSED	ACTION	BY WHOM	WHEN	PROGRESS MARKER
improve conditions of service, employ more staff, ensure adequate facilities for the catchment population. b. (MoH, district health teams) Set clear, proper and timely incentives for HWs, allocate work that is manageable; base PBF funding on the catchment area(target population) and not on the quantity of clients attended and carry out continuous review. c. (MoH, Int) Provide from PBF/ other funds resources (medicines/ reagents, equipment, technology, IT) to improve quality of services d. (MoH) Apply an equity allocation within PBF facility grants to provide funding for these districts to improve their capabilities and support HWs and community activities e. (MoH, Int) Use pooled procurement for medicines at regional level to reduce prices and collaborative training to reduce costs. f. (MoH, facility management, HCC) Plan for and fund continuity when external funds stop.	negotiations, resource allocation, including an equity allocation in PBF and facility investment plans.		assessment done and used in 2020 budget	input to the budget bid. 2. 2020 health budget includes capital budget bid from a needed (gap and capacity) assessment
	Raise a proposal with MoH to implement a community needs and capacity assessment/ resource mapping by MoH and CSOs / HCCs jointly	Country facilitator organisations	Meeting held and method agreed by May 2019	A meeting held and MoH feedback obtained on doing a community assessment to input to resource allocation.
10. FORMALLY RECOGNISE HCCS, AND HCC, COMMUNITY ROLES IN PHC, PBF: a. (MoH) Recognise HCCs in law and structures, with guidelines on and resources for their capacities, election and operation b. (MoH, Int) Integrate HCC and community roles in PHC and in PBF, include HCC, local HW representation in national planning forums and in global meetings. c. (MoH) Involve HCCs in district budget planning, in central and district decisions on targets set for PBF, on its implementation and on evaluating its performance nationally. d. (MoH) Publicise information on PBF funding through TV, radio, posters and community meetings e. Set up an organisation at national level to support, monitor, report on and improve HCC functions and reports.	1. Use EQUINET policy briefs on HCCs and local materials to meet and advocate nationally with MoH for legal and policy functional recognition and training of HCCs in PBF and PHC, building where relevant on existing policy processes, with HCCs as independent mechanisms that build strong links with the community and the facility so that community voice leads action 2. EQUINET to share the legal text for examples of countries that have already formally recognised HCCs in the region (eg Zambia, Zimbabwe)	Country facilitator organisations, partner CSOs and legal resources with HCCs	1. EQUINET policy briefs on HCCs sent by Dec 2018 2. Meeting held with MoH by March 2019 3. Information on legal texts for countries that have HCCs in law shared by March 2019	1. Policy drafted on HCC roles in PBF and PHC 2. Legal proposal drafted for recognition of HCCs
	1. Engage MoH and PBF funders to fund and hold a conference of HCCs to review PBF implementation, peformance and budgets from their lens and where improvements can be made and use the meeting to identify options for national level to support, monitor, report on and improve HCC functions and reports.	Country facilitator organisations, HCCs linking with MoH, relevant CSOs, funders, Info support as needed from TARSC/EQUINET	Proposal for meeting discussed by May 2019 Conference organised in late 2019	1. Meeting held and proposal to hold conference discussed 2. Conference planned and held

3. GENERAL POINTS

ACTION	BY WHOM	WHEN	PROGRESS MARKER
1. Produce a collective brief on who we are and how we came up with the proposed areas of change in the PAROnline process and how they support comprehensive PHC 2. Discuss the findings with local HWs and communities (in saparate meetings and jointly) to get their support for the engagement on them, and the specific actions we are proposing 3. Use the brief in the engagement with the facilities and districts in meetings on the proposals as proposed in other areas	1. Brief drafted by TARSC for input by all (note TARSC will prepare a full report of the work in mid 2019 that will also integrate the feedback from these discussions for everyones input.) 2. HWs and HCCs and community members talking with their local constituencies and then with facilities and districts	By March 2019	1. A draft produced, the group's input obtained and the brief finalised 2. Meetings held with HWs and community members and their support and ideas obtained 3. Meetings held with facility and district stakeholders on the findings
Ensure feedback between all levels on what has been done and that all are acknowledged	All in PAROnline	In the review meetings in March and May 2019	All are aware of and acknowledged in the actions taken at each level
Within country liaise (in person or by email/etc) between the CSF, CM and HW on implementation	CSF, HW and CM	Jan-May	Teams co-ordinated within the sites
Set up a live question and answer document on questions, opposing views likely to be heard / heard ion taking up our proposals with answers on how they can be addressed that can be updated as we go	A HW/CM/CF from each team to act as focal point for providing the questions / objections and how they answered them. A volunteer from the full team to facilitate	Ongoing with inputs By March 2019 and May 2019	A Q and A document that is being shared with nd used by all teams
Develop a communication strategy for taking the work to regional and global level, identify the key organisations to target, what their positions are, allies and opponents and where and with what information to communicate for review by the full team in the August 2019 meeting	Draft by TARSC/ EQUINET with input on specific areas by country facilitator organisations	By May 2019	A draft strategy produced for review by the August 2019 meeting
For the FINAL report being reviewed in August 2019 (not the initial brief for February-June) use it to prepare suitable briefs for different audiences (different format for community, HWs, district managers, national managers, funders) and use the briefs in face to face meetings (and not as a substitute for face to face meetings	TARSC to prepare a draft full report of the work for input by all as a collective product. Discussion of who will produce each of the policy briefs for specific audiences in the May 2019 review meeting	Review of the draft report in August 2019 Roles in specific briefs discussed in May 2019	Full Report of the PAROnline produced Report used for audience specific briefs produced

Appendix 2: Features of PHC

1. **ADDRESSES COMMON HEALTH PROBLEMS.** PHC identifies and provides promotive, preventive, curative and rehabilitative services for the most important health problems in the community. It includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drug.

2. **PROMOTES HEALTH.** PHC reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience.

3. **ADDRESSES CAUSES OF ILL HEALTH.** PHC treats ill health but also identifies what is causing health problems and addresses and works with other sectors to address these causes, such as diet, living and working conditions.

4. **HEALTH IN ALL SECTORS.** PHC involves, in addition to the health sector, all related sectors and aspects of national and community development, such as agriculture, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors.

5. **PROMOTES COMMUNITY POWER, PARTICIPATION.** PHC requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. **PRIORITISES THOSE WITH GREATEST NEED.** PHC gives priority to those with greatest health need;

7. **ENSURES RELEVANT COMPETENCIES.** PHC relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

8. **COORDINATES WITH OTHER LEVELS OF CARE.** PHC should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all

Appendix 3: Targets relative to PHC features

The specific targets present in the sites as assigned to PHC features are shown in the list below under each PHC feature:

1. Addresses common health problems

1. Number (%) population accessing out patient (OPD) services, #OPD cases seen, cases treated according to protocols
2. Number (%) people and HIV+ve patients screened for Tuberculosis / sputum test done and % detection rate/ #TB cases identified and treated
3. Number (%) TB patient defaulters followed / total TB patients successfully complete treatment and sputum negative at 6 months
4. Number (%)pregnant women attending first ANC in first trimester / attending four ANC visits / given deworming/ malaria treatment / ITNs
5. Number (%) pregnant women tested for syphillis and HIV / treated and retained on ART for PMTCT / % babies of HIV+ve mothers born HIV-ve
6. Number (%) pregnant women delivered by a skilled health worker / partgographs done/ # referred to next level if complications/ #given post natal care
7. Number maternal deaths audited/ reviewed / review by district, health facility and Health Committees / recommended actions taken
8. Number (%) <5yr olds attending under five clinic / managed according to IMCI / weighed / not underweight/ dewormed / given vitamen A/ given bednets
9. Number (%) people (and adolescents) HIV tested / know their status/ HIV+ve cases nutritionally assessed / counselled / initiated on ART
10. Number (%) those on ART followed up if defaulters / have viral loads suppressed
11. Number of HIV exposed infants given prophylaxis/ nevaripine / HIV tested by 18 mths and Number HIV positive newborns / infants receiving ART
12. Number newborns given BCG and OPV before maternity discharge/ number (%) <1 year olds fully vaccinated
13. Number (%) accessing SRH services/ receiving condoms/ female counselling and contraception / male circumcision / STI counselling, treatment / HIV info
14. Number (%) Gender Based Violence cases reported managed according to guidelines
15. Number of Hypertension Cases Diagnosed
16. Number cases epidemic disease reported to the facility, managed and with equipment according to guidelines
17. Number (%) OPD cases / women tested for malaria / % testing positive

2. Promotes health

1. Number newborns given BCG and OPV / number(%) <1yr olds vaccinated / fully immunised (BCG, DPT, OPV, Penta3, measles)
2. Number (%) girls 10-12 yrs vaccinated against Hepatitis B virus.
3. Number (%)pregnant women attend first ANC in first trimester / with 4 ANC visits / HIV tested/ given TT/ deliver at facility / receive postnatal care
4. Number < 5 yr olds with monthly growth monitoring / given ITNs / given vitamin A
5. Number (%) accessing SRH and family planning services/ receiving condoms/ female counselling and contraception / #new FP users
6. Number (%) receiving HIV prevention info / know their HIV status / HIV tested/ given ART if +ve
7. Number (%) HIV exposed infants born HIV-ve/ testing HIV+ve by 18 mths
8. Number (%) households access facility / visited by a Community health worker / # (%) facility outreach activities and community activities
9. Increased awareness on chronic conditions, gender based violence and partnership creation
10. Ratio normal to complicated deliveries/ Number neonatal and maternal deaths audited within 7 days

3. Addresses the causes of ill health

1. Number (%) of households with access to safe drinking water, safe sanitation, safe excreta disposal, receiving chlorine
2. Number (%) targeted premises inspected by an environmental health technician
3. Number (%) food outlets inspected and food handlers certified every six months
4. At facility: medical waste disposed according to standards / adherence to OHS, safe water, sanitation standards
5. Number (%) knowing their HIV status / number males circumcised
6. Number of Vitamin A doses given in the month

4. Health in all sectors

None

5. Promotes community power, participation

1. Health Committee functioning at community and facility level / number of meetings held / % action points implemented
2. Number (%) existing Community Health Assistants/ CHWs active
3. Number (%) aware of chronic conditions/ gender based violence (GBV)/ GBV cases brought to facility and support services

6. Prioritises those with greatest need

1. Number elderly, physically challenged, children <2 mths and critical patients attending OPD seen immediately
2. Number of children on Supplementary Feeding Program [SFP] in each quarter
3. Number (%) pregnant women with early booking, first and 4+ ANC visits/ receiving bednets
4. Number HIV tested / all testing +ve remain on ART including pregnant women for PMTCT

7. Ensures relevant competencies

1. Number (%) health workers, community volunteers trained / trained in IMCI/ staff appraised
2. Number (%) individual staff workplans / facility activity plans implemented
3. Number (%) malaria diagnoses confirmed by laboratory

8. Coordinates with other level of care

1. Number (%) of women at risk/ with obstetric complications / TBMDR referred to higher level service within a specified time
2. Number gender based violence clients referred to facility and to relevant support service
3. Number (%) patient referrals from lower level given feedback by facility
4. Number (%) of facility clients receiving integrated care and treatment services, including for HIV
5. Number of management meetings held by departmental heads

9. Other feature

1. Percent continuous availability of essential drugs on tracer list / minimum equipment vaccine storage requirements available
2. Number of active Community Health Assistants with required kit per 1000 people

Appendix 4: Impacts of PBF on PHC

Impacts on community relations and HCCs

Positive impacts

1. Funding issues: Community contributions are being replaced by performance financing
2. Improved targeted services for communities: availability and management of essential medicines (3), investment in infrastructure, utilities (2)
3. Free targeted services, bed net distribution, SRH and MCH ambulance services; improved outreach (4) and better quality of targeted services,
4. Improved community service uptake (12); Increased access, follow up; community referral to of facilities, reduced home deliveries, service delays.
5. Improved relations collaboration, trust, respect between HWs and community groups (5), HW knowledge, skills transfers to communities.
6. Improved recognition of community roles; community information, health, rights awareness (6); involvement, investment in targeted services, funds
7. Strengthened HCC establishment, recognition, incentives; jobs and incomes (4). HCC promotion of target areas (6) HCC social accountability skills.
8. Improved health outcomes: falling levels of minor ailments, SRH problems; MCH complications; falling mortality and child and maternal deaths (4)

Negative impacts

1. Funding raising expectations and service demand, but late payments, patients enrolling in multiple facilities; multiple organisations setting target
2. Limited funds, supplies for and neglect of non-targeted services (5),with fee charges, private providers, community confusion on who benefits.
3. Sustainability concerns (3), and when funds stop or are cut, community not being informed, HWs demand money for these services and diseases return
4. High demand, pressure on numbers worsen service quality, long waiting time, less HW-patient time (2); poor quality, and follow up (2)
5. Poor access to services with poor transport, poor laboratory services and increased referrals.
6. Worsening HW-community relations, collaboration (2), poor HW attitudes to community, HCCs (3), HW corruption, nepotism incorrect use of funds.
7. Communities overburdened, disempowered, uninformed on health rights; on funded targets and why some benefit and not all (2)
8. Communities not participating in decisions on targets; less sensitised, mobilised on non targeted conditions; CHW role not well supported/funded.
9. HCCs not well supported, trained; funded (2); role sidelined; uninvolved in important decisions (2), diverted to managing funds, driven by payments
10. Negative health outcomes: cash payments encouraging unplanned pregnancies; rising disease burdens in areas unfunded by performance financing.

Impacts on health workers

Positive impacts

2. Increased funding, improved HW pay/ incomes, morale, hardwork, professionalism (16)
3. Improved resources, infrastructure, medicines, training promotes HW competency, management capacity, performance, careers and service quality (14)
4. Team work targets. training inspire team work (3), motivate new approaches and learning.
5. Information, monitoring, reporting improves facility planning (2) HW evaluation, practice (4) reduces corruption, improves HW accountability
6. Better links with communities through HCCs and community knowledge and participation in identifying problems and implementing services (3)
7. Improved health outcomes: Reduced Fistula cases , reduced maternal and child mortality, malnutrition

Negative impacts

1. Delayed & low HW payments, shortages of services, infrastructure, equipment, medicine, weaken practice, quality, morale, leisure time (8)
2. Unfunded areas (NCDs) neglected by and frustrating HWs (7); bias services towards target areas not comprehensive care, or effective referral (3)
3. Increased demand, work overload, stress, burnout (9), with queues including from clients from outside the catchment area.
4. Time bound targets raise pressure for multitasking, corruption, falsifying numbers (4), ineligible patients, private practice, poor patient care
5. Brain drain, low morale, poorer working culture among HWs not getting incentives (4)
6. Competition for targets undermine team work (8), generates conflicts between facilities, HWs over use of funds; make HWs only work for targets (2)
7. HWs dont sustain services after targets reached or funding stops (2)
8. Too much clerical work on information needs, given workload, and limited patient feedback mechanism

Impacts on primary health care services

Positive impacts

1. Improved resources, HW skills, medicines, free care, infection prevention standards, outreach, access in targeted high need service areas (16)
2. Facilities have become life-saving rather than dying places and gaps identified and brought to national attention
3. Improved serviced outreach, coverage and quality in target areas and disease prevention targets improve outreach and quality of life (3).
4. Regular monitoring and reporting improves planning, stakeholder involvement, accountability on service performance (2), and mobilisation of other resources for services
5. Increased in education and awareness on and uptake of targeted services (2), adherence to treatment
6. Improved HW – community relations, recognition of community roles, information to community (2), VHTs, HCCs, CHW and community engagement in service planning.
7. More at risk people (women , children, people living with HIV, under-fives, elderly) prioritised.
8. Improved health outcomes: falling levels of minor ailments, SRH problems; MCH complications; falling mortality and child and maternal deaths (4)

Negative impacts

1. External funder driven, decreasing government's responsibility for targeted activities, with concerns on sustainability(3)
2. HW motivation, skills 'glued' to incentives, focus on target areas, leaving other HWs, areas, NCDs, OPDs, comprehensive PHC not supported, despite high disease burdens (15)
3. More emphasis on easily achieved curative targets compared to preventive, community level services (2)
4. Resources, facilities, supplies, transport not adequate for rise in demand generating congestion, corruption, false reporting, stress, incomplete projects(3)
5. Lack of horizontal approach affecting comprehensiveness, continuity and quality of services, generating conflict between community and HWs on what is and is not free (2)
6. Inadequate resources motivates referrals but weak referral system increases the incidence of complications at the facility (2)
7. Health education, promotion work shifted to community groups (2), with inadequate information, CHW support and problems in community culture and beliefs.
8. Pressures, corruption, nepotism misuse of funds, preferential treatment by HWs harming community relations (3)
9. Health workers stop delivery, services decline if funding reduced or stopped (2)
10. Decisions made at central, funder levels and limited local HW, community involvement in planning, access to data (4)

Appendix 5: Progress markers on our actions

The charts below provide the summary of the progress markers we collectively reported for the actions we set in our workplan across both Jan-March and March-May review periods, the first for the local and district level and the second for the national and international levels. Each table shows sum of the level reported by each participant, with each individually selecting a circle for each progress marker on the progress made in the site: a blank circle for no progress; a half-filled circle for some progress; and a filled circle if the action was completed. The progress and factors affecting it are discussed in *Section 6*.

Activity: Progress on actions at local, district and national level

Action	Progress Marker	Quarters	
		Jan-Mar	Mar-May
1. HWs and HCCS will propose to, discuss and agree with facility management a comprehensive plan for promotion and prevention services that is evaluated and reviewed every three years 2. HWs and HCCs locally to meet with the ward and other local leaders to present and discuss these proposals with them for them to take the views up at higher levels 3. Provide HCCs a working space in the facility for members to meet, including with HWs and community members	1. Health workers, HCCs and facility management have met and agreed to prepare a facility plan for health promotion and prevention March 2019 2. A plan for health promotion and prevention is in place after 1 year and evaluated and reviewed after 3 year	2, 4, 10	0, 4, 9
Provide anonymised stories of the negative consequences of not funding PHC and the supplies etc for it at primary care and community level to be used in advocacy work	Stories of the negative consequences of not funding PHC and the supplies etc for it at primary care and community level written and shared	2, 7, 6	1, 4, 5
1. Discuss the findings with the local CHWs to get their views and inputs on how they see their role in prevention how to improve this 2. Include this input in the general discussions with facilities and district (as below) 3. Discuss with CHWs their views on how to strengthen their role, share experiences and identify strategies, including possibly forming an association of CHWs that can meet and communicate for this exchange	Discussion held with CHWs	0, 1, 15	0, 0, 12

Action	Progress Marker	Quarters	
		Jan-Mar	Mar-May
1. Produce a collective brief on who we are and how we came up with the proposed areas of change in the PAROnline process and how they support comprehensive PHC 2. Discuss the findings with local HWs and communities (in saparate meetings and jointly) to get their support for the engagement on them, and the specific actions we are proposing 3. Use the brief in the engagement with the facilities and districts in meetings on the proposals as proposed in other areas	1. A draft produced, the group's input obtained and the brief finalised 2. Meetings held with HWs and community members and their support and ideas obtained 3. Meetings held with facility and district stakeholders on the findings	0, 9, 7	0, 0, 11
Ensure feedback between all levels on what has been done and that all are acknowledged	All are aware of and acknowledged in the actions taken at each level	0, 12, 4	0, 3, 8

Action	Progress Marker	Quarters					
		Jan-Mar			Mar-May		
Build and share learning and insights on the value of, challenges and potentials in using an Online platform for PAR on issues affecting local sites across countries in the region	Experiences of online PAR shared Insights from experience of PAROnline reviewed and learning reviewed.... and documented.	0	1	0	1	4	1
Make clear and widen awareness of the features of comprehensive PHC as articulated at Alma Ata and adopted in policy in the region, and how our proposals on PBF deliver on this	Increased understanding and support by key target groups of features of comprehensive PHC and how the proposals on PBF strengthen its delivery by May 2019	0	1	0	1	2	3
Engage facility managers at the primary care services, the district level and national level MoH to set clear guidelines to harmonise and integrate funding and provision of PBF and non-PBF programmes and services so that patients go through the same procedures	1. Health workers, HCCs and facility management have met, agreed to have facility guidelines to harmonise and integrate funding and provision of PBF and non-PBF programmes and services and raised this proposal with the district 2. Country facilitator	0	1	0	1	1	4
Identify legal resources for litigation (court action) on health issues and violations of health rights and law where relevant	Legal resources for litigation on health issues and violations identified	0	0	0	5	0	1
1. Identify the "neglected" conditions and services for each country involved and hold meetings with district and national MoH, the minister in charge of PHC, (the parliament committee), the officials the views of HWs and communities to have them prioritized 2. CFs with the local HWs and community members to put together case study stories using anonymous cases of what happens to people when these neglected diseases are not included (worsening conditions, costly private care, stress for HWs etc) to back the discussions	1. Neglected diseases list and "stories of consequences" compiled 2. Meeting held with Ministry officials and commitment on addressing the neglected conditions	1	0	0	1	3	1
HWs to discuss with facility and district managers a process for reviewing the target data quarterly and taking up qith MoH nationally annual review of targets to reset new target levels or new target areas as needed taking district inputs into account	1. Meeting held with facility and district on process and inputs for review of targets 2. Meeting held with MoH by May 2019 3. Guidance on target review process drafted	1	0	0	2	2	1
HWs and HCCs locally to meet with the ward and other local leaders to present and discuss these proposals with them for them to take the views up at higher levels, to both MoH and funders	Local leaders know and support the findings and proposals of our work Local leaders take up agreed proposals to higher levels (MoH and funders)	2	7	8	0	1	8
Health workers and HCCs to collectively discuss, agree and propose how incentives should be distributed between all at the facility to fairly recognise workloads and skills and promote team work, and discuss their proposal with facility and district managers.	1. Health workers, HCCs and facility management have met and agreed on a proposal for fair distribution of incentives	3	2	11	0	0	11
Health workers and HCCs to meet with the district to discuss and organise 3 monthly on the job training for HWs and induction training for all HCC members	Health workers, HCCs and district management have met, discussed and identified a plan for HW and HCC training	6	7	3	1	1	8
HW, HCC and facility managers to conduct quality improvement meetings quarterly to see how they are performing on various indicators and close up gaps.	HW, HCC and facility managers have held quality improvement meetings with follow up actions identified	2	8	6	1	4	4
1. Health workers, HCCs to meet with the facility management to identify concrete options for involvement of HCCs, HWs, community members and local Health CSOs in service review and feedback at the facility, including through HCC interaction with communities 2. Community members, HCCs and local CSOs to discuss methods and plans to carry out joint service monitoring, including interface meetings with HWs and PBF verification	1. A joint meeting held with facility management on options for involvement of HCCs and HWs and community members in service review and feedback at the facility 2. Options for involvement of HCCs, HWs, community members and local health CSOs in servic	3	5	10	1	0	11
HW and facility managers conduct self quality assessments (SQA)quarterly so that they can rate themselves with their performance and what their standards In the SQA are and make improvements to try and reach the standards set.	HW and their facility managers have met and understood on how to use the SQA tool for self assessment	5	7	3	5	1	4

Progress on actions at national, regional and international level

Action	Progress Marker	Quarters					
		Jan-Mar			Mar-May		
Produce a collective brief on who we are and how we came up with the proposed areas of change in the PAROnline process and the key features of comprehensive PHC	A draft produced, the group's input obtained and the brief finalised	0	0	1	1	0	7
Develop a communication strategy for taking the work to regional and global level, identify the key organisations to target, what their positions are, who are allies and who would disagree and where and with what information to communicate for review by the full team in the August 2019 meeting	A draft strategy produced for review by the August 2019 meeting	0	1	0	3	3	1
1. Set up a live question and answer document on questions, opposing views likely to be heard / heard ion taking up our proposals with answers on how they can be addressed that can be updated as we go 2. Within country liaise (in person or by email/etc) between the CSF, CM and HW on implementation	A Q and A document that is being shared with nd used by all teams	0	0	0	4	0	2
For the FINAL report being reviewed in August 2019 (not the initial brief for February-June) use it to prepare suitable briefs for different audiences (different format for community, HWs, district managers, national managers, funders) and use the briefs in face to face meetings (and not as a substitute for face to face meetings	Full Report of the PAROnline produced Report used for audience specific briefs produced	0	1	0	3	3	0
Engage after the final report and briefs are prepared external funders of PBF (Gates foundation, World Bank, GFF investors group, IDA, GAVI, USAID, UNICEF, SIDA etc) on the key issues identified.	External global funders engaged on the key issues on PBF and PHC arising from the PAR	0	1	0	4	0	1
1. Hold meetings with the MoH planning department, the Ministry of Finance and parliament to meet the Abuja commitment of 15% government budget to health excluding international funds. 2. Put together information for each country on the trend in the percent allocation to health over the last 10 years and the shortfall between the cost of the essential health benefit /services and the budget as one input to the discussion 3. Identify organisations for and build an advocacy coalition on domestic health financing	1. A document on health budget trends vs Abuja and the cost of services has been compiled in each country by May 2019 2. A meeting has been held with MoH, Ministry of finance, Parliament and feedback obtained on the commitment to implement the Abuja decl		1	0	3	2	1
Develop a shared regional policy on health financing that can inform country policies	Health financing policy principles discussed regionally	1	0	0	4	2	0
Country facilitator organisations to discuss with MoH to do a needs assessment (capacity and gap assessment) against population health needs and essential services for them to identify facility needs to use for budget negotiations, resource allocation, including an equity allocation in PBF and facility investment plans.	1. A meeting held and MoH feedback obtained on doing a needs and capacity assessment to input to the budget bid. 2. 2020 health budget includes capital budget bid from a needed (gap and capacity) assessment	1	0	0	3	2	1
Raise a proposal with MoH to implement a community needs and capacity assessment/ resource mapping by MoH and CSOs / HCCs jointly	A meeting held and MoH feedback obtained on doing a community assessment to input to resource allocation.	1	0	0	3	2	1
1. Use EQUINET policy briefs on HCCs and local materials to meet and advocate nationally with MoH for legal and policy functional recognition and training of HCCs in PBF and PHC, building where relevant on existing policy processes, with HCCs as independent mechanisms that build strong links with the community and the facility so that community voice leads action "nothing for us without us". 2. EQUINET to share the legal text for examples of countries that have already formally recognised HCCs in the region (eg Zambia, Zimbabwe)	1. Policy drafted on HCC roles in PBF and PHC 2. Legal proposal drafted for recognition of HCCs	0	1	0	4	0	2
1. Engage MoH and PBF funders to fund and hold a conference of HCCs to review PBF implementation, peformance and budgets from their lens and where improvements can be made and use the meeting to identify options for national level to support, monitor, report on and improve HCC functions and reports.	1. Meeting held and proposal to hold conference discussed 2. Conference planned and held	1	0	0	3	3	0