PERFORMANCE-BASED FINANCING AND STRENGTHENING HEALTH GOVERNANCE IN THE FRAGILE STATE OF THE DEMOCRATIC REPUBLIC OF CONGO

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ABSTRACT

This article explores the outcomes of performance-based financing for strengthening the health system in the context of state-building in the Democratic Republic of Congo. It focuses specifically on health system governance, which plays a pivotal role in the process of building the health system. Based on long-term qualitative field research, it examines the effectiveness of PBF in three areas of health system governance: structural governance from a capacity-building perspective, health service-provision management and demand-side empowerment for effective accountability. In general, the study found that PBF has positively impacted the process of health system-building in these three areas. Although much is still lacking, health governance and the provision of services improved, while patient-centered care and social accountability strengthened the provider–patient relationship. However, donors, state officials and other stakeholders doubted their sustainability. In addition to structural threats related to state fragility and uncertain sustainability, transforming transactional motivation into transformational change is a challenge. Ultimately, PBF supports state-building in the health sector, but it cannot repair a collapsed state.

Keywords *Performance-based financing, governance, health sector, fragile state, DR Congo*

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INTRODUCTION

Health service effectiveness and accountability constitute major challenges in fragile states, such as the Democratic Republic of Congo (DRC), and trigger various innovations and policy experiments. One of these is performance-based financing (PBF). PBF is the transfer of money or material goods from a funder or other supporter to a recipient, conditional to the recipient taking a measurable action or achieving a predetermined performance target (AIDSTAR-Two-Project 2011). In the health sector, PBF is understood as fee-for-service payments conditional to the quality of care and a health system approach to achieve results defined by quantity and quality of service outputs (NSHIP 2013). Healthcare providers are paid 'for delivering specific services following explicit protocols with a system of inspection and auditing to assure compliance and to raise quality' (Musgrove 2010).

Performance-based payments are also provided for the teams carrying out these inspections to motivate them to be thorough and accurate (Musgrove 2010, 4). Contracting for performance and motivating providers constitutes the core characteristics of the PBF approach. Inspired by a Rwandan PBF experiment, Cordaid, a Dutch NGO, introduced PBF in the South Kivu province (eastern DRC) in 2005 (Mayaka Manitu 2015). A 2012 DRC government policy document regards PBF as a mechanism for public sector reform, in particular for health financing (MINISANTE/CTFBR 2012) and as a model promoting the adoption of a holistic perspective for strengthening the health system.

THE EMERGENCE OF PERFORMANCE-BASED FINANCING IN INTERNATIONAL DEVELOPMENT

PBF emerged during the economic slowdown of the 1980s, the 'lost development decade', which facilitated the introduction of the New Public Management (NPM) reforms in the 1980s–1990s (Torfing and Triantafillou 2013). NPM focused on contracting for financing public service outputs, improving service standards while strengthening accountability based on customer needs, managing by results, decentralizing authority and implementing participatory management (Rhodes 1996).

PBF is regarded as a useful approach to financing health services that can work in both more stable environments and fragile states (Fritsche, Soeters and Meessen 2014). Compared with traditional bureaucratic approaches, PBF has achieved encouraging, but certainly not homogenous, results across countries (Soeters, 2012). These heterogeneous results indicate that contextual variables play an important role in explaining PBF successes. Therefore, understanding what causes the observed differences is crucial.

The present study's relevance lies in its exploratory inquiry of actual PBF outcomes for strengthening health system governance and state-building in a context of pervasive fragility. It provides empirical evidence on the health sector-building outcomes in the context of a fragile health system and multi-actor governance. Such governance implies a network of relevant actors and stakeholders linked through resource interdependence, cooperation, collaboration and even competition for achieving social goals (Koppenjan

and Klijn 2004). Driven by the need to explore the outcomes of PBF, as well as its potential impact on state-building, we ask: *What are the outcomes of strengthening the health system by means of PBF in the context of state-building in the DRC?*

This study explores the effectiveness of PBF in the DRC in light of its contextualized theory of change. A theory of change is the articulation of the underlying beliefs and assumptions that guide a service delivery strategy and are believed to be critical for producing change and improvement (INSP 2005). Theories of change indicate causal connections between activities and outcomes (Stein and Valters 2012), which require insights on a contextual baseline and the intended changes. This investigation focused on PBF's outcomes in three areas which are among the most affected by state fragility in the DRC health sector: 1) strengthening health governance; 2) management of service provision processes; and 3) demand-side empowerment for social accountability.

STRENGTHENING HEALTH SYSTEM GOVERNANCE

A health system consists of all the organizations, people and actions whose primary intent is to promote, restore or maintain health (World Health Organization 2007). Health system strengthening refers to improving the six building blocks of the system, namely governance/leadership, service-delivery, the health workforce, health information, health financing and medical products, vaccines and technologies, as well as managing the interactions between them in ways that achieve more equitable and sustained improvements across health services and outcomes (Ibid).

The DRC health system is organized with a hierarchical architecture at three main levels:

1) the ministry of health (MoH) at the national level is in charge of national policy;

2) the provincial ministry of public health (*Ministère provincial de la santé*) is the provincial branch of the national MoH for policy-implementation and coordination, its provincial health division (*Division provinciale de la santé*) plays an administrative role, whereas the provincial health inspectorate (*Inspection provinciale de la santé*) is its technical wing, and verifies whether health principles and standards are being respected in the province;[1]

3) the Central Health Zone Office *(Bureau Central de Zone de Santé* (BCZ)), the Management Board of the General Referral Hospital (*Comité de Gestion de l'Hopital Général de Référence*) and the Health Centers *(Centres de Santé*), each supported by its health development committee (*Comité de Développement de l'Aire de Santé* (CODESA)), at the operational health zone (HZ) level. The BCZ/HZ Office is the regulatory body at the HZ level. The Management Board of the General Referral Hospital and the CODESA are the organs for community participation in the management of the health facilities. Every health facility thus has its own managerial structure and personnel.

The role of structural governance in strengthening the health system

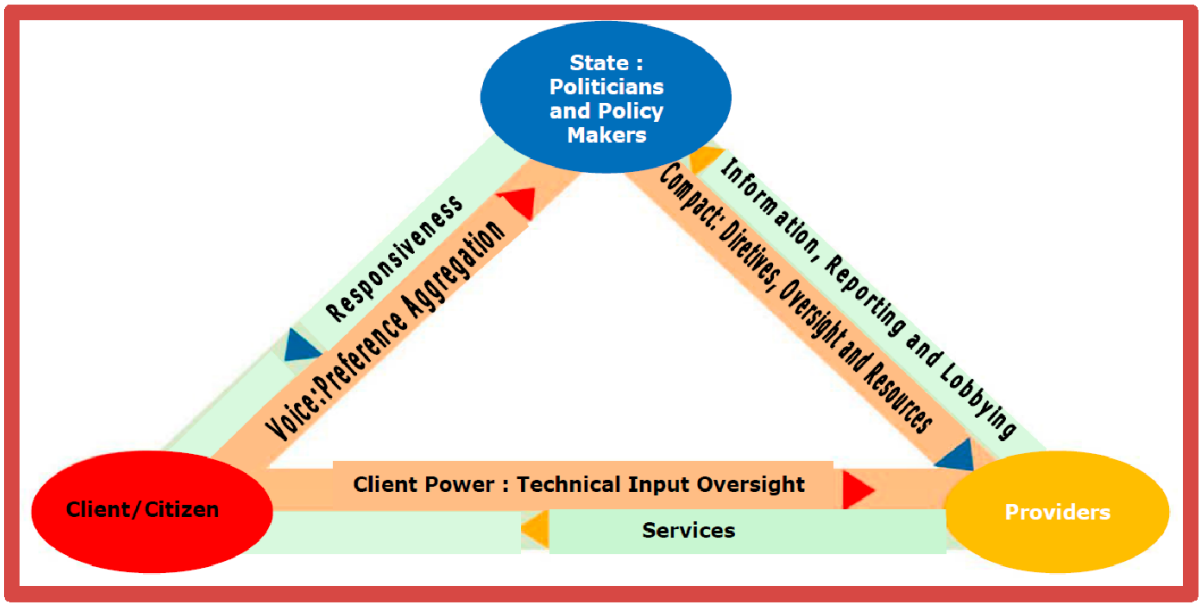
As one of the six building blocks, 'health system governance involves ensuring that a strategic policy framework exists and is combined with effective oversight, coalition-building, regulation, attention to system design and accountability' (World Health Organization 2014). Two types of indicators have been proposed for measuring such governance (World Health Organization 2010a): *rule-based indicators* measuring whether countries have appropriate policies, strategies and codified approaches for health system governance, and *outcome-based indicators* assessing whether rules and procedures are effectively implemented based on the experience of relevant stakeholders. The present study focuses on the outcome-based approach.

In this respect, structural governance is about 'how to structure or organize the state services, what strategic functions the state should perform, what to delegate to agencies, and which services to contract out; it is the question of how to manage the whole system' (Bresser-Pereira 2007). Health governance shapes the rules determining the behaviors of actors and establishes relevant networks and other institutions. Because of three characteristics of healthcare (information asymmetry, the difficulty of evaluating the product and the high costs of error) (Tuohy 2003), strengthening health governance is essential for community wellbeing.

Through better governance, a health system can improve its ability to respond to various challenges, such as demographic, epidemiological, economic, political, medical, and social changes (Greer et al. 2016){Joseph, 2016:healthcare 56;Wang, 2012 #47}. Greer and colleagues (2016) have shown that, when governance is weak, the health system is plagued by corruption, misaligned incentives, […], unintended effects of ill-conceived policies, nepotism, incompetence, lack of trust and difficulties with long-term planning. In this vein, Lewis (2006, 6) argues that 'in healthcare, good governance implies that healthcare systems function effectively and with some level of efficiency'. He further asserts that the production function represents the core of public healthcare systems, embodying capital, labor and governance, which together determine health outcomes. He maintains that increases in labor and capital can improve outcomes, but governance may either dampen or enhance these effects (Lewis 2006).

Health governance involves at least three sets of actors: state actors (policy makers and/or politicians), providers, and beneficiaries/health service users (Health-Systems-20/20 2012). Building on the World Bank's service delivery and accountability framework (Malena & Forster 2004), Brinkerhoff and Bossert (2008) have created a health governance triangle framework that defines the roles, rules, responsibilities and institutions that shape the interactions among the three main sets of actors. These interactions include how governments respond to citizen demands, how providers and citizens engage to improve service quality, and how citizen and provider groups advocate and report on health concerns (Brinkerhoff and Bossert 2008). As the health sector is vital for the survival and health of all Congolese, and one of the main sectors in which citizens interact with the (remains of the) state, improving the governance of the health sector is also a crucial condition for improving overall governance in the DRC (Dijkzeul 2003).

Figure 1: Health Governance Triangle Model



Source: (Brinkerhoff & Bossert, 2008)

Ideally, the state (actors) and health providers establish a compact in which the state provides directives, assumes oversight, and ensures funding; the providers guarantee service delivery, provide information, report and lobby where necessary; and the citizens/clients have a voice, sharing their preferences and expecting responsiveness from the state and providers. The citizens and health service providers should then develop a relationship, where the population provides feedback, inputs, and oversight on expected services (Ibid). In this ideal situation, clients/citizens convey their needs and demands for services, as well as their level of satisfaction, directly to the health service providers, who, in turn, offer a mix of quality services that satisfy the expressed needs and demands. From a multi-actor governance perspective, however, the links between clients/citizens and providers are fraught with power and information asymmetries, capacity gaps, accountability failures, and inequities (Ibid).

In fragile states, such an imbalanced relationship becomes even more problematic because a fragile statehood disempowers citizens. Good health governance therefore rationalizes the role of the government by 'reducing its dominance and sharing roles with non-state actors; empowering citizens, civil society, and the private sector to assume new health sector roles and responsibilities; and creating synergies between the government and these actors' (Ibid, 10). The main difference with the literature and triangle above in the DRC is of course that donor governments and international organizations also play a crucial role in structural governance, and in this case in promoting and funding PBF. In fact, they sustain the health system by supporting policy-making and financing policy implementation and processes of service delivery at the operational level. Donor organizations thus simultaneously substitute for and strengthen the government.

The underlying principles of PBF

The principles of PBF have the potential to strengthen governance. They emphasize the operational relevance of the market and corporate governance for the health system. As applied in the health system, they have a clear division of labor for the actors involved, commitment to health quality, constructive competition among the actors, public–private partnership, management autonomy of health structures, contracting, transparency and verification for social accountability, the rational management of funding to ensure financial viability of health facilities, and, most importantly, person-centered care, which considers the population as both beneficiaries and clients whose voice counts (Cordaid and SINA-Health 2012; MINISANTE/CTFBR 2012; Toonen and Bertam 2012; Witter et al. 2013).

Such person-centered care and support places service users at the center of delivery by supporting their needs, protecting their rights, respecting their values, preferences and diversity, and actively involving them in the provision of care (HIQA/Ireland 2012). Ideally, person-centered care promotes kindness, consideration and respect for service users' dignity, privacy and autonomy (HIQA/Ireland 2012, 25).

Additionally, the emphasis on the division of labor is meant to ensure transparency (Cordaid and SINA-Health 2012; Toonen and Bertam 2012; Witter et al. 2013). PBF's operational setup promotes interdependent actors, complementary and clearly distinct roles for stakeholders, and mechanisms for service quality verification. The inclusion of community-based organizations (CBOs) in the verification of interventions and their outcomes also reflects the ideals of empowering beneficiaries and promoting social accountability. Yet, the PBF principles have rarely been fully implemented in the DRC health sector.

OVERVIEW OF THE INTRODUCTION OF PBF IN LOW-INCOME COUNTRIES

The use of PBF in lower and middle-income countries as a health sector financing tool can be traced to early experimentation with market forces in primary healthcare (Fritsche et al. 2014). This experimentation took place in the publicly funded and provided health system in Zambia's Western Province in the late 1980s and early 1990s, with the purpose of co-financing primary healthcare (Ibid). In Cambodia and Haiti in 1999, NGOs were contracted either to provide health services or to give management support to government-provided health services (Eichler et al. 2009). In both countries, these contracts were output-based, or fixed-price contracts known as performance-based contracts (Loevinsohn 2008). In Afghanistan, performance-based contracting was introduced as a national strategy for health service delivery in 2003 (Fritsche et al. 2014).

The Cambodian experiments exhibited operational differences between two contracting models: Sotnikum and Pearang (Mayaka Manitu 2015). The Sotnikum experiment was done within the public sector as a *contracting-in* model with a purchasing agency and steering committee closely linked to the national health sector hierarchy (Ibid). The Pearang experiment adopted a *contracting-out* model in which the *autonomous external*

purchaser agency (e.g., an international NGO or a local agency) assumes responsibility for the monitoring and follow-up of implementation. Contracting out has become the model advocated by donors, who lack trust in the public sector in crisis countries (Ibid).

Since 2002, PBF has been developed further in Rwanda (Fritsche et al. 2014). The Rwandan government adopted the contracting-out model to decentralize and improve governance (Mayaka Manitu 2015). However, it later switched to the contracting-in approach, because it was reluctant to shift power to international NGOs and wanted to introduce PBF to the whole public sector (Ibid). Following this shift, PBF has expanded rapidly in Africa. In 2008, the Rwandan government scaled PBF up by adopting it in its national health policy. In 2013, there were three countries (Sierra Leone, Rwanda and Burundi) with nationwide PBF programs and 17 with ongoing pilots (Fritsche, Soeters, & Meessen, 2014).[2]

RESEARCH METHODOLOGY

Research Design, Data Collection and Participants

Empirical data for this qualitative study was collected in the Katana HZ, which is located in Kabare territory, 50 km north of Bukavu, South Kivu province's capital. This HZ is composed of one general referral hospital (Fomulac (*Fondation Médicale de l'Université de Louvain en Afrique Centrale*) hospital), one reference health center (Birava) and 17 health centers that took part in the PBF experiment. We visited 15 of these health centers. In addition, to explore the national-level PBF design, adoption and uptake, complementary research was conducted in Kinshasa at the national ministry of health (MoH), in Bukavu at the provincial ministry of public health, at Cordaid offices (in Bukavu and Kinshasa) and in the Idjwi HZ. We also interviewed health management officers from the International Rescue Committee (IRC), Integrated Health Project (*Projet de Santé Intégré*, PROSANI), *Louvain Coopération au Développement* and *Bureau Diocésain des Oeuvres Médicales* (BDOM). Primary data was collected using three methods from August 2013 to April 2015.

1. *Participant observation*

This kind of observation of efforts to implement PBF took place in two settings: First, at the provincial health inspectorate/ division to investigate PBF outcomes on policy coalition-building between state institutions, donor/INGO organizations (especially Cordaid), *Agence d'Achat de Performances* (AAP) and providers at both provincial health inspectorate/division and the HZ level.[3] Second, at health facilities in Katana, in particular to explore the level of internalization of PBF principles regarding patient-centeredness, and to study the providers' motivation and health governance practices.

2. *Focus groups*

These were organized with providers, CBOs, such as the CODESAs, and community members.

3. *Interviews*

In-depth interviews were mostly conducted with key-informants from the state, donors/INGOs and FBOs (e.g., BDOM) in both Bukavu and Kinshasa. Semi-structured interviews were designed for all (potential) participants, but their applicability depended mostly on the profile and availability of the respondents.

Baseline assessment

To assess the baseline situation in the health sector, we also conducted a content analysis of the four main policy papers:

- the Growth and Poverty Reduction Strategy Paper (Second Generation, 2011-2015)(International Monetary Fund, 2007; RDC/MINIPLAN, 2011);
- the Health System Strengthening Strategy (RDC/MINISANTE, 2006);
- the National Health Development Plan (2011–2015)(RDC/MINISANTE, 2010); and
- the 2011-2015 National Health Human Resources Development Plan (RDC/MINISANTE, 2011).

Data Analysis

To identify the main themes in our data and to structure them in a useful way (Attride-Stirling, 2001), we used NVivo software to conduct a thematic network analysis revolving around four main themes: i) state fragility; ii) governance and actors; iii) service delivery; and iv) provider-patient relationships.

Fieldwork Challenges

Health providers working at the health facilities without state pay tend to believe that, with PBF, the money follows the patient and good figures make good rewards; hence, they feel tempted to exaggerate positive PBF outcomes. Gaining access to representatives of some international NGOs also proved to be a challenge. Finally, corruption is rife in the DRC and can be a survival strategy, but it is dangerous or shameful to talk openly about it.

Findings on PBF and Health System-building Outcomes

This section first discusses the baseline for assessing the outcomes of PBF. It then examines whether the PBF experiments have 1) built a policy coalition for improved governance of the health sector; 2) improved the management of service delivery; and 3) empowered local communities.

The Baseline Situation for Grasping Outcomes of PBF's Theory of Change

Based on the content analysis of official national-level policy papers and in-line with the six WHO building blocks, we identified the different types of problems affecting the health system in the DRC. Table 1 presents the main ones:

Table 1: Main Problems

Affected areas of health system	Problems noted
1. Governance/leadership	1. Deficient policy making, policy implementation and social accountability; 2. Poor normative power and weak coordination capability; 3. Politicization of the sector management; 4. Absence of anti-corruption mechanisms; 5. Low concern about the broader social determinants of public health; 6. Poor empowerment of the population regarding their roles in public health and social accountability of both providers and the state
2. Service delivery	1. Poor coverage in terms of geography and financial affordability; 2. Survival strategy (*débrouillez vous*) resulting in a high rate of turnover and commodification of health services, gaming, multitasking and parallel structures; 3. Unclear referral procedures; 4. Low proportion of specialized/qualified staff members; 5. Inadequate conditions in health facilities, many of which are housed in private premises.
3. The health workforce	1. Little or no salary paid to health providers, especially nurses; 2. Unmotivated and frustrated staff; 3. Uneven distribution of health staff between rural and urban/semi-urban HZs; 4. Unethical advancement in position and the absence of provision for retirement (and no severance pay at all); 5. Profusion of below-standard health training institutions.
4. Health information	1. Regulation for health system information is obsolete; 2. Poor information flow; 3. Poor dissemination of public policy.
5. Health Financing	1. Weak public funding and low disbursement rate of the budget; 2. Over-dependence on donors.
6. Medical products, vaccines, and technology	1. Poor availability and management of drugs and health technologies; 2. Weak compliance with both procurement mechanisms and the state supply policy through the National System for Medical Essentials Procurement

Source: Composed by the authors, based on International Monetary Fund, 2007; RDC/MINIPLAN, 2011; RDC/MINISANTE, 2006, 2010, 2011.

Analysis of these policy documents reveals the extent to which deficiencies permeate the entire health system. These malfunctions relate to the weakness of the state and governance functions. Cordaid's theory of change for PBF initiatives aims to strengthen state leadership and structural governance. It offers a contextualized approach oriented towards state-building (see below).

The Introduction of PBF in the DRC

During the height of the Congolese crisis in the late 1990s, Medical Emergency Relief International (Merlin) attempted to enforce a contracting system in the health sector to improve access to healthcare while strengthening the capacity and quality of the local healthcare system in a situation of chronic crisis (Dijkzeul and Lynch 2005). This approach, which pioneered the contract system in the DRC, made a subsidy dependent on the performance of each health facility, although Merlin did not enter into the internal running of the health facilities and, especially, human resource management. However, the implementation of this contract approach did not fully succeed, because Merlin needed to build the capacity of the health system first (Dijkzeul & Lynch, 2005).

Just Crossing Ruzizi River: From Rwanda into South Kivu

In 2005, with Cordaid funding, the Bukavu BDOM embraced PBF. To introduce PBF, a learning mission to Rwanda (where Cordaid was implementing a project in Cyangugu) took place in 2004. This visit enabled Cordaid to launch its first Congolese PBF experiment in 2006 on Idjwi island (Mayaka Manitu 2015; Peerenboom, de Weerd, Mushagalusa, Zabiti and Vroerg 2015).

Since then, various PBF experiments have been carried out and they have differed in terms of design, operation, and effectiveness (Bertone, Mangala, Kwete and Derriennic 2011). The most important PBF experiments took place with the World Bank (in the provinces of former Equateur, Maniema, former Katanga, Bandudu and Kinshasa), the European Commission with EU funding from the 9th European Development Fund (EU-PS9FED) (in Kasai Oriental, the former Kasai Occidental, the former Province Oriental and North Kivu) and Cordaid (in South Kivu and Bas-Congo) (Bertone et al. 2011).

In 2010, PBF initiatives covered 26 million Congolese and took place in 189 of 515 HZs (Bertone et al. 2011), but used different operational models. The EU projects experimented with *contracting in*, whereas Cordaid's projects tested a *contracting-out* model. Cordaid initially had a contracting-in model under the EU-PS9FED funding, but it failed to show conclusive evidence of its effectiveness (Ibid). The EU and World Bank-funded PBF experiments did not successfully apply the underlying principles of PBF, especially the division of labor and rational use of funding by public actors. For example, the work funded by EU-PS9FED was impaired by unclear definitions of roles and divisions of functions between health system management and providers (Lafort, Letournmy and Koussémou 2012). Moreover, in the DRC, where corruption is pervasive, contracting in through state institutions faces obstacles due to weak management and low financial accountability. However, Cordaid's contracting out PBF experiments with AAP as the external purchasing agency (see below) in South Kivu—the focus of the present study—and Bas-Congo have done relatively well.

PBF in Katana HZ: The Story of Cordaid's Engagement with Health System Strengthening

Fomulac Hospital became part of Katana HZ during the subdivision of the national territory into HZs in 1985 (RDC/MINISANTE 2006). Fomulac hospital was founded in 1928 and became one of the most famous health facilities in the African Great Lakes region during the colonial period. Until 2002, the Fomulac general referral hospital was managed as a Belgian project and had a strong reputation for service quality. From 2002 to 2005, the management was transitioned from Louvain University to BDOM. This was meant as a return to self-reliance in the aftermath of the wars, but it plunged the HZ into an emergency situation. The effects of war on the population's lives, poverty and the localization of management severely challenged operations in the HZ. To improve service quality and strengthen HZ management, Cordaid introduced PBF in Katana HZ in 2006.

Cordaid has supported PBF programs in the health, education and rural development sectors since 2011, as well as in selected public administration offices (KIT 2013). Cordaid and the Netherlands Cooperation have so far been the main funders of PBF for health interventions (Peerenboom et al. 2015). Stakeholders consider Cordaid's experiments to be the showcase of the underlying PBF principles. Due to the success of these experiments, Cordaid 'has been facilitating networking and sharing of experiences and lessons learnt with PBF to improve access to and quality of health services' (Cordaid 2013).

Based on its theory of change, Cordaid aims to establish a clear division of labor among the actors in the health system where they mutually control each other, and it provides financial support as an incentive for them to strengthen their governance, policies and service-delivery. Its interventions intend to strengthen the role of the state as a regulatory body, promote social accountability at the system management and service provision levels, and meet providers' expectations regarding decent payment for the delivered outputs. Hence, PBF anticipates agency problems that arise when the desires of the principal and agent conflict (Eisenhardt, 1989). Cordaid thus strongly engages these actors during implementation, and carries out regular monitoring and evaluation activities, ultimately hoping to instil real *transformational change* towards more patient-centered care in the health sector. Transformational change denotes an intrinsic motivation or desire to improve healthcare based on internalized social values of staff members of the health system.

AAP: A Crucial Actor for the Implementation of PBF

In line with Cordaid's contracting-out model, AAP is the *autonomous external purchasing agent* and local fund-holder agency for PBF in South Kivu (Agence d'Achat de Performance, 2011). It is in charge of mobilizing funding, managing donor funding, rational management of PBF finances, solving agency problems at the service delivery level, overseeing implementation of PBF principles, and contracting with providers (Peerenboom et al. 2015). According to PBF's underlying principles, AAP is accountable to the state and to the community through the CODESA (Ibid, 4-7). According to DRC health policy, the CODESA not only owns local health facilities, but as communi-

ty-based committees they also ensure interactive communication between the community and health providers. In the current contracting-out model, AAP is a private but public interest-oriented organization that interacts with all key actors involved in the implementation of PBF experiments in South Kivu. Therefore, AAP confers with state actors and donor organizations at a provincial level, and purchases health services at every level of the local health system.

At the operational level, AAP contracts health service providers at the HZ level (especially the HZ Management Board, the Referral Hospital Management Board and the CODESA—under the leadership of the health center's principal nurse (*infirmier titulaire*). AAP purchases health outputs and verifies the health facility records (*le vérificateur*).

At the provincial and HZ levels, AAP participates with providers and regulators in defining performance indicators in light of the national health policy and professional standards of healthcare provision. At both levels, AAP plays a key role in the process of output evaluation.

PBF AND THE DRC NATIONAL HEALTH POLICY

With the renewal of international cooperation in 2001–2002, donors' engagement in the DRC grew exponentially (Arnould and Vlassenroot 2016). Over time and through donors' initiatives, the government engaged in contracting within the health sector, issuing a first policy framework (*Vade-Mecum du Parténariat dans le Secteur de la Santé*) for these contracting arrangements (RDC/MINISANTE 2002). Officially, the process of promoting contracting initiatives was endorsed nationally with the adherence of the government to the Paris Declaration in 2005. This was followed by the adoption of a strategy to strengthen the health system in 2006.

As shown, external donors had already initiated PBF in the health sector. The first PBF experiments in South Kivu did not include the national level. Mayaka Manitu (2015) has characterized this initial lack of collaboration between the project and the central level as disconnecting PBF from institutional memory. Only in 2010 did a high-level meeting at the ministry of health in Kinshasa review the experiments. This opened the way for the government to formally consent to using PBF as an approach to health sector financing. The meeting assessed PBF's strengths, weaknesses and the modalities of its implementation in light of the different experiments. It concluded that the underlying principles of PBF and its outcomes regarding health system-building and health-service quality outperformed the traditional input model, which is a procedural/processual financing model (Ssengooba, McPake and Palmer 2012). Without abolishing the traditional model, the national MoH adopted the PBF model and encouraged its implementation at the operational level. At the end of the meeting, the government and its partners signed a memorandum of understanding on the adoption of PBF (RDC/MINSANTE 2012a). A direct outcome of this memorandum was the setup of an ad hoc PBF branch (*Cellule Technique du Financement Basé sur les Résultats*, CTFBR) at the national MoH tasked with the internalization of PBF principles (Ibid).

Cordaid and the CTFBR have concentrated efforts to mobilize state officials to adopt PBF at both national and provincial levels. As for South Kivu, the provincial ministry of public health declared PBF, along with community-based health insurance, as health system financing models for the province in 2011. However, at present, PBF survives only because of its external promoters.

PBF Experiments and Strengthening Health Sector Governance in South Kivu

Reinforcing a policy coalition for structural health governance

The structural setup of PBF and its theory of change require coalition-building around a set of values for active partnerships between the state, providers, civil society and donor organizations. We assessed the extent to which PBF has created a policy coalition among its stakeholders. Almost all informants were enthusiastic about PBF, which they considered to be better than the input model for health system-building. However, this enthusiasm was mainly based on the experiences of other countries and pilot experiments in South Kivu and Bas-Congo. Stakeholders praised the PBF approach for promoting a policy coalition based on the ideals of service productivity and quality improvement. They mentioned strategic interdependence and division of labor among the actors, the decentralization of operational decisions, operational flexibility, and social accountability as its distinguishing features. At each level, the actors involved seemed to be aware of their roles and the outcomes of their engagement.

Hence, PBF promotes interactive collaboration among stakeholders to strengthen the structural governance of public health institutions. The implementation of PBF occurs at all three levels of the health system: central, provincial and operational (MINISANTE/CTFBR 2012). State agencies from the three levels constitute the regulatory body, and healthcare providers include clinical staff members as well as public organizations and international and local NGOs. In Kinshasa and Bukavu, as well as at the service provision level in Katana, we observed actors' readiness to collaborate, and their awareness of strategic interdependence and the necessary roles at these three levels of structural governance.

At the national MoH, PBF interventions revolve around macro-level national health governance, especially in terms of policy-making and regulation. The *Comité National de Pilotage Santé* (CNP, National Health Steering Committee) is the high-level national platform for state and donor interactions. Donors, the state and national PBF-related organizations such as CTFBR and *Agence de Gestion Financière* (AGF, Financial Management Agency) participate in the CNP, where they take high-level decisions regarding health sector governance: policy making and implementation, sector priorities, sector management and harmonization and coordination of interventions. At this level, PBF is referred to as an approach that reinforces health sector funding, health system management, and promotes the internalization of good health governance principles.

At the provincial level, the PBF approach focuses on implementing national policy and enforcing its principles. State institutions act as regulators, verifiers and providers under the PBF principles. Hence, Cordaid established performance-based contracts with the Provincial Health Inspectorate. Pursuant to PBF guidance, the provincial ministry of

public health evaluates the performance of the provincial health inspectorate and the provincial health division. With donors' support, the provincial health inspectorate and AAP evaluate the performance of HZs and, in turn, the HZ Central Office (BCZ) evaluates the performance of its health centers. Every structure has its respective action and quality assurance indicators for performance evaluation. The main regulatory structure at the provincial level for the enforcement of PBF, overall health sector governance and stakeholders' coalition-building is the *Comité Provincial de Pilotage Santé* (CPPS, Provincial Health Steering Committee), which is the Provincial CNPS. The CPPS is under the administrative direction of the governor of the province.

In South Kivu, the PBF approach promotes and strengthens coalitions among state institutions, international NGOs, CBOs and the community. For example, all PBF stakeholders in South Kivu are involved in context analysis, identification of needs, setting objectives, defining indicators and performance evaluation. The state representative, as a regulator, endorses the identified indicators and contracts with external partners. AAP takes the lead in monitoring and fund management and contracts with all of the providers, including frontline service providers, public health sector officials and other institutions involved in the process, and CBOs.[4]

Not only do donor organizations and INGOs such as Cordaid support the activities of the state and AAP, but they also participate in monitoring and outcome evaluations of PBF experiments. Cordaid's officer in charge of health described the contextualized philosophy behind PBF's theory of change as 'neither working for nor against, but with the state, in order to reinforce its leadership role'.[5]

PBF sensitizes stakeholders about health financing reform at the national and provincial levels. At both levels, the MoH viewed PBF as a good model for health system financing and implementing a division of labor among key stakeholders. The MoH bodies assume the regulatory role, the HZs play the role of provider and AAP raises and allocates funding. CBOs provide the community voice. According to AAP, this division of labor was initially difficult because many actors were not ready for accountability.[6] An AAP representative noted that the state actors had not experienced a system where they did not have control over the financial management. A provincial health official asserted that 'we do appreciate Cordaid mostly for the introduction of [the] PBF approach, which actually entices providers to positive competition for health quality'.[7]

Implementation of PBF at the health centers concerns mostly the process of service-delivery and working conditions. AAP contracts with individual facilities (Health Centers, and the General Reference Hospital, as well as with the BCZ) for PBF implementation.

The state, donors and providers have constructed a PBF community policy for health sector financing reform. In its implementation, PBF supports capacity-building, which is an essential function of health governance. Capacity-building, in turn, contributes to the institutionalization of good governance practices. In sum, Cordaid attempts to strengthen local civil society and state institutions at all levels.

PBF as a tool for institutionalizing mechanisms for good governance

PBF supports the regulatory function of the provincial ministry of public health and the national MoH. The regulatory outcomes can be identified at multiple levels. State-level entities improve their knowledge regarding their roles and obtain the necessary financial support to fulfil them. Officials at the provincial ministry of public health and the provincial health inspectorate asserted that the approach has been motivating public officials to internalize good practices through contracts. A primary healthcare official within the provincial health inspectorate maintained, 'In line with PBF, staff members understand that when you deliver expected results, you gain; when you do not perform, you put yourself in the situation of a loser'.[8] At the provincial health division, contracting has improved output performance and administrative accountability. Although not all provincial health offices have thus far initiated PBF contracts,[9] in those that have, the culture of accountability instilled by PBF was acknowledged by the head of the provincial health inspectorate: 'PBF improves service quality … in terms of department functioning, effective administration, monitoring and local participation'.

Capacity-building and collaboration through PBF helps to improve human resource development. Cordaid's repeated interactions and meetings with the state entities promoted good health governance, provider performance, patient-centeredness, and strengthened outcomes. Observations from PBF stakeholder meetings revealed how important these interactions have been for improving health governance. Although PBF cannot right all of the wrongs that have long impaired the sector, its contribution is certainly appreciated. In this respect, a representative of Cordaid Kinshasa stated, 'we do not say PBF will solve all problems in the health sector; but PBF rationalizes health sector governance, promotes creativity and raises awareness on state, providers' and beneficiaries' responsibilities'.[10] Regular meetings between the Cordaid and AAP teams and the three provincial health institutions dealt mostly with PBF uptake and implementation, health sector management and community needs assessment, joint endorsement of HZ reports, monitoring initiatives and accountability. These meetings also considered department output reporting, health facilities' action plans submitted to donor organizations and health service provision processes. These iterative interactions are important for the internalization of good governance practices in the health department and HZ regarding health service provision processes. However, for AAP, the internalization of good governance practices require a great deal of patience, because it has been a challenge to transform the mentality of the actors involved.[11]

PBF and Improving Health Service Provision Management in the Katana HZ

Health providers' motivation and strengthening management

The entrenched carelessness of the state for social welfare has ossified lax public service. Everyone struggles firstly for their own survival, transforming public services into assets that civil servants exchange for their personal benefit. Describing this tendency, an official at the national MoH noted that 'civil workers get recruited but cannot live off their jobs'. This was confirmed by another official at the provincial health inspectorate: 'You manage your life from what you do on a daily basis; we live from hand to mouth

[such] that it is hard to apply for holiday [or] be ready for [an] occupational retreat'.[12] This explains the persistence of the self-serving behaviors that were repeatedly reported.

Through performance contracting, PBF anticipates this problem by providing guarantees to both the principal and the agent. In one of the focus groups with the Katana management board, the participants discussed the relevance of the PBF approach according to their professional experience. For them, PBF enables the providers and the community to focus on the common ideal of public health improvement. In contrast to input-based interventions, which are mostly procedural, PBF prescribes analyzing the baseline situation and the overall context before defining intervention objectives. Importantly, the participants stressed extrinsic rewards, which they presented as a distinguishing factor of PBF: 'PBF allows for motivating the agent and living up to the population needs'.[13]

Nurses at a remote health center (in Izimero) unanimously lauded PBF as it was implemented by AAP. According to one of nurses, 'without AAP and PBF we would not have survived. May God bless AAP. May it live long as a lake' [*arhame nka-ngadja,* in the Mashi language]. For a nurse this stance is understandable, because most nurses either erratically receive a small monthly payment or nothing at all from the state. The best paid may get at most 27,000.00 CDF (27.00 USD), and some may receive less than 9,000.00 CDF (9.00 USD) a month, but most receive nothing at all. In South Kivu, in 2012, there were 8,121 known health workers, of which only 732 received some salary; the rest received nothing from the state'.[14] The economic survival of civil servants presents an existential problem with professional repercussions. The magnitude of dysfunction in human resource management affects performance, service quality and professionalization. PBF addresses this situation by helping to solve the agency problem, and is crucial for rational health reform.

Although motivation through financial incentives is crucial in PBF, there are also other sources of motivation. In this respect, providers praised capacity-building. A member of the Katana HZ noted that all contracting agents undergo on-the-job training to enhance productivity and quality. In a similar vein, the HZ administrator maintained that, before the introduction of PBF, it was difficult to recruit paramedic staff, such as laboratory technicians. As PBF responds to the basic needs of the facility and population, staffing gaps were closed in all covered HZs: 'PBF […] has really contributed much to improving work regarding both inputs and infrastructure'.[15]

PBF also leads to improvements in task-oriented behavior. Staff members tended to respect the performance principles promoted by PBF, striving for efficiency and expected outputs. Although their motivation is still mostly *transactional* (incentive-based), it has been a good starting point. Improved task-oriented behaviors were reported in many dimensions, such as reporting, industriousness and human sensitivity, as well as in information accuracy and timeliness. The Provincial Health Inspector asserted that the reports received from PBF-covered HZs were clearer and more accurate than those received from non-PBF sites, because reporting quality and the reliability of intelligence are among the indicators.

PBF and improving service delivery

For many health officials and providers 'PBF is a good initiative that improves the quality of services'.[16] The Katana HZ Administrator held that, since PBF was introduced, the rate of health service utilization, which had plummeted when the Belgians handed over the management of the hospital, has increased again.[17] There is thus a causal relationship between governance and management, and between the implementation of PBF and improvement in service delivery outcomes. Above all, improvements in patient-centered care are being championed.

Health providers and community members generally agreed that PBF has had positive outcomes regarding *responsiveness* in Katana. Only a few people complained about the unsympathetic attitudes of some providers and a disconnect between the claimed service provision improvements and the real quality of services. Of the 15 health centers visited, only one was criticized for uncaring behavior. This low number of grievances does not call into question the overall positive effects of PBF on health outcomes. For example, across health centers, when community members were asked whether they were satisfied with the way healthcare services were being delivered at their health facility, they attested to significant improvements in the provider–patient relationship and context-sensitive pricing. Overall, with PBF, the communities' perceptions of health service provision and health providers is improving.

The *rational management* of drugs and other medical supplies achieved through operational planning is another aspect of PBF. On the basis of health facilities' action plans and indicators, medical products should be managed carefully with PBF indicators. The users of health services in different communities testified to improvements in terms of drug availability, frequency of visits, utilization and professionalism. However, not all health centers received the same appreciation of their performance. Additionally, the improvement in the availability of drugs has differed among health centers. Community members complained about *recurrent shortages of drugs* in many health centers, and the prevailing practice was to prescribe medications for patient self-procurement. All in all, the situation was generally reported to be improving, although reaching a satisfactory level will require further commitments from both the state and donors.

PBF and Demand-side Empowerment for Social Accountability

Active community participation in the process of verifying health facilities' performance empowers the population as key stakeholders in service provision and management. Such participatory verification is crucial for validating health facilities' performance reports. There are two kinds of verification: internal/technical or objective verification, and external or subjective verification (RDC/MINSANTE 2012). *Internal verification* refers to technical tools and/or administrative principles regarding clinical or biomedical consultation guidelines and administrative reporting effectiveness. This kind of verification is conducted regularly (on a monthly and quarterly basis) by AAP and state representatives within health facilities. *External verification*, also known as quality verification, is conducted by an independent team of experts and CBO representatives, including CODESA members. Quality verification focuses mostly on cross-checking the reliability of the data provided by the health facilities with the beneficiaries, as well

as their degree of satisfaction. AAP noted that community members had rejected incorrect or fraudulent statements incorporated in some of the facility reports.[18]

For some participants, multitasking observed at AAP as fund-holder, external purchaser and especially verifier is a weak spot in the implementation of PBF. Multitasking was mentioned as a potential obstacle to both rational management of funding and administrative accountability.

Still, PBF empowers communities through promoting patient-centered care, recognizing their rights to contribute to the process of service provision as both clients and beneficiaries. PBF engages CBOs, in particular CODESAs, which, in turn, are requested to raise awareness of community entitlements. In the rural zones, such as Katana, community empowerment is crucial for social accountability and voice. In the DRC, community participation is 'poorly understood' (RDC/MINISANTE 2006). However, 'with PBF, the community has become an active stakeholder aware of their statutory roles'.[19]

In addition, Cordaid also implements a program called *PBF–community*, which aims to empower the community to interact productively with healthcare providers. The community is represented mostly through its CODESA, which also serves as the interface between the health facilities and the community. As such, the CODESA members work to convey the population's aspirations to the health facilities but also to sensitize the community on health-related issues. Community members stated that, although the situation has not yet sufficiently improved, there have been some promising changes. Participation patterns have begun to shift from nominal participation to interactive participation. The community-empowerment initiative has strengthened the collaboration between health facilities and the community through performance verification.

Unfortunately, state weakness disempowers active participation in the provision of health services. The population's voice is still too weak to achieve full social accountability. Four factors explain this weakness. First, the concept of community is blurred. In a context permeated by social patronage and conflict, it is not always clear who belongs to the community or how one becomes a community representative. Second, health workers have become increasingly self-regulated and lax in the quasi-absence of the effective regulatory power of the state. Third, in rural zones, providers enjoy social power over most poor communities. Fourth, there is inadequate understanding of the quality of care and the social determinants of visits to health facilities in rural communities.

ANALYSIS

In sum, health officials consider PBF interventions more important than any other type of interventions to improve performance and strengthen health sector governance. However, there are critical challenges to institutionalizing good governance practices related to both the shift among providers from a transactional incentive-based motivation to transformational behavioral change and the assertiveness of the state in its stewardship

role through which the welfare of the community and the providers should be championed.

Despite criticism on AAP's multitasking, most respondents expressed their (relative) optimism about further strengthening health service governance, service provision management improvement and community-centered healthcare.

Almost all participants appreciated PBF outputs and even outcomes regarding institutionalizing good governance practices, but only a handful could imagine the sustainability of PBF without donors. Moreover, the current socio-economic system, insecurity, and especially fragile statehood continue to influence PBF negatively, as they have with other donors' interventions in the DRC. The overall context of public management, characterized by endemic corruption (Trefon 2011), undermines social accountability and the success of development interventions. Therefore, scaling up PBF to the whole country and achieving sustainability appear to be insurmountable challenges at this moment. However, the findings of this study have underlined the potential of PBF for motivating staff to increasingly deliver commendable outputs, despite fragile statehood.

CONCLUSIONS

This study explored PBF's health-building outcomes and the strengthening of health governance in light of PBF's contextualized theory of change. It noted problems in all six building blocks of the health system. In response, our analysis revolved around three types of outcomes of PBF for structural health governance: 1) strengthening health governance in terms of the state's regulatory capacity and coalition-building; 2) health service provision management, which concerns providers and service-delivery processes; and 3) demand-side empowerment, which is a requisite for social accountability.

Regarding *strengthening health governance*, PBF reinforces structural governance of health sector organization, management and accountability. PBF empowers the state with organizational capacities while also helping to institutionalize good governance practices. It supports the government's regulatory role, coalition-building and social accountability through enforcing national policy, division of labor and patient-centered care. Through structural governance building and the institutionalization of good practices, PBF mediates the setting of goals and ideals, as well as building a coalition to work for their implementation. In contrast to other interventions, PBF renders the state more actively visible in system design, coalition-building, regulation and stakeholders' interactive collaboration.

Concerning the *outcomes of service provision processes management* in Katana, the majority of participants in this study viewed PBF favorably. This study found that contracting dealt with the principal-agency problem by motivating health workers, developing indicators and providing performance incentives, thus addressing the laxness observed in the public sector. PBF also provides useful support regarding the rationalization of health management. Through promoting contract-based market principles and integrated management, PBF inputs not only help to attract new health staff, but also

improve task-oriented behavior. This study noted some progress in terms of behavioral change and good practices, such as readiness for financial accountability, commitment to quality, productivity and patient-centered care in the Katana HZ.

In terms of *demand-side empowerment*, PBF gives power to communities through promoting patient-centered care and recognizing communities' rights to participate in the process of service provision as both clients and beneficiaries. PBF engages with CBOs, which, in turn, work to raise awareness within the community regarding their entitlements. Active participation of the community in the process of verifying health facilities' performance records empowers the population as a key stakeholder in health service management. It allows the interactive participation of the community, which is necessary to establish a more effective state–society relationship. Although the capacity to participate effectively for social accountability is still weak, the communities in Katana testified that PBF efforts raise social awareness on the relevance of their interactive participation in health service provision.

Although there are many indications of positive effects, PBF interventions in the DRC face structural challenges that make achieving sustainability difficult. As a result, the approach remains confined to pilot experiments that so far fail to scale up. Many challenges are related to state fragility. PBF implementation relies mostly on inputs from external donors, which creates dependency and anxiety regarding their withdrawal. The MoH itself is dependent on donors' financial incentives for implementing performance policy. Thus, at the moment, PBF seems to be about *transactional*, incentive-based motivation for the state at governance and management levels, as well as for providers at the grassroots level. It is challenging and time-consuming to move beyond transaction-based motivation to create a real behavioral *transformation* among providers. Moreover, there is a need to further clarify the division of labor, an issue that was raised by many respondents as a critical way to prevent unpredictable outcomes related to conflicts of interest, multitasking, and unreliable reporting. In sum, it is costly to scale up and achieve sustainability in the absence of a working state. Strengthening the state's willingness and capacity is necessary for the success of any donor-inspired scheme. PBF supports health sector-based state-building, but it cannot repair a weak, corrupt state. Further research is needed on achieving transformational behavioral change in a context where the state itself is a main cause of social weakness.

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NOTES

[1] During participant observation, the provincial health division and the provincial health inspectorate had not yet been separated in South Kivu. This finally took place in 2016.

[2] Benin, Burkina Faso, Cameroon, the Comoros, the Central African Republic, Chad, DRC, the Republic of Congo, Kenya, Lesotho, Liberia, Malawi, Mozambique, Nigeria, Tanzania, Zambia and Zimbabwe

[3] See footnote 1.

[4] Interview, Bukavu, 11/11/2014

[5] Interview, Cordaid Office, Bukavu, 22/10/2013

[6] Interview, AAP, Bukavu, 11/11/2014

[7] Interview, Provincial ministry of public health, Bukavu, 03/11/2013

[8] Interview, Bukavu, 03/03/2015

[9] Only five offices had implemented PBF at the time of this study.

[10]Interview, Kinshasa, 26/01/2014

[11] Interview, AAP, Bukavu, 11/11/2014

[12] Interview with medical doctor, Bukavu, 06/11/2013

[13] Interview, Katana, 11/04/2014

[14] Provincial Health Inspectorate records

[15] Interview, Katana HZ Admnistrator, Katana, 25/02/2015

[16] Interview, Bukavu, 03/10/2013

[17] Interview, Katana, 25/02/2015

[18] Interview, Bukavu 11/11/2014

[19] Katana, 25/02/2015

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