REPORT OF THE STEERING COMMITTEE MEETING –MULTICOUNTRY PBF NETWORK

Kigali, November 24-25th, 2011

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I. Introduction

On 24th-25th November 2011 at Lemigo Hotel at Kigali, there was a Steering committee meeting which was hosted by HDP. The opening ceremony started at 8 O'clock AM, it was done by the Director of HDP who is also the Executive Secretary of Multi-country PBF Network. He precised that, that meeting was the third which was held in order to present the results of the Mid-Term Evaluation that was carried out in 7 country members of Multi-country PBF Network in which it is included Rwanda, Burundi, DRC, Tanzania, Zambia, RCA and Cameroon. This meeting brings together the participants from the different countries that are mentioned above. The duration of the project is 3 years (from 01/01/2010 to 31/12/2012). Its financing budget is 3.9 million Euros and the stakeholders of the fund are European Union for75% and Cordaid for 25% of that budget. After the speech of the main speaker, he welcomed all the participants in Rwanda and handed over to Monique Lagro who is the facilitator of the day working. Then she presented what is scheduled in agenda of the day which is attached on this document.

II. Overview of meeting agenda

The first day working was devoted to the presentation of the results of the mid-term evaluation for every country in morning, then in the afternoon there was the work in group. The next day which was the last of the workshop was reserved for the country review of action plan 2012, presentation on the web site use and different various subjects which were detailed in the last part of the report. Then the agenda of the meeting, the debates and group works are attached to this report.

III. Presentation of the objectives of Multi-country Network

a. Overall Objective of Project

Improve health sector functioning through sharing of experiences with the PBF Approach in 7 countries (Burundi, Cameroon, Central African Republic, DRC, Rwanda, Tanzania and Zambia)

b. Specific objectives

1. **Establish an international exchange network among the 7 countries**
2. **Learn through action-research**
3. **Reinforce the capacities of Cordaid's partners and other key actors (local administration and health authorities)**
4. **Promote community participation in PBF programmes and community-based health insurance schemes, and experiment with synergic activities**

Expected results

1. **An inter-country experience sharing network is operational (HDP)**
2. **Action Research:**
    a) **Community PBF operational in BURUNDI & CAMEROON**
    b) **Systemic synergy effective between HIV/AIDS programme and PBF in DRC**
    c) **PBF approach harmonised between state and church in CAMEROON, TANZANIA & ZAMBIA**
    d) **Purchasing agencies have a well developed institutional base in BURUNDI, CAMEROON, CAR & DRC**
    e) **Influence of PBF on HR management is known**
3. **Capacity building**

    a) **A PBF training institute exists in each of the 7 countries**
    b) **In each country there is a partner capable of independently promoting and expanding PBF experience**
4. **Community participation**
    a) **Client's voice is strengthened**
    b) **Harmonisation mechanisms between PBF and CBHI are studied in DRC and Rwanda**

After exposing briefly the objectives and expected results, the Speaker mentioned about the objectives of Mid-term evaluation.

IV. Presentation of the objectives and results of the Mid-term Evaluation

a. Global objectives of Mid-Term Evaluation

- **To assess relevance, effectiveness and efficiency of the 7-country project and to recommend adaptations in ongoing activities, in order to increase effectiveness and efficiency and ensure sustainability of benefits**
- **The mid-term review uses the agreed log frame of the contract between the EU and Cordaid, as well as the country log frames**
- **The MTR is conducted by a joint team of internal (Cordaid and HDP) and external/independent consultants as well as local coordinators from partners involved in the implementation**

b. Specific Objectives of Mid-Term Evaluation

- **Assess the relevance and logic of the design**
- **Assess the activities implemented per partner**
- **Assess how well HDP and Cordaid have coordinated the entire Project**
- **Assess the functioning of the international network**
- **Assess the level of achievement of intermediate results and identify factors that positively or negatively influence smooth implementation of the Project**
- **Formulate recommendations intended for the Project Coordination and partners to improve Project implementation**

c. Working methodology

- **Documentary review of project document, progress reports, budgets and expenditures, proceedings of meetings & workshops**
- **Interviews with Cordaid partners, MoH officials, health facilities, community representatives etc.**
- **Field visits to the pilot sites in all 7 countries**
- **Data collection and analysis**
- **Short restitution and discussion on provisional observations and the recommendations from the mission of evaluation**
- **Thorough restitution at the end of the mission in Rwanda during a Project Steering Committee meeting**
- **An overall report will be produced with separate country reports as annexes**

d. Evaluation team

- **Peter Bob Peerenboom & Christian Habineza (CAR, DRC & Cameroon)**
- **Maria Paalman and Ernest Schoffelen (Burundi, Rwanda, Tanzania & Zambia)**
- **Project Coordinators, each in another country than their own (learning experience)**
- **Paalman and Peerenboom will evaluate the contributions by HDP and Cordaid itself**

IV.1. Presentation of the Mid-term results per country

The presentation of evaluation results per country occupied a whole morning time of the first day's schedule. Those evaluation results were set according to the expected results in the project. The first one is for Burundi.

IV.1.a. Mid-term Evaluation results in Burundi (Gaspard Hakizimana and Adrien Nahimana)

- **Evaluation of the project according to the expected results.**

In the same way like other countries, the evaluation was done according to the expected results and the statement is the following:

- **The health community program PBF is active; the purchase of indictors HIV/AIDS Community was done by AAP... In fact the purchase of those indicators was adopted by the government of Burundi and was implemented since it was extended at national scale in April 2010. But this is the result of pilot project of previous Cordaid and it's not for the Multi-country project. There are also two ASLOs (Local Associations) at Makamba for the purchase of 5 HIV/AIDS indicators.**
- **The local institution base of AASS agencies and interpersonal exchanges among agencies are not enough developed. This result does not valid because the Government of Burundi decided to implement the PBF through the provincial committee of verification and validation since 2010.**
- **The planed survey about the PBF influence on human resources management was not. This result is to be achieved at the level of these 3 countries; Rwanda, Burundi and DRC. Then the action research will be conducted under the responsibility of HDP in Burundi and RDC.**

- **The identified institute capable to train in PBF is the National institute of Public Health under the responsibility of the public health ministry. The negotiations are in process in order to sign a contract between both sides.**
- **The partners of Cordaid (Coped and IADH) are able to promote and expand independently the PBF program in their countries. It is justified by the following reasons: Coped seems to have certain capacities to manage PBF among its health facilities (FOSA) and The contributes in training the community health workers group; the IADH which is the new agency that was established by former staff of Cordaid seems to be much powerful to play the role of advocacy before the National and provincial authorities whereas Coped seems unable to do that role.**
- **The client voice is also reinforced because there is the representation of the community voice in health committee where there is a representative per health facilities in conformity with the National policy and also the Multi-country project reinforces the capacity of 27 health committees (COSA) at Makamba. But it should be noted that the investigation of verification and client satisfaction are not yet carried out.**

- **Strength nesses, weaknesses, opportunities and threats.**

The evaluation in Burundi showed the strength nesses, weaknesses, opportunities and threats of Multi-country project. Among the strength nesses, there are the trainings and reinforcement of GASC which contributed in increasing the services to be needed.
Among the weaknesses of Multi-country project, there is a contra-verification which is not yet set up for the PBF community and the budget of the project which does not include the funds for international exchanges.
Among the opportunities of the project, the experience of GASC trainings for the PBF community should be expanded in documenting well evidences and cost of its training services .
Among the threats of the project, the national PBF model which does not follow the separation of function and sustainability of PBF community is not for promising.

- **Recommendation**

Thus it was recommended to recruit an expert for documenting well the Impact of community health workers group on health care needs.
IV.1.a.l. Lessons learnt in evaluation of PBF community at Makamba in Burundi

Among the important lessons learnt there is :
- **A community which organizes itself through civil societies (COPED, IADH) for improving the system of function of health sectors and the FOSAs get satisfied with what was received from PBF.**
- **The free health care which were not shared with all the health facilities, in whatever church-based or publics. The church-based health facilities can accept to provide free health care because they are not subsidized at the same title as the public's. However, the institutional base of civil society commits itself to bring there the best performances (success story).**
- **There is also the implication of pair coordinators in evaluation which is an assisted or guided auto-evaluation, the capacity building, especially for the project whose the general objective is the same even certain specific objectives are similar in our country.**

- **The fact of defining the methodology together in advance, collecting tools such as the questionnaires identify the partners to be interviewed is an approaching that reinforce the network except the good neighbourhood between two countries, there is this aspect of reciprocal evaluation.**

IV.1.b. The results of Mid-term evaluation in Cameroun (by Christian Habineza and Adolphine)

- **Evaluation of the project according to the expected results.**

The African local partner's network was created and active. But according to the evaluation done, there are the strengthnesses and weaknesses.
Among the strengthnesses, there is the staff team which is active, participates in conferences and does multiple contacts.
Regarding the weaknesses, there is a need of increasing the level of documentary sharing, designing a website which is proper to CODASC and running the use of forum of group discussion.

The health community program is active but it is characterized by the strong and weak points.
In the strengthnesses, there are health community workers who are active, the health centers which continue to sign contracts with health community workers and the research on community participation which is in process to be carried out.
Among the weaknesses, there are such like lacking of the official dialogue structures, contractual approach of health committees (COSA's), an association of CHW without recognized official structure (Nonprofit organization) and which is not put in network in terms of federation.

The PBF approach is harmonized between church and government and there are the following strengthnesses: A regional conference and national forum which has been organized, a memorandum of understanding on the purchase of PBF indicators, the relationship of collaboration between the CODSC, the health region and Ministry of public health are good, training of many responsible persons which has been done and integration of nonprofit sectors on PBF approach.
But also, there are the following weaknesses: the lack of MoU between Catholic church and Government, the lack of health professionals salary payment by the administration of the private health facilities and less competitive policy in the church-based health facilities.

The local institutional base for the special funds is not yet well developed and interpersonal exchange has not yet been well carried out because the world bank project is not yet implemented in eastern region. So this expected result cannot be achieved but the perspective is good because the project of the law on legal status is in process of being established.

The CODASC is able to promote and expand the PBF experience independently due to the following strengthness: the staff which was trained, the REDSSEC project which has been

implemented, the training sessions which have been organized, the national forum and regional workshop which were done, the CODASS position which is recognized by Public Health Ministry and it has been proceeded to the PBF extension in other social life.
Concerning the weaknesses observed, there is especially a closing of REDSSEC which has even risked weakening the CODASC capacity. The management in CODASC by the Multi-country project own staff so then there should be the separation of function, and lack of publication of good practice on CODASC internet website.

Concerning the reinforcement of client voice, it has shown the following strengthnesses: the management committees (COGES) are active, the use of associations with the community base for verification, the research in process, the presentation of community verification before management committee and at least the integration of satisfaction score in quality bonus calculation.
However there are weaknesses that need to be improved especially: the creation, trainings and health workers framing as well as the coherent PBF community program.
In AOB, it was noticed that the reorientation document of activities and second allowance of budget was not available, the reporting system is not in accordance with logical frame of the project and the action plan of 2012 is not yet worked out.
For concluding, it should be underlined that CODASC participates actively in Multi-country network. It takes part in important role on the strategy of public health Ministry
Comparing the PBF program. The expected results will be probably achieved if it is considered on the reorientation of the project comparing the rest of the executing project of World Bank.

- **Recommendations**

At the end of evaluation, the evaluators have recommended to start up the contract system at least in one whole health district since the month of January and apply good relationship between church and Ministry of health in order to reinforce the positioning and influence of the church and doing advocacy in order to make progress of MoU between church and Government.

IV.1.b.1. lesson leant by peer evaluator from DRC (by Adolphine)

- **In order to implement the PBF program, it is needed to think about the financial resources,**
- **No discrimination when the PBF program is started,**
- **Make difference between the institution partnership and project,**
- **The PBF approach should be extended in other development sectors.**
- **It is always important to take the ownership of accountability To Whom It May Concern.**
- **It's particularly necessary to publicize the project records.**

IV.1.c. The mid-term evaluation results in RCA (by Peter Bob Peerenboom and Jean Pierre Tsafack)

- **Evaluation of the project according to the expected results.**

The African local partners network is created and active and it is due to the following strengthnesses: there is an assistance service for the local partnership which has been created, the studies tours which has been done for example in Rwanda, in Cameroun, the participation in conferences which is effective, the exchanges on website of Multi-country network which have been done and multiple contacts in that frame.
Concerning the weaknesses to be improved, there is a low level of sharing documents that needs to be put right, the creation of ASSOMESCA'S own website and insufficient of use of discussion group/ forum.

Regarding the experiences relating to the transformation of emergency help in development program in RCA: there are study tours as it was planned in DRC where such experience is much advanced. Moreover, there is obviously the lack of suggestion occasion on how to introduce PBF in emergency zones. Among the other project benefits, there is affiliation of ASSOMESCA in OCHA network and the participation of ASSOMESCA in partners meeting which was piloted by WHO.

The OCF are the agencies which have a well developed local institutional and interpersonal base which are ensured. The steering and dialogue committees at the ASSOMESCA level have been established, the ASSOMESCA involvement level is still weak and that the reference terms are in process to be elaborated.

ASSOMESCA is a capable agency to promote and expand independently the PBF experience. This is demonstrated by the following strengtnesses: it is the local partner which is recognized by the Ministry of public health, the establishment of assistance services whose the staff is in charge of program, the organizing of international steering committee, the organizing of training session in PBF, the organizing of national workshop, the occupation of central position in the members network with the functional office and its involvement in managing conflicts.
Among the weaknesses, there are the positioning of staff in charge of PBF program, the project management to be preferably in region with active OCF, the training of its members groups and other important actors.

For the reinforcement of the client voice, the strengthnesses are the initiative of community project and the capacity building of local societies.
In this regard there are also the weaknesses such as the lack of mastering and promoting the concept of client satisfaction, the importance of running the health facilities and the health care quality as well as the promotion, the running of health and management committees in the health facilities of their members.
In AOB, there is an issue about the process of closing the project of the 9th European Fund for development, the pharmacy store and the necessity to create a PBF assistance service in the ministry of public health and his coordination mechanisms by the same ministry. The debate has been done about the position occupied by the OCFs for the future and the necessity of designing the budgeted action plan 2012.

- **Conclusion**

The results of evaluation concluded that ASSOMSCA is a faithful and active partner of the Network. Its role in the country is important and it has advanced to occupy the central position in the health sector. So the prognosis seems to be positive and we can conclude that the achievements are beyond expected results.

IV.1.c.1. Lesson learnt (by Jean Pierre)

The first important lesson learnt is the involvement of the government (Ministry of public health) in all levels of the project implementation which guaranties the sustainability of the project resources. Both Ministries in charge of primary education and of secondary education have been involved in the implementation of the education PBF project in the Baturi Diocese. The second lesson learnt is that the ministry of health was also involved in the implementation of the health PBF project in Maroua-Mokolo diocese.
The last is to know how to conduct an evaluation such like this. Indeed we learnt that the evaluation has to be participative and conducted by the external and internal resources.

IV.1.d. Mid-term evaluation results in Tanzania (by Maria and Clement)

With the arrival of Multi-country PBF project; the evaluation results showed that it operated recently the changes. Normally the government has a complicated system of financing the health institutions that managed by the churches with several grants and 10-15 % from the donor basket fund for based-faith hospitals with the contribution in nature and financial contribution for the public health facilities.

The formalization of the working relationships between the government and health facilities managed by the churches under the MoU as a part of the health strategy. The Christian Social Service Commission (CSSC) was going for full cost recovery on fee-for –service basis. But the government decided to only input financing of basket fund money by output financing on basis of billing. However the budget is by far not enough to provide all services mentioned in the contract. Where there is no service agreement there are no basket funds. The MCH, HIV/AIDS, TB, STD etc. services have to be provided for free. These result in the decrease of income for church facilities while the number of services decreases without financial compensation. There is no national PBF program but several pilots have been done or are on-going with the support of Cordaid in 5 dioceses and of Norad in Coastal Region. But there are two main problems; the social welfare of the Ministry of health (MoHSW) does not favor the health facilities autonomy system very centralized. Another problem is that MoHSW sees the FBOs as competitors not as cooperative.

In the frame of harmonization approach between the church and government it was stated that there was a needs evaluation in 12 church health facilities on the health facilities management, human resources, infrastructure, HMIS etc... which was done and must to be used to formulate PBF indicators and targets. And also a workshop was done to identify performance and quality indicators .around 5/12 health facilities have now a business plan based a costing exercise. But, all of these preparations have not been used for the service agreements (SAs) in Rungwe which do not contain specific PBF characteristics which seem to be the same as the SAs in other areas of the country. The output financing is very general and there are no additional funds available for incentives, no quantifications of services, no targets, no indicators and no verification. Lastly there is an informal agreement with DMO

which is that the targets and prices calculated by CSSC will be used for a number of MCH indicators.

In Rungwe District only two church hospitals have now a service agreement, but 10 church PHC facilities not yet because according to the Ministry of health it would involve receiving cash but their staff are not trained in financial management and there is no an establishment for an accountant.
The PBF approach has been a catalyst to push the government to sign the SAs in Rungwe, however the SAs make now the church based health facilities worse off.
The SA could be a small step towards the PBF but Tanzanian environment is not conducive at the moment. This is the reason why the result was not achieved.

An institute identified to be able to host the trainings is Kirimanjaro Christian Medical Centre (KCMC) as a national training centre located in Moshi. Around 5 health professionals have done the SINA health course. KCMC has done several trainings sessions in Rungwe and refresher courses are planned but there is a lack of budget. KCMC has adapted the English SINA health training modules to Tanzanian situation in collaboration with CSSC and with technical assistance provided by Cordaid, those modules are translated in Kiswahili, lessons plans and teaching were produced. But the MoHSW was not involved this is the reason why the results are not satisfactory.
CSSC is a partner able to promote and expand independently the PBF program. In fact there are 3 resources persons from CSSC who have done health SINA course. CSSC has organized the campaign of advocacy for contractual PBF approach as a national PBF forum. It is also scheduled in 2012 an international meeting for sensitization of governments and donors in DSM. There is also a public and private district PBF forum but CSSC representation in TWG on health financing is weak. Some information materials on PBF have been made a constant sharing of PBF information has resulted in group of MoHSW staff in favor of PBF, even if these staff have also done the health SINA course but they are not enough highly profiled to make a difference. The non-conducive environment in Tanzania makes difficult any attempt of advocacy for PBF. This is the reason why the expected result is not yet achieved.

In term of strengthening the client voice, the health facility committees are mandatory, and community members are included. Around 7 of the 10 church health facilities in Rungwe District are actively meeting but the satisfaction surveys are not down there. The hospital boards of faith-based health facilities are appointed by the Bishops without election of community members. Briefly it can be concluded that the expected result was not achieved.
It has been recommended that the CSSC is advised to organise a study tour to CHAZ Zambia, including key MoHSW officials, the KCMC/CSSC should present final modules to MOHSW for approval, and seek accreditation from National Council for Training, the CSSC should ensure that a qualified person represents the organisation in the TWG/HF, the CSSC should develop a PBF advocacy strategy (request TA from Cordaid?) and lastly it is recommended to organise exchange between Rungwe and Sumbawanga, where 12 faith-based PHC do have SAs and are paid in cash, even without having accountant.

IV.1.d.1. Lesson learnt (Clément)

Generally as observations perceived, there are a success project implementation requires a correct project design, initial pilot should not depend on other sources of financing other than the financing agency, auxiliary activities should be correctly tied to the project as main object and not otherwise and clarity on the roles of stakeholders in the design process.
Specifically there is effective visibility strategies (Bill Boards, T-Shirts, and enhanced sharing of information through the network).
The way to implement the lessons learnt is to replicate the production of bill boards to enhance visibility for PBF, EU, CORDAID and CHAZ and to engage with CSSC on the utilization of the multi-country website (lobby – project should support staff capacity development).
In response to how to Conduct an evaluation, it is needed to know the project you are evaluating, know the objective and expected outcome, understand the context and appreciate the purpose of the intervention, to use relevant evaluation techniques and methodology and consider time to inform the scope of work, to use effective feedback mechanism, deliver lessons leant and inform the implementation of the activities in the subsequent period.

IV.1.e. The Mid-term evaluation results in Rwanda (by Ernest and Adrien)

- **The evaluation results according to the expected results of Muticountry project.**

HDP is confimed as the Cordaid partner capable to promote and expand independently every PBF program in its country, it is a partner well recognized at national and international level. HDP is facing the problem of the lost building capacity in the competent human resources because of the death of two headquarter staff members. It is revealed that the capacity building of the staff in English is to be strengthened. The request of evaluation among the country members has been done but it was not scheduled in the annual action plan of every country.

Concerning the reinforcement of the client voice, there were training of 11 people from community cooperatives with aim of promoting the affiliation to the health mutual and the contribution gathering, reinforce the commitment and the responsibility of community health committee and the voice of community in the management of health center.
For promoting the affiliation to the health mutual and contribution gathering, this experience has started since August 2011 and it is still so early to evaluate the impact. But as the cooperatives staff trainings are part of national policy, the launch of pilot project has no added value. It's only needed the documentation for effectiveness of these cooperatives. The other question which is remaining is the sustainability of this system. There is also challenge to formalize the relationship between cooperative and the health committee except that there are informal exchanges which are going on at the level of the community in term of commitment reinforcement and responsibility of community health committee as well as the voice of community in the management of the health center.
The evaluation showed the following strengthnesses: the HDP is recognize as an expertise centre specialized in PBF trainings, it defends the voice of community in the centralized government environment and then it developed the experience with health mutual.
Within the weaknesses of the Rwanda multicountry project, there are the insufficiency of expertise in research and of capacity building in English. On other side, there are other

opportunities to be exploited by the muticountry project such like expanding technical assistance in Anglophone countries, contributing powerfully in international debate pertaining to the strenghness of the community voice and the relationship between PBF and health mutual.
This evaluation showed that the main threat faced by the multicountry project is relating to the sustainability of the community PBF program.

- **Recommendations**

At the end of evaluation, it was recommended to look for additional support for the research project, built capacity in English permitting the project staff professionalize in it , run out a comparative study on: « the impact of community verification on the health care quality and the impact of cooperatives on the affiliation to the health mutual in comparison with the government interventions ».

IV.1.e.1. Lesson learnt (by Adrien)

There is a strong involvement of private institution (HDP) in health mutual through: institutional support (implementation, juridical status, advise), technical support (training, tools, monitoring/evaluation),financial support (motivation of frame institutions).
There is also the strong community leader's involvement in health mutual development (COSA or GASC or local elected): community sensitization/mobilization.
There is also the strong collaboration between Health facilities (FOSA) and health mutual: integration of health mutual in the FOSA, near approach policy, payment system of medical actions are effective and fast, there is monthly declaration of bill by FOSA to health mutual for monthly payment.
Lastly there is a strong involvement of government in health mutual development: sensitization/mobilization for affiliation to the health mutual done by the local leaders, the government support to the community leaders who excellently performed in mobilization and sensitization (cow for family) elaboration of vulnerability criteria and fixing the contribution by scaling up categories of people (2000rwf-3000rwf-7000rwf) care of vulnerable people for 25%, existence of institution coordination of health Mutual in the visited District, affiliation to the health mutual which gives right to the health care and services in whole country through information technology system.

According to the health mutual development, there is a will of government to encourage and support the income generating activities development of community members who have average income in order for the annual contribution could not be as a burden to the household income, to reduce the rate of vulnerability in the community known as very poor by assistance and diversification of income generating activities in order for that poorest category of people could not be as a burden to the government.
The evaluation team has done all possible to give the evaluation feedback to all actors of the project implementation.
The most important lesson learnt and needed to be implemented in Burundi is what concerning the health mutual. In this frame work the consortium COPED/IADH with the support of existing institutions such as COSA, Organized Community institutions as

association and GASC and church organizations will implement a pilot experience of health mutual.

IV.1.f. Mid-term evaluation results in DRC (christian and Sebastien).

- **The evaluation results according to the expected results**

Before presenting, it should be noted that the Multicountry project knew the change of SPS caritas partner which was replaced and its responsibilities was distributed into other two agencies which are BDOM of Boma and Cordaid Kinshasa.
The African local partners network is established and active and there are the following strengthnesses: the participation in conferences, the documents sharing and the multiple contacts were already done. In other hand there are also the weaknesses to be improved such like the project documentation on diocese web site, organizing the study tours and sharing all the documents including training modules.

The synergy between HIV/AIDS program and PBF is effective and the strengthnesses are following : the indicators are harmonized, the budget and work plan are consolidated at the health facilities and ECZ level, the local associations were identified and trained, the baseline study for the health mutual was already done and the assistance services for PBF promotion were already created.
These are also the weaknesses: the community indicators which are not yet elaborated, the community contractualization which is not active, the research which is not carried out and the development of solidarity mechanisms which is still in process.

The CAFCC has a developed local institutional base and ensured interpersonal exchange with the following strengthnesses: the regular attendance of the quarterly meetings and sensitization of provincial key actors.On the other side, it has the following weaknesses to be improved: annual provincial meeting that was not done, a national meeting was not held and the process of external system did not start yet.

The capable institute identified to give training in PBF is AAP Bukavu because it has the trainers and it is enough experienced. Moreover, there are training modules adapted for DRC and developed for several levels.

The advocacy for PBF approach at national level done by Cordaid is effective. Even if the partnership with SPS Caritas was interrupted, the advocacy was done and the exchange was facilitated. There were also the facilitations for a PBF assistance service creation in the Ministry of Public Health and the particular attention was oriented to the Ministry of Public Health.

In terms of strengthening the client voice, there are associations' members who were trained and signed the contracts, the verification was done and CODESA is active.

Then in AOB, it was pointed out that there was a trend to external system of CAFSS, the budget reallowance is shown in the reports, there were delays in verification and payment, there was less consumption of provided and scheduled budget, the budgeted action plan 2012 was available and the preparations are in process for expanding the PBF approach at the provincial level.

- **Conclusion**

Lastly, there are three statements: the diocese participates actively to the network but the implementation of the project went on slowly. The BDOM could benefit from a very active

exchange with other partners. The expected results can be achieved with condition of accelerating the implementation of the project and monitoring closely the project activities.

- **Recommendations**

Therefore, it was recommended as follow:

- To ensure the autonomy of CAFESS by the end of December 2011
- To accelerate the process of CAFESS external system.
- To make an official document that contains the activities changes and budget reallowance.
- To change the national conference into the international workshop where it will be invited the representative of purchase agencies supported by Cordaid.

IV.1.f.1. Lesson learnt (by Sebastien)

The very important lesson learnt in the visited country was relating to the institutional base process of AAP/OCF and the involvement of church in PBF contractual approach. And also the evaluation method and approaches must be adapted according to the reality of each country (culture, customs).
Regarding the question of knowing how to implement it in home countries, the representative of RCA said that there should be an institutional base of PBF and church involvement.
But for the Cameroon, it should be proceeded to remove the barriers which are blocking the PBF implementation.
Another very important learnt in conducting the evaluation is relating to the experience of team members (the change of methodology according to field conditions, how to know the attitude to have before each situation, how to gather the needed information with the help of meetings and making decision tools for the development actors and how to organize a dialogue which is a conducive occasion of exchange.

IV.1.g. Mid-term evaluation Results in Zambia (by Maria et Sule)

- **The evaluation results according to the expected results**

The statement done on the ongoing activities of the project showed many changes came with the multicountry project arrival. In July 2011 Zambia has become a low-middle income country and there seems to be large unbalance in income. The government of Zambia has started a large MCH focused RBF programme with funding of World Bank as an impact study. All health services are free and there are no user fees. The government has committed to increase the rate of the budget for health from 6% to 15% by 2015.

The PBF approach is harmonized between church and government because in Zambia , the health institutions are totally paid by the government: salary, 75% of operational costs, drugs and training. The infrastructures and maintenance belong to the church. The relationship between church and government is good. The CHAZ/PBF project is doing its activities in 8 health facilities including both public and church facilities. CHAZ is represented in the technical working group (TWG) and in the health care financing (HCF).The indicators, subsidies, the quality assurance and verification tools have been harmonized between CHAZ and RBF project. Then they use the same trainers from Zambia University. But the using advices of subsidies were different. It can be concluded that this expected result was achieved.

The identified institute is the University of Zambia chosen for trainings. Around 5 staffs from University of Zambia have already followed the health SINA course and have been also trained by MSH project. The University of Zambia has collaborated with CHAZ to conduct the baseline study. The implementation document of the project and training curricula for the community representatives in which 40 members were trained and also there was a new purchase agency SCCP that was trained. The health facilities staff was trained by Cordaid/ETC Crystal. It can be concluded this result was achieved.

The partner able to promote and expand independently the PBF program is CHAZ whose two staff have already followed the health SINA course and it is only the PBF program coordinator who is actively involved. There is no critical mass in this program. CHAZ promoted the PBF approach in several government institutions and coordination groups at different levels and the designing lessons were well documented. This resulted in the design of WBRBF project. Consequently, It has been designed the other NGOs which involved themselves in output-based financing. Therefore the small project Cordaid/CHAZ had a great influence on the design of a huge project called RBF. The analysis concluded that the result was achieved.

For the reinforcement of the client voice, around 40 community representatives are already trained how to conduct the client satisfaction surveys in the case of PBF in 2 intervention areas of the project. Other surveys were carried out and the feedback was given at the same to the health facilities staff. This resulted in more transparency in health facilities use of the subsidies. The health centers have an Advisory committee made up of the community representatives whose most of them are the community health workers. And then 2 community representatives of them are on the health facilities financing committee which decides how the bonus will be divide other the staff. But the PBF community verification in the health facilities is not yet taking place. It is concluded that the result was achieved.

By means of the baseline study carried out, the PBF approach is implemented in 2 pilot districts in which the project started in 4 health facilities whose 50% belong to the government and another 50% to the church. One district is financed by the Muticountry project and another one by the Cordaid funds. The staff was trained and the steering committee was functional. Around 12 indicators were purchased in hospitals same like in the health centers.
At the beginning CHAZ acted as a purchasing agency. But at the end it has subcontracted the purchasing functions for becoming a local NGO in charge of contracts, verification and salaries calculations. Its staff was trained for a week. So far CHAZ is still a stakeholder which pays the subsidies to the health facilities. Then it was signed the quality evaluation contract between DHMT and CHAZ.

In the project there is a full separation of functions. The health facilities utilization was increased and the service quality was improved. The staff was more motivated and then the punctuality in the service was improved. But CHAZ decreased PBF subsidies for consultation and admission because the utilization was much increased. Then the use of subsidies was dispatched as follow: 50% for staff bonus, 40% for investment and operation cost, 10% for community activities. The subsidies were used for example for contracting an additional clinical officer, procurement of small supplies and additional medicines, contracting the community health workers, painting health facilities, buying mattresses, repairing toilets, new uniforms etc. This analysis concluded that the result was achieved.

- **Recommendations**

According to the evaluation results, it was recommended that:

- **The community verification can be combined with satisfaction surveys, but should be done in the community.**
- **The Hospital PBF indicators should be different from public health centers indicators.**
- **The LPA could go on a study tour to IADH Burundi or AAP Sud Kivu.**
- **The Budget for LPA should be re-assessed (salaries of staff not included) and it is better to visit HDP which is experienced in that.**
- **The Project should consider to change quality bonus from stick to carrot system.**
- **The increase in health budget provides a window of opportunity for local govenment in Samfya and Mpika to scale up PBF to whole district (together around 60 HFs).**

IV.1.g.1. Lesson learnt (by Sule)

1. **Most important lessons learnt from Zambia are these:**

- **The Government support towards Faith Based Health Facilities on HRH and supplies have made the facilities to be collaborative partners in health care**
- **Harmonious relationship between the state and CHAZ has made PBF project implementation smooth**
- **Staff is motivated due to monthly bonus and autonomy they exercise in managing Heath Facilities**
- **There has to be a minimum level of financing to implement PBF project- as for purchase of indicators**

2. **In response to the question related to how to apply lesson Learnt in Tanzania, the first of all is to do PBF advocacy and Lobbying at National Level, and incorporate the experts to take part in the PBF discussions through various working groups and to solicit funds for purchasing indicators through Service Agreement or other sources**
3. **According to the question in response to how to conduct Evaluation, we learnt that the involvement of the project implementers in evaluation has increased understanding of the members in knowing what is taking place in other country and clear understanding of the project design is important.**

IV.1.h. Mid-term evaluation results of the Multicountry project (by Peter Bob Peerenboom)

- **The evaluation results according to the expected results**

During this presentation, the statement has been done and the strengthnesses and weaknesses have been brought out about the establishment and the functioning of the African local partners' network.
Among the strengthnesses, it was noted that HDP team was functional and was organizing the conference, even it did the multiple contacts, study tours and the mid-term evaluation, its web site is functional, the database and the library are available.
For the weaknesses to improve, there are a clear and proactive coordination, the web site internet which is interactive, edition of information newspapers, the utilization of discussion forum/group, the results publication at several levels and the establishment of international network of technical assistance.

Concerning the research about the "PBF program influence on the human resource management" is recognized, the tender announcement for the research was done, the readers group was organized, the institute of research was identified, the starting of the research is scheduled in January 2012 and it is planned to do a scientific publication.

HDP is confirmed to be able to promote and expand independently the PBF experience and it showed the following stregthnesses: the staff is trained, it was organized the training sessions and international workshops, its international position is very well recognized and supported by the African local partners and the mid-term evaluation results.
Among the weaknesses, it is needed to organize the consultancy network, to deal in network with other actors and to reinforce its internal organization.

Regarding the conduct of a survey on the harmonization mecanisms between PBF and health mutual, the tender announcement was done but it was failed, the readers group is about to be created, the second tender announcement was done and unfortunately it took a long procedure for starting.

Concerning the administrative coordination, it was revealed the following strengthnesses: regular reports, budget and regular accountancy operation, the fluid communication, the tangible base of the first year of the project.

Among the weaknesses, it was pointed out the change of Cordaid coodinator in 10 months after the starting of the project, the role of HDP which was not clear, the role of Burundi and DRC Cordaid which was still vague, lack of action plan 2011 for the network coordination, the lack of document of activities reorientation and budget reallowance.

- **Recommendations**

It was recommended to the network coordination to the budget reallowance confirm by writing, to clarify the role of the coordination at the level of HDP and Cordaid Kinshasa and Bujumbura, to insert the technical assistance needs in the work plan 2012 and to reinforce the internet web site utilization.

V. Programming of network activities and AOB

In the afternoon of the second day, it was discussed about the programming of multicountry project activities and AOB..

V.a. Closing of the multicountry project and its sustainability

This issue has raised many discussions and every country delegation representative was invited to give his contribution. In concluding, the facilitator reminded briefly the ideas given and able to sustain the network such as the web site, the fact that there are potential sponsors who can invest in, the trainings which can be organized continuously, the salaries which are may be difficult to pay but can be supported by any donor, possibility of organizing the steering committee, developing bilateral and regional cooperation. The facilitator suggested again that the members of the network are the partners of Cordaid which is the catholic church-based organization while they are the civil society Organizations. He proposed them to create, as the civil society organizations, a steering committee of activities able to plan the activities for the future. They continued to discuss about other issues with the facilitation of Ernest.

V,b. Annual report 2011

It was required to all partners to submit the annual report before the end of 2011 in order for European Union to do the budget reallowance on time because when the report delays to

reach to the headquarter, it becomes difficult to give the funds. If there are also the partners who planed many activities in December 2011, they should do all their best.

V. c. Meeting scheduled in Tanzania

The facilitator informed that the meeting in Tanzania was postponed in February 2012. Each partner received a copy of the meeting plan and methodology adopted. It was wished to have the partners' feedback but most of them didn't do so. If there are comments, it is a good opportunity to give them, the facilitator said, because the meeting will be attended by the authorities of high level in order to advocate for the PBF program. There are two main themes chosen: "The power decentralization is necessary for PBF program" and "the harmonization of different PBF approach". It was proposed to hold this meeting with the summary of PBF achievements.

According to the Executive Secretary of the network, this meeting will be held from 22 to 24 February 2012 at Dares-Salam in Tanzania. The high level of the participants is important: it is needed to invite the minister and the high level technicians. If it is aimed to invite the minister, it will be the minster of Tanzania who will invite his colleagues. For RCA, it was proposed to invite the minister of finance and of the health. For DRC, the mobilization was done for the invitation of the technicians of high level in the concerned ministries. But Cordaid suggest that it should be better to invite the high level authorities as the ministries or their cabinet directors. According to the facilitator, the scheduled available budget is for 2 participants by country: the ministry and another participant.

The Executive Secretary of the network apologized for the delays in the preparations of the meeting but proposed that it should be better to invite two important sponsors by country member to participate to the conference. He précised that this conference is limited to 7 countries members. But it will be an opened window for 7 to 10 others participants from the countries which are potential members of the network such as Congo Brazzaville, South of Soudan…

Another participant suggested that it should be strategic to choose judiciously the participants. It should be better to invite the minister and a member of civil society organization who is a potential member of the network. In closing the debate on this issue, the Executive Secretary of the network gave the final precision that if it is the minister who is invited, it should be good to say that before in order to finalize all arrangements relating to the transport and protocol. It should be better to confirm that before Christmas Day.

V.d. Presentation on the internet web site use (by Dr Théophile Ngoi)

At the beginning of his presentation, the speaker precised that it is necessary to have a web site through which an international exchange network among 7 countries will be created, in order to learn more in action research, to strengthen the partner capacities and promote the community participation. Indeed the advantage of the web site is to ensure the visibility of the project, to gather the data and information for the users.

The creation of the internet exchange use forum, the data base, the field visits and the international organization conference are necessary. The exchange among different projects is a good occasion of harmonizing the approach which will be shared on web site.

After explaining some used expressions in internet web site communication such as web, www, web page, navigation…, he said that there are 4 elements to be considered during the navigation such the home page, the forum /group, new post and posting message and then he opened the debate.

V.e. Thematic meeting 2012

The facilitator of the meeting asked the question for getting to know when the partners are going to propose and send the themes of the meeting and when they think the meeting will be held. It was agreed that every partner will prepare and give the feedback.For concluding the debate, the facilitator made a positive statement. He said that for the future of the network the discussion were successful because all the partners expressed their will to keep on going and to sustain the gained of the multicountry project by 2012.He appreciated the HDP for organizing the meeting on logistic and simultaneous translation aspects.

VI. Evaluation of the workshop organization.

Before closing the workshop, there was an appreciation of the workshop organizing. Therefore, the ¾ of participants appreciated with "excellent" score the hospitality of HDP and the services given to them. Then for the logistic the half of participants appreciated it with "good" score and less than a half appreciated it with "excellent" score. For the content guidance related to the conference participation and communication with HDP during the conference more than a half appreciated them with "excellent" score and less than a half appreciated them also with "good" score. The "medium" and "insufficient" scores were almost ignored. For the question of knowing if the participants were satisfied by the meeting organization and other offered services, two participants responded respectively that there were particularly satisfied with a very good conference organization and how the organizers are skilled in preparing such meetings. In suggestions, four participants respectively proposed that it should be better to improve in the future the transport from the airport to the hotel especially for those who arrive late at night and to increase the number of HDP staff.

VII. Workshop closing ceremonies

At the end of the workshop, the Executive Secretary appreciated the participants for the successful discussions and experiences exchanges which contributed a lot for the success of the meeting. He was proud of the achievements of meeting objectives and he wished respectively to the participants to go back safely their home countries and invited the participants to maintain the exchanges. Lastly he appreciated also the work accomplished by the staff of HDP.

Annex I: Agenda of the Meeting

Provisional agenda for the Nov2011 Kigali steering committee

Time	Activity	Location	Remarks
11/23/2011			
.....	Participants arrival	Hotel: Chez Lando	Transport from airport: HDP
11/24/2011			
……..> 08h00	Breakfast	Hotel: Chez Lando	
08.15	Departure to Lemigo	Hotel: Chez Lando	By a Bus
08.30 - 09.00	Welcome, introduction of participants, agenda	Hotel: Lemigo	Christian Habineza
09.00	Restitution résultats evaluation		Moderator: Monique Lagro
09.00-09.10	Objective mid-term evaluation		Maria Paalman
09.10 - 09.40	BURUNDI		Ernest 15";Gaspard 10"; Q&A 5"
09.40 - 10.10	CAMEROON		Christian, Adolphine
10.10 - 10,40	CAR		Peter Bob, JP Tsafack
10.40 - 11.00	COFFEE-TEA		
11.00 - 11.30	TANZANIA		Maria, Clement
11.30 - 12.00	RWANDA		Ernest, Adrien
12.00 - 12.30	DRC		Christian, Sebastien
12.30 - 13.00	ZAMBIA		Maria, Sule
13.00 - 14.00	Lunch	Hotel: Lemigo	
14.00 - 14.45	Evaluation of the Network	Hotel: Lemigo	Peter Bob 20"; discussion 25"
14.45 - 16.00	Groupwork I per result		

	Result 2a. A community PBF program is functional		**Cameroun, Burundi, Rwanda + RDC ; facilitators Ernest et Peter Bob**
	Result 2c. The PBF approach is harmonised between Church and State		**Cameroon, Tanzania, Zambia + RCA; facilitators Maria and Christian**
16.00 - 16.30	**COFFEE-TEA**		
16.30- 17.45	**Groupwork II per result**		
	The LPA agents are well institutionalized; interprofessional exchange is ensured between these agencies		**Burundi, RDC, RCA; facilitators Peter Bob, Ernest**
	The voice of the client is strengthened		**Zambia, Tanzania, Rwanda, Cameroon facilitators Maria, Christian**
17.45 - 18.00	**closing session**		
18.00	**Departure to hotel**		**By Bus**
18.45	**Departure to restaurant**		
19.00	**Dinner for all participants**		**Offered by HDP**
21.00	**Departure to Chez Lando**		**By Bus**
11/25/2011			
.....> 08.00	**Breakfast**	**Hotel: Chez Lando**	
08.15	**Departure to Lemigo**	**Hotel: Chez Lando**	**By Bus**
08.30 - 10.00	**2012 workplan review**	**Hotel: Lemigo**	**Each country reviews its annual plan based on the results of the MTR**
10.00 - 10.30	**CAFÉ-THÉ/ COFFEE-TEA**		
10.30 - 13.00	**Peer Review du 2012 workplan**	**Hotel: Lemigo**	**Each country discusses its annual plan changes with one other country and v versa based on the results of the MTR**
	RDC and CAR		**Christian**
	Cameroun and HDP		**Peter Bob**

	Tanzania and Zambia		**Maria**
	Rwanda and Burundi		**Ernest**
13.00 - 14.00	**Lunch**	**Hotel: Lemigo**	
14.00 - 17.45	**Network activities -AOB**	**Hotel: Lemigo**	
1	**Meeting Tanzania**		**Ernest, Christian**
2	**Closing of the MCP and its sustainability of the Network**		**Monique, Ernest**
3	**Website**		**Ngoie Theo**
4	**Thematic meeting 2012**		**Ernest, Christian**
5	**Annual report 2011**		**Ernest**
17.45	**Closing**		**Monique, Christian, Ernest**
18.00	**Departure to Chez Lando**	**Hotel : Lemigo**	**By Bus**
18.45	**Free time**		
11/26/2011			
08.30 - 11.00	**Bilateral discussions Coordination< >Country**	**Hotel: Chez Lando**	**Each country must make apointment w Chrisitian and Ernest**
17.00	**Departure participants**		**Transport to airport: HDP**

Annex II: Debates

II.a. Debate and clarification questions – Case of Burundi

By the end of the presentation, the participants asked questions for getting clear. Then a participant asked a question for knowing what is the relationship between IADH/COPED and the ministry of public health with regard to the Multi-country Network? Is there any collaboration relationship between them? In response of question, he said that there are two partners in Burundi but the first is Coped which its weaknesses has been revealed in advocating and lobbying PBF approach. But after the departure of Cordaid, it has been created another initiative known as IADH which is also a new organization for advocacy of PBF approach. The IADH and COPED are the actors in which the Multi-country project develops exchanges and Coraid assures the coordination. These both organizations are two partners that involve in Implementation of Multi-country project.

At the question raised by another participant for getting know on which level where there is an obstacle for Coped could not do the role of advocacy. They responded saying that Coped is a National NGO. It could do that well, but it could be taken much time and effort but then there was another organization known as IADH which has been established for doing the advocacy as it has all the requirements for doing that, and it is recognized well by the Ministry of health and the Coped could just complete.

Another participant raised a question suggesting that among the project objectives there is capacity building of local civil societies it would be known if the project was not working in contradiction with the objective. The speaker responded saying that it's not the Cordiad which has created IADH but the local members. He also emphasized that there were no competition between both organizations because IADH has experience in PBF and coped has sufficient experience in community program management. Then both organizations mutually complete each other.

At the question for knowing which kind of between public health institute and Coped in training domain, he responded saying that in looking for the institute which could train on PBF, it's that institute which was able to be identified because it has more other branches apart from the public health, such as agriculture and so on... the big experience of PBF domain does not belong to that institute but it will need the help of these organizations; Coped and IADH.

II.b. Debate questions- Case of Cameroon

In the frame of the management policy of a trained health staff, it was asked the question for knowing which kind of perspectives that was planned by the church in order to sustain its staff and not see being snatched its trained staff. It has been responded that there were reinforced a project team, and it has never been separated the institution and project. It is

being training for many people in order to attempt to overcome this problem of staff exodus. But it should be reminded that there are many difficulties at national level

The government and church are competing. The salary payments in church institutions have already started but their relationships within that domain are not strong.

At the question of knowing the reason why there is no good relationship between church and Government and even if it is done many activities but they are not known. It has been responded that the relationships have been already started and that what concerns about the publication of the results, it is a kind of mentality problem that is raised in African oral tradition. People work but they are not interested in publicizing the results of their works. It's an issue of mentality evolution that needs to study about.

II.c. Debate Questions - Case of R CA

To the question relating to know if the system organs of money transfer are created and active, it was been responded that the organs have been created but they function out of the church.

Comparing to Burundi, the speaker précised that the agencies in Burundi had failed because the management committees are not active, differently it was précised in RCA that the organs of money transfer systems are best active and operational. They are civil societies that have advanced for the project management. The public administration recognizes their utility. In RCA, it has been established everywhere the management committees.

To the question of knowing the reason why it has been mentioned about the website while is not used for sharing the information with others, it has been responded that there is no website but it is being to find how it can be created.

To the question of knowing what concerns the PBF education project in Cameroun, it is possible to share the indicators relates to the education, it was responded that the project is going to start in 2012 and that the indicators are not yet well elaborated. But the first draft of those indicators can be shared for the primary education.

To the question of knowing which kind ASSOMESCA's role in OCFs, it was responded that ASSOMESCA created a committee of coordination and the OCFs was created by Cordaid. That management committee permits ASSOMESCA to do the advocacy at the Ministry level, churches and communities.

At the end of that debate, it was asked to the manager of website network to render the information that relates the PBF- education available on website.

II.d. Debate question- Case of Tanzania

The first participant wished to correct and comment on certain declarations that were done during the presentation. In Tanzania every service is not for free but there are some people who are exempted and there are indicators who target certain categories of people as there are other fees for expenditure.

Even though the government is centralized, it's not for all to be centralized. In fact 45% of health professionals are church organization.

To the question of knowing if the PBF in Tanzania is active, it is done the purchase of indicators and if the constitutions are autonomy, it was responded that the situation is handled over the church and that in contrary the collaboration between church and government is not good. Moreover the process of signing contracts delays. Briefly it can be concluded that PBF approach is not functional because there is no purchase of indicators.

II.e. Debate questions- Case of Rwanda

Many questions were asked at the same time. The first question is to know which is the input of the cooperatives for strengthening the voice of the community. Another concern is to know how the community appreciates the sustainability of the PBF program. And then, another participant said that HDP gives the financial support but he wanted to know how it proceeds with the health mutual. The last participant asked a question to know why the most of people who were trained the way of management in PBF program say that to separate responsibilities is a good way of managing such programs.
In response to the question relating to the input of cooperatives, the speaker gave the example of Rusizi and Nyamasheke districts. He explained that there are the strategies of grouping together around fifty households for electing a volunteers committee which receives the contributions and send them to the health mutual. It happened the volunteers to be discouraged then they gave up. So HDP engaged to find how this committee can be strengthened and works as a cooperative. Now it is active.
Regarding the financial support, it was précised that there is a financing system which is organized apart and the verification system which is also apart.
For the separation of the responsibilities, there is a misunderstanding and confusion about this issue in the present situation. You may wonder if a buyer is the one who has to pay the money or one who has signed the contract with the health professional. Indeed the buyer has two responsibilities: paying and signing contract. But these two responsibilities must be separated and distributed into two agencies because the separation of responsibilities (buyer, health professional and regulator) must be respected for an effective and transparent management. But if the same roles are managed by the same agency, there is risk of cheating because the agency is supposed to take all the responsibilities.

II.f. debate questions – case of DRC
Concerning the question of knowing the strategies or methods used for the project visibility, it was responded that it had been used the posters, sticker papers and there was a meeting organized ad hoc for sensitization of the parliament.
About the question of getting know how they proceeded for harmonizing the actions and churches, the answer given was that the church signed the MoU with the government in the health sector. So far the relationship between the State and Church is good. The PBF program involves the government, church and private institutions.
Relating to the question of knowing how the bottleneck was removed in order to purchase after the departure of the key partner, it was responded that there was no bottleneck but after the departure of the partner, it was necessary to wait for the European Union confirmation for restarting the purchase activities. According to the fact of removing the barrier of this situation, the purchase agency began the external system process whether the church could be involved or not. The funds used belonged to the European Union. But it is attributed to the church because it was the first to engage in it.

II.g. Debate questions – Case of Zambia
To the question of getting to know how it was succeeded in project especially for the use of user fees in Zambia, it was responded that there were some encouraging strategies
That helped to succeed in improving service quality and the clients were satisfied. It was reminded that there was no need of user fee for implementing the PBF project. And even if the clients would not pay those fees, the project could be succeeded.
Concerning the question of knowing if the multicountry project has the capacity for reinforcing the CHAZ, it was responded that there was a certain project in charge of strengthening the capacity building. This project lasted for 2 years. Then the Ministry of

Public health established another project for 5 years which helped in training of many people. So far there are many capacities in the country. A statement was done between PBF in Zambia and DRC. These both projects have different things but they can work mutually and complete each other. Zambia and DRC can exchange the experience for external system of PBF approach.

The participants wished to know if the electronical copies , it was responded that HDP will be in charge of the text translation in two versions: French and English. After that, the HDP Coordinator and Executive Secretary of the network proposed to the participants to take a remembrance picture.

II.h. Debate questions- Case of Multicountry Project

A participant asked a question wishing to know the consequences of identifying the institute of research as it was done in DRC. In responding, the speaker pricised that they wished to do research in the health sector but they completely cancelled the research. They mentioned about that but there a moment that it could not work out.

Another participant wished to know if the budget reallowance could be possible while there were still the activities without budget. It was responded that there were more opportunities to submit the suggestion of budget review in order to request to the European Union at Bruxels for adjustment.

Another participant reminded that last year they did the same exercise but there was no any result. It was responded that it was proposed to change the budget around 15% in 2010 but now there is 15% beyond in European Union. It was said that for planning it should be good to refer to the original budget.

Concerning the raised worries by the participants that relates to the publication and documentation, it was responded that it could possible to improve these publication and documentation by the help of consultant through technical assistance which will be implemented in order for editing an international newspaper.

Regarding another worry raised because of the web site which must serve within all 7 countries, it was answered that that web should have to be adapted for sharing the information and data like downloading documents, identification of thematic areas, integration of other activities and facilitating its use by the partners. The precised that there is schooled the presentation on the use of web site and it will be possible to exchange and give the possible improvement to do.

The last participant proposed the recommendation to Cordaid for what concerns the research. He said that if the research proposal was useless, the budget proposal was done but the budget given was insufficient. It was the reason why he requested Cordaid to advocate for an additional amount in order to achieve this activity.

II. i. Debate on the presentation and use of the internet web site

To the question of knowing if the partners receive the messages and give the feedback, the partners say that the procedures of the web site internet use are complicated. They say they have difficulties in giving feedback and that when they are in the navigation process, they are blocked.

The partners asked also the question relating to know the link on which they should press for visiting the library. It was also asked how they can obtain the documents. They wanted also to know if they should buy them or they can get them for free. The speaker précised that there are report pieces, but the posted documents are not enough. He responded saying that for visiting the library, it should be better to arrange the web site pages according to the categories and finally the information on web site is not organized well as a virtual library. Another participant proposed to make the sub-menus for not waiting for long time.

Concerning the question of knowing the link of on which they should press for subscribing and being a member, it was responded that they should press on forum and go to « new post » and that is easy. For the worries raised by one of participants relating to that the most messages on that web site are in French and it is more benefitable to the francophones than the Anglophones. It was responded that it belongs to the manager to post the documents at same time in English and French. The speaker appreciated the participants for the comments and criticisms done and promised that he is going to consider, then he asked to the partners who send documents that relate to their planned activities for posting, to check if the messages received by the manager of the web site.

II. j. Closing of the multicountry project and its sustainability

The afternoon session was facilitated by Ernest but the discussion on the current subject was facilitated by Peter Bob. Given the scheduled activities, he reminded that the project started in 2010 for ending by 2012.The final evaluation is scheduled by 2012 in the last term. Last time, we talked about the network and partner developed and we underlined that real partnership was beyond the project, he said. The question mark is on the partnership developed in this project. There are interesting exchanges done. There are also a partnership between the Network members and Cordaid and the partnership among the countries themselves. According to the facilitator, the remaining question is to know what the future of that partnership is. He wished to know further more if the partnership should be interrupted and if the network keeps on going, it will be interesting to add other partners. He opened the debate discussions and then gave the opportunity to each country to express their opinions and suggestions.

It was given the time to speak to the representative of Burundi. Concerning the sustainability of the network, he suggested that it should be a focal point for bringing together the existing common activities of the network. He also mentioned that there are many things to do in order for PBF approach to be a reality especially to the community-based PBF. In Burundi, the Ministry of Public Health limited his interventions in only health centers. This is a way to exploit more for improving the health of people. His colleague more said that the network is the the product of PBF and the experience benefits should be shared among all seven countries. Given that the partnership is beyond the activities done in the network country members, it is proposed that if there is an opportunity to maintain the exchanges on web site, this will be very interesting.
For the case of Zambia, the delegation proposes that if the network was created, it should be preferable to continue to look for funds in order to reinforce the exchanges and expand the membership in other countries. To look for other various resources is necessary for financing the network. He more said that there is a way to maintain the partnership by means of contribution but there should be an available coordination agency for receiving and managing the finance.

On the side of Cameroon, the network brought many things especially in the frame of the training and sharing the experience in PBF. Actually, there is a wondering of what can be done if the network ends. The representative of Cameroun said that he began to approach his colleagues of RCA for discussing how to solve this issue.

For Cameroon, the representative found that it is firstly needed to reinforce the training area because the PBF approach is still new and young. It is an experience which needs to grow up. The network became so dynamic that cannot be stopped by only financial issues.

In the DRC point of view, this issue is in two levels: there are the informal exchanges to be extended and the formal exchanges permitting to add other partners and maintain the relationship between the partners and the organizations which we collaborated with up to now. It is possible for the partners to organize themselves and contribute as Zambia said.
It is necessary to establish the steering committee as an eye of the network. Because if for example there is a tender announcement, the steering committee can inform other network members. According to the DRC representative, It is important to do something practical for the sustainably of the network and consolidation of the works meetings. Another representative said that the shared experience is wonderful. But there are other organizations which support certain countries such as CPGL, EAC... There is a way to approach them and advocate for financial support.

For Rwanda, the representative said that he has the same point of view with his colleagues. His philosophy is that the network is a received gift that cannot be wasted but to exploit usefully. If the closing time is by 2012, there is no reason of being held by scattering mind. It is possible to maintain the network through the gained from the multicountry project.
According to what Peter Bob said, the exchange circle was extended and the partnership which brings the participants together is beyond the project. Then it is also possible to do something which is practical with the neighbor of Burundi for example. Even there are various available resources and the stakeholders can continue to give support.
About Tanzania, the representative expressed his opinion saying that in his country the PBF project was still young. The project is still pilot while in other counties such as Rwanda and Burundi are advanced to the level of national strategy. So there is a big difference. The way is still long for convince the government because it is necessary to have enough advocacy activities. Because of that, he thought that it's needed a network and a coordination office using the simple means. The last Tanzanian representative said that it is needed to implement the experts' forum in PBF program and it should be developed the web site for sharing the information in order to succeed.

According to Cordaid representative, it is needed to maintain and expand the network. Cordaid is the main actor which has an important role especially in Africa. It is possible to make difference in Africa with the PBF approach. It is needed to put together the experience efforts for reinforcing the network. She précised that it is possible to start with the existing partnership and do advocacy and lobby for financial support.

The RCA delegation considered that the gained of the network is the opportunity of experience exchanges as it was experienced during the visits done in Zambia, Cameroon and Rwanda. Concerning the activities, Cordaid initialized the PBF activities but there are other stakeholders who are interested in PBF such as World Bank, European Union, MSH etc... There are some ways to approach them. The capacities of exchange between the counties were stimulated by such organizations. The training of the staff was made possible by means of the capacity building of multicountry project. Then each one is able to do advocacy by himself.

For the point of view of the network coordinator, he confirmed that the Executive Secretariat of the project in Rwanda there are the concrete actions which can permit to maintain the network such as the internet web site. It will be managed by HDP after closing the project. The collaboration in training area will be also maintained. He said again that their colleague from Tanzania is ready to share the tender announcement. He took this opportunity to inform to the partners that to submit in such tender as a group of partners is better than doing as just one. The representative of Cordaid emphasized his opinion saying that Cordaid has a department of tender announcement in the world. There is certain opportunity for the NGOs to be connected. It will be possible to organize a sponsors' session in Rwanda and to work with the network coordination.

Annex III: Group Works

IV. Group work on results

The group works started in the afternoon of the first day of the workshop. The objectives were to help the participants to know what activities are conducted in other counties for achievement of results, to know what are the achievements (results) and constraints in different countries and to identify elements in other countries that can be applied in their own country.

The process: appoint the chairperson to lead discussion, appoint one reporter, short introduction per country on achievement and constraints, discussion to identify common lessons learnt and specific constraints, each country identifies one element that is of specific interest for their own country.

Results: One flipchart with general key conditions that need to exist to achieve the result, one flipchart with for each country a group recommendation for activities 2012 and suggestions on how to overcome constraints.

The participants were divided into 4 work groups. The discussion themes were chosen per result. Then the first theme of group I corresponding to the result R2a is this one: A community PBF program is functional. The discussion group on this theme was composed of the participants from Cameroon, Burundi , Rwanda and DRC with the facilitation of Peter Bob and Ernest.

The second discussion theme of group II is based on the result R2c and is the following: the PBF approach is harmonized between Church and State. The discussion group on this theme was composed of the participants from Cameroon, Tanzania, Zambia and RCA with the facilitation of Maria and Christian.

After the break time, the group works continued in group III. The discussion theme was corresponding to the result R2d and was the following: the LPA are well institutionalized;

interprofessional exchange is ensured between these agencies. The members of the group are from Burundi, DRC, RCA and their facilitators were Peter Bob and Ernest.

The last discussion theme of group IV referred to the result R4a which is the following: The client voice is strengthened. The group members were from Zambia, Tanzania , Rwanda and Cameroon. It is facilitated by Maria and Christian.

IV.a. Summary of group work I relating to the theme corresponding to the result R2a: a community PBF program is functional.

Tableau R2a: a community PBF program is functional

Analyzed points	Burundi	Cameroun	DRC	Rwanda
Brief presentation per country	institutional scale up	institutional scale up	institutional scale up	institutional scale up
	-Definition of missions for different community actors : COSA, GASC, ASLOs	-Definition of missions for different community actors : COSA=Association of ASC	-Definition of missions for different community actors : ASLOs involved in community survey and et the sensitization in conflict-armed zones	
	-Definition of PMA in the favor of GASC	-Existence of a PMA in favor of COSA	-Existence of a PMA in favor of ASLOs	
	-Scale up of community PBF project with agreement of MSPLS	-Existence of dialogues institutions implemented by MSPLS not functional : FSPS, COSADI		
	-Mobilization of funds of Cordaid for the project	-Necessity to implement intermediate institutions between the CDS and ASC which are part of COSA in catholic health areas: paramedical staff)		

	-Identification of ASC	**-Involvement of villages chiefs in the system**		
	-Technical support from the ASC to GASC	**-subsidies of CDS and of its COSA deposited on a general account in intervention area of the project**		
	-Service agreement of GASC among the CDS, CPVV and Cordaid	**- In intervention area where the project is not yet started, It can exist many CDS in the same health area with one COSA.**		
	-Respect of health structures			
Constraints	**- Tools to be designed : Questionnaire for community survey on GASC activities**	**- Management problem of a common account**	**-ASLOs involved at the same time in the community survey and sensitization**	
	- Sustainability of GASC activities at the end of pilot PBF activities	**-difficulties of expanding the experience in not catholic health facilities**		
	-the needs of organizing the contre-verification	**- Public institutions of dialogues not functional**		
solutions ways to the constraints	**- Take benefit from the pilot experiences of other countries**	**-advocacy in MSPLS in order for the dialogue institutions to function**		
	- tools design in process			
	-Strong involvement of MSPLS institutions in the pilot action implementation			
	-Synergy between PBF multicountry project and community PBF			
	-Involvement of GASC in other COPED projects.			

IV.b. Summary of group work II relating to the theme corresponding to the result R2c :

The PBF approach est harmonized between the Church and the State.
The critical concern is how we do for improving the relationship between the state and the Church. Indeed there exist a lot of problems and suspicions between these stake holders in the sector in the implementation of PBF and other services. The church is facing many challenges in working in environments dominated by governments. As a result several constraints are experienced. The government charges taxes to FBOs for establishing health facilities and other developmental projects such as FBOs getting charges for taxes for establishing health centers. Government does not acknowledge the services that the FBOs are providing. There are delays in disseminating of information and guidelines. There are delays also in dissemination of policy from the national level to the district and grassroots making delays in decision making at community level.
Table2 R2c: The situation on the ground is as can be seen from the table below.

Description	Cameroon	CAR	Tanzania	Zambia
Official agreements	No	Yes MoU	Yes MoU	Yes MoU
Finances from the state and the church	Little not systematic	Yes Some	Yes Some what	Yes 90 %
Ways of collaboration	PBF facilitation	Mutual TA participation	PPP forums meetings	Equal partner
Assessment of relationship	Weak at 10 %	Average	Good 60 %	Very good

- **Way forward and opportunities available to the FBOs**

1. **Proactive in positioning**
2. **Advocacy for PBF in government**
3. **Signing of agreements**

- **Strategies that the church can take to deal with the situation:**

1. **The church needs to state its position and their contribution to the well-being of the population**
2. **The church must be proactive in approaching government and state their complementary role that they provide to the state and not in competition.**
3. **The church should have one voice – a common approach between the catholic and protestants as they have common needs and constraints**
4. **The church should provide ongoing advocacy on matters that concern them**
5. **The FBOs must be transparent in financial management**

6. **The church must have a strong leadership representation as a front for discussion issues with government.**

IV. c. Summary of group work III relating to the theme corresponding to the result R2d : The LPA have the institutional base; the interpersonal exchange is ensured between those agencies.

IV. d. Summary of group work IV relating to the theme corresponding to the result R4a : The client voice is strengthened

Summary of Discussion on Result 4a: The Voice of Clients is strengthened
Countries: CAR, Cameroun, Tanzania and Zambia:
The Discussion on the above result was based on sharing the experiences of these four countries in terms of success and Constraints as follow:

1. **Zambian Experience:**

a) Achievement

- **There are Neighborhood committees and health Centre committees that represent the community**
- **Formerly they were not functioning well when there was no funding**
- **Recently, their mandate is strengthened through training and involved in decision making through quarterly meetings**
- **They have minutes (whose Contents is assessed) as part of performance**
- **They carry out clients satisfaction survey and exit interviews**
- **Local Purchasing Agent is in place for verification purposes, and report that to Fund Holders Agency**

b) Constraints

- **There is no sufficient funds to train the committees on their roles and responsibilities (Though 5 Representatives from HFs were trained who will train their counter parts)**

Note:

- **The issue of Community Verification as being part of community participation was briefly discussed as participants had two different opinions, one being that it is not part of community participation, and the other supporting it as part of community participation. Finally it was agreed that it is part of community participation as far as action it improves the power of the community, and community concern raised have an action as PBF then is not limited to figures only but to quality part.**
- **The concern was raised if these committees really represent the opinion of the community or their opinions. After some discussion It was then noted that in most cases they are representing interest of those paying them. However, in areas whereby PBF project works well the risk is minimized as they receive the refund for transport and even some refreshment.**
- **From Rwanda, it was learnt that the Community at facility level are paid when involved in the community works.**
- **The group members probed into what motivate the people to be in the committees. After some brief discussion it was realized that: They include: Financial gain, recognition in the group/community and having exposure.**

2. **Cameroun**

The Voice of Clients is strengthen through the following ways:

- **First, through the involvement of health committee (comprised of church leaders, village leaders and representative of community members) in the area to comment on the quarterly business plan prepared by Health facility management**
- **Second, by making use of two members of the community who are responsible for health activities, and they check services delivered at the community and finally prepare the report on quarterly basis to the Health after being approved by the village leaders/ Chief**
- **Third, through the Local associations which make community survey, the community opinion are strengthen as if the next Business plan of the health centre does not show strategy to improve the weakness pointed, the facility Business Plan is rejected**
- **Basically the Community Surveys have these functions:**
  - **Verify if what is claimed by the health facility is true by contacting the patients/ clients**
  - **It is also collect the opinion of the clients in regards to affordability of the services provided**
  - **It collect information on Customer care by the health centre staff**
  - **It captures opinion of the clients on areas to improve in the service provision**
- **The Association submits the report of the community surveys to the project. Thereafter, the project meet with the health workers/ staff at the facility**

3. Tanzania

- **The situation here is that there are Health Boards at Hospital and Facility Governing Committees at the lower levels (from Health Centres and Dispensaries)**
- **They draw members from the community, owners of facilities and management teams, and Government**
- **They are responsible for the following functions:**
  - **To approve the plans for the health facilities**
  - **They are responsible for approve of the facility budget**
  - **For the hospitals, they approve the appointment of the in charge of the hospital, the Hospital Administrator and matron/ Patron**
  - **They are responsible for the infrastructure development in the health facilities**
  - **They approve the amendment of the user fee at the health facility**
  - **They are linking the community and health facility management**
  - **They meet on quarterly basis, which in most cases is not the case especially for the lower level facilities**
  - **They are in the office for the period of three years**

Therefore, these briefly explain how Clients Voice is strengthened in these countries.