Health Systems & Reform, 3(2):91–104, 2017
Published with license by Taylor & Francis
ISSN: 2328-8604 print / 2328-8620 online
DOI: 10.1080/23288604.2017.1291218

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Research Article

Transferring the Purchasing Role from International to National Organizations During the Scale-Up Phase of Performance-Based Financing in Cameroon

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Keywords: Cameroon, performance-based financing, policy transfer, purchasing role, scaling-up

Received 16 September 2016; revised 20 December 2016; accepted 26 December 2016.

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Abstract—The World Bank and the government of Cameroon launched a performance-based financing (PBF) program in Cameroon in 2011. To ensure its rapid implementation, the performance purchasing role was sub-contracted to a consultancy firm and a nongovernmental organization, both international. However, since the early stage, it was agreed upon that this role would later be transferred to a national entity. This explanatory case study aims at analyzing the process of this transfer using Dolowitz and Marsh's framework. We performed a document review and interviews with various stakeholders ($n = 33$) and then conducted thematic analysis of interview recordings. Sustainability, ownership, and integration of the PBF intervention into the health system emerged as the main reasons for the transfer. The different aspects of transfer from international entities to a national body consisted of (1) the decision-making power, (2) the "soft" elements (e.g., ideas, expertise), and (3) the "hard" elements (e.g., computers, vehicles). Factors facilitating the transfer included the fact that it was planned from the start and the modification of the legal status of the national organization that became responsible for strategic purchasing. Other factors hindered the transfer, such as the lack of a legal act clarifying the conditions of the transfer and the lack of posttransition support agreements. The Cameroonian experience suggests that key components of a successful transfer of PBF functions from international to national organizations may include clear guidelines, co-ownership and planning of the transition by all parties, and posttransition support to new actors.

INTRODUCTION

Performance-based financing (PBF) programs have been implemented to improve the delivery of health care services

in low- and middle-income countries (LMICs).[1-3] In a nutshell, under such programs, health care facilities and health care workers receive financial resources upon taking measurable actions or achieving predetermined performance targets.

Research has been performed on PBF in LMICs that shows positive effects on several incentivized services[4-10] but also some uncertain results.[11-16] Despite the mixed findings, PBF has expanded rapidly in Africa, often in the form of pilot projects that have later been scaled up.[17] This rapid expansion has been enabled by the strategy taken by some countries as well as the main PBF funders, especially the World Bank, to accelerate its diffusion by adopting a quite standard PBF package, whose introduction is technically supported by international consultancy firms or nongovernmental organizations (NGOs) staffed with international experts who have acquired PBF expertise in countries where PBF had been rolled out earlier (e.g., Burundi and Rwanda).

This externally supported approach has a drawback: at some stage, there is a need to transfer part of the capacity to national actors. This is significantly driven by the need for external agencies to deploy resources most efficiently.[18] Thus, there is substantial interest in how to best plan for and implement transitions from external organizations to local counterparts and[19] to reduce costs and ensure sustainability after the funders' withdrawal, a well-known challenge for development projects.[18]

Indeed, inadequately executed transfers risk reversing health program gains.[20] In many programs, transitions have been conducted on an ad hoc basis, where the division of responsibility between international and local organizations has not been clearly outlined and purposeful monitoring during the posttransition period was not defined.[20,21] However, the Avahan experience in India, for example, a project aiming at reducing the spread of HIV, suggests that transition can also take the form of a positive and enabling process that improves program functioning and enhances local leadership.[22]

In addition, health systems display the characteristics of complex adaptive systems,[23] and as de Savigny and Adam[24] point out, an intervention in one area will typically have consequences, often unforeseen, for many others. Therefore, understanding an intervention such as PBF requires focusing attention on power relations and on the ways in which it might be possible to construct new forms of "social contracts for health care which build on existing areas of competence and good practice, whether mediated by states, markets or other institutional actors."[25]

For PBF programs, the complexity of the transfer from external organization to local counterpart is substantial as the transfer is framed as part of a wider process of program scale-up. However, little evidence exists on such scaling-up and transition processes in LMICs[11] because the efforts to share lessons learned in global health have been limited so far.[26-28] In particular, there is a dearth of literature examining the transfer of capacity to the national level, aimed at enabling scale-up and integration. This is particularly challenging because PBF is not an easy intervention to implement and scale up—it requires the development of new institutional arrangements or existing organizations to take on new roles, including developing and managing performance contracts, purchasing health services, and verifying results.[29]

In Cameroon in 2011, the World Bank and the government started a PBF program in four regions of the country. According to the intervention model, performance contracts link key actors of the health care system to an independent performance purchasing agency (PPA). The PPA is responsible for verifying the quantity and quality of services as well as purchasing the services from health care centers on a fee-for-service basis. In Cameroon, the PPA role was initially played by a local organization in one region and two international organizations in three other regions. In the Littoral Region, a local organization called the Regional Fund for Health Promotion (RFHP) was recruited through mutual agreement. In the Northwest and Southwest, an international organization called European Agency for Development and Health (AEDES) was recruited through an international call for tenders to play the role of PPA.[30] Similarly, in the East Region, an international organization called Catholic Organization for Relief and Development Aid (CORDAID) was recruited as the PPA. However, it was agreed upon at an early stage that a Cameroonian entity—that is, the RFHP—would eventually take over the purchasing role for all regions to facilitate sustainability and ownership of the PBF program in the long term.

The PBF experience in Cameroon provides a unique opportunity to further our understanding of how transfer processes unfold. We conducted a case study as part of a multicountry research initiative supported by the Alliance for Health Policy and Systems Research that examines scale-up processes for PBF in low- and middle-income countries. Within the broader research, the objective of this study is to specifically assess the transfer process of the purchasing role from international to local organizations during the scaling-up phase of the PBF program in Cameroon. In addition to informing Cameroonian decision makers regarding the PBF transition process, our study has implications for other countries seeking to transfer PBF purchasing functions to national organizations, as well as more generally for those seeking insights on transferring institutional arrangements for health

systems strengthening to country-level organizations and institutions.

METHODOLOGY

Study Design

Our study takes the design of an explanatory qualitative case study.[31] The case is defined as the PBF program in Cameroon from late 2011 to March 2015, and the levels of analyses are related to the conceptual framework described below.

Conceptual Framework

Examining the transfer of the purchasing role from international organizations to national agencies in a PBF program requires understanding the process by which knowledge related to or generated by the previous system is used in the new one. Based on that, we adopted the institutional transfer approach to examine these dynamics. The term *institutional transfer* was first coined by David Apter in the 1950s.[32] Institutions are the rules of the game in a society or, more formally, are the humanly devised constraints that shape human interactions.[33] They can be formal (laws, constitutions, contracts) as well as informal (custom, traditions, ways of conduct). The main role of an institution is to reduce uncertainty by establishing a stable structure to shape human interaction.[33]

We adapted our framework from Dolowitz and Marsh's[34] work and broke down the concept of institutional transfer into several key dimensions that could feed our analysis and be formulated in terms of questions: (1) What are the purposes of the transfer? (2) Why do actors engage in institutional transfer? (3) Who are the actors involved in this process? (4) What are the sources of transfers? (5) What are the different forms of transfers? (6) What are the factors that promote or restrict transfers? and (7) Whether and to what extent the observed transfers resulted in success or failure. These questions allow us to understand the dynamics of institutional transfer, by focusing on the process by which knowledge tied to institutions in the former organization is used for the development of institutional and administrative arrangements in the new organization. By analyzing the influences and interactions that characterize the actors involved in the transfer process, the framework makes it possible to isolate the sources of the observed changes.[35]

Instruments, Sample and Data Collection

The study involved two concurrent qualitative data collection methods.

Document Review

A document review was important for this study to understand the PBF policy, design, and implementation. Documents provided background and context, allowed us to identify additional questions, provided supplementary data, served as a means of tracking change, and enabled triangulation of findings. Moreover, documents were useful to gather data on events that could no longer be observed and on information that has been forgotten.[36]

A total of 20 documents were reviewed, including contractual documents, PBF program design documents, implementation guidelines, strategic meeting reports, the road map for the PPA transfer, and evaluation reports. Appendix 1 is a list of the documents reviewed.

Individual In-Depth Interviews

Using semistructured questionnaires, we interviewed 33 actors involved in the transfer process. These key informants were selected using a purposive approach that provided contrasting views in terms of the work, level of activity (central/regional/peripheral), and categories of actors.[37] The main selection criterion was their involvement in the transfer process. Respondents included donor representatives, policy makers, international organization staff, and researchers. We also interviewed managers of health services at the district level, health care providers working in public, private not-for-profit as well as for-profit health facilities, and managers of the national and regional drug supply system. In each of the key groups, we interviewed specifically the focal persons involved in the transfer process and used a snowballing technique to identify others, until data saturation was reached.

Data Management and Analysis

Patterns and categories emerging from the literature were used to develop predefined themes. We organized a one-week workshop to train the research team and to ensure a common understanding of the themes. All interviews were transcribed and analyzed using QDA Miner Lite (Provalis Research, Montreal). The coding of data was oriented by organizing the data around conceptual categories. We conducted thematic analysis,[38] guided by our conceptual framework and our knowledge of PBF, to extract the main themes from the documentation and the in-depth interviews. A hybrid deductive–inductive approach allowed us to assign data to predefined themes and to derive new themes from the data. Data analysis started in the field, forming an iterative relationship with document analysis and interviews.[38-42]

Therefore, we were able to constantly compare the value of emerging categories for sorting the collected data. At the same time, it provided an opportunity to share and confirm our findings and subsequent interpretations with participants as advised by Hartley and Miles and Huberman.[38] Moreover, combining the initial transcription of collected data with early analysis helps to gain insights and plan strategies for collecting new data as suggested by Marshall and Rossman.[41] The analysis was conducted through a stepwise process. First, the research assistants analyzed the in-depth interviews. Then, the principal investigator conducted synthesis of the findings and all discrepancies were discussed among the team of researchers.

Ethical Considerations

The study protocol was reviewed and approved by Cameroon's National Ethics Committee for Human Health Research and the World Health Organization's Research Ethics Review Committee. All respondents provided verbal or written informed consent.

RESULTS

Discussions on the transfer of the purchasing role started early in 2012 at the time the PBF project was launched in the three regions. The process aimed to transfer the performance purchasing role from international organizations to regional organizations (i.e., the RFHPs). At the beginning of the project, two staff members from the RFHP in each region participated in a seven-day regional training for PBF trainers. Training RFHP staff was part of a capacity building plan, before any transfer process. In addition, the RFHPs were, from the beginning, part of the regional regulatory teams in charge of conducting the PBF quality assessment in hospitals.

During the project evaluation, the World Bank organized two national events. In September 2012, a workshop was convened to discuss progress, challenges encountered, and the way forward for the implementation of PBF by the four PPAs.[43,44] During this workshop, participants discussed the fact that the transfer process of purchasing to national organizations was not yet underway. In May 2013, at the second event, the PBF national meeting,[45] findings and solutions were discussed to improve the implementation of the program, including the transfer of the PPA role.

Despite these events and discussions, the transfer process did not progress until April 2014, when the minister of health sent a correspondence to international organizations, mentioning the need to begin the transition.[46] Indeed, the PBF program had been envisaged to last three years: a firm period of two years and a contingent one of one year. However, due to budgetary constraints, the contingent period was reduced to six months (January–July 2014) and later extended by another six months due to the ineffectiveness of the transfer process, as observed by the end of July 2014.

In July 2014, several actions were implemented to accelerate the process of the transfer including a visit of RFHPs' teams from the Northwest and the Southwest to the Littoral Region, where the PBF program was already using the RFHP as performance purchasing agency, as well as a meeting for the development of a road map and tools to facilitate the transfer. At this time, the transfer process began to get up to speed. By the end of December 2014, the transition was completed in the Northwest and Southwest Regions, although the consortium of NGOs in the East negotiated a six-month contractual extension up to June 2015.

The analysis of this series of events allow us to divide the transfer process into three phases: (1) a preintensive phase (before July 2014), (2) an intensive phase (July–December 2014), and (3) a posttransfer phase (after January 2015).

What Did the Transfer Consist of?

The first element of the transfer is labeled "soft." It concerns transmitting to the national organizations ideas, expertise, and even what some called "the PBF spirit." This form of transfer was essentially performed through meetings, exchanges, and trainings.

The second element of the transfer, the "hard" one, consisted of the handover of equipment, logistics, and all technical tools—for example, computers, vehicles, procedures, manuals, and so on. It was performed in accordance with the ministerial note of December 2014 concerning the transfer, which stated in paragraph 2 of Article 2 that the transfer would be preceded by an open inventory with a report signed by both parties and under the supervision of the Regional Delegate of Health.[47]

The third element refers to the transfer of decision-making power. By acquiring all of the rights to make decisions,[48] the RFHPs gained their new role as PPAs. Their decision-making power focused on the content of the PBF program and included dimensions such as leadership and strategic purchasing. Strategic purchasing entails using financial resources effectively and efficiently to align incentives to health priorities to improve the health status of the population. It includes selecting providers and signing contracts, defining the services to be funded and attaching payment rates, putting in place a verification and enforcement system, transferring funds to facilities, and using information systems to improve the accountability and the effectiveness and of provider payments. Although the cooperation agreement

between the Ministry of Public Health (MoPH) and the RFHP was slow to be put in place, the right of decision making was granted de facto because it was guaranteed at the end of the transfer. It materialized through the Ministerial note of December 2014 and was enforceable from January 1, 2015, in the Northwest and Southwest.[47] One informant highlighted the transfer of the decision-making power with the following quote: "They transferred all their power to the special funds. Because special funds became like the bosses of PPAs. . . . I think that when we say transfer, it is at all levels" (Implementer, Northwest Region).

The Purposes of the Transfer

The sustainability and ownership of the PBF program were identified as main reasons for the transfer. Actors at the decision-making level as well as partners had raised the issue of ownership, determining who has decision rights over the project. It was felt that in order for the PBF approach to have a chance of being scaled up, it needed to be integrated within the existing structure of the health system. This would increase its legitimacy for the partners and make it easier to defend the government's budgetary decisions. The objective of sustainability was also partly linked to this ownership dimension. There was no doubt that the concerns of sustainability and scalability of PBF were already part of the issues that arose at the central level of the MoPH. On the other hand, the World Bank's main interest in the transfer process, as the main technical and financial partner, seemed to be cost reduction. The transfer to national structures was seen as a strategy to minimize costs (as international organizations were more expensive) and as an excellent strategy to anticipate constraints during the scaling up, as one official expressed:

> The PBF is an importation. When we import, we must first bring know-how into the country. Foreign expertise must not stay forever. It must be transmitted to the nationals because it is more sustainable and cheaper like I said earlier. So, it is more likely to remain when it is nationals who are in control and it's evidently much cheaper than importing work force. (Policy maker, Ministry of Public Health)

For actors at the operational level, the purpose of the transfer was related to the "horizontalization" of the health system. In Cameroon, vertical programs are often attributed to donors or NGOs. Therefore, local actors often perceived the PBF project as an AEDES or CORDAID project. This impression was reinforced by the fact that these two organizations had offices far from the buildings for health services and used vehicles that bore no sign of the MoPH. As one informant put it:

> The PBF program is still viewed as a vertical program because it is implemented by a vertical structure. It is important to replace the international NGO by a national structure that was already carrying out other health activities. (Implementer, Southwest Region)

Engaging in and the Source of the Transfer

From the start, the RFHPs were identified as potential entities to take up the PPA role. In the Littoral Region, where the RFHP played this role since the beginning of PBF implementation, the model showed some apparent success, in terms of clarifying the roles and responsibilities of staff in health facilities, enhancing supervision from the regulation level, increasing the reliability of service delivery,[30] and quality improvement at health facilities.[49] In the three other regions, international actors played the PPA role, and it was planned that the role would be transferred to the RFHPs after a certain period of implementation. The contract[50] between the PPAs run by the international organizations and the government stated: ". . . the Ministry's vision is to ensure that the performance purchasing agency role be progressively assumed by the RFHP."

Furthermore, the ministerial decision giving guidance for the transfer process noted that the responsibility of AEDES and CORDAID in the management of the PPA would be finished once the transfer was complete, indicating unambiguously that the transfer process was to occur from the international organizations to national entities.[47] Finally, it was envisaged that the MoPH would sign a protocol of collaboration with the RFHPs for the implementation of the project.[47]

Main Actors Involved in the Transfer

Several actors with varying levels of interest and influence were involved in the transfer process (Figure 1).

Firstly, there were actors from the central and regional levels of the Ministry of Public Health. At the central level, there were officials of the PBF project management unit; that is, the department in charge of coordinating the PBF activities. The PBF project management unit was the main body in charge of overseeing the transfer process. Actors from the central level worked with experts from the World Bank, especially those at the sub-regional office in Yaoundé, to plan the transfer process. At the regional level, the delegates to whom the powers of the MoPH were delegated ensured that the guidelines from

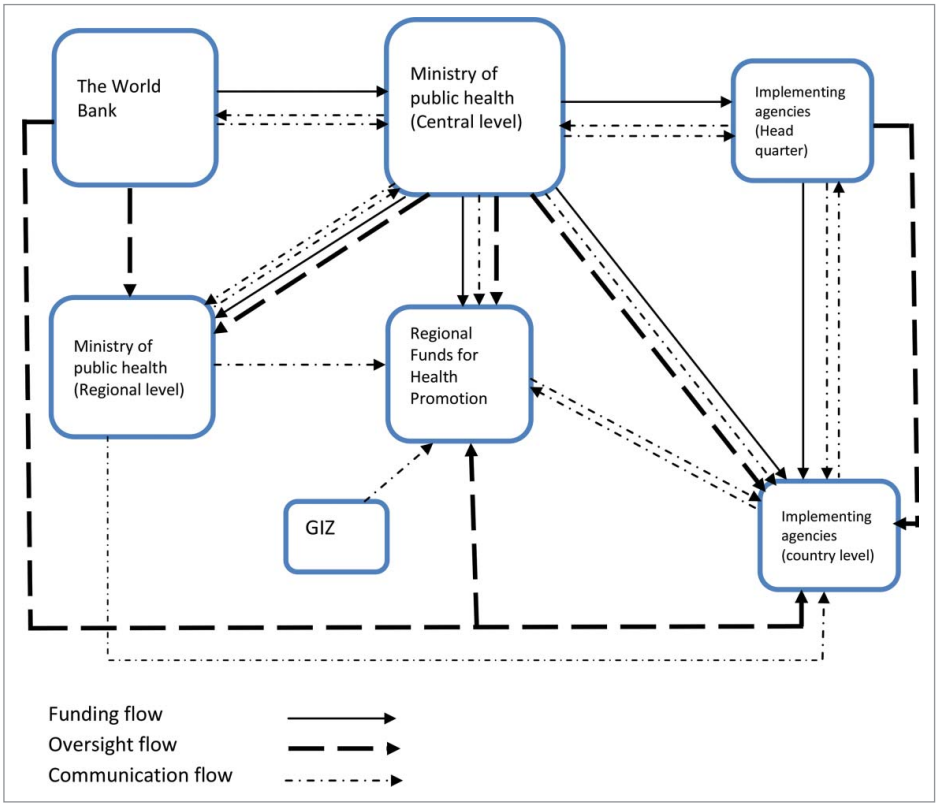

FIGURE 1. Main Actors Involved in the Transfer

the central level were respected. They greatly influenced the transfer process according to their level of commitment.

The technical assistants from the international organizations in charge of the purchasing role (AEDES and CORDAID) were also at the heart of the transfer process. In most cases, they initiated contacts and meetings with other stakeholders at the regional level to help the transition. One of their main activities was to mentor and coach key RFHP staff right from the beginning of the project to gradually build their capacities during the transition period and ensure an effective takeover.

The RFHPs and its managers were key elements in the process because they had to take the new function of PPA. These agencies were preexisting entities in each of the regions. They had been created by the GIZ (*Gesellschaft für Internationale Zusammenarbeit*, or German Cooperation) as regional dialogue structures, consisting of representatives of the communities (one third of the members), the MoPH and public administration (one third), and donors (one third). Thus, they constitute participatory governance bodies at the local level in the health system. The state, through the regional delegates of health had a dual role in the transfer process. It acted as (1) a regulator by virtue of powers delegated by the minister of health and (2) the chairman of the RFHP's management committee. The German Cooperation, which technically and financially supported the RFHPs, was also involved in the transfer process. Although in the beginning this important partner was not in favor of the RFHPs also playing the role of purchasing agency for the PBF project, it contributed to the intensive phase of the process in a consultative role. Interviews with some respondents who played key roles in formulating the program give us more insight:

> No … well I think since it was GIZ who supported the Funds [RFHPs], of course there was this discussion with GIZ to use the Funds for the PBF and as you well know, GIZ was against PBF in the beginning, uh maybe specifically because of the PBF approach that lies on market theory, but at the end of the day, they were great advisors for the transition. (Official, international organization).

Finally, our data indicate that the conversation on the transition framework was not extended to include the community.

Factors that Enabled the Transfer

The majority of respondents promptly stated that the most important factor that positively influenced the transfer was the fact that this transition was planned from the start. In addition, it was not something new in the strategic debate among the different stakeholders. Rather, most of these people were keen to see the process done. To this effect, a competence development plan, with specific objectives, expected results, and time frame for the results, was to be produced by international organizations and discussed with both the central and regional levels of Ministry of Health.[50]

As part of this early plan, key management staff from the RFHPs became members of the PBF regional steering committees, which held quarterly meetings. These steering committee meetings were important opportunities to open space for a conversation and experience-sharing among the regulators, PPAs, and health units involved in PBF as well as representatives of the beneficiary committees.

Another important factor was the expertise created by international training courses on PBF. A Dutch firm (SINA HEALTH) collaborated with national actors to regularly provide a two-week course on PBF that usually attracts more than 25 participants from many Francophone African countries. Cameroonians usually represent half of the participants. The importance of this training course is pointed out by the following quote: "Now, we must have more than 200 people trained in the 14-day PBF course, with all of the approaches, all of the philosophies. So there is the material, there are resources in Cameroon" (Implementer, East Region).

There was a gradual increase over time in the amount of staff training provided to help prepare for the transition. Following the initial training, the RFHPs worked out a schedule for in-depth and refresher capacity building for the staff. In line with these efforts, managers of the RFHPs attended an international training on PBF, and other staff underwent continuous training.

A third factor that facilitated the process was the modification of the RFHPs' legal status. RFHPs initially held the status of associations and it was legally impossible for them to receive public funds and to manage them according to market mechanisms. This obstacle was removed when RFHPs became public interest groups. The law was voted on in December 2010. This new legal status confirmed that RFHPs were dialogue structures, exercising a public service mission. It also established a partnership between the government, several technical and financial partners, as well as the community of the region represented by the members of dialogue structures.

Additionally, there have been changes in the RFHPs' organizational structure. RFHPs initially focused on managing drugs and other health products. Since October 2013, they developed a new organizational structure that includes a support department for health promotion activities and partnership. This new section hosts the PPA, as one informant noted: "The reorganization of the regional funds for health promotion to a public utility institution made it a good structure into which the PBF could fit" (Implementer, Northwest Region).

Finally, the experience in the Littoral Region was another enabling factor because its performance was inspiring and reassuring about the relevance of this choice and served as a proof of concept.[30,51]

Factors that Hindered the Transfer

A major difficulty for the transfer was related to the legal framework under which it was envisaged. Indeed, a legal document providing such a framework was needed to kick-start the transfer, because bureaucrats of the RFHPs thought that they could not engage in the transfer process without an official administrative authorization from their hierarchy. This official note, which was finally signed by the Minister of Public Health on December 24, 2014, stipulated that the transfer of the management of the PPA to the regional funds was to be effective as of January 1, 2015. The need to wait for a legal framework to start the transfer process contributed to delays, as highlighted by the following quote:

> The contract remained somewhat vague with respect to the transfer modalities. Hence, there was a need for a ministerial memorandum to clarify the conditions and contents of the transfer. But you know how things happen in our country. It always takes time. The result is that the note was signed at the time the transfer process was supposed to be completed. (Implementer, Southwest Region)

Despite the intervention of the Health Sector Support Investment Project steering committee, which provided some indications concerning the steps to follow for the scaling-up phase, the shortcomings in legal arrangements still persisted. For example, there was no collaboration agreement clarifying the responsibilities of each party; as one official put it: "The MoU between the Funds [RFHP] and the MoH is not yet ready. So what is the benefit of Funds if the MoU is still on the table?" (Policy maker, Northwest Region).

The short timeline of the intensive phase of the transition also appears to have hindered good management practices. The five-month period allowed for it was very tight and did not facilitate a gradual strengthening of relationships and learning, as well as the good planning of the implementation process.

In addition, there were no formal agreements in place for posttransition support. Instead, the government's guidelines simply defined a specific date when all of the activities of the international organizations had to stop altogether. As a consequence, with the exception of the East Region, the transfer process was conducted without establishing a cohabitation period during which the outgoing team would support the new team and the new PPAs were established after the former teams had already stopped their operations.

Another hindering factor was the lack of agreement between the international organizations and RFHPs regarding the issue of managing human resources used by the PPAs. This was a gray zone in the ministerial directives that gave room to different interpretations. Point 2 of Article 3 of the ministerial note[47] stipulated that "the staffing plan will highlight the positions filled or to be filled in such that recruitment is launched within the best possible time, based on validated terms of reference and the profiles required by the post."

The different interpretations of this directive created some tensions. The outgoing PPAs' managers expected that their staff would automatically be transferred to the new PPAs, whereas the RFHPs' managers considered that it was legitimate for them to constitute a new team for the new PPAs.

Moreover, the variation in pay scales posed a challenge. The government's budget imposed lower wages for the new PPA staff compared to the wages offered by international organizations. This salary reduction of the managing staff (i.e., managers and assistant managers) led almost all of them to drop out. The salary scales also varied from one PPA to another, raising the issue of salary harmonization across the different PPAs.

A final hindering factor was the concern regarding the ability and willingness of the RFHPs to implement PBF through the PPA role. Some of its members were openly reluctant. Some did not demonstrate that they wanted to possess PBF-related skills and blocked the process of giving drug management autonomy to health facilities, as shown by the following extract:

> He [the manager of the RFHP] still refused to go for the training. How can someone manage PBF activities if he is not trained? He had to be removed! We cannot entrust one billion six hundred thousand CFA francs (i.e., two million dollars) to someone who does not know what is inside so, uh … that's it, it is very important that the institution, the Management Committee of the RFHP accepts the PBF. (Implementer, Southwest Region)

Appreciation of the Transfer Results

During the first three months of 2015 (i.e., the posttransition period up to when our analysis was conducted), the transfer seemed effective in the sense that the consortium of international organizations had already withdrawn, giving room to the RFHPs, which were henceforth responsible for managing the PPAs. All equipment acquired during the implementation of the project by international organizations had been transferred to the RFHPs. In the process of shifting key decision rights on how to use funds for health services, the RFHPs took up the entire responsibility for the stewardship function in directing the PBF program. This was seen by many respondents as a major achievement toward the integration of the PBF program within the health system as well as an initial articulation of the country leadership. The exercise of recruiting staff and signing of contracts for the new national PPAs started in January 2015, therefore legitimizing the decision right dimension of the RFHPs on the PBF program. Data from key informants highlighted the positive appreciation of effective implementation of the transfer; as some policy makers from regional and central levels put it:

> The Cameroonian experience clearly proves that the RFHP can be rendered capable and effective in taking up the functions of national PPA in each of the ten regions of Cameroon within the framework of scaling up PBF. The RSFHP should be retained as model for every region. (Policy maker, Northwest Region)

> Handling the implementation of the project through a national organization is a matter of legitimacy and ownership. Now that the RFHP is in charge of the PBF program, and given the fact that the Ministry of Public Health (the regulator) in Cameroon is now quite aware and knowledgeable of the PBF principles, the future of PBF in Cameroon is bright. (Policy maker, central level)

However, a striking element during this first quarter was the absence of a contract for PPA-recruited staff. Furthermore, activities related to the implementation of the PBF program occurred quite slowly. For example, the performance contracts with health institutions, regulators, and community-based organizations were not yet signed. Thus, there were no coaching activities, reporting/verification, and quality evaluations conducted in two regions (Northwest and Southwest) during this period. This was exacerbated by the fact that the Ministry of Public Health at the central level established contracts with the RFHPs only many months after the withdrawal of the international NGOs in the Northwest and Southwest Regions. The gap between the withdrawal of the international organization and the takeover by the RFHPs

also raised concerns among health facility staff about a possible termination of the PBF program. Several informants recalled the difficulties that health facilities faced during the phase immediately after the transfer:

> All the activities that were supposed to be going on, they are now frozen. The new PPA has not signed contracts with the health units up till now. The Region has not come down for supervision despite the fact that we at the district are still going and trying to see how we can actually carry out our activities. Ironically, we have received a letter from the Regional delegate that we should continue to carry out the activities as if the contracts were already signed. (Implementer, Northwest Region)

> As soon as the RFHP took the control of the PPA, it caused some delays in the transfer of funds and it created a lot of problems in the health units, until some personnel had to leave. They resigned. They resigned because they could not be paid. The reserves that were usually kept, were exhausted and some of the personnel left. Projects that were planned in the business plan were suspended and so many things went wrong. (Implementer, Southwest Region)

DISCUSSION

This study assessed the transfer of the purchasing role from international organizations to national entities during the scaling up process of the PBF program in Cameroon. Results highlight that the main reasons behind the transfer were to ensure the sustainability, ownership, and integration of the PBF intervention into the health system. However, the criteria that guided the choice of the RFHPs as the only possible option for overseeing the implementation of the PBF after the international withdrawal remained unclear.[30] This option seems to have been guided by the fund holding role that was to be handled by RFHPs, in which the state is a great player. Policy makers should stay vigilant with this model because the fear is that the institutionalized monopoly of the RFHPs could undermine the efficiency of the verification role in the long run. In this sense, another possible option for the transfer, such as a national NGO assuming the PPA role that is limited to the service of verification, while the fund holding component lies within the responsibilities of the RFHPs, could have been a more relevant alternative.

The elements of transfer that we identified consisted of the decision-making power, the soft elements (e.g., ideas, expertise, spirit), and the hard elements (e.g., computers, vehicles, procedures manuals). We also found that several factors enabled the transfer, including (1) the fact that it was planned from the start, (2) the presence of local expertise, (3) modification of the RFHPs' legal status, (4) modification of the RFHPs' organizational structure, and (5) the previous experience acquired in one region (Littoral Region). Despite these enabling features, multiple factors hindered the process, such as the (1) lack of a legal framework clarifying the conditions of the transfer, (2) lack of posttransition support agreements, (3) lack of agreement between international organizations and RFHPs regarding the management of human resources used for the PAAs, (4) short timeline of the intensive phase of the transferal, (5) salary reduction for managing staff, and (6) lack of participation of actors at the frontlines. Many participants criticized the transition process and reported the discontinuation of numerous PBF activities, thereby questioning the success of the transfer.

Overall, the success of the transfer, defined as the achievement of expected results, was relative. It was quite effective for elements such as the transfer of decision-making rights but remained problematic for some others; for example, for transfer-related activities implemented (or not) in the immediate posttransfer phase. In addition, given that the transfer process continues to evolve over time, it is difficult to judge the success or lack thereof of transfer at a particular moment in time.

The most important factor that allowed the relative success of the transfer was the fact that the transition was planned right from the beginning of the PBF implementation process. This finding supports past research suggesting that planning and implementing transition strategies introduced at the time of program inception could contribute to reduce operational challenges. For example, Gardner et al.[52] argue that transition strategies should be integrated into all aspects of programming, program planning and design, implementation, as well as monitoring and evaluation.[52] This point has important policy implications because, in fact, many global health interventions are implemented without sufficiently considering how they will be transferred to local entities later on.

This study also highlights the "pollination" role of international organizations during the transfer process through knowledge and competence flows gained from previous experience of successful PBF programs. This is in line with the findings of some authors who have pointed out the role of international organization in diffusion of innovation.[53] In addition, the study underlines the value of good practice-sharing within the country, in the case from the Littoral Region where the PPA function was already handled by a national organization. The presence of structures that facilitate learning and sharing have been found to positively encourage adoption and diffusion of innovations.[54]

However, the transfer cannot be simply seen as a "copy and paste" process,[55] and the lack of tailored and active planning during the preintensive phase manifested itself in different ways. For example, there was no clear guidance to carry out the process at the central level, thus leaving it to each Region to drive changes in their own way. Though more coordination and follow-up from the central level would have allowed a smoother transition, these differences also emphasize the critical importance of the environment for successful transition and suggest that management strategies will likely need to be adapted to reflect different circumstances on the ground.[52,56]

This study also emphasizes that international organizations that implement health interventions in LMICs need to adopt pay scales that are compatible with local government budgets to facilitate transfers and long-term sustainability of health interventions. Donors should work with governments to understand how national and donor policies could impact program integration to avoid distortions early on.[57] This is illustrated by the fact that many PBF experts used by the international organizations in Cameroon migrated to other countries that needed PBF expertise once the intervention was transferred to national entities due to the significant pay reduction. The finding is consistent with arguments by others, namely, that the coordination and harmonization of salaries and incentives may be required to get the commitment of key actors to specific development programs and to address brain drain.[58,59] Governments in less-developed countries also have to learn to channel the potential of their own people by providing adequate incentives for them to stay and excel.[60]

Regardless of the reasons behind the transition, the transition process itself proved to be challenging, with a risk of disruptions to services and, in the most extreme instances, their discontinuation.[56] In turn, if the health system is to be understood as a complex adaptive system,[24] the transfer of a program, which was also seen by various stakeholders as its integration, will foster interactions between the program and the wider system within which it is rooted. This complex interaction can be understood to be an essential aspect of sustainability that can possibly generate system-wide changes over time.[61]

Drawing on the findings of this study, we developed a list of ten recommendations for decision makers who are considering transferring the implementation of PBF programs to local actors (Table 1). Future research should empirically test these recommendations and further develop overarching guidelines that can be adopted to facilitate such transitions.

1	Start discussing and planning the transition early on
2	Set up inclusive policy dialogue to seek high-level commitment and participation from different actors
3	Consistently build country capacity (e.g., training on the intervention to be transferred)
4	A well-established transition plan with a clear timeline of activities should be prepared at the beginning
5	Explicit guidance outlining the objectives, actors, sources, and forms of transfer should be developed at the central level with budgetary line
6	A communication plan involving all stakeholders, from the central level to frontline staff, should be worked out
7	A legal framework to conduct the transfer should be established before starting the intensive phase of the transfer
8	An overlap period during which the outgoing team supports the new team should be implemented to facilitate the transition process and ensure a greater continuity for PBF activities
9	A formal posttransition support agreement should be clearly defined
10	Transition plans should include explicit procedures for absorbing human resources and harmonizing pay scales early on so that staff do not have to take lower salaries or are motivated to leave during the transition

TABLE 1. Recommendations to Transfer the Performance Purchasing Agency Role

Limitations

One limitation of this study is recall bias. Interviews were conducted a long time after some of the activities described were held. However, the potential recall bias was reduced by combining multiple sources of data. Furthermore, a social desirability bias may have arisen if participants wanted to portray the transfer program in a positive way, because some stakeholders may have had vested interests in such a positive picture. Moreover, the transfer process of the purchasing role was still ongoing at the time of data collection, and some elements that emerged later may not have been captured. However, the most up-to-date information available to the authors on the transition of the PBF program in Cameroon confirms our findings and identifies delays in the payment of subsidies and in the signing of new performance contracts with health facilities as the main causes of the slowdown of activities during the immediate posttransition period.[62] At the same time, these challenges seem to have been successfully managed and to have had limited consequences on the program.[62] This is consistent with a study in India where the lack of early "wins" does not appear to have been a significant barrier to the overall program of transition.[56] A follow-up study would be useful to provide more insights on how the transition process evolves over time. Though the benefit of using Dolowitz and Marsh's

conceptual framework was that it offered an opportunity to synthesize several concepts related to the transfer, allowing us to understand what causes and impacts the process of transfer as well as how it leads to particular outcomes,[63] it did not offer insights into how organizational structures affect learning processes. In addition, it remained unclear what performance and its dynamics meant within the framework of the transfer process in this case study. Further research is needed to investigate how the transfer from an external to a national agency affects how performance is measured. Finally, though we draw some lessons from Cameroon's PBF experience in transitioning the PPA from international to national organizations, we recognize the limitations of a single case analysis and emphasize the need for comparative case studies to improve the generalizability of these lessons beyond the Cameroon case.

CONCLUSION

International organizations have supported the implementation of PBF programs in many LMICs, such as Cameroon, which were introduced with the aim of increasing the quantity and quality of health care services. However, the performance purchasing role must be transferred from international organizations to national entities to enhance ownership and sustainability in the long term. Ensuring a smooth transition process is crucial because it may influence the proper functioning of the PBF program, its long-term development, and the delivery of health care services for vulnerable populations. The experience in Cameroon suggests that key components of a successful transfer may include clear policy guidelines, an extended and sequenced time frame, coownership and involvement in the planning of the transition by all parties, detailed transition planning, and engagement of staff and provision of posttransition support to promote exchanges between departing and incoming teams. Lastly, transition plans should include explicit procedures for absorbing human resources and harmonizing pay scales early on, so that the staff's motivation is not reduced by lower salaries posttransfer and that this does not lead to their ultimately leaving the agency's employment during the transition.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

I.S., J.C.T.F., and D.M.T. have been involved in the implementation of the PBF program in Cameroon. The other authors have never been involved in implementation of a PBF program.

I.S., J.C.T.F., and D.M.T. can be described as insider researchers because they served/serve as key implementation actors. This may present certain concerns regarding the trustworthiness and objectivity of the judgments made by the research team. However, it should be noted that concerns regarding the objectivity of the research findings reported are minimal, considering the scientific rigor of the other members of the research team from the Catholic University of Central Africa and from the University of Montreal.

ACKNOWLEDGMENTS

We are most grateful to Enandjoum Bwanga, the National Coordinator of the Cameroon Health Sector Support Investment Project, and Dr. Paul Jacob Robyn, the World Bank's Task Team Leader in Yaoundé, for their kind support. We also thank all the research assistants at R4D International, particularly Ajeh Rogers Awoh, Mark Nbenwi, Blonde Ngo Mbo, Léonard Ndongo, Albert Le Grand Amba, and Marlène Tchoffo, for their great commitment for field activities for this study and all of the key informants whose availability and insights made this research possible. We are much indebted to Bruno Meessen and Zubin Cyrus Shroff, who reviewed the first draft of this article and provided valuable comments. The authors also acknowledge the work of the anonymous reviewers who provided us with extremely helpful comments and feedback. Finally, we thank Maria Paola Bertone for her careful editing work.

A.M.T.T. and I.S. received a training bursary from the Canadian Institutes of Health Research. V.R. holds a CIHR-funded Research Chair in Applied Public Health.

FUNDING

This research was supported by the Alliance for Health Policy and Systems Research with funding from Norad.

AUTHORS' CONTRIBUTIONS

I.S., E.K., J.C.T.F., D.M.T., and V.R. designed the study protocol and coordinated the data collection process. A.M.T.T. and I.S. helped analyze the data. I.S., A.M.T.T., and H.Y. wrote the first draft of the article. All authors read and approved the final article.

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APPENDIX: LIST OF THE DOCUMENTS REVIEWED

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