

Health Results Innovation Trust Fund Mid Term Review

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Health Results Innovation Trust Fund

Mid Term Review

Final Report

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The evaluation was undertaken by IOD PARC (www.iodparc.com) in 2017. The team leader is Emma Henrion. The team members are Roger Drew (until May 2017), Annalize Struwig, Enrique Wedgwood Young, Madeleine Guay, and Christiane Duering. Quality assurance was provided by Nick York and Franke Toornstra. For further information, contact emma@iodparc.com.

Acronyms

AfDB	African Development Bank
ANC	Ante-Natal Care
CAR	Central African Republic
CCA	Caisse Autonome d'Amortissement
CHW	Community Health Worker
CO	Country Office
CoP	Community of Practice
CPGs	Country Pilot Grants
CTN	Cellule Technique Nationale
DAC	Development Assistance Committee
DEC	Development Economics Group
DFID	Department for International Development
DHIS	District Health Information System
DLI	Disbursement-linked indicators
DPO	Development Policy Operation
DRC	Democratic Republic of Congo
GAVI	Global Vaccine Alliance
GFF	Global Financing Facility
GoC	Government of Cameroon
GoR	Government of Rwanda
HCC	Health Centre Committees
HF	Health Facility
HMIS	Health Management Information System
HNPGP	Health Nutrition and Population Global Practice
HRITF	Health Result Innovation Trust Fund
IAWG	Inter-Agency Working Group
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IE	Impact Evaluation
IEG	Independent Evaluation Group of the World Bank
INGO	International Non-Governmental Organisation
IPF	Investment Project Finance
K&L	Knowledge and Learning
LGA	Local Government Area (Nigeria)
LMICs	Low- and Middle-Income Countries
MoH	Ministry of Health
MoPH	Ministry of Public Health
NGO	Non-governmental Organisation

NSHIP	Nigeria State Health Investment Project
OECD DAC	Organization for Economic Cooperation and Development Development Assistance Committee
PAD	Project Appraisal Document
PBF	Performance Based Finance
P4R	Programme for Results
PIU	Project Implementation Unit
PNC	Post Natal Care
RBF	Result-Based Financing
RFHP	Regional Funds for Health Promotion
RMNCAH	Reproductive Maternal, Neonatal, Child and Adolescent Health
RMNCAH-N	Reproductive Maternal, Neonatal, Child and Adolescent Health, and Nutrition
TTL	Task Team Leader
UNDP	United Nations Development Programme
WB	World Bank
WHO	World Health Organisation

Executive Summary

The Health Results Innovation Trust Fund - overview

The Health Results Innovation Trust Fund (HRITF) is a World Bank-managed multi-donor trust fund, established in 2007 with support from the Government of Norway, joined by the Department for International Development (DFID), UK, from 2009. It supports low and middle-income countries to design, implement, monitor and evaluate results-based financing (RBF) interventions in the health sector to improve maternal and child health. The Fund supports RBF projects in 28 countries in Africa, South East Asia, Eastern Europe, Central Asia, Latin America and the Caribbean. The HRITF will complete in 2022 and funds are fully committed. As of August 2017, the total value of donor pledges to the HRITF was US\$478.2 million.

A primary objective of the HRITF programme is to build and share an evidence base from different RBF approaches. To build the evidence base, the Trust Fund has supported a variety of RBF approaches and has been developing a learning portfolio of rigorous impact evaluations and other studies. There is a variety of mechanisms such as a website, global workshops, publications, tools and guidance, to share evidence. When the HRITF was established, its main intended impact was on outputs contributing to maternal and child health outcomes through supporting design, implementation and monitoring and evaluation of RBF mechanisms as well as developing and disseminating the evidence base for implementing successful RBF mechanisms. Over time the HRITF has developed an appreciation of RBF's contribution to health system strengthening, which is now seen by the Trust Fund as one of the main areas for potential impact.

The Global Financing Facility

In 2015 the Global Financing Facility in Support of Every Woman Every Child (GFF) was established as a mechanism to support delivery of the Sustainable Development Goals (SDGs) for Reproductive Maternal Neonatal, Child and Adolescent Health, and Nutrition (RMNCAH-N). The GFF has a more strategic focus on financial and health system reform, results, and sustainability and does not prescribe a specific model such as RBF. It is based on a partnership with bilateral and multinational donors, foundations, and the private sector. The GFF had US\$762 million equivalent contributions as of October 2017. The GFF provides a successor fund to the HRITF. The HRITF is now working within the framework of the wider GFF. The World Bank Secretariat for the HRITF took on a dual role in 2015 and is now also the Secretariat for the GFF Trust Fund Committee.

Evaluation objectives

- **Objective 1:** To assess the performance of the HRITF against the given goals and outputs of the programme (as described in the results framework) identifying strengths, weaknesses and lessons learnt.
- **Objective 2:** To determine what progress has been made in addressing the recommendations from the previous 2012 evaluation.
- **Objective 3:** To make recommendations to inform on-going and future programming specifically aimed at (a) improving the performance of the current HRITF programme from a donor, implementer and country level perspective and (b) supporting the design and implementation of future RBF approaches being considered.

Method

The review was based on a document and data review; three “deep dive” visits to Cameroon, Nigeria and Zimbabwe (see Annex 9); and 12 virtual case studies (Afghanistan; Benin; Burkina Faso; Burundi; Democratic Republic of Congo; Ethiopia; Gambia; Haiti; Liberia; Senegal; Tajikistan;

Zambia). The country visits and case studies included interviews with selected country stakeholders in HRITF RBF projects. In addition, interviews were conducted with over 20 RBF donors, practitioners and experts (see Annex 5). The study was undertaken between April and September 2017.

Generalisability: the HRITF supports a wide range of variety in the RBF models in a wide variety of country contexts. Generalisations for learning purposes are made in the report; however, findings do not necessarily apply to all countries and RBF projects.

Evaluation results

Country level

Impact

Health system strengthening is seen widely by countries and global stakeholders as one of the main potential impacts of RBF. There have been contributions to each of the six pillars of health systems¹, as set out below.

Service delivery and quality: Impact evaluations suggest improvements in utilisation and coverage of RMNCAH but these improvements are not consistent and vary between and within countries and services. Improvements to quality of services are often reported by country stakeholders as one of the key positive impacts of the model. The impact on quality of care from the evaluations appears broadly positive, reflecting structural and process quality improvements introduced by RBF, but not for all measures. Quality of care often only improved for certain aspects of care, rather than across all incentivised indicators.

Health information systems: RBF has made a major contribution to strengthening information systems, including the use of online portals for data collection and integration with District Health Information System 2 (DHIS 2). At country level, RBF has contributed to stronger reporting and monitoring. Eleven countries have developed portals for real-time reporting, increasing transparency. There is evidence of increased country capacity for monitoring, evaluation and use of learning from experience gained from piloting and implementing RBF and from support for evaluations and technical assistance for implementation.

Health workforce: RBF can contribute to strengthening the recruitment and retention of qualified health workers through making work and pay conditions more attractive. RBF incentives are also used successfully to incentivise recruitment in remote areas with staff shortages. Reported positive changes in staff behaviour from facility managers in Cameroon and Nigeria, included reduced absenteeism, improved interaction with patients, improved quality of care, increased productivity, and improved activity reporting. However, impact evaluations show that RBF does not consistently improve staff motivation and productivity. Staff in non- RBF facilities can also be demotivated.

Finance: RBF contributes effectively to capacity at facility level, through increasing the financial and managerial autonomy and overall capacity of health facilities. Country results portals data suggest that the quality of financial management is on the whole improving. However, delays in making payment to facilities in most case study countries also weakened facility financial resources. RBF provides a method for increasing funding available to primary care provision in country systems, which tend to allocate health budgets in favour of tertiary and secondary levels, and for improving the balance of use between levels of care. RBF has the potential to contribute to health finance reforms where it is aligned with national health policy developments, such as social insurance. There were

¹ The WHO framework describes health systems in terms of six core components or “building blocks”: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance, www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf

examples of this in Burkina Faso, Rwanda, and Cameroon. However, there are risks to financial systems and sustainability when RBF payments substitute for domestic base funding, seen in two case study countries.

Leadership/governance: RBF improves accountability, especially to local communities. Impact evaluations for Afghanistan, Zimbabwe and Zambia found increased levels of community involvement in RBF facilities, where local committees were actively involved in the governance of health facilities. The requirement for facility level business plans and regular reporting against these strengthens community governance and accountability. Use of community groups in verification processes also strengthens local accountability.

Access to commodities and medicines: Evidence from completed impact evaluations and country portals on equipment availability is generally positive. Data from country portals shows that there are improvements in drugs management indicators. Supply chains are addressed by RBF through improving the availability, quality, and management of relevant drugs in health facilities. In countries where supply chains are weak, or drugs very expensive, RBF can be used in conjunction with regulatory intervention to help increase availability of medication.

While there is positive reporting from facilities and administrators on the impact of RBF, to date, many of the findings of the impact evaluations are not conclusive in aggregate. This mixed evidence is not surprising given the large size of the portfolio, heterogeneity in context, content, and rigour of implementation. There are improvements in some health and utilisation outcomes, but not all, and improvements are shown for different outcomes in different countries. Quality improvement and supply chains show more improvements, although again results are mixed. Evidence from three impact evaluations which included comparator groups with similar levels of finance and supervision to the treatment groups but without conditional payments, showed that providing additional financing alone can provide similar levels of improvement in various aspects of coverage and quality. Studies on the cost effectiveness of RBF have been undertaken but are not conclusive and indicate a need for more research comparing RBF to different interventions, and comparing different RBF approaches, for instance combining demand side measures and value for money studies.

Implementation and learning at country level

There have been improvements over time in developing country-level RBF models which are better tailored to country context, drawing on learning from pilots, other countries and earlier RBF implementation experiences. A wider range of RBF models is now being supported by the HRITF, including more community based and demand side interventions. There was good evidence of countries using monitoring data to modify implementation processes, tariffs and indicators to increase effectiveness. Efficiency has also improved with experience, learning and adaptation. RBF pilots have been shown to be cost-effective in all three countries that did the analysis, but assumptions will need to be validated over time. The inherent focus of RBF on results can lead to more effective spending. Data verification is also found to work well in the portfolio. Several countries with longer-established RBF models have explored risk-based approaches to verification and use local organisations rather than International Non-Government Organisations (INGOs) to reduce costs and increase sustainability. In countries with longer standing RBF implementation such as Cameroon and Zimbabwe, RBF is being scaled up to national level and integrated with health financing reforms.

Governments use a wider range of evidence than impact evaluations to decide on whether to continue RBF. There were already commitments to continuation and scale up made in several countries before completion of the impact evaluations, although governments were aware of the emerging main findings. This suggests that other evidence from implementation monitoring and review data, such as RBF contributions to health system strengthening are also used to inform decisions to scale up. It may also indicate weak integration of the process of using evaluations to systematically help planning and decision-making with country stakeholders. In HRITF supported pilot projects, there is a tension

between fulfilling country needs to support improvement and scale up, and meeting impact evaluation requirements.

Working in partnership and country ownership

World Bank engagement with country and development partners in supporting RBF at country level was identified as an area for improvement by the 2012 evaluation. Since then there have been improvements in communication and coordination by the World Bank country teams with other partners. The HRITF's Knowledge and Learning grants have been used to help countries decide if RBF is relevant. Open collaboration and strong consultation with various stakeholders has often contributed to successful design and implementation but was noted as not being consistently undertaken at an early stage. There are still however examples of countries where engagement with partners has been patchy and a perception from country partners that there has not always been a thorough risk assessment prior to the development of RBF project proposals. Alignment with different partners' work is still weak in several countries. More consistent use of the available funding could have contributed to better preparation, including enhancing alignment with the work of other development partners. Fragmentation of different partners' work is seen by external stakeholders as one of the major risks to implementation. This was also a recommendation of the 2012 evaluation.

The extent to which the World Bank support has consistently and effectively engaged with country stakeholders is limited. Often in earlier RBF projects, the RBF Project Implementation Unit (PIU) is external to the Ministry of Health (MoH). Learning from this experience has led to PIUs increasingly being located in MoH in later projects. There were also instances of weak or ambivalent government ownership for the RBF projects supported by HRITF, reducing the effectiveness and relevance of the project. Early engagement also enables more robust risk mapping and mitigation.

Sustainability at country level

Sustainability and transition of RBF projects have not received sufficient attention from the HRITF. Thirteen countries will receive GFF funding, which will provide continued funding for the short term; some countries are accessing funds from other partners. Several countries are planning to increase the share of health in national budgets and increase domestic funding for RBF as part of wider health finance and system reform, for instance to introduce social health insurance. However, to date these changes have not been implemented. Lack of continued funding is a major risk to sustaining RBF in several countries when HRITF funding ends. For some countries, the step to RBF sustainability is still distant since there remain significant system weaknesses and capacity gaps. These are constraints to sustained implementation of RBF without continued technical support. Countries may also decide not to continue the pilots; understanding the reasons for this will be key research for any future RBF implementation.

Trust Fund level

Trust Fund management

The HRITF is on track for achieving or exceeding almost all targets for its objectives and outputs, as set out in the Results Framework that was agreed in 2013 in response to the 2012 evaluation recommendations. It successfully managed the impact of a reduction in fund value experienced with currency fluctuation in 2014, with relatively small impact on the programme. The HRITF has reduced its administration costs to less than 1% and has improved the rate of grant disbursement to countries so that in 2017 it was very close to its overall country disbursement rate target, an improvement from earlier years. However, there are some delayed grant disbursements, and full disbursement by 2020 will not be achieved without steps being taken to accelerate disbursement or amend the allocations. Delays in starting were partly, but not only, due to external events such as Hurricane Matthew and the Ebola outbreak.

The HRITF is unique among World Bank Trust Funds in the explicit use of country grants in conjunction with wider International Development Association (IDA) lending operations. This linked approach allows the Trust Fund to provide a strategic and catalytic role in focusing IDA lending on RMNCAH and optimises the effectiveness of both funds. The HRITF also benefits from IDA's rigorous supervision and performance management architecture. The HRITF model shows the benefit and efficiency of linking Trust Funds to other Bank lending to optimise value. Placing the HRITF's management in the World Bank provides several advantages for piloting RBF projects and generating evidence.

Supervision costs (defined by the Bank as for technical support and specialist consultants) are higher than other Bank instruments such as Programme for Results (P4R); this is a planned high level of activity. Such technical support is seen by the HRITF as a good use of funds which supports design and implementation, as well as building country and World Bank capacity. The 2012 evaluation recommendation to increase support for Task Team Leader (TTL) capacity was implemented and continues to be relevant for the HRITF.

The HRITF Results Framework has increased accountability to donors, although the content of reports is still limited and does not include standard country level reports which would increase transparency. There is scope both at global and country levels to improve progress reporting on health outcomes through comparing actual with planned performance. There is a lack of a standardised definition of operating costs at project level, and insufficient country reported finance data which are barriers to comparison for learning purposes and to planning for transition. This lack of data on costs is a consequence of a results-based approach, in which input financial data is not reported to the HRITF.

The 2013 Results Framework and Conceptual Framework provide a model for assessing trust and country level performance separately but fall short of addressing a recommendation by the 2012 evaluation that it should develop an integrated HRITF theory of change. The HRITF still has no single, integrated framework that articulates the relationship between the Trust Fund and the RBF-related results it seeks to support at a country level. This weakens the assessment of effectiveness.

Since the HRITF model when originally established did not explicitly consider impacts on health systems and equity, these are not included in the Results Framework. Project design and related impact evaluations finalised to date therefore do not assess these factors, although most RBF projects do in practice address equity. The HRITF is addressing the shift in focus by ensuring that health systems and equity are, where feasible, addressed in the 2017 Learning Strategy. Several planned evaluations include questions on equity.

Evidence and knowledge

The HRITF is generating a wealth of evidence on RBF implementation. The development of method papers and the well-regarded impact evaluation toolkit to improve methods and measures for assessing RBF has been productive. The impact evaluations are of a high standard, well managed, well implemented and useful. Eight impact evaluations have been completed, and a further sixteen are in progress; these are high quality, rigorous evaluations which are widely acclaimed. Other evaluations and studies drawing on the impact evaluations and qualitative work have been produced. Thirteen peer reviewed publications have been published. A wide range of other research and evidence is generated by the Bank and by HRITF supported countries.

Research is heavily weighted to impact evaluations of *whether* RBF works, which has cultivated an atmosphere of learning and results. Even so, the relative gap in the published evidence on *how* RBF works, and on evidence on process and implementation, has induced the HRITF learning strategy to expand its activities to address these topics. More recent and planned future evaluations, for example in Cameroon and the Gambia, utilise a wider range of methodologies and have a stronger focus on where, how and why RBF works. A gap in evidence relates to impacts on the wider health system as a

whole, not originally seen as one of the main results areas for HRITF. As a consequence, evaluations focus principally on the RBF mechanism without consistently addressing the wider system context. The 2017 HRITF Learning Strategy addresses process issues and other identified gaps in the evidence but has limited funds for additional research.

Evidence and learning are disseminated through the www.rbfhealth.org website, bulletins and social media, as well as global, regional and country workshops, all supported by the HRITF. The website has been significantly improved since the 2012 evaluation, but requires further improvement to improve ease of use, ensure quality of content, and enable country led research to be more widely accessible. Knowledge brokerage is central to the HRITF, but it is not adequately resourced to be fully effective. There is potential to build on a recommendation from 2012 to increase links with other relevant platforms such as the PBF Community of Practice, and find ways to more fully embed research capacity in country systems.

Sustainability at Trust Fund Level

All the Country Pilot Grants (CPGs) will complete in 2020 and will require options for transition, either to continue pilots, scale up, or end RBF. Specific technical support to countries for scaling up is required for those countries that may choose to continue with RBF. When the HRITF was developed, sustainability and scale up were not part of programme design; however, both are now relevant since several countries (Cameroon, Zimbabwe, Nigeria, and Zambia) are scaling up. Scale up is taking place, but not always with a clear, resourced plan. For some countries, persistent weaknesses and capacity gaps inhibit scale up or sustainability. For others, political ownership may be lacking. All will require additional funding; linking RBF to other health finance reform may help integrate it into the larger system.

Proposals for sustaining the HRITF and its legacy are not clearly specified. It will be important to maintain focus on the HRITF projects and reporting to ensure transparency and accountability for the Trust Fund's work until its completion. Evidence from the HRITF projects will need to continue to be collected and reported until the end of the HRITF funding to ensure that learning is completed and consolidated.

Impact on the Bank and its wider role, and on GFF

The Trust Fund, through supporting RBF, has contributed to raising the profile of the World Bank in the global health agenda for RMNCAH and results-based financing in health. The size of the fund and its sole focus on RBF and RBF knowledge has also raised the profile of RBF globally. The evolution of HRITF into the GFF indicates that learning from HRITF has been used to inform a more systemic and strategic approach, which will take a system wide approach to RMNCAH, one of the weaker areas of RBF which was by necessity project based. The partnership structure of GFF indicates that there has also been learning about the importance of partnership working.

Lessons learnt for future RBF programmes

1. A stated strategy (or theory of change) for the RBF, established at an early stage, will be key to ensuring there is a shared understanding of the RBF's objectives and a tool to assess its effectiveness.
2. Early strategic discussion by donors and partners of the strategic factors is needed to determine the choice of countries to invest in, for instance the level of health burden, political and economic context, probability of scale up and eventual sustainability.
3. Early engagement with development partners is critical at country level to ensure alignment with their work and assess local contextual and system risks.

4. Government ownership for RBF is a critical enabling factor for effective implementation, and in countries where there is weak government ownership, progress is slow.
5. Clear, resourced transition plans for sustainability are needed from the start of donor support to each country as well as at the end of support.
6. Support to public finance management to develop fiscal space is needed as well as to wider health finance reforms such as social health insurance systems and strategic purchasing.
7. A proactive and transparent communication strategy, appropriately targeted to different audiences, is essential to supporting wider understanding of and engagement with RBF.

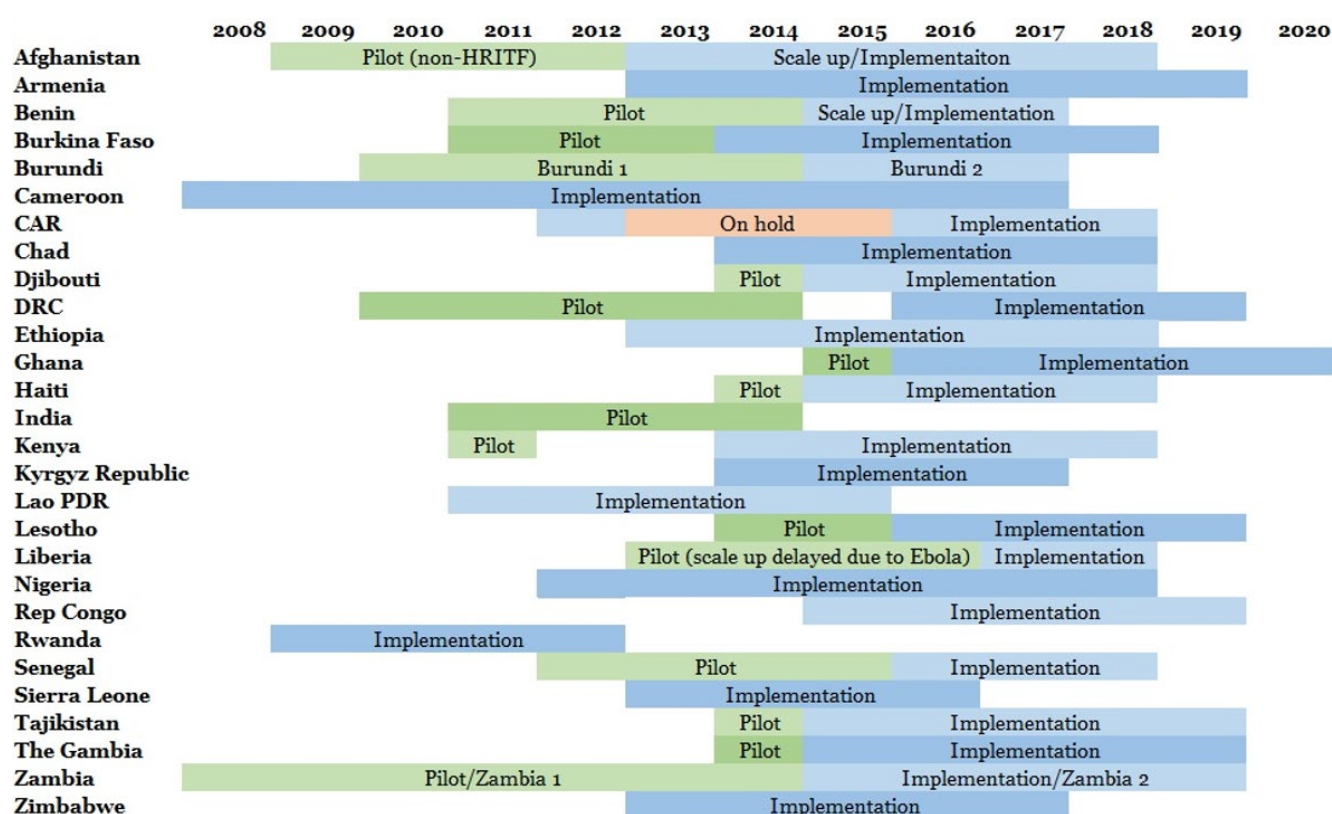
Recommendations

1. Maintain a clear and separate focus on the HRITF performance through regular reporting on the progress towards the HRITF Results Framework until the final HRITF financed project closes and all HRITF funds are spent.
2. Agree suitable revisions to the DFID/ HRITF logframe to ensure it remains fit for purpose given the current status of the programme and is true to the original intent and scope of the HRITF without expanding its objectives.
3. Continue to report to donors on an annual basis on the current and expected future status of all HRITF financed country grants and impact evaluations.
4. Assess, with country stakeholders, future options for all HRITF country projects to identify and agree plans for next steps following the end of HRITF support including project adaptation or termination, scale up, sustainability, funding and technical support. Share updates on options with donors six monthly.
5. Ensure publication and implementation of an updated HRITF learning strategy and plan with a focus on developing knowledge products from existing and planned programmes and impact evaluations to maximise learning and evidence available to country audiences, development partners, donors, the wider RBF research and practice community, and Bank staff.
6. Explore and agree with donors the opportunities for optimising use of planned evaluations and for additional research on evidence gaps (provided resources are available). This may include value for money, cost effectiveness, equity, health systems strengthening, quality of care and demand side versus supply side health financing models (including RBF). (See paragraph 63 for a full list of topics).
7. Improve the, dissemination and accessibility of learning products to country partners and audiences, development partners, donors and the wider RBF research and practice community.
8. Continue to strengthen partnership engagement, communications and transparency in working with country partners and development partners in planning and implementing RBF projects and evaluations, including on transitioning to scale up and sustaining successful RBF programmes.
9. Ensure adequate staff capacity of the secretariat to implement the above recommendations and report to donors on staffing capacity as part of work plan discussions.

The Health Results Innovation Trust Fund

1. The Health Results Innovation Trust Fund (HRITF) is a World Bank-managed multi-donor trust fund, established in 2007 with support from the Government of Norway, and joined by the Department for International Development (DFID) in 2009. The aim of the fund is to support low and middle-income countries (LMICs) to design, implement, monitor and evaluate results-based financing (RBF) interventions in the health sector. The Fund supports 28 country RBF projects in Africa, South East Asia, Eastern Europe, Central Asia, and Latin America and the Caribbean. The HRITF will complete in 2022. The HRITF is unusual that its country grants are used in conjunction with International Development Association (IDA) lending to LMICS so that most HRITF projects are aligned with larger IDA supported health programmes. Details of all the supported countries, the purpose of support, size of funding and the start/end dates are summarised in Annex 2. An overview of grants and countries is presented in Figure 1.

Figure 1: Effective start/end dates for Country Pilot Grants and pilots



2. RBF has been used for over 15 years in lower and middle-income countries to strengthen health services, and for longer in higher income countries. It is used to incentivise performance and can be designed to increase access and uptake of services as well as service delivery and care quality. By shifting the emphasis from input-based distribution and use of resources to incentives tied to various outputs, RBF schemes also aim to promote greater accountability of service providers, improved management, efficiency and equity of service delivery, as well as strengthened health information systems. In LMICs, the primary objective for RBF has often been to increase service supply and utilisation, although the value of RBF in improving quality is now more widely recognised.

3. Throughout this report, RBF is defined as "any programme that rewards the delivery of one or more outputs or outcomes by one or more incentives, financial or otherwise, upon verification that the agreed-upon result has actually been delivered. Incentives may be directed to service providers (supply side) programme beneficiaries (demand side) or both"². Performance-Based Financing (PBF) is a term used for supply-side RBF approaches in which fee-for-service payments are usually adjusted by the quality of the services³. In this report, the wider concept of RBF is generally used (except where PBF is the term used by countries in country examples).
4. The Trust Fund mechanism is based on three grant types:
 - I. **Knowledge and Learning Grants:** provided to LMICs to support the development of knowledge about RBF. The aim of these was to develop pilots, build local capacity, and enable countries to decide whether RBF is the right approach for their country context and health system challenges, and thereafter apply for Country Pilot Grants to support the implementation of RBF projects. Thirty Knowledge and Learning Grants have been provided to support this objective.
 - II. **Country Pilot Grants (CPGs):** these are used to enable countries to implement and scale up RBF approaches. CPGs support a specific range of activities, including;
 - a. RBF agreements with health facilities and supervisory bodies
 - b. Incentive payments
 - c. Verification
 - d. Monitoring and evaluation
 - e. Programme management
 - f. Capacity building and technical assistance

Originally, the main aim of CPGs was to support countries in their progress towards goals outlined in their national health plans and accelerate achievements towards the Millennium Development Goals⁴ (MDGs) relating to women's and children's health. Initially, health outcome indicators relating to MDG 1c (nutrition), MDG 4 (child mortality), and MDG 5 (maternal mortality) were the principal means of tracking the result of the fund. Over time, however, appreciation has grown of RBF's role in contributing to health systems strengthening, which is now seen by the Fund's management as a key result of effective RBF implementation.

- III. **Evaluation Grants:** these are used to support impact evaluation and other assessments in countries receiving CPGs to contribute to the global evidence base on RBF. They aim to provide evidence of the effectiveness of RBF approaches, and how RBF can be used to support health systems strengthening and improve health outcomes across different contexts. They are mostly carried out by World Bank teams in partnership with national authorities; some have been carried out by independent evaluators. To date, the HRITF has provided evaluation grants for 24 impact evaluations, four qualitative impact evaluations, five programme assessments, and five enhanced programme assessments. As of 2017, six of the 24 impact evaluations had been completed and published. Three standalone impact evaluations have also been carried out in which the RBF activity was not financed by the HRITF⁵.

² Musgrove, 2013

³ Fritsche, G., Soeters, R., Meessen, B., The performance-based financing toolkit, 2014, World Bank

⁴ The HRITF was established when MDGs were current and continues to refer to MDGs.

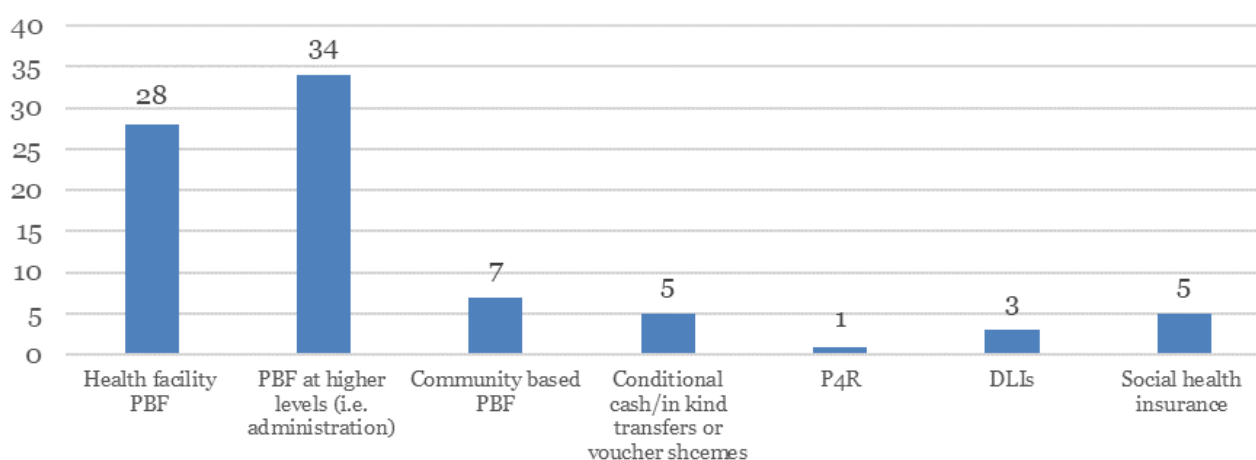
⁵ Standalone impact evaluations have been undertaken in Argentina, China, and India (Karnataka).

Key Financial Information

- As of August 2017, the total value of donor pledges to the HRITF was \$478.2 million equivalent.
- In total, \$2.2 billion of IDA lending is allocated to health activities linked to HRITF funding (2017).
- All Knowledge and Learning Grants were closed by 2014, and all Country Pilot Grants were committed, and Board approved by 2015.
- A total of 28 countries have or are currently implementing Country Pilot Grants (two grants, for Yemen and Pakistan, were withdrawn before they commenced in 2016).
- Country Pilot Grants range from \$0.4 million to \$20 million in value, and in almost all cases, countries have linked grants to IDA loans for linked or complementary activities.

5. A primary objective of the HRITF programme is to build and share an evidence base from different RBF approaches that could inform their application in pilot countries and beyond. To build the evidence base, the Trust Fund has supported a variety of RBF approaches. Figure 2 illustrates the number of different RBF mechanisms supported⁶. The predominance of health facility and higher administrative level-based mechanisms, and supply side mechanisms more generally, is partly due to the choice of countries for these approaches. Community-based and demand-side incentives are increasing in number, with some countries developing them as RBF programmes becomes more mature and their potential value becomes clearer. Following the 2012 evaluation's recommendation to diversify the range of approaches and countries has led to richer data, but a challenge in that diversity can be a barrier to generalisation of conclusions about the contributions and impacts of RBF.

Figure 2: Range of RBF mechanisms supported by the HRITF 2017



Notes:

⁶ Note that some countries use more than one approach

P4R - Programme for Results is a financing instrument which uses a country's own institutions and processes, and linking disbursement of funds directly to the achievement of specific programme results created by the World Bank in 2012.

DLIs – Disbursement Linked Indicators: Incentives are linked to specified policies or process measures.

6. In 2014, currency exchange losses due to global market fluctuations posed a challenge to the HRITF, and the Trust Fund had an unanticipated deficit of \$50 million. Through programme and project adjustments, this deficit was reduced to \$20 million by 2017. There was careful management by the Secretariat to ensure minimal impact on the programme including on knowledge and learning activities.

HRITF Theory of Change and Results Framework

7. The 2012 evaluation⁷ of HRITF identified the absence of a Theory of Change or a Results Framework for the HRITF as an area to address. In response to the evaluation, in 2013 the HRITF developed a fund-level Results Framework and a conceptual framework⁸. These are considered to form the results architecture for the HRITF.
8. The results framework was developed, in close collaboration with the donors, from the four objectives which framed the Trust Fund when it was established (see Annex 4). In 2013, the Trust Fund introduced fund-level Results Framework outputs against which its performance is assessed. Both the objectives and the outputs are set out in Table 1 below; these are not completely linked indicating the iterative development of the results framework. For instance, output 1, is not linked to an objective; there is no output related to objective 4.

Table 1: The HRITF objectives and outputs

HRITF objectives	Fund Level Results Framework outputs
1. Support design, implementation and evaluation of RBF mechanisms	1. Country-level objective: to accelerate the progress toward achieving Millennium Development Goals (MDGs) 1c, 4, and 5 ⁹
2. Develop and disseminate the evidence base for implementing successful RBF mechanisms	2. Low and middle-income countries develop increased awareness of and capacity to design and implement RBF approaches in health
3. Build country institutional capacity to scale-up and sustain the RBF mechanisms, within the national health strategy and system	3. Effective design and implementation of RBF in low and lower middle-income countries
4. Attract additional funding to the health sector	4. Evaluation of RBF programmes supported
	5. Countries have access to a robust evidence base on RBF and institutional capacity for sustainability
	6. HRITF is administered efficiently and effectively

9. The conceptual framework (see Figure 3) articulates expected country-level results or changes which are to be achieved through results-based financing (RBF) at four system levels, namely the health facility, health systems, community and political-economic levels. It was originally designed to support learning and structure evidence gathering. The HRITF still has no single, integrated framework that articulates the relationship between the Trust Fund activities and the RBF-related results it supports at a country level.

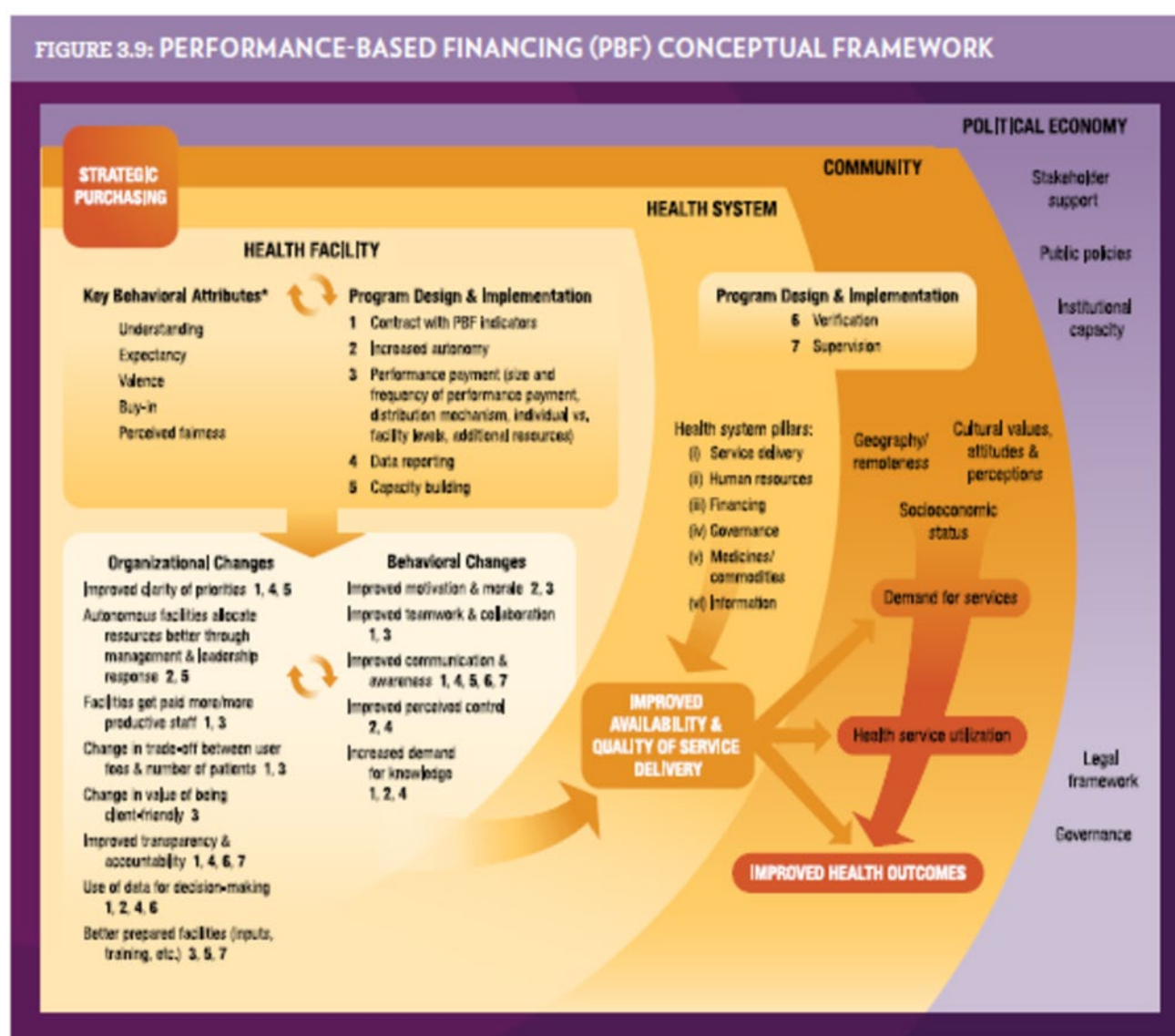
⁷ See <https://www.norad.no/om-bistand/publikasjon/2012/evaluation-of-the-health-results-innovation-trust-fund-hritf/>

⁸ Hasan, R., Vermeersch, C., Rothenbühler, E., Vledder, M. and Mabuchi, S. *Results-Based Financing Programs in the Health Sector: Conceptual Framework and Methodological Options for Programme Design and Evaluation*, World Bank 2013

⁹ The Results Framework uses the MDGs to report against, which were current when the HRITF and Results Framework were established.

10. While the conceptual framework is reported to be well-used for programme design and evidence gathering, it has some gaps as an explanatory model at the country level. For example, the contribution of HRITF and RBF to health system strengthening, which has become a more explicit area of potential impact for HRITF as a result of learning from the projects, is not clearly articulated. As a result, health system strengthening is not currently systematically assessed, although it now is perceived by donors, the Bank, global and country stakeholders as a major contribution of RBF. The relative prioritisation and relationship between evidence generation (originally a primary objective) and improving health outcomes (introduced as an output by the 2013 Results Framework) is not clearly articulated.

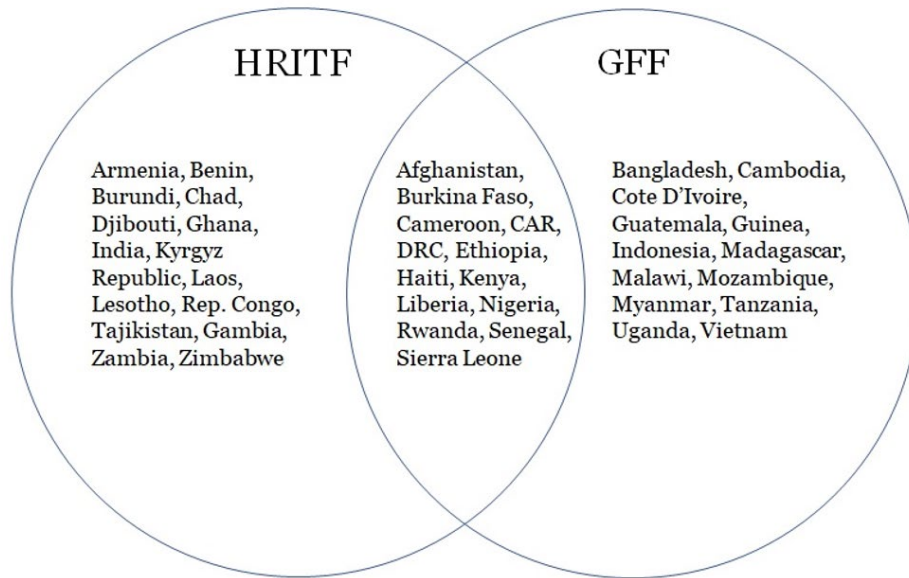
Figure 3: Performance based financing conceptual framework



11. In 2015 the Global Financing Facility in Support of Every Woman Every Child (GFF) was established as a mechanism to support delivery of the SDGs for RMNCAH-N. It developed from a realisation both that greater levels of finance are needed and that it is critical that countries are the in the driving seat for delivering results. In 2015 the HRITF was restructured into the GFF Trust Fund with \$762 million equivalent contributions as of October 2017.
12. The objective of the GFF is to dramatically scale up the resources available for RMNCAH-N and to align partners around prioritised investments that generate results, while ensuring that countries are on a trajectory toward universal health coverage and sustainable health financing. Development of domestic resources is intended to close the resource gap for RMNCAH-N. The GFF mobilises and helps coordinate financing from a range of external sources to fill the gap in financing needed for RMNCAH-N. This includes the financing from the World Bank, Gavi, the Vaccine Alliance, the Global Fund to Fight AIDS, Tuberculosis (GFATM) and Malaria, bilateral donors, foundations, and the private sector. The GFF also brings together the technical expertise of UN agencies and the community-reach of non-governmental and faith-based organisations, as well as the innovation and speed of the private sector. A key element of the GFF model is that it coordinates with other sectors that influence health and nutrition outcomes, such as education, water and sanitation, and social protection.
13. The GFF is governed by an Investors Group. To complement the work of the broader facility, a multi-donor trust fund – the GFF Trust Fund – has been established at the World Bank. The GFF Trust Fund model used GFF funding in conjunction with grant funding to IDA or International Bank for Reconstruction and Development (IBRD) projects, substantially increasing the amount of available funding for RMNCAH at country level. The GFF Trust Fund is governed by a Committee consisting of the donors to the trust fund. Committee membership includes Canada and the Bill and Melinda Gates Foundation, as well as Norad and DFID, the two HRITF donors.
14. The GFF does not prescribe the models that it supports but has a clear focus on financial and health system reform, results, and sustainability. There are some RBF country projects, although the GFF country programmes will not necessarily use RBF¹⁰. The GFF also differs from the HRITF in that it does not have an explicit learning agenda. Learning from the HRITF will be used by GFF, and the GFF Investors Group is a key stakeholder and audience for this evaluation.
15. The World Bank Secretariat for the HRITF took on a dual role in 2015 and is now also the Secretariat for the GFF Trust Fund Committee. Thirteen HRITF supported countries are funded by the GFF (2017), as illustrated in figure 4 below.

Figure 4: HRITF and GFF supported countries

¹⁰ www.globalfinancingfacility.org



Purpose of the evaluation and methodology

Objectives

16. This mid-term evaluation is the second evaluation of the HRITF. A first evaluation was carried out in 2012¹¹, and a third, final evaluation is planned at the close of the Trust Fund. This mid-term evaluation is formative, designed to consolidate learning from the generated and emerging results, evidence and processes involved in establishing, implementing and evaluating an RBF approach. The findings will be used to improve programme performance for the remainder of the Trust Fund's life, and to support the design and implementation of RBF mechanisms being considered under the Global Financing Facility (GFF). The period evaluated covers the HRITF from its start in 2007 to 31 October 2017.
17. The primary audience for the report is the donors, DFID and Norad, and the World Bank which implements the HRITF. The report is also intended for other audiences including governments, policy makers and implementers at country level, the GFF Investors Group, and the research community and the community of practice for RBF.
18. The evaluation has three main objectives:
 - **Objective 1:** To assess the performance of the HRITF against the given goals and outputs of the programme (as described in the results framework) identifying strengths, weaknesses and lessons learnt.
 - **Objective 2:** To determine what progress has been made in addressing the recommendations from the previous 2012 evaluation.
 - **Objective 3:** To make recommendations to inform on-going and future programming specifically aimed at (a) improving the performance of the current HRITF programme from a donor, implementer and country level perspective and (b) supporting the design and implementation of future RBF approaches being considered.

Methodology

19. An evaluation framework was developed to organise evidence and reporting to ensure that the evaluation objectives and questions set out in the terms of reference are addressed. The framework is in [Annex 2](#). The framework:
 - I. Organises key evaluation questions according to the five OECD DAC evaluation criteria¹², with the addition of equity as a sixth criterion;
 - II. Differentiates between questions relevant to the Trust Fund as a mechanism, and RBF as a funding modality at country level;
 - III. Ensures that the evaluation questions are systematically addressed; and
 - IV. Facilitates data triangulation and analysis.
20. During the inception period the evaluation methodology was discussed, developed and agreed with the evaluation steering group, comprising representatives from DFID, Norad and the World

¹¹ Evaluation of the Health Results Innovation Trust 2012, <https://www.norad.no/om-bistand/publikasjon/2012/evaluation-of-the-health-results-innovation-trust-fund-hritf/>

¹² Development Assistance Committee, Principles for Evaluation of Development Assistance, OECD 1991

Bank. Interview tools for country and global stakeholders were reviewed by the Evaluation Steering Group, and tested in the first deep dive country visit to Zimbabwe and following initial global interviews.

21. The evaluation used a mixed method approach and triangulation to generate findings based on quantitative and qualitative evidence drawn from multiple primary and secondary data sources. Sources included performance and financial reports, interviews with key stakeholders and focus group discussions. Data from the different sources were triangulated and reviewed iteratively by the evaluation team to develop findings both at the Trust Fund and country level.
22. Data was gathered for this evaluation through four methods:
 - I. A document review of project and programme documents and data, country documents, wider research literature, and unpublished research from the World Bank.
 - II. Remote interviews with 24 global stakeholders with experience and knowledge of RBF and/or the HRITF from development partners, universities, donor governments, foundations, and consultancies. In addition to the global stakeholders proposed by the Evaluation Steering Group for interview, four volunteers from the PBF Community of Practice were interviewed, using the www.thecollectivity.org platform. (See Annex 5 for a list of participants).
 - III. Three country case study visits (Cameroon, Nigeria, Zimbabwe) of five working days each (see Annex 9). During these visits interviews and focus group discussions were held with the World Bank country team, country stakeholders from national and local government, civil society, health providers and verification agencies, development partners, INGOs, and health facility staff. Country stakeholders were mainly identified by the TTL, supplemented with others identified by interviewees and volunteers from the PBF Community of Practice. Visits were undertaken to health facilities and local health/government administrations as well as to government and INGO offices.
 - IV. Twelve virtual case studies (Afghanistan; Benin; Burkina Faso; Burundi; Democratic Republic of Congo (DRC); Ethiopia; Gambia; Haiti; Liberia; Senegal; Tajikistan; Zambia) based on desk reviews of country reports and remote interviews with 4 - 8 country stakeholders in each, including the country TTL. Country stakeholders were mainly identified by the TTL, although in a few cases interviewees identified others.
23. In addition, an initial induction visit to the World Bank in April 2017 was undertaken by two team members and a second visit in September 2017 to discuss interim findings. Both contributed to the evidence used and enabled interviews with Secretariat members and other World Bank staff.
24. A weighted criteria analysis of HRITF-supported projects was undertaken to identify case studies. Criteria included type of RBF mechanism, value of grant, region, and availability of impact evaluation. The 15 projects with the highest ratings were included as deep dive or virtual case studies.

Limitations to the evaluation

25. Limitations to the evaluation include:

- I. Given the range of different RBF models and country contexts, amounts of country grants and linked IDA, generalisation across the country projects is treated cautiously, and is not always possible. Case studies provide a range of examples, which are cited. Where similar challenges or facilitating factors related to process and results were found, these are reported.
- II. The timing of the field work was set for the July-August period in 2017, when some key country and global stakeholders were unavailable. This was not ideal but was unavoidable given the start and end dates of the evaluation. However, by extending some interviews and case studies into September, all were completed.
- III. The three deep dive countries selected are relatively successful RBF projects; in retrospect it would have been more informative to have visited at least one country facing implementation or design difficulties. Since the majority of HRITF projects are in Africa, this offered a sufficient potential range of models and experiences. The virtual country case studies were selected to include a wider range of project implementation experiences, to mitigate potential bias. The virtual case study sample was also designed to ensure some representation from countries outside Africa, so that there was a wider regional spread.
- IV. The HRITF has no single, integrated framework that articulates the relationship between the Trust Fund and the RBF-related results it seeks to support at a country level. This limits the extent to which the relationship between the performance of the Trust Fund and its effectiveness and contribution at country level can be investigated.
- V. Access to country level data such as country project financial reports was patchy. This was mitigated to some extent by interviews and by the HRITF Secretariat supplying a large volume of data and documents.

Findings

Relevance

Key findings

Country level

- The HRITF's Knowledge and Learning grants have been used to help countries decide if RBF is relevant.
- Effective support for RBF is based on a design that is relevant to country health systems, and addresses bottlenecks and contextual challenges.
- Longer standing RBF programmes are better aligned with country health and health reform policies.
- The World Bank's partner engagement shows evidence of improvement, however there is still evidence of weak coordination with partners.
- There is variation in the level of ownership, contribution, and relevance of RBF programmes across and within countries.
- There is a perception from country partners that there has not always been a thorough risk assessment prior to the development of RBF project proposals.

Trust Fund level

- The HRITF has established a relevant mechanism to investigate whether RBF can, in different contexts, contribute to improvements in RMNCH health services.
- Through the HRITF, RBF has been piloted in a wide variety of contexts, and this has facilitated the generation of a substantial body of evidence.
- Placing the HRITF's management in the World Bank provides several advantages for piloting RBF projects and generating evidence.
- Although RBF can be helpful to health system strengthening, the pilot approach limits the extent to which this is assessed.
- An inherent tension between fulfilling country needs and meeting impact evaluation requirements is common for projects supported by the HRITF.

Country level

- 26. The HRITF's Knowledge and Learning (K&L) grants have been used to help countries decide if RBF is relevant.** HRITF K&L Grants enable technical dialogue and learning to help IDA eligible countries make informed decisions as to whether RBF is an appropriate modality or not. Twelve countries used the grant to help decide whether to go ahead with RBF pilots. Of these, ten decided to adopt an RBF model, and three countries (Yemen, Haiti,

and Central African Republic) became HRITF supported projects¹³. Despite the apparent rigour of this process, there are stakeholders at country and global levels who believe that decisions to proceed with RBF did not always take sufficient account of its impact on the larger health system, or of its implications for health system reform¹⁴. K&L grants have also been used for technical assistance for redesigning and scaling up existing RBF pilot schemes.

27. **Developing an RBF model design that is relevant to country health systems, bottlenecks and contextual challenges is key to its effectiveness.** A criticism mounted by global stakeholders has been the HRITF's use of a standardised approach to RBF, based on a model that was successful but specific to the Rwandan context. There was evidence of examples of this in earlier years, such as in the initial RBF interventions in DRC and Afghanistan, where design weaknesses led to no change in outcomes, or to negative outcomes¹⁵. For example, the first HRITF project in DRC lacked effective sanctions and weaknesses in reporting led to financing distortions that undermined the purpose of RBF¹⁶. Learning from these and other earlier programmes has enabled the HRITF to support a more flexible and diverse approach to design, and to ensure better relevance and responsiveness to context in more recent projects.
28. **There is variation in the level of ownership of RBF programmes across and within countries.** The inclusion of countries which are at best ambivalent about implementing RBF using the World Bank-supported model raises a question about the extent to which it is fully regarded as relevant by their governments. In some countries, this appears to be linked to lack of government ownership. In Benin for instance, changes in political leadership have contributed to limited ownership from the government, which still lacks a national entity to implement RBF, resulting in weak integration with country systems. In Nigeria, there is strong ownership at state level for RBF, but this is less evident at the federal government level. In Zimbabwe there has been strong ownership at ministerial level as well as at local levels.
29. **Longer standing RBF programmes are better aligned with country health and health reform policies.** In many countries where the HRITF is operating, there have been longstanding RBF programmes supported by NGOs, governments, and/or other development partners pre-dating HRITF involvement. In these countries, alignment of HRITF supported initiatives and the extent of integration of RBF mechanisms within country systems is greater. These countries have had the opportunity for iterative reviews and adaptation of design and implementation models, and to gather sufficient evidence to inform policies and plans. In some countries, such as Cameroon and Haiti, RBF was already, or is in the process of becoming, well integrated in health policy, systems, and practice, as well as with emerging plans for health financing reforms including introducing universal health coverage and health insurance policies.
30. **Partner engagement shows evidence of improvement.** In Haiti

Issues with Partner Engagement

In DRC, there were several years of a fragmented approach, until donors signed a Memorandum of Understanding (MoU) to coordinate activities.

In Tajikistan, it was felt that there had been insufficient engagement with country development partners in the design of the project to fully understand the risks associated with RBF.

In Burkina Faso, the RBF design process did not involve partners, and most are still not engaged, although the EU and WHO are now supporting the move to strategic purchasing, the evolution of RBF in Burkina Faso, as led by the Government.

¹³ HRITF Knowledge and Learning Grants, Vergeer, P., Duravic, I., Bien, E., World Bank 2016.

¹⁴ Soucat A. et al. (2017). Pay-for Performance Debate: Not Seeing the Forest for the Trees. *Health Systems & Reform*, 3:2, 74-79.

¹⁵ Qualitative synthesis review on PBF schemes in HRITF- NAG, 2013, unpublished draft provided by the World Bank to the evaluation team.

¹⁶ Impact evaluation on PBF in the district of Haut Katanga, DRC, World Bank policy note, 2014? (no date given)

and Liberia, for example, where the RBF model is implemented together with pre-existing USAID programmes, there has been more successful collaboration with partners. In Zimbabwe, the other major multi-donor trust fund providing support to the health system, adopted the Bank-supported model at the bequest of government. In the Gambia, coordination with other development partners goes beyond the health sector, and the project also coordinates with the EU and WFP on efforts related to safety net programmes.

31. **There is a perception from country partners that there has not always been a thorough risk assessment prior to the development of RBF project proposals**, through the assessment of local health systems or through discussions with country-based technical partners who may have valid and relevant knowledge. Questions regarding how consistently the Bank engages with other development partners to ensure alignment remain. There are cited instances such as early engagement with Ghana where there were already plans for social insurance, and where local health systems, political and social risks, sustainability issues and partners views were not identified and addressed. Fragmentation of different partners' work is seen by external stakeholders as one of the major risks to implementation. This was also a finding of the 2012 Evaluation.
32. **The preparation phase is crucial to adapting the RBF mechanisms to the country context and in ensuring government ownership.** Open collaboration and strong consultation with different stakeholders are observed by various stakeholders to contribute to successful design and implementation.
33. **The contribution and relevance of RBF can vary according to context.** A review of the evidence from case studies indicates that there have been different purposes to RBF mechanisms in different contexts. In fragile contexts, as in Haiti and Liberia, RBF can contribute to putting the basic building blocks for primary care systems to improve the health system's functioning. In Afghanistan, for example, RBF contracts with NGOs enabled the provision of primary health services in areas where the government had no credible reach. On the other hand, in more established health systems that are relatively well-functioning and resourced, RBF can help build capacity and technical knowledge for financial reform and for improving systems. In Tajikistan for example, RBF appears to have been conceived primarily as a modality for defining common quality standards in the context of a highly centralised post-Soviet model.

Trust Fund level

34. **The HRITF has established a relevant mechanism to investigate whether RBF can, in different contexts, contribute to improvements in RMNCAH health services.** The HRITF facilitates a systematic, evidence-based build-up to RBF implementation. Pilot projects are subject to process and impact evaluations; the latter aimed at measuring attributable impact through a range of health systems strengthening and health outcome indicators, to inform scale-up. In Zambia, for example, the HRITF funded a pre-pilot (one district, 2011), followed by a pilot (pre-pilot district plus 10 more districts, 2012 – 2014) that was subject to a process and impact evaluation, before implementing the Zambia Health Service's Improvement Project (2015 – 2019).
35. **Through the HRITF, RBF has been piloted in a wide variety of contexts, and this has facilitated the generation of a substantial body of evidence** on the effectiveness of RBF across different political-economic and health system contexts. The learning focus of the HRITF, in which knowledge is generated on the effectiveness of RBF under different contexts, is valuable in its contribution to the global evidence base and in informing country decisions on whether and how to use it.
36. **Placing the HRITF's management in the World Bank provides several advantages for piloting RBF projects and generating evidence.** The World Bank has global reach, strong fiduciary risk management and performance management systems, and often significant

convening power in the countries in which it operates. The World Bank has been active in supporting the health sector in many of its member countries, which has provided a good entry point for piloting RBF mechanisms. In this respect, it is a suitable organisation for working with countries to test RBF approaches. In almost all cases, HRITF CPGs are undertaken in conjunction with larger IDA grants or concessional lending for aligned health programmes, which has increased the available funding for RBF pilots.

37. **While RBF can be helpful to health system strengthening, the pilot approach limits the extent to which this is assessed.** One of the assumptions under which the HRITF operates is that RMNCAH-focused RBF can catalyse wider health systems strengthening. A pilot approach may not be fully relevant to conceptualise and measure RBF as a system-wide intervention. Most RBF mechanisms target specific aspects of health systems, but do not necessarily situate them strategically within the wider political and health system context. In this respect, the development of the GFF as a successor to HRITF, which has a wider focus on system reforms and sustainability will help increase relevance.
38. **In HRITF supported projects, there is a tension between fulfilling country needs and meeting impact evaluation requirements.** The HRITF model supports incremental scaling up of RBF based on robust evidence from impact evaluations. However, there is also a strong country aspiration to demonstrate results in terms of health systems strengthening and improved health outcomes, which can override waiting on evidence from impact evaluations. There is also a tension at country level between delivering evidence, including on what does not work well, and delivering improved health outcomes.

Effectiveness

Key findings

Country level - effectiveness of implementation

- RBF contributes effectively to the financial and managerial autonomy and overall capacity of health facilities.
- Improvements in supervision at facility level have been experienced as positive.
- Projects experience significant delays in payments to facilities.
- There is evidence of country capacity building for verification delivery and processes.
- Country programme data and evidence is used well by countries to inform country programme adaptations.
- The HRITF has contributed to building country capacity for evaluation.
- Building institutional capacity for RBF has been more effective when there has been early engagement with a range of country stakeholders.
- Governments use a wider range of evidence than impact evaluations to decide on whether to continue RBF.
- Government ownership for RBF is a critical enabling factor.

Trust Fund level - effectiveness of implementation

- Overall the HRITF is on track or exceeding its targets for all outputs with positive progress on the six health results indicators.
- World Bank Task Team Leaders and Health Specialists play a critical role in facilitating country capacity development.

Trust Fund level - learning and evidence

- The heavy emphasis on impact evaluations is integral to the purpose of the HRITF in obtaining evidence of impact.
- The impact evaluations are of a high standard and well implemented.
- The development of methodology papers and impact evaluation toolkits to improve methods and measures for assessing RBF has been productive.
- There is a growing wealth of evidence from countries' own research, and scope to develop this.
- There is a gap in the published evidence on *how* RBF works.
- There is a question whether the Trust Fund focus on impact evaluations has come at the expense of operational, 'on the job' learning and research.
- Evaluations focus on the RBF mechanism without consistently addressing the wider health system context.

Trust Fund level - knowledge sharing

- The HRITF has provided a good range of different methods and tools for sharing evidence and learning; there is potential to share evidence from countries' own research more effectively.
- Accessing evidence from HRITF projects from the website is currently not easy.
- Knowledge brokerage is central to the HRITF, but it is not adequately resourced to be fully effective.
- The potential to increase and widen the use of learning and evidence through links to other knowledge platforms; global RBF workshops could bring in a wider range of perspectives.

Country level

Implementation of RBF

39. **One of the most effective aspects of RBF is contribution to the financial and managerial autonomy and overall capacity of health facilities.** Evidence from facility visits and reports shows the positive impact of having available budgets to spend on facility infrastructure and equipment, and to recruit additional staff. For example,

Examples of learning and programme adjustment

In Zimbabwe, there was a re-calibration of indicator tariffs to focus on both the quantity and quality of health coverage. Tools such as the facility business plan and performance reporting templates are revised to improve their quality and increase levels and effectiveness of use.

In Tajikistan, indicator definitions and approaches to measurement were modified following a technical review mission that revealed confusion among health facilities.

roofs had been repaired, lighting installed, water supplies improved, and wards and delivery rooms made fit for purpose. Facilities also used performance related payments to recruit additional staff, to increase their capacity to see and treat patients. The empowering effect of autonomy on facility managers and staff was evident in facility visits, and also reported in a survey of the PBF Community of Practice members. However, the extent to which this was due to additional funding, or to the RBF model is not conclusive; findings from studies¹⁷ and field visits show that facilities receiving additional finance alone, also see equivalent improvements in the quality of premises and in capacity to recruit additional staff.

40. **Improvements in supervision at facility level have been experienced as positive.** In both Nigeria and Cameroon, facility staff and supervisors noted that increases in the quality and regularity of supervision were effective tools for quality improvement. The Cameroon impact evaluation, found a clear effect for the importance of additional financing plus reinforced supervision through PBF instruments. Enhanced supervision and monitoring alone however were not sufficient to improve health outcomes.

41. **The projects experience significant delays in payments to health facilities.**

In general, RBF has proven an effective means of directly channelling flexible resources to facilities and supervisory bodies. However, payments delays are widespread and were experienced in all countries, with delays ranging from a few weeks to three or more months. Of the case studies, only Nigeria has an efficient payment system, using an online portal so that payment is processed within three weeks. Delays in disbursements impact negatively on the efficiency of planning and budgeting at the facility level as well as demotivating staff. It also affects capacity to maintain quality of care and supplies. This is a critical aspect of RBF to strengthen to support sustainability and scale up, since without timely and reliable payment for results, the efficacy of RBF is lost.

42. The use of RBF payments by facilities is not systematically tracked or monitored. This is an opportunity to explore in the future to gather evidence on infrastructural improvements brought about as a result of RBF.

Examples of payment delays.

In Cameroon, delays in payments have been a consistent problem, partly due to the number of steps in the payment processes, partly due to the increased spread of PBF without sufficient accounting staff to support it, and partly to the lengthy processes of the Caisse Autonome d'Amortissement, (CAA) which processes all World Bank funding. Delays in disbursements of up to 10 months have been experienced.

In Tajikistan delays experienced in the payment of incentives have been attributed to instability in the Tajik banking system.

In Zimbabwe, delays have been due generally to the failure by facilities to submit the required documentation in time.

In Liberia, severe delays were attributed to misunderstandings between the Ministry of Finance and the Project Implementing Unit.

43. **Regular review and modification of processes and tools supports effective implementation.** Evidence from case studies shows the importance of active review and modification of the tools and processes used, led by the country project implementation units. These changes are informed by monitoring and evaluation data and include revisions to indicator tariffs to incentivise hard-to-achieve indicators and reduce incentives for those that are easier to achieve; changes to the definition of indicators to ensure clarity and relevance; and the addition and removal of indicators. Reviews often focus only on RBF and are not always well connected to wider country systems and processes.
44. **Country programme data and reviews are used well by countries to inform country programme adaptations.** Countries visited in the three deep dive visits showed strong use of

¹⁷ Exploring the impact of Performance Based Financing on Health workers' performance in Benin, Lagarde et al, 2015

monitoring and evaluation data to identify strengths and weaknesses in the country programme and used these to inform amendments to the design and implementation of the RBF.

45. **There has been good use of learning from implementation by the HRITF from earlier HRITF experiences.** For instance, the DRC CPG 1 in Haut Katanga, which led to unanticipated negative impacts, and did not work well, showed the importance of ensuring that the model design is appropriate to the context to avoid introducing processes that are not aligned to local context, as well as to supporting implementation with good communication to ensure awareness at facility level. HRITF projects which started later in the programme have been informed by other countries' experiences to avoid these mistakes.
46. **There is evidence of country capacity building for verification delivery and processes work well when tailored to context.** Country verification systems include verification by internal organisations (as in Rwanda, Cameroon), external agencies where there are less robust health systems, or a combination of both. Where the health system and RBF model are mature, as in Cameroon, the lead for verification can transfer from INGOs to country agencies. Cameroon is now piloting peer verification and validation for hospitals. Community based organisations contribute in some models through providing community quality assessment and validation of quantity, such as in Tajikistan and Zimbabwe. The process of verification itself has undergone modification in some countries, for example in Zimbabwe and Cameroon, to reduce costs and burdensome administrative and reporting processes. Zimbabwe is currently exploring risk-based approaches, which will provide a more flexible, responsive and cost-effective way of working to tackle higher risk processes or areas, rather than using a one-size-fits-all approach.
47. **Building institutional capacity for RBF has been more effective when there has been early engagement with a range of country stakeholders.** In Ethiopia, it was found that investing resources up front to ensure that task teams and government counterparts fully understand the mechanisms of RBF, helped to overcome the initially steep learning curve and keep costs down.
48. **Building capacity for impact evaluations has been effective.** The HRITF has contributed effectively to building country capacity for evaluation through supporting stakeholders' participation in developing and implementing impact evaluations. Country evaluation workshops are tailored to country knowledge needs, and World Bank country teams actively involve MoH and country implementation teams in the impact evaluations to build country ownership of the process and product. Targeted workshops on impact evaluations have been held for several country teams, including Benin, Cameroon, Central African Republic, Nigeria and Rwanda. From case study findings the extent to which countries fully engage in the impact evaluations and publish papers on RBF independently from the HRITF, is partly dependent on the strength of the existing health research academic community in each country.
49. **Governments use a wider range of evidence than impact evaluations to decide on whether to continue RBF.** Governments report that impact evaluation results inform their next steps in relation to scaling up RBF. There were, however already commitments to continuation and scale up made in several countries before completion of the impact evaluations, although governments were aware of the emerging main findings. This suggests that other evidence from implementation monitoring and review data, such as RBF contributions to health system strengthening are also used to inform decisions. An exception is the Haut Katanga impact evaluation which documented the challenges and weakness in the RBF design, and was used to inform a second, improved design supported by the Bank and other partners. A different exception is Ethiopia, where impact evaluations of RBF pilots have been abandoned and it is not clear on what evidence the scale-up of RBF will be based.
50. **Government ownership for RBF is a critical enabling factor for effective implementation, and in countries where there is weak government ownership,**

progress is slow. In Liberia, for example, misunderstandings between the Project Implementing Unit and the Ministry of Finance regarding the purpose and functioning of the supported RBF mechanism led to delays in implementation. There was also a perception in targeted facilities that the RBF mechanism was a ‘World Bank’ project, which the PIU worked hard to counter. Lack of engagement with the MoH at pilot stage is found to be a barrier to subsequent scale up in a study by Shroff et al.¹⁸. The extent to which the World Bank support has consistently and effectively engaged with country stakeholders is limited. Often the PIU is external to the MoH, which in Nigeria and Cameroon diminished government ownership of RBF.

Trust fund level effectiveness as assessed by the 2013 Results Framework

51. **The HRITF is on track to achieve or exceed its targets for all outputs.** Fund level results for the six Fund-level outputs are reported in the annual Results Framework report to donors. With the exception of the global results for health outcomes, the framework mainly reports on activity data and expenditure data. The weakest area has been in relation to disbursements, although this has shown improvement and is discussed in more detail in the section on efficiency.
52. **There is positive progress on the six health results indicators.** Country level reporting for the HRITF Results Framework at Trust Fund level is based on six indicators of standard maternal and child health services to measure progress towards the MDGs. Numbers of women and children receiving these services each year with support from HRITF supported RBF projects have been reported in a comparable format since 2013. The graphs below show aggregated data from these reports. Numbers for FY 2017 are an estimate by HRITF and so may vary in later reports¹⁹.

Figure 5: No. of 1-year old children fully immunised with support from CPGs

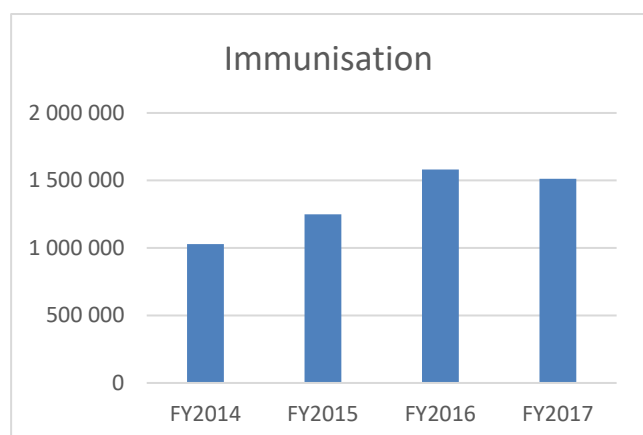


Figure 6: No. of women delivering their babies with a skilled birth attendant with support from RBF CPGs

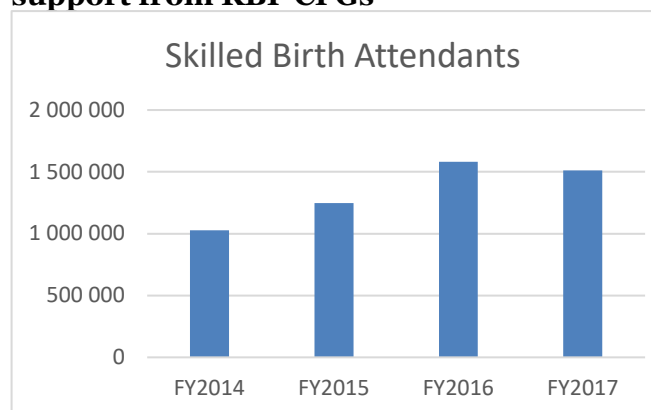


Figure 7: No. of pregnant women receiving at least 1 ANC visit with support from RBF CPGs

Figure 8: No. of pregnant women receiving postnatal care with support from RBF CPGs

¹⁸ From Scheme to System (Part 2): Findings from Ten Countries on the Policy Evolution of Results-Based Financing in Health Systems, Shroff, Z, Bigdeli, M, Meessen, B., Health Systems & Reform, 3:2, 137-147, DOI: [10.1080/23288604.2017.1304190](https://doi.org/10.1080/23288604.2017.1304190)

¹⁹ Results Framework indicators FY2017 report – final, World Bank, report to donors

support from RBF CPGs

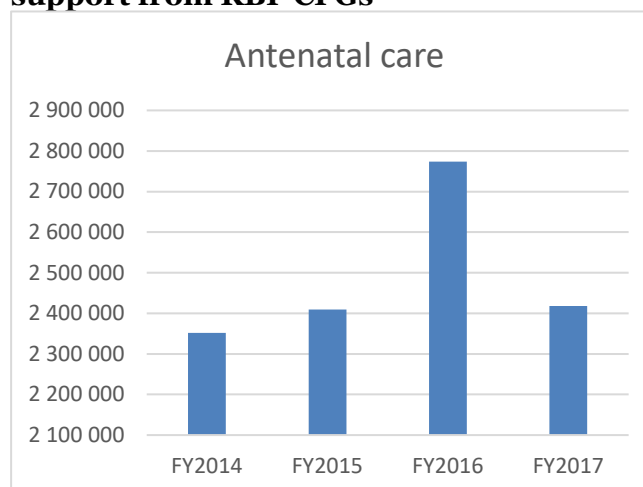


Figure 9: No. of HIV+ pregnant women receiving antiretroviral therapy for Prevention of Mother-to-Child Transmission with support from RBF CPG

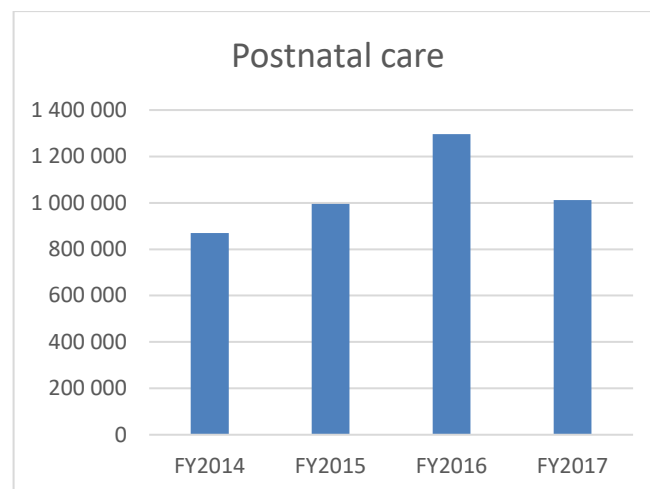
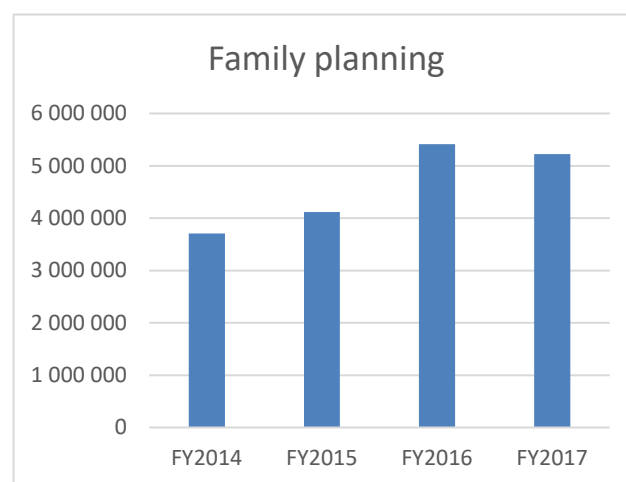
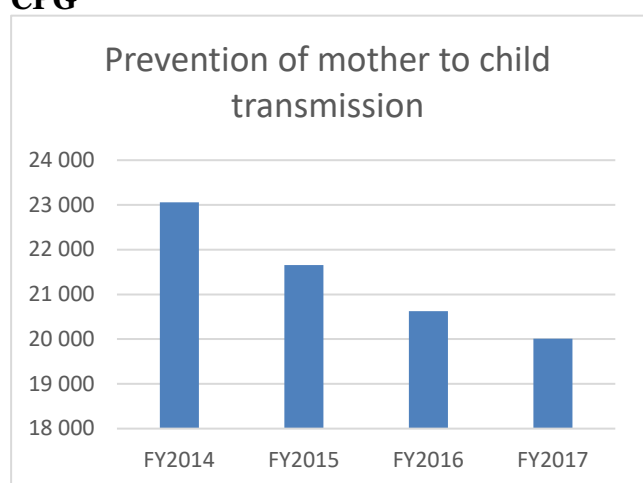


Figure 10: No. of women aged 15-49 using modern family planning methods with support from RBF CPGs



53. Key observations in relation to the reported results include:

- The decline in estimated numbers in 2017 reflects the end of nine HRITF projects by mid-2017 (see Figure 2, and Annex 3). The values are reported for each year in the Trust Fund lifetime, and so there was a peak during the years where there were the highest number (and large) CPGs in operation. As CPGs complete, the volume of services supported reduces.
- Overall, there is positive progress on the selected indicators, although the results show different rates of progress for some indicators.

54. Data for these indicators are drawn from country level data systems; indicators are purposely broadly defined to allow for the lack of perfect comparability among countries. For example, for "number of pregnant women with at least 1 ANC visit", the value includes data for both "at least 1 ANC visit" and for "at least 4 ANC visits".

55. **Task Team Leaders and World Bank Health Specialists continue to play a critical role in facilitating country capacity development.** The Results Framework indicator for TTLs' training was exceeded in several years. TTLs provide expertise and identify and facilitate capacity building support to countries. Ensuring that these Bank staff have the right levels of expertise and access to knowledge is essential to assuring the quality of their input. TTLs note that the supervision (the Bank term for technical support, used to provide specialist advice and consultants for country and country team capacity building) budgets are important in helping build country capacity.
56. There are however still views from country stakeholders that the quality of TTL expertise can be variable. Since the 2012 Evaluation, there has been increased effort and resource put into training TTLs and country teams. Workshops and peer learning events have been held and more direct assistance and supervision from the secretariat is now provided. Until 2016, there were regular internal Bank workshops for exchanging information and experiences. These have been largely replaced by external speakers since the advent of GFF in 2016, which do not provide the same peer to peer learning on current design and implementation challenges. In 2015, the Technical Assistance Support for RBF Implementation (TASRI) service was set up to provide technical advice and assistance to TTLs and country teams, contracted with an external provider. It provided a call down service to respond to country and TTL needs. This service was used very little and the contract was ended in early 2016. Reasons for non-use were not made clear.

The quality, relevance and use of evaluation and learning

57. **The HRITF learning strategy has been heavily weighted to the impact evaluations, which are a core element of HRITF and integral to its purpose in obtaining evidence of impact.** There are 24 impact evaluations supported by HRITF, of which eight are complete, and sixteen more are due to be completed. There has been a reduction from the original planned number of impact evaluations since the budget was affected by a decrease in the value of the HRITF fund due to currency exchange fluctuations (see section on Efficiency). This is being managed carefully to maximise the value of impact evaluations supported, but means that some evaluations originally planned will now not take place. At present the impact evaluation portfolio is due to be complete by the end of the HRITF in 2022, with all baseline data collected by the end of 2017²⁰.
58. **The impact evaluations are widely seen to have been well managed and implemented.** The expertise of the Bank in conducting rigorous and well implemented impact evaluations is widely acknowledged, and the evaluations are seen to contribute high quality evidence on RBF which is valuable in assessing the RBF mechanisms. There are the inevitable challenges of conducting an impact evaluation when the programme is affected by external and implementation factors. For instance, in Benin, the implementation of different interventions in treatment arms of the impact evaluations was not effectively managed which led to confusion and unclear results. In other examples, such as Cameroon, there was a government decision on which facilities would be included which weakened the impact evaluation design. Contextual challenges such as availability of supplies, and industrial action also affected implementation. The impact evaluation authors have identified and addressed these methodological challenges in impact evaluation reports.
59. **There is a wealth of information from countries' own research and case studies on RBF, with potential to add to global evidence.**

²⁰ Impact Evaluations and emerging lessons, Kandpal, E., World Bank 2016

There are some highly relevant published discussion papers on www.rbfhealth.org, for example from Burkina Faso on the effects of implementing RBF on finance, from Tanzania on accountability mechanisms, from Zambia on health worker motivation, and from Burundi on verification systems, all planned and undertaken with HRITF support. In Nigeria, a large volume of operational research has been undertaken throughout Nigeria State Health Investment Project (NSHIP) implementation to inform learning on the job. This has been conducted by the Federal Ministry of Health, the National Primary Health Care Development Agency and the technical support agency. There is potential to build on country research, particularly to understand the contextual and content factors that may explain variation in outcomes. Country research provides valuable information, often timelier than Bank products. Country data sources, including administrative data from health management information systems, may be exploited to provide insights on how RBF works.

Examples of operational research in Nigeria

- A study on the determinants of health facility performance.
- A study on demand side barriers to service utilisation in RBF facilities.
- A review of financial flows from the Federal, to State, to Local Government, to Facility levels.

60. **There has been productive development of method papers and toolkits to improve methods and measures for assessing RBF.** These include papers on qualitative research, cost effectiveness, health worker motivation and a review of quality improvement methodologies. HRITF toolkits for implementing RBF impact evaluations are published on the website and have been widely downloaded. An initial research study of cost effectiveness, following a study in Zimbabwe and Zambia, is being developed further to explore value for money methodologies for RBF.
61. **There is a gap in the published evidence on *how* RBF works, and a question on whether the focus on impact evaluations has come at the expense of operational, ‘on the job’ learning and research.** The focus of impact evaluations completed to date has been on impact on utilisation, coverage and quality, with an underlying question of proving whether RBF leads to improved results compared to a baseline and to facilities without RBF. The questions of how RBF works, under which conditions and in what contexts have been less clearly addressed. However, the HRITF 2017 Learning Strategy will consider these questions moving forward. A meta-analysis of research on RBF drawing on all published sources and grey literature is planned. Recent impact evaluations, such as the Cameroon impact evaluation (2017), consider process of RBF more explicitly²¹. Future impact evaluation designs have a stronger focus on the “how”, for instance in the Gambia impact evaluation, a proposed mixed-methods approach with an embedded process evaluation will include an explanation of how and why changes have taken place, as well as assessing impact.
62. **The unit of evaluation focuses on the RBF mechanism without consistently addressing the wider system context.** Although the impact evaluations set out the country context, they primarily consider whether the RBF works as a mechanism. They do not necessarily provide an understanding of how the RBF project interacts with country health systems and how much it can contribute to wider systems strengthening, a point also raised by Soucat et al.²². While each impact evaluation identifies some key health systems weaknesses to consider, such as shortages of qualified staff and weaknesses in supply chains or M&E, the impact evaluations have

²¹ Evidence from an Impact Evaluation in the Health Sector in Cameroon, Policy research Working Paper 8162, Damien de Walque, Paul Jacob Robyn, Hamadou Saidou, Gaston Sorgho, Maria Steenland, World Bank

²² Agnès Soucat, Elina Dale, Inke Mathauer & Joseph Kutzin (2017) Pay-for- Performance Debate: Not Seeing the Forest for the Trees, Health Systems & Reform, 3:2, 74-79, DOI: [10.1080/23288604.2017.1302902](https://doi.org/10.1080/23288604.2017.1302902)

not consistently been situated within the structural and political context for health. For instance, in Nigeria, the RBF programme provides a very high proportion of facilities' funding in the absence of adequate base funding from the state and local government. In other countries, the RBF payments are smaller in relation to base funding. There is a risk that RBF interventions are framed as a single model, when in practice they are a range of approaches whose effects depend on the interaction of several variables²³.

63. **There are still gaps in evidence on specific topic areas which could be used to inform current and future RBF projects.** These include evidence on scale up processes, facility management, supervision, demand-side barriers and interventions, and on implementation processes. Other aspects of health systems have been identified as gaps for future evaluations in the revised 2017 HRITF Learning Strategy, such as the impact on supply chain, governance and accountability, user fees, equity of access and utilisation, and on the supply and deployment of health workers. While it is not the role of the HRITF to assess all aspects of RBF, these are important areas to consider.

Knowledge sharing

64. **The HRITF has used different methods for sharing evidence and learning with countries, TTLs and the global RBF community.** These include:
- Global workshops for countries, country teams and experts to meet and share learning. The global workshops are viewed by the Bank as key events for information sharing and peer to peer learning, with attendance for instance at the 2016 Zimbabwe workshop of over 100 people from 25 countries. These workshops have been highly valued by participants²⁴.
 - Country and regional workshops for practitioners on implementation and evaluation. Learning from other countries is widely cited as valuable by country teams.
 - www.rbfhealth.org provides information and updates on all the HRITF supported projects and impact evaluations, and has links to country RBF portals, access to toolkits and guidance, and provides access to a resource page of relevant internal and external publications.
 - An RBF e-learning package, developed for training purposes and available through the website, has received high levels of demand. The RBF toolkit and the impact evaluation toolkit have been widely downloaded. The RBF Facebook page is widely used.
 - Thirteen peer reviewed articles on impact evaluation results from HRITF financed evaluations have been published to 2017²⁵. Papers have been presented through participation in international conferences such as the International Health Economics Conference and the International Health Systems Research conference.
 - Impact evaluation data sets have been published through the World Bank micro-data library and are accessible to researchers.
 - Country portals are accessible on the website for eleven countries receiving HRITF support, which are a source of operational and progress data.

²³ Paying for performance to improve the delivery of health interventions in low and middle income countries, Witter, S., Fretheim, A., Kessy, FL, Lindahl, AK, Cochrane Database of Systematic Reviews, 12, Issue 2, 2013

²⁴ Post workshop survey report, Argentina 2014, World Bank internal report

²⁵ HRITF Results Framework indicators report FY- 2017 FINAL, World Bank, 2017

- A RBF bulletin is produced regularly.
- Presentations at international conferences and other events to present results from the impact evaluations.

65. **Accessing evidence for learning from the website is currently not easy, particularly for country-led operational research and learning.** Searching www.rbfhealth.org by country pages and resource pages is not always fast or straightforward. The search mechanisms and architecture does not facilitate swift access to the required products. The full value of available evidence is not maximised to the wider practitioner and research community. There is a clear opportunity to review and enhance the website architecture, functionality, display and content and to improve the functionality and design of search engines to enable improved searches and retrieval. Improvements to the website are planned.
66. **There is potential to increase and widen the use of evidence through links to other knowledge platforms.** The **PBF** Community of Practice, which is independently run, provides a platform for practitioners and academics working with RBF to share knowledge and experiences. At present, it is largely based on membership from African countries, with the potential to extend to other regions. The two have different functions, and independence for each should be maintained, but there is scope for reviewing the relationship between them and potential for increasing engagement and to explore ways of ensuring that there is greater global access to knowledge generated by the HRITF. There is also potential for more active and structured engagement with other partnership platforms and forums for health financing and RBF to optimise access to knowledge and evidence.
67. **Knowledge brokerage is central to the HRITF, but it is not adequately resourced to be fully effective.** Knowledge management is a specialised function, and there is a lack of resource and capacity to ensure the evidence available is fully used and accessible. This may be addressed by having specialised and dedicated staff to manage the function, and by the development of a strategy and operational plan for the work. With the Bank's intention to merge RBF knowledge management with GFF activities, this is an area to consider, both to maintain the future of the RBF knowledge portfolio and for the wider knowledge work for the GFF. As part of this it will be important to clarify the audiences for RBF knowledge.
68. **The global RBF workshops could bring in a wider range of experiences.** There is an external perception that the global RBF workshops do not always make the best use of bringing together a diverse array of experts and practitioners. Global participants in the workshops interviewed observed that the content and speakers can appear dominated by the Bank, which can limit the diversity of views on RBF and the opportunity to consider different approaches. There is potential to have a wider range of speakers to bring in different experiences.

Efficiency

Key findings

Country level

- HRITF contributes to increasing efficiency in health service delivery through increasing the funds available to the frontline of primary care.
- The efficiency and management of RBF projects has improved with learning and experience.
- Evidence shows that RBF models have adapted to increase their efficiency.
- Analysis of country operating costs was not possible due to insufficient data on expenditure at country project level.
- Verification costs have been reduced in innovative ways in some countries; accurate, validated reporting requires continuing support and attention.
- Evidence on the cost effectiveness of RBF is not conclusive and further study is needed.
- Two impact evaluations show that providing additional financing with supervision may deliver similar levels of improvement as a RBF approach; a third shows mixed results.

Trust Fund level

- Management of the Trust Fund benefits from the Bank's strong project management and fiduciary capacity to manage activity. Reporting to donors has improved.
- The HRITF has shown the benefit and efficiency of using Trust Funds in conjunction with IDA lending to optimise value.
- The HRITF budget has been allocated broadly as planned; administration costs have been reduced and are now low.
- HRITF disbursements are not on track and full disbursement by 2020 will require accelerated disbursement.
- HRITF supervision costs are larger compared to other Bank instruments because they also include the supervision of implementing an RBF project.
- The average cost of RBF preparation activities was below the HRITF indicative levels for preparation.

Country level

69. **RBF provides a method for increasing funding available to primary care provision in country systems which tend to allocate health budgets in favour of tertiary and secondary levels.** In Cameroon only 10% of national health budget reaches primary care facilities. Expenditure at primary care level is cheaper to provide per output, and includes preventative care, which reduces the likelihood of later and more costly health care needs and services. More investment at primary care level also increases the efficiency of use of staff and other health resources. Lastly, it is more efficient and cost effective for service users, who thereby have lower transport and care costs through accessing adequate and generally more affordable care locally. Data in Nigeria indicate that there has been a shift in the delivery of certain services from the secondary to the primary level, which is viewed as a major efficiency gain.
70. **HRITF projects at the start had high operating costs, but these have declined over time.** They now amount to between 10% and 30% on average of the total costs according to the Bank's reports and other studies, as process efficiencies have been introduced. Implementation of RBF incurs high costs for project management, and for verification and health facility supervision. Project operating costs, according to the HRITF definition, includes verification (which can account for up to 20% of budgets), supervision and overhead costs, training, communication or other items. Transaction costs²⁶ for the government include a variety of costs, such as the creation of new national structures (for project management and verification), new administrative and legal requirements for contracting, and opening bank accounts for health facilities. The costs per capita tend to reduce with scale up, as shown by the Bank's studies on cost effectiveness in Zambia and Zimbabwe²⁷. In Zambia, it was found that the RBF comes with a set of procedures, roles and responsibilities which could crowd, or partly replace or duplicate, existing arrangements.
71. **A key piece of learning for efficient management is the importance of starting with low indicator tariffs.** This helps keep the overall cost low, so that the payments are marginal to overall resources. Low tariffs at the start also offer more manoeuvrability within available resources. Once tariffs or performance payments have been set, it is difficult to reduce them without causing negative reactions at facility level, although it has been done in at least one country (Zimbabwe) with no adverse effect.
72. **Evidence shows that RBF models have adapted to increase their efficiency.** In DRC, transferring the lead for implementation from a NGO to the Provincial Purchasing Agencies, which will have lower costs as well as building country ownership and capacity, is anticipated to reduce operating costs from 40% to 20%; a similar change was made in Cameroon. These changes also support greater sustainability and ownership and show the benefits of transferring from international to national agencies. Countries have used learning from monitoring data to revise tariffs to ensure they are more efficiently used, as well as effectively incentivising different indicators. Tariffs are paid from a relatively fixed budget, which has to be managed to optimise results for payments, and ensure the total budget is within agreed limits.
73. **Verification costs are being reduced by some countries using peer review and in others by taking a more risk-based approach.** Having a third-party organisation undertake counter verification (validation) is seen as key to assuring the independence and accuracy of

²⁶ Aid transaction costs might be defined as the costs necessary for an aid transaction to take place but which add nothing to the actual value of that transaction (Retrieved in the WEB: <https://www.oecd.org/dac/evaluation/dcdndep/44135805.pdf> OECD, Transaction costs in Aid, 2009).

²⁷ Cost-effectiveness analysis of results-based financing in Zambia: Results from a cluster randomized trial. Washington, Zeng W, Shepard DS, Nguyen HT, et al DC: World Bank, 2017.; interviews with country teams.

results and helps to build confidence in results even though it adds significantly to real and opportunity costs associated with RBF. The operation and staffing of verification processes is very costly. In the longer term it may be possible to reduce costs through using lighter touch methodologies. Zimbabwe is currently exploring risk-based approaches, and other countries may well follow suit, if there is sufficient confidence in the quality and transparency of reporting. Peer review is being developed in Cameroon for hospitals and inter-region verification.

In Zimbabwe, the RBF operating costs were reported as very high initially, as high as 50% of the total budget. According to the Bank and Cordaid (the Project Implementing Entity), these have declined over time and now amount to between 23% and 25% of the total cost. Cordaid has lightened the verification approach, with less frequent and less rigorous verifications, to reduce the costs.

74. **Accurate, validated reporting requires continuing support and attention.** RBF depends on accurate data on results to allocate tariff payments fairly, avoid waste and inappropriate incentives, which is why verification is so important. However, introduction of performance-based payments can be a considerable system and cultural change in countries with weak health systems. In Burundi, external validators found that there can be variance between reported and validated data as high as 45%²⁸. The Burundi report notes that over-reporting was also due to weak or misunderstood definitions of indicators, poor completion of reports, failure to include signatures and dates, so that data was rendered invalid. In Nigeria the variance between reported and validated data was initially high but has reduced over time. Weaknesses in applying sanctions can also be an explanatory factor of inaccurate reporting²⁹.
75. **Operating costs are not consistently defined or reported, which makes it difficult to compare project costs.** The wide range of activities covered by “operating costs” in the HRITF projects include many activities which might more usually be categorised as direct costs. For instance, verification is a direct cost of RBF and may well include other elements, necessary to RBF. Training and supervision are essential since coaching activities support effective implementation and reporting quality. Each HRITF project defines operating costs differently, making it difficult to compare and analyse use of funding. It will however be necessary to develop a clear analysis of the different operating and direct costs of RBF to inform future cost effectiveness studies, and to allow governments and other stakeholders to understand what expenditure is needed to introduce, scale up and sustain RBF.
76. **Analysis of operating costs was not possible due to insufficient data on expenditure at country project level.** For instance, reports provided to the evaluation team did not present the breakdown of the project costs e.g. operating costs, verification and supervision costs. The lack of data is consistent with a results-based programme which does not require detailed input data from countries. However, the lack of detailed expenditure data makes it difficult to understand where and on what money is spent, how expenditure has changed over time, and how efficiency could be improved. More analysis is required to provide information on what the start up and running costs are for RBF.

Cost effectiveness

²⁸ Rapport de contre verification des donnees quantitative and qualitative pour finance base sur la performance : 2nd semestre 2015, Government of Burundi, 2016

²⁹ Verification of results-based financing for health, Vergeer, P., et al, World Bank, 2016

77. **Evidence on cost effectiveness is not conclusive and further study is needed.** Three cost effectiveness studies in Argentina, Zimbabwe and Zambia have been carried out to date³⁰. The results of these studies show RBF programmes, although costly, to be cost-effective with a positive impact on quality and coverage of RMNCAH services. The Zambia cost effectiveness study which included a comparative input financing arm, showed that this achieved higher QALYs rates, although at high cost. The studies project the relative increase in cost effectiveness over time as the programmes mature, showing increasingly positive results as implementation costs reduce. However, this is based on assumptions that costs will reduce and that health outputs are maintained, both of which will need to be tested at a future date for accuracy. The systematic review also notes the lack of long term evidence of the cost effectiveness of interventions. There is scope to explore these findings in future work on cost effectiveness to identify the specific contribution of RBF compared to other interventions.
78. **Evidence from three impact evaluations suggests that that additional financing alone may provide similar levels of improvement as RBF.** The difficulty in isolating the impact of RBF from the impact of additional resources has been noted³¹. Three impact evaluations seek to identify the differences through use of comparison groups with additional financing only. In two completed impact evaluations, the evaluation design tested for the relative effect of different components of the RBF modality. A summary of findings is set out below; these indicate that while RBF can improve coverage and quality, additional financing alone can provide very similar rates of improvement. In Cameroon, there was a “clear effect of additional financing, irrespective of whether it was linked to incentives, in combination with reinforced supervision through performance-based financing”³². Qualitative evidence from Cameroon suggests a possible anticipation effect: facilities initially receiving additional financing were told that if they performed well, they could become PBF facilities and link pay to individual performance. In Nigeria, only interim findings were available as the impact evaluation was not complete, but these tend to be mixed. Given the higher level of inputs and costs, for RBF to show value for money, it will need to demonstrate evidence of other system impacts beyond coverage, utilisation and structural improvements.

Table 2: Summary findings for impact evaluations with an additional financing comparison group

Country	Impact evaluation design	Results
Cameroon	Four groups: 1) RBF treatment group; 2) The same level of financing as component 1, but not linked to performance, and with the same levels of supervision, monitoring, and autonomy as RBF; 3) No additional resources or autonomy, but the same levels of supervision and monitoring as RBF; 4) Pure comparison.	For groups 1 there were significant increases in coverage of the children’s vaccinations (including the polio 3 vaccine) and maternal immunization against tetanus as well as the coverage of modern methods of family planning, but no significant changes for timely ANC and in-facility deliveries; however, the difference in coverage for these indicators between group 1 and group 2 was not significant. Groups 1 and 2 both increased the average availability of necessary equipment, particularly materials for delivery and neonatal care.

³⁰. Cost-effectiveness analysis of results-based financing in Zambia: Results from a cluster randomized trial. Washington, Zeng W, Shepard DS, Nguyen HT, et al DC: World Bank, 2017; Cost-effectiveness of results-based financing in Zimbabwe: a controlled pre-post study. Washington, DC: World Bank, Shepard DS, Zeng W, Mutasa R, et al. 2017.

Rewarding provider performance to enable a healthy start to life: Evidence from Argentina’s Plan Nacer. Washington, DC: World Bank, Gertler P, Giovagnoli P, Martinez S. 2014

³¹ Effect on child and maternal health services of payment for performance to primary care providers, in Rwanda, Basinga et al 2011, Lancet

³² Evidence from an Impact Evaluation in the Health Sector in Cameroon, Policy research Working Paper 8162, Damien de Walque Paul Jacob Robyn Hamadou Saidou Gaston Sorgho Maria Steenland World Bank 2017

Zambia ³³	Three groups: 1) RBF treatment group; 2) Additional finance only; 3) Pure comparison.	Institutional deliveries and skilled birth attendance increased substantially in group 1 relative to group 3 but increased by even more in the group 2 relative to group 3. Staff motivation was higher in group 1 on reported feeling adequately remunerated for activities, but there were no other significant differences apart from than slightly higher levels of wellbeing compared to group 3. Groups 1 and 2 showed similar improvements for nine indicators directly targeted by the RBF programme through the incentive structure.
Nigeria ³⁴ (interim findings, IE not complete)	Three groups: 1) RBF treatment group 2) Additional financing group (but with supervision) 3) Pure comparison group	Interim findings show that relative performance between groups 1 and 2 seems to be a function of the level of labour intensiveness of the service. Group 1 does better than Group 2 in institutional delivery, worse in child immunisations, and the same for improving facility quality. In all of those cases, Group 1 did better than Group 3.

79. A World Bank systematic review of cost effectiveness of health systems interventions to strengthen RMNCAH notes the constraints to comparability³⁵. The impact evaluations of RBF programmes generally demonstrate a positive impact of financial incentives on quality and coverage of RMNCAH services, such as prenatal care, institutional deliveries, and postnatal care. The review found that other interventions had a lower relative cost-effectiveness ratio than the RBF programmes. However, these were all smaller scale interventions, and the review proposes that they would have higher cost effectiveness ratios if at larger scale as in the RBF cases. Most of the studies available have compared interventions such as RBF to the status quo, not to other system interventions.
80. A different systematic review³⁶ notes that several challenges to assessing the cost effectiveness of RBF. RBF is a complex intervention that targets multiple services making it difficult to evaluate the impact of RBF on health. Complex modelling is required because diverse people and many conditions are affected. It is difficult to obtain good quality cost data in LMICs because the information is not easily accessible. Lastly, international partners occasionally resist sharing their costs.

Trust Fund level

81. **Management of the Trust Fund benefits from using the existing structures and processes of the World Bank which increases the efficiency of management.** The oversight of the HRITF programme is under the responsibility of the World Bank Health Nutrition and Population Global Practice (HNP GP) and the day-to-day management under the responsibility of the HRITF Secretariat (until 2016), now the GFF Secretariat (from 2016), which operates under the Bank's management, policies and procedures. The HRITF supported activities have been mainstreamed into the regular health work of World Bank country offices. Task Team Leaders from HNP GP lead on HRITF projects at country level and are responsible for the appropriate management of the project with the country teams.
82. The HRITF works with the Bank's structures, management rules and regulations, and uses robust financial controlling mechanisms both internally and in contractual relationships with partners.

³³ Friedman, J et al, Impact Evaluation of Zambia's Results Based Financing Pilot Project, World Bank (2014?)

³⁴ NHFS-NSHIP Comparison, World Bank 2017, internal presentation

³⁵ Wu Zeng, Haksoon Ahn, Ha Thi Hong Nguyen, Donald S. Shepard, Dinesh Nair, RBF Health, Cost-Effectiveness of Health System Interventions in Improving Maternal and Child Health in Low- and Mid-Income Countries: A Systematic Review, 2017 Unpublished, internal communication

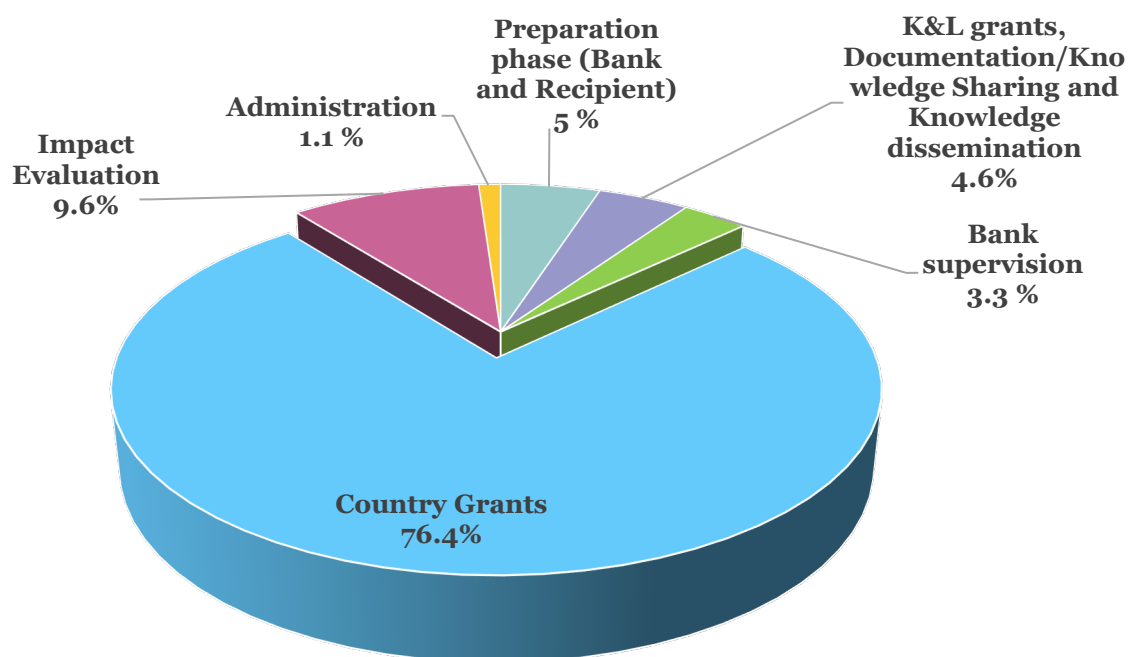
³⁶ Turcotte-Tremblay AM, Spagnolo J, De Allegri M, Ridde V. Does performance-based financing increase value for money in low- and middle-income countries? A systematic review. *Health Econ Rev* 2016; 6(1): 30

83. **Reporting of the Trust Fund to donors has improved over time.** In response to recommendations from the 2012 HRITF Evaluation, the Results Framework was developed in 2013, and standardised annual reports to donor consultation meetings were introduced. Communication of information has improved. Donors now have access to the World Bank's Donor Portal which provides information on project disbursement. Reporting to donors could be improved through more frequent information updates, greater transparency on progress and funding at country level, and inclusion of information on delays to disbursements.
84. **The HRITF is unusual as a Trust Fund in linking IDA to the HRITF grants to optimise value.** The availability of HRITF grants acts as an incentive to country teams and governments to increase IDA lending for RMNCAH. The availability of HRITF grants for RBF makes the IDA lending in health, a more attractive proposition to governments. IDA and Trust Fund support can play complementary roles, with the Trust Fund introducing specific benefits, such as the support for knowledge and learning and capacity building, and IDA supporting a wider programme of health sector support. This linked approach allows the Trust Fund to provide a strategic and catalytic role in focusing IDA lending on RMNCAH, and optimises the effectiveness of both funds. The GFF has used learning from this and uses a model linked to IDA, derived from the HRITF experience.
85. **Use of the HRITF grants in conjunction with IDA has benefits in efficiencies since IDA and HRITF administration can be combined,** reducing Bank transactional costs in grant preparation, reporting and management. It also provides flexibility since the grant and IDA can be used to complement each other. This has allowed country teams to use these two sources as balancing funds, as in DRC where the IDA credit approval was delayed, or in Cameroon, where the HRITF disbursement was brought forward when IDA credit was delayed. The use of HRITF grant as a balancing resource contributes to fluctuations in CPG disbursements year on year
86. One risk of the linked funding approach is that a given country's IDA credits may be pulled to health sector lending when in fact a different sector may be more in need of funding. A full assessment of added value of the Trust Fund would need to consider the opportunity costs to the country of not investing IDA credits in another sector.
87. **The Bank has allocated the HRITF budget broadly as planned to achieve the four objectives of the programme**³⁷. The indicator targets in the HRITF Results Framework aim to allocate less than 1% on administration, global advocacy and reporting and at least 75% of total funding committed for recipient executed grants. Allocation has improved over the lifetime of the Trust Fund to 2017, and current allocations are close to the Results Framework target values (See Figure 12). The Bank reduced its administration costs over the years: from 2.3% in 2013, to 1.6% in 2014, to 1.4% in 2015 and 1.2 % in 2016 and 2017. The total funding committed to government counterparts increased from 60% in 2013, to 66% in 2014, 67% in 2015 and 72% in 2016. (See Annex 6 which shows allocations to all activity categories 2008 -2017.)

Figure 12: HRITF Projections for Disbursements by Activity Category 2008 – 2020³⁸

³⁷ In the 2010 Arrangement between the Bank and DFID and in the HRITF results Framework

³⁸ Source: World Bank HRITF Financial report updated 2014 to 2017, Annex 5



88. Between 2008 and 2017, HRITF disbursed \$394.7 million which is 79% of the total commitments (\$498.6 million) and 82% of the total fund value (\$478.2 million), as reported in the HRITF August 2017 Financial Update. Assuming that HRITF will resolve the budget deficit, the undisbursed amount based on the last reported fund value is \$83.5 million.

89. Of the 15 country case study projects in this review, four disbursed their CPGs earlier than initially planned (Burundi, Cameroon, Burkina Faso, Zimbabwe), and eight experienced delays in disbursement because of implementation difficulties (Afghanistan, DRC, Ethiopia, Gambia, Haiti, Senegal, Tajikistan, Zambia - See Annex 5). From these eight delayed projects, three are currently identified by the Bank for possible part cancellation by the end disbursement date unless the project closing date is extended (Haiti, Senegal, and Zambia). All three are reported³⁹ to have improved disbursements in mid-2017.

90. Disbursements have been delayed due to a variety of factors, including delays in CPG implementation; changes in political leadership; and environmental catastrophic events such as hurricanes (Haiti). These delays were not unexpected given the focus of HRITF on countries with weak systems and fragile contexts. The Trust Fund mitigates delays and challenges through amending grant disbursement timing, and amending project objectives where appropriate, but indicate the need for continuing strong risk management and mitigation actions.

91. **The average cost of RBF preparation activities was below the HRITF indicative levels.** An indicative allocation of up to \$1.1 million was earmarked in 2010 for Bank teams or recipients for each RBF project proposal for the preparation and appraisal of an RBF project, including Knowledge and Learning grants⁴⁰. It included funds for the Bank and recipient to prepare the proposal, to commission studies, to assess the value and feasibility of RBF mechanisms, funds for the recipient to design and pre-pilot of RBF projects or project components, and funds for the Bank to support the appraisal.

92. **In practice, projects committed very different levels of funds to finance the preparation activities.** This range results from the HRITF providing RBF preparation funding

³⁹ Internal communication from the World Bank

⁴⁰ In the 2010 Arrangement between DFID and the Bank, the allocation levels were indicative, and were subject to change.

and pre-pilot funding in addition to Bank preparation funding—some used the full scope of this additional funding, others chose to use none of it. For instance, in Afghanistan, the project spent \$190,000, (17 % of the indicative level available), in Burkina Faso, \$230,000 (21%), and in Benin, \$470,000 (43%). Other projects spent more for these activities, as in Haiti or Liberia where the projects spent \$1.22 million and \$1.24 million respectively for preparation activities. In the 15 country case studies on average, \$570,000 was spent on preparation. This compares⁴¹ with an average of \$554,000 for preparation for Programme for Results (P4R) operations⁴² and \$548,000 for investment project finance (IPF), indicating that financial support to preparation was not much higher than these comparators.

93. **Bank supervision costs had a larger budget compared to other Bank instruments, illustrating the importance of supervision to the RBF project.** The Bank spent 4% of the HRITF on supervision costs, close to planned budgets. Bank supervision costs are primarily for provision of technical consultants and training to support projects and TTLs in country (i.e. not direct supervision to health facilities). The supervision costs amounted to \$322,000 per country project on average for the 15 case studies⁴³. This is more expensive than the costs for the following comparators: P4R average supervision costs are \$261,000 per country project (82 percent of HRITF costs) and the Bank-wide average for IPFs of about \$110,000 (34 percent of HRITF costs)⁴⁴. The higher levels reflect the need for more specialist assistance for RBF compared to other programmes and is a planned feature of the HRITF model.

⁴¹ Programme for Results, an early stage assessment of the process and effects of a new lending instrument, IEG, World Bank 2016
<https://ieg.worldbankgroup.org/evaluations/program-for-results>

⁴² For each PforR operation, the Bank carries out a process of identification, preparation/assessment, appraisal, and implementation support. The appraisal is informed by three assessments: a technical assessment, a fiduciary assessment, and an environmental and social systems assessment. These assessments identify measures to enhance performance, build capacity, and mitigate risks, which are reflected in an integrated risk assessment and in the resulting Programme Action Plan (PAP). Preparation also includes the identification of disbursement-linked indicators (DLIs), each with a verification protocol to ensure that a credible mechanism is in place to monitor and verify its achievement (World Bank, Two-Year Review, 201, p.ix),

⁴³ Calculated from the 15 evaluation case studies portfolio for which the Bank spent \$7.4 million to supervise the 23 CPGs, or \$322,000 at average.

⁴⁴ Programme for Results, Two-Year Review World Bank Operations Policy and Country Services, 2015

<http://documents.worldbank.org/curated/en/624411468140040506/Program-for-results-two-year-review>

Impact

Key Findings

Country level

- Impact evaluations suggest some improvements in utilisation, coverage and quality of care of RMNCAH, but these benefits are not consistent across all countries, services or facilities.
- RBF has made a major contribution to strengthening information systems, including the use of online portals for data collection and integration with DHIS 2.
- RBF pilots have contributed to improvements in financial management at facility level, sometimes supporting a transition to strategic purchasing.
- RBF improves accountability, especially to local communities. The effect of that accountability is limited where evidence is not acted on.
- Supply chains are addressed by RBF through improving the availability, quality, and management of relevant drugs in health facilities.
- RBF has proven a potentially effective approach for strengthening human resources in health facilities including a reduction in staff absenteeism, attraction of staff to rural areas, but impact evaluations show mixed effectiveness in improving staff motivation and productivity.
- Quality improvement of services is often reported by country stakeholders as one of the key positive impacts of the model. Evidence from the impact evaluations and country portals suggests while broadly positive, the impact is not consistent across all measures.
- RBF's inherent focus on results can lead to more effective spending.
- There are risks to financial systems when RBF payments substitute for base funding - repetition.
- There are risks to country management systems when RBF replaces, rather than develops, capacity.
- Risk to financial systems occurs when the RBF payments substitute for domestic base funding.

Trust Fund level

- Health system strengthening is seen widely by countries and global stakeholders as one of the main potential contributions of RBF, but data on impact on health systems is not routinely monitored.
- The World Bank has increased the level of support it gives to RBF and RMNCAH, additional to HRITF.
- The Trust Fund, through supporting RBF, has contributed to raising the profile of the World Bank in the global health agenda for RMNCAH and RBF in health.
- Learning from the HRITF has been used to inform the development of the GFF. Further learning on RBF, building on the HRITF evidence legacy, will continue to strengthen RBF-related activities within the GFF and with other donors.

Country level

94. **Impact evaluations suggest some improvements in utilisation, coverage and quality of care of RMNCAH, but these benefits are not consistent across all countries, services or facilities.** The Haut Katanga and Afghanistan impact evaluations, which assessed early projects with some acknowledged design weaknesses, also identified difficulties in programme design and implementation, which partly account for the nil or negative results. Findings for these impact evaluations point to the potential risk of weak programme design and relevance.

Table 3: Impact on utilisation and coverage – summary from impact evaluations

Country	Change in targeted indicators
Argentina 1	Beneficiaries had a 19% lower probability of low birth-weight compared to non-beneficiaries. Beneficiaries have a 74% lower chance of in-hospital neonatal mortality in larger facilities, approximately half of this reduction is due from fewer low birth weight babies and half from better postnatal care.
Argentina 2	Increase in number of antenatal visits; 24.7% increase in tetanus vaccination coverage.
Afghanistan 1	There were no significant changes in any of the targeted MCH indicators.
Cameroon	There was an increase in child immunisation and in maternal tetanus immunisation and improvements in coverage of family planning, but no increase for others, such as antenatal care visits and facility-based deliveries. The difference between the RBF and additional financing group were not significant.
DRC Haut Katanga	There was no measurable impact on increase in utilisation or coverage of assessed indicators compared to the comparison group.
Rwanda 1	A 23% increase in institutional deliveries and a 56% increase in preventive care for young children. No increase in women completing 4 PNC visits, or in full child immunisation.
Zambia 1	Institutional deliveries increased by 13% and skilled birth attendance increased by 10%; however, the enhanced financing arm (with no RBF) showed higher rates of increase for each at 17.5% and 14.2% respectively.
Zimbabwe 2016	There was a general increase in RBF and control facilities in health service utilisation. Key indicators such as skilled provider deliveries, institutional deliveries and deliveries by caesarean sections improved at a faster rate in RBF facilities.

95. **RBF has made a major contribution to strengthening information systems.** The requirement to record and report on activities has helped create stronger data sets for reproductive, maternal, and child health. This has been facilitated through the introduction of stronger paper based and digital systems for recording and reporting. There is self-reported and externally observed evidence that the centrality of quality data to RBF is transforming staff's understanding of the need for data, through fostering an environment in which recording and using data is accepted as a routine component of day-to-day work. Data collection and the accuracy and completeness of data recorded is improving.
96. Eleven HRITF supported countries now use portals to record and report data from RBF. In a number of countries, national Health Management Information System (HMIS) data is complemented by data produced by RBF-supported facilities. RBF datasets are now being integrated with the national HMIS and DHIS2 in Cameroon, Nigeria, and Haiti and other countries. While there are some interoperability issues outstanding, these are recognised, and steps are being taken to address them.
97. **RBF pilots have contributed to improvements in financial management at facility level.** Facility financial autonomy has been strengthened through the establishment of independent bank accounts and budgets. This has also strengthened managers' capacity for financial management and purchasing. Contracting processes provide the underpinnings for more strategic financial management of health facility expenditure processes for clear accountability for expenditure. Quality indicator data from available country results portals suggests that the quality of financial management is on the whole improving as the graphs below (with the exception of the borough medical centres in Cameroon) illustrate:

Examples of impact on information systems

In Afghanistan, the impact evaluation found that while there was no statistically significant variance between HMIS use in control and intervention facilities, qualitative data did indicate that routine verification had changed health workers' behaviours to be more attentive to documentation and reporting of patients.

In Zimbabwe, a process evaluation found that the RBF approach had fostered improved accuracy and timeliness of health providers reporting HMIS data. This was evidenced by declining trends in income loss by facilities due to data errors. The mid-term review of Zimbabwe's RBF pilot also found that HMIS data quality had improved.

Figure 13: Average quality of financial management scores, Nigeria

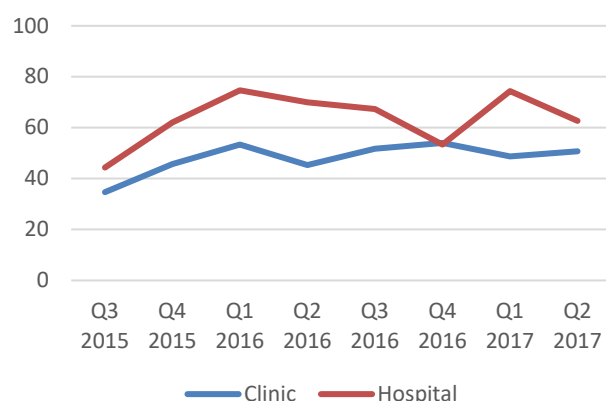


Figure 14: Average quality of financial management scores, Cameroon

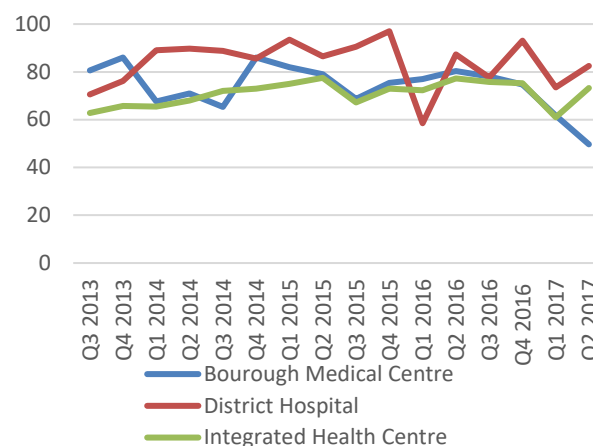
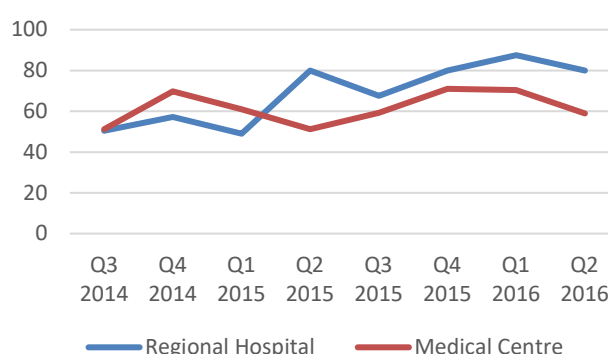


Figure 15: Average quality of financial management scores, Burkina Faso



98. **RBF can support the transition to strategic purchasing.** Effective use of RBF mechanisms requires a robust data base and a stronger HMIS, enabling more robust analysis of needs to inform priorities for purchasing plans, to monitor performance and adapt plans. RBF has also helped develop methods for costing and categorising services and activities to provide the building blocks for strategic purchasing. In Nigeria, the RBF mechanism has been designed to support and develop strategic purchasing. In Burkina Faso, following a change in government, the newly developing health policies refer to strategic purchasing rather than RBF as the base of health financing and management⁴⁵.
99. These are positive developments which point the way to wide integration of important elements of RBF in a whole system change, which goes beyond RMNCAH. Several countries (Armenia, Kenya, Kyrgyz Republic, and Tajikistan) are also using the RBF model to inform and structure social health insurance models.

⁴⁵ Interviews with key informants and country team, Burkina Faso

100. Accountability has improved with RBF.

It is noted as one of RBF's major achievements where RBF works well. The requirement for facility level business plans and regular reporting against these strengthens community governance and accountability. The impact evaluations for Afghanistan, Zimbabwe and Zambia found increased levels of community involvement in RBF facilities. In Zimbabwe, there was a positive relationship between the frequency of Health Centre Committee (HCC) meetings and their functionality, and health facility performance⁴⁶.

Health centre accountability to communities in Nigeria

Health Centre, Facility and Ward committees in Nigeria play a key role in reviewing and agreeing the facility business plans. This provides an opportunity to make sure that community needs are addressed, and to feedback community concerns on quality and quantity of care. These committees function successfully and are widely perceived as a key benefit. Committee members interviewed clearly had been actively involved, noting changes that they had made to facility business plans. Wider governance for health also appears to have improved, as planning has become more bottom-up, and issues encountered at the ward and local level can be addressed by steering committees at the district, provincial, and national levels.

101. Accountability, however, is only effective if acted upon.

Examples were given from case study interviews and reports in Haiti, Benin, Burundi, Tajikistan and Nigeria where underperformance and recommendations from verification agencies were not effectively followed up or sanctions not consistently enforced. Accountability must be upheld system wide and at all levels to be effective. There is a risk to accountability if it is held by the organisation rather than the individual. For example, in Nigeria where local government and state level payments are based on organisation wide performance, there is no individual accountability, allowing individuals to “coast”, weakening the link between action and reward.

102. Impact evaluations showed varied results for quality of care. Improvements in quality of care are often held to be one of the main benefits of RBF. Quality indicators include a range of quality aspects related to care, including availability, standard and cleanliness of premises and equipment, hygiene management, tracer drugs and medicines management, financial planning, supervision, as well as standards related to the treatment for e.g. antenatal care, maternity, family planning, and outpatient consultations. The impact on quality of care from the evaluations appears broadly positive, reflecting structural and process quality improvements introduced by RBF, but not for all measures. Quality of care often only improved for certain aspects of care, rather than across all incentivised indicators.

Table 4: Impact of RBF on quality

Country	Summary of findings
Argentina 1	Reduction in in-hospital neonatal mortality.
Afghanistan 1	The RBF health facilities had a statistically significant higher performance on engagement of community in decision-making, staff receiving training, equipment functionality, health facility management functionality, pharmaceuticals and vaccines availability; more time was spent with clients.
Cameroon	A significant impact on the availability of essential inputs and equipment, qualified health workers, and increased satisfaction among patients and providers.
DRC Haut Katanga	No impact on patients' perceived quality of care. Reduced levels of equipment and supplies in the treatment facilities.
Rwanda 1 (demand side)	Increased quality of prenatal care.

⁴⁶ The World Bank (2015) *Process Monitoring and Evaluation II of Zimbabwe's RBF Project*

Rwanda 2 (supply side)	No significant impact on outcome indicators (no significant differences in the rate of women who report timely ANC and PNC or skilled-attended in-facility delivery).
Zambia 1	There was minimal change in individual measures of structural quality across the three groups ⁴⁷ . However, the aggregate index for structural quality showed more gains in the RBF group as compared to the pure control group. Aggregate quality measures of delivery rooms were significantly higher in RBF facilities as compared to both control groups. Process measures for quality of ANC and child care showed better results for RBF facilities, compared to both control groups. There were also higher levels of patient satisfaction in some dimensions of ANC and child care in RBF facilities, compared to the two control groups.
Zimbabwe	Mixed results for quality indicators; no significant increase in quality of equipment and supplies; no increase relative to control in client satisfaction.

103. **Quality improvement of services is often reported by country stakeholders as one of the key positive impacts of the model.** The improved quality of care is reported by local communities. However, increased quality of care is not consistently evident from country portal data on quality scores. Indicators vary between countries to reflect local context. From the data for Nigeria, there has been a general increase of the total quality score between 2015 and 2017. However, there is considerable variation and some fluctuation in quality scores in the three pilot states and also at health facility level, as well as between different indicators⁴⁸. In Cameroon, there appears to have been an overall reduction in quality scores between 2013 and 2017 at national level⁴⁹. This may be the effect of periodic reviews of quality checklists, which raise standards, so that they are harder to achieve, although this would need to be investigated further.
104. In Nigeria, the British Medical Journal Quality Pack has been piloted in 22 health facilities and quality improvement and plans for scale up are being developed to build a data driven culture of quality improvement. The extent to which quality is improved is an area for future research and evaluation, which could be linked to other research on impact on health systems.
105. **From country visits and reports, there appears to be positive spill over effect of quality improvement from RMNCAH to non RMNCAH services within facilities.** Increased supervision requirements have increased the quality of supervision for non-RBF facilities as well as RBF facilities. The availability of equipment and facility infrastructure improves quality for services other than RMNCAH. However, increases in equipment need to be placed in context. In Zimbabwe, there was an intersection with a multi-donor Health Transition Fund programme which also provided supply side support for equipment and supplies so that there was a general improvement in supply chains across all health facilities.
106. **RBF has proven a potentially effective approach for strengthening and streamlining human resources.** RBF has helped to establish norms that can contribute to the development of a human resources for health architecture, including job descriptions, productivity standards, training and supervision, and performance-related pay. Staff absenteeism is improved by RBF payments, which incentivise punctuality and presence. Reported changes in staff behaviour from facility managers in Cameroon and Nigeria, included reduced absenteeism, improved interaction with patients, improved quality of care, increased productivity, and improved activity reporting. In Cameroon, the evaluation found that RBF had increased opportunities for staff to use their skills “on the job”.
107. RBF can contribute to strengthening the recruitment and retention of qualified health workers through making work and pay conditions more attractive in supported facilities. There has been

⁴⁷ The three groups are: (1) Facilities where RBF was being implemented; (2) Facilities that received only additional funding, which was not linked to results and (3) Facilities that received no RBF or additional funding. The latter two are referred to as the control groups.

⁴⁸ <http://pbf-nigeria.org/data.html> shows quality scores for Nigeria

⁴⁹ <http://www.fbrcameroon.org/data.html> shows quality scores for Cameroon

some success in attracting workers to remote and poor areas, where there have been shortages of health workers, for instance in Cameroon and Nigeria. More time is needed to assess how long workers will stay and help address the imbalance in workforce distribution.

108. **However, quantitative analysis from studies on health worker motivation in Benin, Zambia and Zimbabwe in 2015^{50, 51, 52} found relatively little impact of RBF on productivity and quality of care.** In Zimbabwe, a process evaluation found that there can be negative impacts: the perceived inadequacy in the number of staff presented a serious risk to the effectiveness of RBF, and it was noted that RBF was perceived to have increased health-worker workload due to emphasis on better record keeping, financial, and administrative duties. The same is reported from the Gambia. The evidence from impact evaluations on health worker satisfaction and motivation is mixed and shows little evidence of improved motivation. In Cameroon, the impact evaluation found no evidence that RBF had positively impacted on health worker wellbeing as defined by the WHO, and that conversely, RBF had a small, but negative impact on reported opportunities to upgrade skills through training. In Zimbabwe, the additional workload led to worker burnout. There were also experiences of demotivation when supervision was rushed, irregular and overly focused on check lists⁵³.
109. **Supply chains are addressed by RBF through improving the availability, quality, and management of relevant drugs in health facilities.** Many HRITF supported RBF models include quality indicators, which assess the availability within the facility of standard medications and the quality of medicine management. In countries where supply chains are weak, or drugs very expensive, RBF can be used in conjunction with regulatory interventions, to help increase the availability of medication. For instance, in Nigeria, the development of the Drug Revolving Fund (DRF), aligned to the Nigerian States Health Investment Project (NSHIP- the RBF programme), has helped to ensure a stronger, cheaper and higher quality supply of medication. RBF facilities can access this and are now reported to no longer have stock outs. RBF usually includes indicators to incentivise minimum standards for medicine management and the availability of tracer drugs, which leads to an improvement at facility level. Evidence from quality indicators from the results portals, indicates improvement for drugs management, as the Figures 16 – 18 below illustrate. Exceptions are in Burkina Faso, where scores have declined, as well as the borough health centres in Cameroon.

Figure 16: Average essential drugs management quality scores, Nigeria

Figure 17: Average essential drugs management quality scores, Cameroon

⁵⁰ Results based financing impact on human resources for health, Benin. Lagarde et al, 2015

⁵¹ Results based financing impact on human resources for health in Zambia, Shen et al, 2015

⁵² Results based financing impact on human resources for health in Zimbabwe, Nguyen et al, 2015

⁵³ Rewarding Provider performance to improve quality and coverage of maternal and child health outcomes. RBF pilot report, Zimbabwe, World Bank, 2016

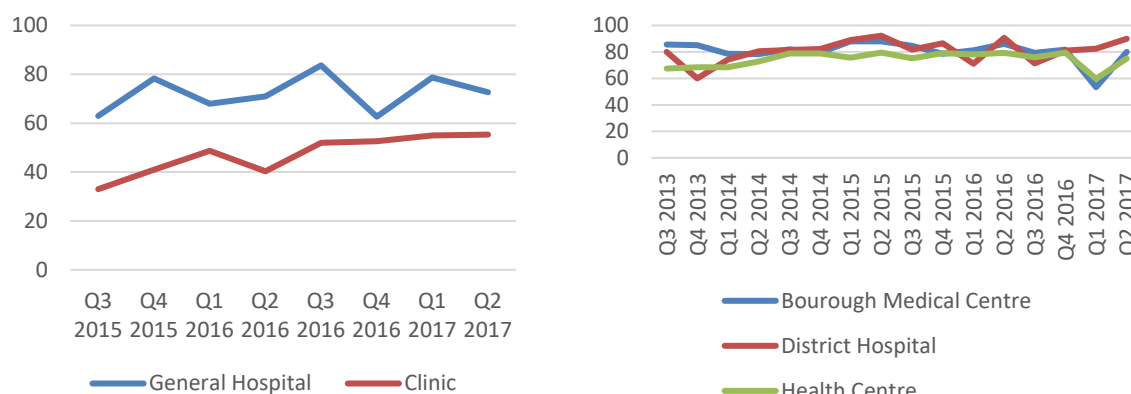
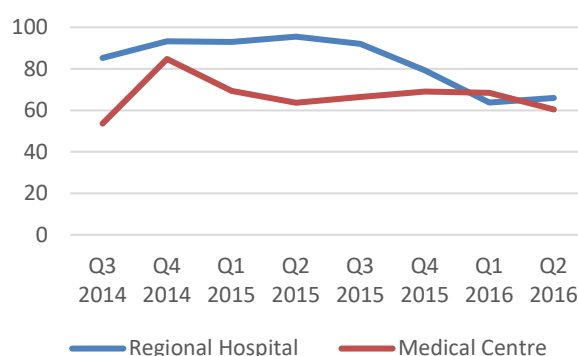


Figure 18: Average management of medicine and equipment scores, Burkina Faso



110. Evidence from completed impact evaluations on equipment availability is generally positive. In Afghanistan, for example there were statistically significant improvements for equipment functionality and health facility management⁵⁴. In Cameroon there was a significant improvement in terms of the availability of inputs and equipment, although this was due to the effect of additional financing, irrespective of whether it was linked to incentives. In Zambia, it was found that 53% of RBF funds received by facilities were spent on the purchase of medical and non-medical goods and services⁵⁵; however, some of the medical equipment purchased initially was not always suitable, e.g. autoclaves were too big, high on energy consumption and required distilled water which is not freely available and of low quality. In Zimbabwe, the impact evaluation found that some clinics had improved their diagnosis of non-incentivised conditions because RBF funds had allowed them to purchase equipment, including diabetes testing machines, sphygmomanometers, weighing scales, and height measuring machines⁵⁶.

Unintended impacts

111. RBF's inherent focus on results can lead to more efficient spending. In Zambia, district offices in the control districts (which received additional funding and equipment, but not linked to

⁵⁴ An Impact Evaluation of the Results-based Financing Intervention in Afghanistan, Royal Tropical Institute 2015

⁵⁵ Evidence from an Impact Evaluation in the Health Sector in Cameroon, De Walque, D. et al, World Bank 2017

⁵⁶ Rewarding Provider Performance to improve Child and maternal health outcomes in Zimbabwe, World Bank, 2016

results) used comparatively larger proportions of their funding for activities and inputs that are not directly linked (or only tenuously linked) to improved health outcomes, e.g. mass campaigns, transport costs. In RBF districts, expenditure on these items was comparatively low, with the bulk of funding going towards activities and inputs that could improve the achievement of results.

112. Risk to financial systems occurs when the RBF payments substitute for base funding, so there is no incentive to strengthen domestic systems. Examples include:

- Zambia and Zimbabwe, where the RBF funds ended up playing a substitutional role instead of being additional to domestic funding⁵⁷. The core funding for facilities became RBF funding, leading to a risk of dependence on the RBF payments.
- Nigeria, where the lack of public funding for primary health facilities and staff meant that RBF funding was often the main source of funding available. In one clinic, the RBF funding was ten times greater than the payment from government and constituted 87% of the quarterly budget reviewed.

113. RBF payments to targeted facilities can confer disadvantages on non-RBF facilities, which often experience a reduction in service users and fees. Financial substitution also weakens the overall financial sustainability of RBF.

114. RBF can be disruptive to local systems and markets. The RBF approach has in some cases been disruptive to local systems, markets and communities. For example:

- Where facilities with RBF improve in quality, people use them in preference to non-RBF supported facilities, which may then become financially non-viable due to lower use and user fees. In Nigeria, facilities in some areas closed down as a result of increased competition brought in by RBF support. This is not necessarily negative – in Nigeria there was an identified need to reduce the oversupply of poorer quality health facilities.
- While motivating staff in treatment (RBF) facilities, it can be demotivating to staff in control facilities.

Trust Fund level

115. The World Bank has committed to RBF as a model and has increased the level of support it gives to RBF and RMNCAH. Between 2008 and 2014, the Bank increased the share of lending for RBF financing to 65% of the Health, Nutrition and Population (HNP) portfolio (including some non-HRITF projects)⁵⁸. IDA lending for health and social services across all IDA eligible countries increased between 2012 and 2016, both in relative and absolute terms. This may also be due to the availability of HRITF funding in 28 IDA eligible countries, which has influenced IDA to be spent on RMNCAH and results-based projects. In 2016, 22% of all HNP country projects had HRITF financing for RBF (26 out of 104 projects)⁵⁹. Internal analysis by the Bank shows the proportion of HNP commitments related to maternal, child health, reproductive health and nutrition, net of HRITF funding, has increased from 10% in 2007 to 20% in 2015⁶⁰.

116. The Trust Fund, through supporting RBF, has contributed to raising the profile of the World Bank in the global health agenda for RMNCAH and results-based financing in health. This includes participation in international, regional and country conferences and workshops and increased visibility through publications and the RBF website. The Bank has become a more visible actor at country level in health developments and RMNCAH

⁵⁷ Impact evaluation of Zambia performance-based financing pilot project, World Bank 2014 (?)

⁵⁸ RBF scale up business plan, draft for consultation, 2014, internal communication from the World Bank

⁵⁹ Data provided by the World Bank

⁶⁰ Data provided by the World Bank

where HRITF grants and associated support have been provided. The scale of the HRITF and the evidence generated by it contributes to raising the profile of RBF globally. The Trust Fund is also reported by Bank staff to have helped develop an approach for the HNP GP based on a portfolio rather than on programmes which potentially allows a more systematic approach to generating evidence and learning to improve effectiveness and impact for health programmes.

117. The HRITF has been part of a wider shift in HNP GP focus of attention from inputs to results and has produced a wide body of evidence on RBF that is useful to the Bank's health sector work. There are examples of specific learning such as on verification processes and arrangements and formulation of Disbursement Linked Indicators (DLI), which have been used for Programme for Results (P4R) programmes in health as in Ethiopia.

118. **Health system strengthening is seen widely by countries and global stakeholders, as one of the main potential contributions of RBF, but data on impact on health systems is not routinely monitored.** At the start of the HRITF, the focus was on health outcomes rather than health systems. As a result, the impact evaluations and Results Framework were not designed to capture information on systems. Data was collected on coverage, usage and service quality, commodities and medicines, health workers' motivation and productivity. Wider systems issues such as supply chain and information, and the relationship between RBF and system-wide health worker supply were not addressed. As noted elsewhere in this report, however, the emphasis on the systems-strengthening aspect of RBF has increased in recent years. Findings below come from later impact evaluations, country interviews and observations.

119. **Learning from the experience of HRITF has been used to inform the development of the GFF.** The GFF has drawn learning from the experience of HRITF and develops the objectives of HRITF to a strategic level. The GFF objectives are to build health finance strategies to ensure sustainability and health system reforms, for country ownership, to focus on health system strengthening, and to create a coordinated platform for different stakeholders and donors. These objectives are critical to ensuring relevance, sustainability and impact. These objectives emerge from the experience of HRITF as the strategic and operational management areas which require increased attention to ensure sustainable success. The limitation of HRITF as a mechanism focusing on the piloting of RBF is that it focuses very closely on the RBF mechanism and has not always sufficiently addressed the wider system reforms. The GFF offers an opportunity to use and continue the learning, building on the HRITF evidence legacy, and apply it in relation to RBF and other health system improvement investments.

Equity

Key Findings

Country level

- The HRITF has mitigated the risk of incentives resulting in developing strengths in some areas at the expense of others.
- Most RBF projects at country level address equity in their design. Equity dimensions include gender, geographical remoteness, equity of provision and access, and poverty.
- In some countries, the supported mechanisms are deliberately piloted in rural, and hard to reach areas experiencing low levels of quality, coverage, high poverty rates and poor health outcomes.
- There is use of equity weighting or bonuses to compensate for the added difficulties and cost of working in remote and poor areas.
- The HRITF has increased use of demand-side RBF as a strategy for extending coverage, which often includes measures to address equity of access and use.
- Equity is not routinely monitored or reported at country level.

Trust Fund level

- The HRITF portfolio composition has targeted lower and middle-income countries with weaker RMNCAH indicator results to address equity through programme design.
- The HRITF's promotion of flexible design has enabled an equitable focus of effort.
- Equity is not consistently addressed in completed impact evaluations but greater focus on equity is planned in forthcoming evaluations. There is limited data on RBF's impact on equity.

Country level

120. **An equity risk often faced by interventions in the health sector involves the development of strength in certain areas at the expense of others, through task and resource shifting to incentivised areas, but this has not happened with HRITF projects.** Evidence gathered at the country level suggests that on the whole, the Bank has been successful in evading this risk. In countries like Zambia, the design of RBF pilots includes measures to prevent this (performance incentives would not be paid if non-incentivised service delivery falls below an agreed level). Completed impact evaluations have not found evidence of a decline in the provision of non-incentivised services. Stakeholders emphasised during interviews that improvements in clinical and infrastructural quality, through the provision of RBF, have had a positive impact that goes beyond the incentivised services.
121. **All RBF projects supported by the HRITF focus on maternal and child health and therefore necessarily concentrate on meeting the health needs of women and girls.** Different projects variously address the dimensions of poverty, dimensions of ethnicity/exclusion (indigenous groups), dimensions of health facility resources and quality. Dimensions of location are also addressed, such as areas which are more remote, areas with poorer socio-economic indicators, and areas with low access to services and poorer health outcomes. Remote areas are often less well served and have poorer health and socio-economic indicators and therefore targeting these is intended to improve access and outcomes more equitably.

122. The RBF mechanisms supported by the HRITF incorporate an equity focus using several methods, set out below:

- In several countries, including Zimbabwe, Cameroon, Haiti, and Nigeria, facilities receive remoteness or hardship weighting based on their remoteness from government centres to compensate for the difficulties presented by distance, recruitment and retention of staff, and more dilapidated infrastructure. The size of the health area and low population densities that create viability issues (high running costs) are also considered an equity issue in some countries and compensated by bonuses. In Zimbabwe and Senegal, however, remoteness bonuses have not been sufficient to compensate for the naturally low volume of patients that remote clinics receive owing to sparsely populated catchment areas.
 - In some countries such as Zambia, the supported mechanisms are deliberately piloted in rural, and hard to reach areas experiencing low levels of quality, coverage, high poverty rates and poor health outcomes. In others, as in Nigeria and Cameroon, the pilots have been in less remote areas, and the scale up is now addressing the more remote, poor areas, some of which also have insurgency issues. An example from Nigeria showed that RBF can work well even in these more challenging settings and can be used to ensure that there is access for displaced populations through incentivising providers to work differently e.g. in mobile clinics and aligning development partner resources. Data is not yet available to show effectiveness in terms of utilisation or coverage.
 - In DRC, some of the RBF pilots are targeted to poorer and remote areas, a proportion of which also include indigenous people. These pilots provide free health care to indigenous people to improve their health outcomes, which are worse relative to other groups in DRC.
 - In several countries with user fees, there is a fund to pay for the care of the poorest people to ensure that they can access health care. Typically, this is targeted to the poorest 10%. In Burkina Faso, there has been a more proactive approach to enroll the poorest 10% in facilities who are now accessing care.
123. Facility level data reviewed from a selection of facilities in both Nigeria and Cameroon indicated that the use of free care is below the target percentage for free care, and this was supported by interviews with staff. This suggests that either free care is not routinely offered, or that there are supply or demand side barriers to taking it up. There is a lack of higher level reporting in both countries on access by poorer groups to substantiate these findings across a larger data set.
- 124. The HRITF has increased use of demand-side RBF as a strategy for extending coverage, which often includes measures to address equity of access and use.** Some more recent HRITF supported RBF pilots are explicitly built on demand-side strategies, as in the Gambia; others have introduced demand-side pilots as the need for them has become clear, as in Nigeria, Cameroon, and Senegal. A small, qualitative study of barriers to utilisation in Nigeria found that costs of care, transport to facilities and cultural attitudes were main barriers⁶¹. Demand-side pilots include vouchers, conditional cash transfers, community engagement, social health insurance, social mobilization, behaviour change, and engagement of traditional healers. At present, there is limited evidence on the effectiveness of demand-side RBF generated by HRITF supported projects, since the demand side projects have been developed recently.
125. There is evidence that RBF health facilities and their workers have taken ad hoc independent action to develop local demand-side initiatives to improve access for more remote or poorer people. In both Zambia and Cameroon incentives were offered to hard-to-

⁶¹ See <https://www.rbfhealth.org/resource/if-you-build-it-they-will-come-lessons-barriers-service-use-pbf-facilities-nigeria> 2015

reach groups, including offering a delivery set (e.g. blanket, baby clothes, diaper, etc.). In Cameroon, health facilities were also using part of the performance payments to pay for transport for poorer women to access health facilities and, where needed, hospitals for deliveries. Consistent evidence on the impact of these different country interventions on take up was not available.

126. **Equity is not routinely monitored or reported at country level.** When the HRITF was established, there was not a strong focus on equity within project monitoring, although in practice most projects do address it. As part of future RBF country project developments there is a need to ensure that dimensions of equity (access, utilisation) are monitored in relation to specified groups such as women, girls, poorer people, and indigenous groups.

Trust fund level

127. **The HRITF portfolio composition has deliberately targeted lower and middle-income countries with weaker RMNCAH indicator results.** This builds an element of equity into the programme design.
128. **The HRITF's promotion of flexible design has enabled an equitable focus of effort.** Revisions to the project design are made to the incentive prices paid to facilities/supervisory bodies to encourage an even distribution of focus across all incentivised services and to discourage them from focusing excessively on “low lying fruit” – i.e. services that are relatively easy to deliver and which attract a sizeable incentive payment.
129. **The extent to which the completed impact evaluations have addressed equity varies.** The Zimbabwe impact evaluation found that there were accelerated gains or greater positive effects for the less educated groups and for the poor. The Cameroon impact evaluation considers the impact of the RBF on reductions in user fees, but does not have a specific focus on equity. There is a stated intent in the 2017 HRITF Learning Strategy to address utilisation and equity in the impact evaluation portfolio. Several planned future evaluations include questions on aspects of equity, illustrated in Table 5 below.

Table 5: Questions relevant to equity in forthcoming impact evaluations

Country	Questions relevant to equity
Benin	Measuring the impact of RBF on health outcomes and equity.
Burkina Faso	Does RBF improve financial access to and utilisation of quality health services for vulnerable populations without systematic targeting of the poor? Does RBF improve financial access to and utilisation of quality health services for vulnerable populations through systematic targeting of the poor for improved health service coverage among vulnerable populations?
Central African Republic	What is the effect of the RBF programme on access and utilisation of MCH services across different socio-economic groups?
Republic of Congo	Does the combination of RBF and pro-poor targeting mechanisms improve financial access to and utilisation of quality health services for vulnerable populations more than RBF alone?

Sustainability

Key findings

Country level

- Political ownership by governments is essential to scale up, but strong ownership is not consistent across all HRITF country grant supported countries.
- Developing models where the incentives account for a relatively small proportion of health budgets assists sustainability.
- Lack of continued funding is a major risk to sustaining RBF post HRITF country grants.
- Linking RBF to other financial reforms such as health insurance provides an opportunity to sustain the benefits of RBF and integrate it in country health systems.
- For some countries, the step to sustainability is still distant since there remain significant system weaknesses and capacity gaps. These are constraints to sustained implementation of RBF without continued technical support.
- Scale up is taking place, but not always with a clear, resourced plan.

Trust Fund Level

- Arrangements for individual countries' transition away from HRITF are not clear.
- There is a need for technical assistance to sustain RBF pilots until the end of grants and to support transition.
- The planned impact evaluations will be completed, however, it will also be important to maintain the evidence legacy of the HRITF.
- Maintaining focus on the HRITF during transition to GFF will be important to ensure transparency and accountability.

Country level

130. **Political ownership by governments is essential to scale up, but strong ownership is not consistent across all HRITF supported countries.** There is evidence of countries with strong ownership of RBF, such as Cameroon, Zimbabwe, and Burkina Faso, where RBF has or will be scaled up nationally. In these and other committed countries, RBF is more likely to be sustained in the longer term if other conditions of sustainability are met. However, in other countries, there is a lack of government ownership and institutionalisation of RBF, which weakens the possibility of sustainability. In some countries there will be valid decisions made not to scale up the HRITF pilots, where RBF is not an appropriate solution.
131. **Developing models where the incentives account for a relatively small proportion of health budgets assists sustainability.** In countries such as Cameroon, where RBF is a relatively small proportion (though highly effective and valued) of facility health budgets, the sustainability issue is likely to be less challenging than in other countries such as Nigeria, where there has been significant financial substitution. In Haiti, sustainability has been addressed to some extent using cost control measures to ensure that the costs of RBF are not high, enabling future Bank funding, and potentially future domestic funding. Where RBF provides a high proportion of facilities' staff and running costs sustainability is harder to achieve.
132. **Linking RBF to other financial reforms such as health insurance provides an opportunity to sustain the benefits of RBF and integrate it in country health systems.** Most countries implementing RBF projects are also undertaking significant health financing reforms to accelerate universal health coverage, by developing social health insurance, and, in some cases, developing their strategic purchasing capacity. There is an opportunity for RBF principles and methodologies to be built into country health financing reforms. In Burkina Faso, this potential is already being addressed through current financial reforms, which take a wider strategic approach to reforms including RBF. **Geographic scale up is a key indicator of sustainability, for successful pilots, and requires clear plans.** Scale up to different regions/states is now taking place in countries with more mature RBF pilots, such as Cameroon and Nigeria, but sometimes without the opportunity to integrate the learning from pilots, or to develop strategies and capacity to sustain it. The plans for scale up do not consistently appear to have detailed arrangements for roll out with resource requirements for scale up. There are also countries for which scale up is not appropriate.

Examples of ownership shortcomings

In Benin, following initial support, changes in government led to limited ownership and leadership for RBF; no national implementation entity was developed.

In Nigeria, there is strong ownership at state level for RBF, but this is less evident at federal government level.

In Cameroon, there was similarly weaker ownership and leadership at Government level than subnational.

Challenges in scale up

In Cameroon, the government has committed to scaling up RBF to the whole country by 2020; this seems potentially achievable, since almost half the country is already covered. However, the two last regions to be included are two regions which are particularly challenging due to remoteness and insurgency, as well as poverty and poor resources. There are also challenges in assembling resources sufficiently quickly to meet the timetable, and a concern that very little extra staff or expenses costs have been allocated to support the work from an implementation unit which is already under resourced.

In Zimbabwe, scale up occurred before the final release of impact evaluation results. In Nigeria, scale up has also taken place prior to the completion of the impact evaluation.

In Zambia, concern has been raised about MoH's rapid scale-up of RBF, without ensuring that the necessary implementation capacity at provincial and district levels is in place.

133. **Lack of continued funding is a major risk to sustaining RBF post HRITF pilots.** A criterion for HRITF eligibility is a positive track record in the management of external funds to support health systems strengthening. The HRITF 2017 Results Framework reports that 15 countries anticipate some additional donor funding by 2018. The extent to which additional external funding for RBF is adequate, and the period it will cover is not stated. Thirteen out of 28 HRITF countries will receive GFF support for RBF: DRC, Cameroon, Ethiopia, Nigeria, Tanzania, Kenya, Sierra Leone, and Senegal. Some countries now have phase 2 HRITF and IDA funding, and some countries expect to continue receiving IDA for RBF after the end of HRITF funding, but these funding sources are not anticipated beyond 2020 at present.
134. Longer term sustainability will rely on an increased contribution from domestic funding. Some governments are already committing to contributing to funding RBF, but at low levels, and from relatively small health budgets. Fourteen HRITF supported countries anticipate contributing to RBF from their domestic budgets⁶². In the longer term, increased government commitment will be the most effective way of ensuring sustainability and to demonstrate full country ownership of RBF.
135. There is an opportunity for RBF models to adapt and develop beyond their current “pure” RBF focus, to a clearer orientation to health systems strengthening within the context of financial reforms to help ensure sustainability. A key area to address in future assistance is technical assistance to governments to develop models for integrating the funding for RBF within the domestic budget.
136. **For some countries, the step to RBF sustainability is still distant since there remain significant system weaknesses and capacity gaps. These are constraints to sustained implementation of RBF without continued technical support.** For instance, there are continuing weaknesses in information systems, which are not yet integrated with HMIS or are not yet fully reliable. Verification processes are not yet robust in all countries, and will need continued support to embed and evolve. Country leads at different levels will need continued capacity building for the skills to analyse, plan and monitor plans and budgets. There are shortages of qualified health workers or of health workers willing to relocate to remote areas, though RBF may help in this regard by providing higher incentives to those working in remote areas. Without these basic systems building blocks in place, it will be difficult to institutionalise RBF and develop a strategic approach to health purchasing.

Trust Fund level

137. **Arrangements for individual countries’ transition away from HRITF are not clear.** There is no HRITF documentation of the longer-term status of each country’s plans for scale up and sustainability. There is an urgent need for the HRITF to consider transition plans for all current CPGs and to develop options for the longer term in discussion with national governments. As the Trust Fund moves into its final phase, the Results Framework will need to develop indicators for transition for the country projects.
138. **There is a need for technical assistance to sustain RBF pilots until the end of grants and to support transition** including on monitoring and evaluation, alignment with HMIS systems, improving the efficiency of payment systems, strengthening financial systems and reforms, and enabling integration with country institutions.
139. **Approaches to ensuring supporting transition are not a part of the HRITF model but are now becoming relevant to address.** The HRITF model focused on generating evidence to inform decisions on whether to scale up but had given less attention to how to support transition. However, it is now a more relevant question, especially as several countries are scaling

⁶² HRITF Framework indicator, FY 2017, report to donors, World Bank

up to regional and national level. A draft proposal to obtain funding for scaling up was developed in 2014 by the HRITF Secretariat, but was not progressed by the Trust Fund. The proposal included increasing IDA allocations, gaining increased partner commitment, and gaining private sector support as well as assumptions that an aggressive approach to scale up would be effective. It also noted that much of this work was very ambitious and required significant implementation support⁶³. Some of the thinking in the proposal is consistent with the GFF model that was subsequently developed, and which may be seen to provide sustainability possibilities for some HRITF supported countries. There remains a gap in practical support for planning and managing transition, as well as funding it.

140. **Maintaining focus on the HRITF during transition to GFF will be important to ensure transparency and accountability.** The HRITF is now entering the final four years of its life. The HRITF has 24 current CPGs yet to complete, and a research and knowledge programme to complete, consolidate and disseminate. There is a continuing requirement for purposes of accountability to donors and countries to retain a separate focus on specific HRITF outputs and performance. Reporting on these will need to be continued until the end of the HRITF. A composite Results Framework for HRITF and GFF was proposed. However, the Bank and donors ultimately determined to maintain a separate HRITF Results Framework that is made fit for purpose for the current status of the programme by the Bank. The end date of HRITF would benefit from clarification, as in different documents this date varies from 2018 to 2022. A staged plan for transition to GFF, including reporting requirements, will be needed to ensure transparency.
141. **The planned impact evaluations will be completed, however, it will also be important to maintain the evidence legacy of the HRITF.** There are currently 16 impact evaluations to complete and disseminate, as well as other evaluations and studies planned in the 2017 Learning Strategy. A meta-analysis of RBF research is planned. These activities are all essential to achieving the HRITF objective of developing, analysis and using evidence, and to provide good value from the HRITF. Options for maintaining and updating evidence following the end of the HRITF could fruitfully be considered to maximise their value and impact for the Bank, the donors and the wider RBF research community.

⁶³ RBF scale up business plan, unpublished draft for consultation, 2014, internal communication from the World Bank

Review of progress on recommendations from the 2012 HRITF Evaluation

Overview of changes made since the 2012 Evaluation

- 142. The Trust Fund has made many changes and adaptations to the management, implementation and support provided to the Trust Fund programme, in response to experience from earlier years.** The 2012 recommendations have been considered and addressed to enable the HRITF to be more effective. There have been improvements in reporting and accountability to donors, and in transparency about operations and allocation of budgets. The portfolio of approaches supported, and diversity of countries included has widened, including a clearer focus on poorer and high burden countries such as Nigeria and DRC, Liberia. Within the constraints of existing commitments and the adverse impact of the 2014 currency value drop, the Trust Fund has sought to be flexible to accommodate the reality and unpredictability of working in poor and fragile states.
- 143. There is a strong sense from the Secretariat and TTLs that Trust Fund management and allocation processes are now mature and work better.** There has been a marked growth in the use of learning and knowledge products and events as these have been developed, reflecting the increase in evidence available, and the development of a critical mass of interested countries with RBF projects. New tools have been developed to meet identified needs which are well used and appreciated. There is greater clarity on the opportunities for RBF to contribute to wider health system strengthening and financial reforms. The Secretariat and research team in Development Economics Group (DEC) has greater capacity, following the addition of new team members.
- 144. Three of the four key recommendations from the first evaluation remain relevant:**
- Develop a robust Theory of Change and Results Framework for the HRITF.
 - Tighten up the management of country projects and improve the learning agenda.
 - Develop transition plans early.
- 145. Other aspects of the recommendations from 2012 which remain pertinent include:**
- Strengthening early engagement with donors, partners and country stakeholders.
 - Maintain a proactive communications strategy to ensure transparency and support effective partnership working.
 - Strengthening the capacity of TTLs.

The relationship with the PBF Community of Practice will still benefit from a strategic review to identify opportunities for strengthening south-south, and south-north contributions.

Assessment of progress against recommendations from the 2012 Evaluation

- 146.** The 2012 HRITF evaluation identified 31 recommendations which were accepted by the HRITF. The recommendations were initially reviewed in 2012, and a progress update was produced in 2013 and further updated in September 2016. The recommendations cluster into broader areas which are used by the HRITF to report on progress. These are reported against below with short commentaries on progress on each.

Improving the Results Framework

- 147. Recommendation 1:** Define clearly and explicitly in a Results Framework, the results that the HRITF expects to achieve over time for each of its four objectives, and include indicators to

measure such progress. The 2012 evaluation also recommended that there should be a theory of change for the HRITF.

148. **Progress made:** In 2013 the HRITF agreed a Results Framework, in close collaboration with the donors, which reports against five outputs, each of which has a defined set of indicators. The outputs are reported on annually at the donor consultation meeting, and provide a transparent and measurable report, which provides accountability for implementation and management of the Trust Fund. The framework also enables the Trust Fund to show activity and progress on five key indicators of RMNCAH to show progress in programme results. The Results Framework reports largely on activities. This enables assessment of process, inputs and outputs, but is weaker in providing information on effectiveness and impact. A conceptual framework for RBF was developed in 2012-13 which is now widely used for learning.

149. **Progress still needed:** There is still no integrated Theory of Change for the Trust Fund which would assist with assessing progress, reviewing the continuing relevance of assumptions and providing accountability.

This outstanding issue is also relevant for the GFF.

Balancing a demand driven approach with the need for strong evidence base

150. **Recommendation 2:** The Trust Fund needs to develop a more strategic approach in the choice of pilots and **Recommendation 3:** A more flexible approach is needed to allow for individual country circumstances.

151. **Progress made:** There has been greater proactive exploration of interest with countries, and inclusion of a wider range of RBF models and the deliberate inclusion of more fragile and conflict affected countries to understand the potential of RBF in fragile states. There has been greater flexibility in the use of grants, for instance second grants have been provided, and grants have been amended to reflect changes in country context, for instance in Haiti where natural disaster delayed implementation. End dates for grants have been extended to reflect country difficulties in implementation e.g. Ebola outbreak, natural disasters, delays in implementation due to political instability. There are now a wider range of approaches in the HRITF programme, including more demand -side and community models.

152. **Progress still needed:** It is still not evident that there has been a strategic discussion with donors or partners of the strategic factors determining choice of pilots, although, since the funds are now all allocated, this recommendation is less relevant. The recommendation to discuss RBF projects more with other partners and donors is still relevant.

This outstanding issue is also relevant for the GFF.

Improving and streamlining reporting

153. **Recommendations 4 - 12 (summarised):** There were seven recommendations to the HRITF for improvements to the quality, content and clarity of reports to donors, as well increasing donors' access to HRITF data. There were also recommendations for reducing the burden of reporting on the Trust Fund.

154. **Progress made:** The recommendation that the HRITF should report against the four Trust Fund objectives was implemented for the 2013, 2014 and 2015 annual progress reports. The full HRITF progress report was stopped in 2016. Reporting to the donors on the HRITF objectives is now undertaken through the Results Framework in the annual donor consultation meetings. This is a less comprehensive report and does not provide the same level of information on delivery against objectives other than the five outputs, although it is supplemented by a country activity reports, updates on knowledge and learning and case study examples. As recommended by the

2012 evaluation, the midyear report was dropped, as it was excessively burdensome to the small HRITF secretariat. Trust Fund financial reporting was increased to ensure a fuller report to include cash flows, and forecasts by activity and country by calendar year with a comparison of the previous year's expenditure with the actual one. In addition, donors receive quarterly disbursement projections. Donors were given access to the World Bank portal to allow them to review data independently. The recommendation for the HRITF work plan to be used by donors at the annual donor consultation meetings to review progress against the plan, and to use these to become more forward looking and strategic, was followed up.

155. **Progress still needed:** It is not clear whether the recommendation to report on staff capacity for the HRITF in the light of the substantial growth of the HRITF was followed up.

This outstanding issue is also relevant for the GFF.

Selection and operation of CPGs - policy level recommendations

156. **Recommendations 13-15 (summarised):**

- There is a need for more thorough feasibility assessments, and for clarity about what aspects will be supported in the pilot when compared to the contents of the original application.
 - In addition to country criteria the Bank should only support RBF pilots where it has the capacity to take them forward effectively e.g. TTL with practical experience of RBF, strong support from the HRITF team in Washington, adequate resource, and a strong country team.
 - Social analysis should be improved as a step prior to exploring social inclusion issues that are closely linked to gender, equity and poverty. The Bank should use its social assessment toolkit.
157. **Progress made:** Feasibility, risk and social assessments are now routinely used. There has been a notable increase in effort and resource put into training TTLs and country teams since 2012. Workshops and peer learning events have been held and more direct assistance from the secretariat provided. An indicator has been added to the results framework that 80% of the TTLs should be trained which was exceeded in several years. The e-Learning course on RBF is also open for Bank staff. The Technical Assistance Support for RBF Implementation (TASRI) service was set up to provide technical advice and assistance to TTLs and country teams in 2015-2016, contracted with an external provider. It provided a call down service to respond to country and TTL needs. This service was used three times, but also had six cancellations due possibly to a mismatch of offer and expectations; reasons for cancellation were not identified in the final report from TASRI. The contract was ended in early 2016. The performance-based financing toolkit has been developed which includes addressing equity. Social assessments have been incorporated in the e-Learning module as well as in the TTL workshops. Social analysis is used routinely in Project Appraisal Documents (PAD).
158. **Progress still needed:** There is still a need for more and continued training for TTLs. The recommendation for more space for TTLs to discuss RBF was met well through the deep dive/brown bag lunch (BBL) workshops, which have been replaced by external speaker events. The BBLs are missed by some TTLs who saw them as valuable and practical opportunities for exchanging information and learning. While some TTLs are highly skilled and experienced in RBF, there are still perceived capacity gaps for other TTLs and country teams, and external observers note continuing variability in TTL commitment and capacity in relation to RBF.

This outstanding issue is also relevant for the GFF.

Strategically oriented and more hands-on HRITF team

159. **Recommendation 16:** The Bank may need to strengthen the human resource base of the HRITF Team that appears way too narrow to respond to the challenges ahead. Either the team should grow or time from RBF experts should be freed up and purchased by HRITF for them to provide additional analytical support to the HRITF team and its programme manager.

160. **Progress made:** The staff of the HRITF team has been increased since 2012, although the team is still small, and the team now includes experienced TTLs; the DEC working on the impact assessments has had an additional 4 members. It has recently been expanded slightly to address GFF Trust Fund's needs as well as those of HRITF.

161. **Progress still needed:** The HRITF team is now in transition to the GFF Trust Fund, and the specific staff requirements of HRITF and GFF Trust Fund should be considered separately to ensure both can be met adequately from available staff resources, and resource needs for additional staffing for GFF identified.

This outstanding issue is also relevant for the GFF.

Monitoring, documentation and dissemination of learning and evidence

162. **Recommendations 17 – 25:** These recommendations concerned the need for a stronger focus on documenting designs and pilot implementation and providing support to countries for such documentation; balancing the support to impact assessments with support for programme documentation; for more flexible funding for impact assessments; to assess financial, operational and transaction costs linked to RBF implementation; to improve the website; to make clear the link between the HRITF global and country learning programmes; and to reach out to the RBF communities of practice in Asia and Africa.

163. **Progress made:** There has been a large improvement in the website and improvements continue to be made to increase its accessibility and ease of use. Website country pages are now available and links to relevant documents and websites are included. In addition to the impact assessment portfolio, programme assessments and enhanced programme assessments as well as qualitative studies have been added. There have been examples of greater flexibility in funding for impact assessments.

164. **Progress still needed:** There is still a lack of systematic documentation of implementation at country and global levels in general which would assist the generation of evidence on implementation, although there are exceptions. A tool kit for cost effectiveness studies has been developed. There is however still a lack of information on the financial, operational and transactional costs of RBF implementation, although the cost effectiveness studies will begin to address cost issues. There is still room for further improvement in the website, as noted in this report's findings, and to ensure that it enables faster and more efficient retrieval of information.

165. There is still a lack of clarity on the links between the country and global learning programme. A specific recommendation was for stronger links with the PBF Community of Practice (CoP), which is still limited. This may be a missed opportunity for co-development of learning and exchange of ideas. It also leads to a perception by CoP members of a lack of engagement with the global south and the wider RBF community.

These outstanding issues are also relevant for the GFF.

Sustainability and attracting additional financing

166. **Recommendations 26-31:** These recommendations addressed resources for country capacity building, stakeholder engagement and information sharing, having a proactive information strategy for partners and donors, and country level sustainability and funding.

167. **Progress made:** The Bank 2016 response to the recommendations notes that capacity building is required in all projects, and it is now included in CPGs. The Bank also notes that stakeholder analyses are now formally part of every phase of a project cycle (planning, design, implementation

and review) and that courses have been organised for TTLs in which stakeholder engagement have been an important part of the learning.

168. **Progress still needed:** Capacity building is, however, often not well specified, and would benefit from a more strategic approach for institutional strengthening. The recommendation was for TTLs to be able to apply for additional funds for country capacity building if needed, which has not taken place, possibly due to lack of additional funds. TTLs also noted in case study interviews that they sometimes need more technical input on capacity building (supervision costs) than they have.
169. There is still a need for a more proactive information and communications approach to engage partners and donors from an early stage. No information or communication strategy for partners or donors has been developed to date. The Inter Agency Working Group (IAWG), which ended in 2015, was well thought of by partners, and seen to provide a useful forum for discussion and information sharing, but has ceased to meet since the start of the GFF; it will be important to ensure that its function is adequately fulfilled by GFF governance and oversight forums.
170. The evaluation recommended that steps should be taken for the HRITF team to explore funding and sustainability issues linked to the RBF pilots with donors well before these come to an end, and that options papers for countries where pilots do not continue should be developed.

These outstanding issues are also relevant for the GFF.

Conclusions

Relevance

171. The HRITF is a relevant mechanism for testing the extent to which RBF financing can strengthen health systems and outcomes in a range of settings, using RMNCAH as an entry point. Accelerating progress towards the MDGs (and now the SDGs) remains a very important and relevant development issue for low and middle-low income countries. Generating knowledge on RBF and how it can contribute to equitable, improved health outcomes in different contexts is valuable to country decisions on if and how to use it. The focus on knowledge and evidence is helping inform countries to develop, implement, evaluate and adapt their use of RBF.
172. However, evidence regarding the extent of the Bank's engagement with government to ensure sufficient levels of ownership is mixed. There has not always been optimal engagement with relevant government structures during the design phase to make good use of government systems and structures. Not all relevant departments are consistently engaged; for instance, Ministries of Finance, which have a strong stake in health finance reform, have not consistently been involved in programme design and implementation. There is a perception from country partners that there has not always been a thorough risk assessment prior to the development of project proposals, which can weaken design and implementation. There are questions regarding how well the Bank engages with other development partners to ensure alignment.
173. The systems-strengthening aspect of RBF was originally not clearly conceptualised or explicitly addressed by the HRITF. As a result, it has not been emphasised in the framing of the HRITF's objectives and the objectives of the country pilots supported, as well as in the Results Framework, and in the learning and evidence that has been generated to date. This is a missed opportunity, since the systems strengthening effects of the supported mechanisms are seen to be one of the principal contributions of RBF.

Effectiveness

174. The HRITF has no single, integrated framework that articulates the relationship between the Trust Fund and the RBF-related results it seeks to support at a country level. This limits the extent to which the relationship between the performance of the Trust Fund and its effectiveness and impact on the ground can be investigated in relation to the performance frameworks used by the HRITF.
175. The HRITF is on track or exceeding its targets for all outputs as assessed in the Results Framework. These including the six indicators of standard maternal and child health services used to measure progress towards the MDGs as well as effectiveness of Trust Fund implementation.
176. The HRITF has contributed to enhancing knowledge of RBF in over thirty countries through improving access to knowledge and evidence through grant assisted work. Some earlier HRITF supported projects had design weaknesses, which significantly affected the success and impact of the projects. Learning from these experiences and country knowledge has contributed to better designed projects. Country projects also show evidence of modifying processes such as verification, supervision and coaching to increase effectiveness. There has been good use of peer to peer learning between countries, as well as workshops and training supported by the HRITF. The expertise of country teams has been developed. However, there is still scope to further build systemic and institutional capacity to manage, evaluate and sustain RBF.
177. One of the most effective aspects of RBF is its contribution to the financial and managerial autonomy of health facilities. Evidence from facility visits and reports shows the positive impact of having available budgets to spend on facility infrastructure, drugs and equipment, and to recruit

additional staff. Facility autonomy and community oversight have facilitated more relevant and transparent resource use. Delays in payments however, which were found in almost all of the case studies, had a disruptive effect. Quality improvement is often reported by country stakeholders as one of the key contributions of the RBF, although quantitative evidence is not as strong as qualitative reports on improvements.

178. The value of the rigorous and well implemented impact evaluations is widely acknowledged, although they have not to date addressed some of the key questions where evidence is required. The extent to which impact evaluations alone have been used to inform decisions to scale up RBF is not clear, since some pilots have been scaled up where results are mixed. The questions of how RBF works have been less clearly addressed. More recent impact evaluations, process and qualitative evaluations seek to address these questions, yet there are still gaps in evidence, for instance on scale up, facility management, supervision, transaction costs, demand-side barriers and interventions and on implementation process. There is wealth of country research and evidence as well as some internal Bank papers, but these are not always accessible to an external audience.
179. The HRITF has supported global learning workshops attended by participating countries and others which are well attended and found very useful by participants. HRITF has supported the creation of a large, resource base for knowledge and evidence, including many different knowledge and learning products and tools, hosted on the www.rbfhealth.org website, which is well used and valued. Accessing the large amount of evidence and learning available, however, particularly country-led operational research and learning is not straight forward or easy. There is scope for improvement to the Bank's knowledge management capacity and function to improve general access to evidence.

Efficiency

180. The HRITF is unique among World Bank Trust Funds in that it explicitly uses grants in conjunction with wider IDA lending operations to maximise funding available. HRITF-supported mechanisms therefore contribute to and catalyse wider health reform programmes and benefit from IDA's rigorous supervision and performance management architecture. The HRITF model shows the benefit and efficiency of linking Trust Funds to other Bank lending to optimise value.
181. The Bank has allocated the HRITF budget broadly as planned to achieve the four objectives of the programme, and has shown increased efficiency in health care delivery through reducing administrative costs. Currency exchange losses in 2014 have been carefully managed to ensure a minimal impact on the programme; two country programmes that had not yet begun were halted, and some later impact evaluations were cancelled. HRITF annual disbursements have been low in past years, partly reflecting difficulties in starting or implementing CPGs; they have increased in recent years. However there are six countries where there have been significant delays in disbursement against original allocations. There remains in 2017 \$83.5 million (16.7%) of the HRITF to be disbursed by 2020.
182. HRITF contributes to increasing efficiency through increasing the funds available to the frontline of primary care. More investment at primary care level also increases the efficiency of use of staff and other health resources. Evidence shows that RBF models have adapted to increase their efficiency, for instance through transferring implementation from INGOs to Provincial Purchasing Agencies and through revisions to tariffs to ensure they are more efficiently used, as well as effectively incentivising different indicators. Verification costs, which are significant, are being reduced by some countries through using peer review, and in others by taking a more risk-based approach.
183. HRITF projects have had high operating costs although costs have declined over time and now on average amount to between 10% and 30% of the total costs according to the Bank's reports

and other studies. Each HRITF project defines operating costs differently, making it difficult to compare and analyse use of funding, which may make planning for scale up more difficult to cost. There was insufficient country cost data to assess and compare operating costs. The quality of financial analysis and reporting is an area for improvement.

Cost effectiveness

184. Cost effectiveness studies in Argentina, Zimbabwe and Zambia show RBF programmes, although costly, are cost-effective with a positive impact on quality and coverage of RMNCAH services. Evidence from two different systematic reviews of the cost effectiveness of RBF come to different conclusions on whether RBF is cost effective. More research is called for by both. Comparative impact evaluations based on RBF-supported facilities compared to facilities that received additional funding which is not linked to results show that additional financing alone can often provide similar or not significantly different levels of improvement and benefit.

Equity

185. The Trust Fund targets countries with poorer RMNCAH outcomes, building an element of equity into its design. All RBF programmes supported by the Trust Fund focus on maternal and child health and therefore necessarily focus on meeting the health needs of women and girls. They also, variously, include dimensions of poverty, and ethnicity/exclusion, as well as poverty, remoteness and access. There are some findings in impact evaluations that there were accelerated gains or greater positive effects for poorer and less educated groups. However, little data is collected which would demonstrate impact on equity issues. Completed impact evaluations have not found evidence of decline in the provision of non-incentivised services. Increased community and beneficiary participation has been a prominent feature of the mechanisms supported.

Impact

186. The focus of the impact evaluations completed to date has been on the impact of RBF on coverage and utilisation, quality, health workers' behaviours and they show that while there is evidence of improvements in these dimensions of care, this is not consistent across countries, services or facilities.
187. HRITF has made significant contributions to health system strengthening. Improvements in information systems and data availability and quality are often reported. In many countries, national HMIS data is complemented by data produced by RBF-supported facilities. The contribution of RBF pilots to financial management is significant, and may, with information system strengthening, be one of the most important aspects of RBF in terms of building institutional capacity and sustaining change. However, there are risks to this when the RBF payments substitute for base funding. There was evidence of countries now linking RBF to wider financial reforms including health insurance and strategic purchasing which will optimise the use of RBF. Accountability at country and community level has greatly improved with RBF and is noted as one of its major achievements. Supply chains and drugs management have also been strengthened. Evidence on unintended as well as intended impacts of RBF, and the way that RBF interacts with wider country health systems, is relatively limited.

Sustainability

188. For some countries, the step to sustainability is still distant since there remain significant system weaknesses and capacity gaps. Even where there is a strong commitment to RBF, there is generally not sufficient funding to sustain it, although GFF is providing follow on funding in thirteen HRITF supported countries. Domestic funding has not yet made significant contributions to sustaining RBF, and there are examples where HRITF funding is substituting for national financing. Scale up is now taking place, but proposals for scale up do not appear to have been accompanied by detailed plans and costings for funding scale up. All the CPGs will end by 2020 and will require options for transition out of HRITF, whether this is to continue pilots, scale up, or

end RBF. For those countries where the RBF pilot model is considered appropriate there will be a valid decision not to scale up RBF.

189. There are also issues to address to ensure the sustainability of the HRITF and its legacy. The GFF has used learning from the HRITF to develop a larger and more strategic funding vehicle to improve RMNCAH-N outcomes through health system strengthening. Maintaining focus on the HRITF during transition to GFF will be important to ensure transparency and accountability. Evidence from the HRITF projects will need to continue to be collected and reported until the end of the HRITF funding to ensure that learning is completed and consolidated.

Recommendations

1. Maintain a clear and separate focus on the HRITF performance through regular reporting on the progress towards the HRITF Results Framework until the final HRITF financed project closes and all HRITF funds are spent.
2. Agree suitable revisions to the DFID/ HRITF logframe to ensure it remains fit for purpose given the status of the programme currently, and is true to the original intent and scope of the HRITF without expanding its objectives.
3. Continue to report to donors on an annual basis on the current and expected future status of all HRITF financed country grants and impact evaluations.
4. Assess, with country stakeholders, future options for all HRITF country projects to identify and agree plans for next steps following the end of HRITF support including project adaptation or termination, scale up, sustainability, funding and technical support. Share updates on options with donors six monthly.
5. Ensure publication and implementation of an updated HRITF learning strategy and plan with a focus on developing knowledge products from existing and planned programmes and impact evaluations to maximise learning and evidence available to country audiences, development partners, donors, the wider RBF research and practice community, and Bank staff.
6. Explore and agree with donors the opportunities for optimising use of planned evaluations and for additional research on evidence gaps (provided resources are available). This may include value for money, cost effectiveness, equity, health systems strengthening, quality of care and demand side versus supply side health financing models (including RBF). (See paragraph 63 for a full list of topics).
7. Improve the, dissemination and accessibility of learning products to country partners and audiences, development partners, donors and the wider RBF research and practice community.
8. Continue to strengthen partnership engagement, communications and transparency in working with country partners and development partners in planning and implementing RBF projects and evaluations, including on transitioning to scale up and sustaining successful RBF programmes.
9. Ensure adequate staff capacity of the secretariat to implement the above recommendations and report to donors on staffing capacity as part of work plan discussions.

Learning for future RBF programmes

There is an opportunity to use learning from HRITF to strengthen some areas of activity related to future RBF programmes, including:

A stated strategy (or theory of change) for the RBF, established at an early stage, will be key to ensuring there is a shared understanding of the RBF's objectives. This should be a clear statement of objectives, assumptions and measures to assess progress. It will enable the RBF programmes to ensure that its work supports these objectives and to assess how well they are being delivered, and where it may need to adapt to improve outcomes and impact. The strategy (theory of change) will need to be integrated with country programmes, so that the links between them are clear. Lack of an integrated theory of change and a related results framework has hampered HRITF assessment of effectiveness and reduces clarity on purpose.

Early strategic discussion by donors and partners of the strategic factors to determine the choice of countries to invest in is critical, for instance level of health burden, political, system or financial context, probability of scale up and sustainability. This should be informed by and inform the theory of change, and also the extent and models of engagement with countries. Involvement of country counterparts in these discussions would improve country engagement and the relevance of proposed RBF programmes. A clear approach to strategy, system and context factors would assist both with country and programme selection, programme risk assessment and management.

Partnership engagement and alignment is a key area of learning. The experience from development partners in HRITF is that the World Bank has not always worked as well as it could in partnership and that there is a need for it to increase openness, information sharing and transparency. Partners also noted the need for earlier and sustained engagement, and evidence from the case studies showed that where time was invested in developing partnership approaches and there was openness to partner views, more successful results were achieved.

Sustainability and transition are key elements of the aid life cycle. The need to develop transition plans early was identified by the 2012 HRITF evaluation and continues to be relevant. There is learning in terms of developing clear and resourced plans for developing sustainability and for transition from the start of RBF support as well as at the end of project stage.

Addressing public finance management is important, as well as health financing reforms. HRITF support to finance reforms has been largely focused on RBF related financing. There is scope to widen this to wider health finance reforms, particularly social health insurance systems, and a move to strategic purchasing, which may provide models for sustained change. Adequate fiscal space is needed to enable increases in national financial commitments to health; strengthening public finance management more generally will enable stronger health finance management and funding.

Adequate staff capacity to support RBF implementation is necessary to ensure effectiveness in relation to Secretariat support and reporting to the donors, knowledge management and communications. Secretariat and country team staffing capacity will require regular review, including review and development of skills and knowledge required to support implementation at country level by TTLs and specialists.

Knowledge brokerage is another area where there is scope to review the existing HRITF platforms and capacity, and to consider how these can be enhanced to strengthen knowledge management and evidence in future. Lack of access to evidence was observed by country and global stakeholders and partners as well as the need for links between country and global health evidence.

Annex 1: Terms of Reference

Title:	Terms of Reference for a Performance Evaluation of the Health Result Innovation Trust Fund (HRITF)
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INTRODUCTION

The Department for International Development (DFID's) mission is to help eradicate poverty in the world's poorest countries and this is underpinned by our set of values:

- Ambition and determination to eliminate poverty
- Ability to work effectively with others
- Desire to listen, learn and be creative
- Diversity and the need to balance work and private life
- Professionalism and knowledge

DFID is seeking to work with Service Providers (SP) who embrace the DFID supplier protocol and in addition demonstrate Corporate Social Responsibility (CSR) by taking account of economic, social and environmental factors in an ethical and responsible manner, complying with International Labour Organisation (ILO) standards on labour, social and human rights matters.

Value for Money (VfM) is important for all DFID programmes and as such, in all our activities, we will seek to maximise the impact of DFID's spend on programmes and encourage innovative ideas from our partners and suppliers to help us to deliver Value for Money.

The Department for International Development (DFID) leads the UK Government's work to end extreme poverty. DFID works directly in 28 developing countries across Africa, Asia and the Middle East. The UK Government's long-term vision for the Middle East and North Africa region is a prosperous, stable region based on open, democratic societies with greater social, economic and political participation of its people.

DFID has transformed its approach to transparency, reshaping our own working practices and pressuring others across the world to do the same. DFID requires Suppliers receiving and managing funds, to release open data on how this money is spent, in a common, standard, re-usable format and to require this level of information from immediate sub-contractors, sub-agencies and partners.

It is a contractual requirement for all Suppliers to comply with this, and to ensure they have the appropriate tools to enable routine financial reporting, publishing of accurate data and providing evidence of this DFID – further IATI information is available from; <http://www.aidtransparency.net/>

SUMMARY:

DFID would like to commission an evaluation of the Health Result Innovation Trust Fund (HRITF). The purpose of this evaluation is to consolidate what we are learning from the generated and emerging results, evidence and processes involved in establishing, implementing and evaluating an Results Based Financing (RBF) approach. The findings will be used to improve programme performance but also to support the design and implementation of RBF mechanisms being considered under the Global Financing Facility.

The main objectives of this evaluation will be:

Objective 1: To assess the performance of the HRITF against the given goals and outputs of the programme (as described in the results framework) identifying strengths, weaknesses and lessons learnt.

Objective 2: Determine what progress has been made in addressing the recommendations from the previous 2012 evaluation.

Objective 3: To make recommendations to inform ongoing and future programming specifically aimed at (a) improving the performance of the current HRITF programme from a donor, implementer and country level perspective and (b) supporting the design and implementation of future RBF approaches being considered.

Recipients: The recipients of the services of this evaluation are DFID and Norad. The primary audience for the report will be DFID/Norad and the World Bank

Scope and Methodology: It is expected that a mixed methods design combining analysis of primary and secondary quantitative and qualitative data will be appropriate to respond to the evaluation questions. The evaluation will involve analysis of information from approximately 8-10 implementing countries through desk reviews, interviews and from country visits to a select number of countries.

Timeframe: Starting in last quarter of 2016 for a period of 7 months

Budget: £150,000-£250,000

PROGRAMME BACKGROUND

The Health Result Innovation Trust Fund (HRITF) is a World Bank-managed multi-donor trust fund, which was established in 2007 with initial support from the Government of Norway and then DFID from 2009, to support countries to design, implement, monitor and evaluate results-based financing (RBF) interventions in the health sector. Through Country Pilot Grants (CPGs), HRITF was designed for low income and lower middle-income countries to make progress towards goals outlined in their national health plans, and accelerate achievements towards the Millennium Development Goals (MDG) for women's and children's health (MDG 1c: nutrition, MDG 4: child mortality and MDG 5: maternal mortality). A primary output of the HRITF is to support a variety of Impact Evaluations and programme assessments to contribute to the global evidence base and knowledge on RBF. The value of donor pledges to the fund is \$480.3 million of which \$396 million is for RBF programmes in 30 countries. Countries have also linked this funding to \$2.2 billion from IDA. The HRITF programme ends in 2022.

A primary objective of the HRITF programme is to build the evidence base for different RBF mechanisms, support countries to decide whether to continue using these mechanisms, or not, and where they are shown to be successful, support countries' ability to maintain and expand RBF mechanisms. Building the evidence base will contribute to our understanding of how/if an RBF approach leads to better performance and efficiency and how/if RBF strengthens the underlying health system in a sustainable way. This will build evidence for what works best in different contexts and about both the performance and impact of the different instruments. A detailed overview of the programme and an update on the performance to date is provided in the background section at the end of this terms of reference. This information will be critical to consider in responding to this submission.

BACKGROUND TO THE PERFORMANCE EVALUATION 2016

The HRITF agreement mandates periodic, donor initiated, independent, external evaluations in 2011, 2016 and 2022. The first of these was successfully undertaken in 2011/2012 covering the period 2007-March 2011 and a full report is available⁶⁴. The key recommendations from the first evaluation included: a) develop a solid results framework for HRITF, theory of change and establish more strategic annual reporting structures; b) ensure a more strategic approach to selecting countries is developed; c) tighten up management of country projects and improve the learning agenda; and d) develop transition plans early. Since the previous evaluation, many of the issues highlighted have been addressed such as the development of a results framework that is used to monitor annual performance and a conceptual framework⁶⁵. A management matrix based on the recommendations was drawn up and is revisited through annual review processes to monitor progress (see Attachment A).

EVALUATION PURPOSE AND OBJECTIVES

The purpose of this evaluation is to consolidate what we are learning from the generated and emerging results, evidence and processes involved in establishing, implementing and evaluating an RBF approach. The findings will be used to improve programme performance but also to support the design and implementation of RBF mechanisms being considered under the GFF.

The main objectives of this evaluation will therefore be:

Objective 1: To assess the performance of the HRITF against the given goals and outputs of the programme (as described in the results framework) identifying strengths, weaknesses and lessons learnt.

Objective 2: Determine what progress has been made in addressing the recommendations from the previous 2012 evaluation.

Objective 3: To make recommendations to inform ongoing and future programming specifically aimed at (a) improving the performance of the current HRITF programme from a donor, implementer and country level perspective and (b) supporting the design and implementation of future RBF approaches being considered.

This evaluation will be guided by OECD DAC evaluation criteria including: relevance, effectiveness, efficiency, impact and sustainability. The evaluation will assess how well the HRITF upholds the Paris Declaration principles looking at country ownership, alignment, harmonisation, accountability, and results focus. A gender lens will need to be applied to assess how relevant an RBF approach is particularly for women and girls. A key component will be to describe the processes required to design, implement, monitor and evaluate an RBF approach in different contexts, highlighting useful and less useful practices and approaches. This information will support any course corrections required by the overall HRITF programme, as well as support countries to take stock of what has been successful or challenging as the pilot projects mature and some move towards a transition phase. Findings will also be used to inform activities being supported by the GFF.

Due to the differing stages of implementation of the HRITF, evidence of the impact and sustainability of a RBF approach will be less widely available and likely to exist mainly in the countries that have completed impact evaluations. Therefore, this evaluation will focus mostly on the outputs of the programme. However, in countries where impact evaluation and programme assessment findings are available, the evaluators will be requested to carry out more detailed case studies – assessing the programme assumptions from the output to the outcome and impact level.

⁶⁴ <https://www.norad.no/om-bistand/publikasjon/2012/evaluation-of-the-health-results-innovation-trust-fund-hritf/>

⁶⁵ <https://www.rbfhealth.org/resource/performance-based-financing-conceptual-framework>

It is expected that findings from this evaluation will contribute to the broader HRITF learning agenda and complement other activities involved with evidence generation that are explicit outputs deliverables of the HRITF programme e.g. the planned country learning conference in September 2016, and meta-analysis of results and implementation learning to be carried out by the World Bank. The World Bank is currently developing an overall evaluation framework which will consolidate all the findings and results from the different knowledge and learning activities and a draft framework is due to be completed by the end of 2016.

POSSIBLE EVALUATION QUESTIONS

Below is a set of potential questions under the three main objectives of the evaluation. These will be honed during inception phase, based on feasibility and timelines, and in agreement from the supplier and the evaluation steering group (see below). Relevant questions will need to ensure that they can assess each of the OECD-DAC criteria and cross cutting themes such as on gender, as specified above.

Objective 1: To assess the performance of the HRITF against the given goals and outputs of the programme identifying strengths, weaknesses and lessons learnt.

Potential questions looking at overall programme, processes, performance and cross-cutting themes:

1. What have been the key achievements and challenges in establishing and evaluating an RBF approach and building institutional capacity at a country level? How did the HRITF respond to any challenges?
2. To what extent are the programmes designed to reach marginalized, harder to reach and most vulnerable populations including women and girls? Are there any promising practices or approaches that do not seem to be working well? Was there beneficiary involvement in terms of design, implementation and monitoring and if so what level of participation was there and how effective was this?
3. What factors are critical for or a hindrance to, the successful design, implementation and monitoring of both the pilot projects and the impact evaluations? What factors are critical to build institutional capacity and awareness about RBF approaches?
4. Have there been any significant changes in the way the HRITF has been managed or implemented over time? If changes were made, why? What if any has resulted from these changes?
5. What is the evidence of the extent of country ownership in the supported activities?
6. How have the RBF mechanisms aligned with country policies, initiatives, development assistance and partnerships e.g. country systems, GFATM, GAVI, existing bilateral programmes? What influence have these country initiatives had on the implementation of an RBF approach?
7. How effectively and efficiently has the HRITF been managed by the donors and the WB and has this offered good value for money?
 - Were there sufficient human resources to deliver the tasks? How effective were the governance structures? How effective and efficient have the financial management and reporting processes been? Have resources been allocated to the right priorities? Have a sufficient number of different RBF mechanisms been introduced and tested?
8. How has evidence or lessons learned been used at the different stages of design, implementation and transition by countries? What evidence has been most useful and why?
9. Have RBF lessons positively or negatively influenced country policies, perceptions, decision making, practices including addressing gender or implementation course (short and medium term)? If yes, what and how? If not, what might be required or done differently?
10. How relevant, rigorous, of good quality and timely has the current and completed generation of evidence been from the programme? Or, if evidence is still forthcoming, how likely is it to meet key policy decision windows? Does anything need to change?
11. Based on the current knowledge and learning portfolio, what are the likely key knowledge and learning gaps moving forward?

12. In what ways, if any, has the emerging evidence and lessons from the HRITF affected the global RBF agenda, the knowledge base and the community of practice?
13. How have lessons learnt been used by the World Bank and how has the HRITF affected the way, the World Bank operates in countries e.g. GFF? How much is RBF integrated in the broader World Bank programmes including on Health, Nutrition and Populations? How has the HRITF affected the role of WB in MNCH globally, including work with partners?

Potential ‘deep dive’ questions focused on analysis of countries with impact evaluations (both completed or in progress) and assessing all DAC criteria:

1. What impact has the RBF approach had on health outcomes in different contexts?
2. Have there been unanticipated (positive or negative) effects or consequences of the instruments on the implementer, and/or on the beneficiary, and/or on health outcomes?
3. What evidence has emerged as to whether RBF incentives impact (positively or negatively) on behaviour of the implementer and / or beneficiaries?
4. Have the RBF mechanisms lead to improvements in efficiency – in converting inputs to outputs?
5. Have the RBF mechanisms lead to improvements in effectiveness – in converting outputs to outcomes?
6. Is there evidence that the RBF approach presents good value for money compared to other health financing models?
7. Where feasible, how sustainable are the outputs, outcomes and impacts delivered by the HRITF programme?
8. How relevant, rigorous, of good quality and timely has the generation of evidence been from the programme?

Objective 2: Determine what progress has been made in addressing the recommendations from the previous 2012 evaluation.

1. To what extent have the recommendations from the previous evaluation been addressed? How well has this been done? Have any recommendations not been taken up and why?
2. Did the recommendations change programme implementation and if so what changes were made and how has this affected the programme performance?

Objective 3: To make recommendations to inform ongoing and future programming specifically aimed at (a) improving the performance of the current HRITF programme from a donor, implementer and country level perspective and (b) supporting the design and implementation of future RBF approaches being considered.

1. Based on current progress, what evidence is there that programme outcomes (and hence assumed impacts) are likely to be achieved?
2. Based on question 1, what changes to the programme, including programme management and forward plans, are required for the HRITF to achieve its four objectives and improve programme performance?
3. Where are the gaps in institutional capacity required to sustain or transition RBF mechanisms from pilots and how best should these be addressed moving forward e.g. what technical assistance is required from the programme, what may be the role of GFF, other partners etc.?
4. Do the recipients have the necessary discretionary financing and capacity to continue to implement an RBF approach beyond the phase of the pilot? If not, are alternative plans being developed and what are these?
5. Has the global context changed since RBF was introduced and how would this affect the design, implementation, monitoring and evaluation of RBF processes in the future?
6. Are the learning and evaluation frameworks fit for purpose including the consolidated evaluation framework and do any changes need to be made? If so, what changes would be recommended?
7. How well are the country RBF evaluations/assessments going to be to support key policy decision making points as they are currently designed, in terms of timing and evidence needs? What will be the most useful way to present this evidence? Is other evidence generation required to

complement current evaluations/assessments and is it within the scope of the programme to generate this evidence?

RECIPIENT

The recipients of the services of this evaluation are DFID and Norad. The primary audience for the report will be DFID/Norad and the World Bank. There will be a number of stakeholders interested in the findings from this evaluation including: governments of pilot and other countries, the Global Financing Facility (GFF) Trust Fund Committee, the GFF Investors Group, DFID Ministers and the DFID RBF learning group and the broader development community. Not all information will be relevant for all stakeholders, but an outline is provided in Annex A to summarise the likely requirements of each⁶⁶.

SCOPE

This evaluation is expected to start in the last quarter of 2016 and be completed within a 7 month period. This evaluation will review progress of the HRITF programme with a focus (but not limited to) on the period from July 2011 until September 2016⁶⁷. The evaluation should use a mixture of approaches, methods and tools to answer the questions in a way that meets the intended use, purpose and audience.

The evaluation will involve analysis of information from implementing countries through desk reviews, interviews and from country visits to a select number of countries. It is recommended that the country visits focus on countries with completed impact evaluations. It is preferable that there is a gender balance in the evaluation team.

The evaluation will focus on the following target groups:

- Policy and decision makers involved with HRITF design and implementation, including officials from the Ministry of Health and Finance at national and district levels where appropriate.
- Programme implementers including national, provincial and district health managers, health workers, civil society and relevant national researchers involved with implementation of the impact evaluations.
- Donors e.g. DFID, Norad, GFATM, Gates Foundation
- Other key partners in the GFF and community of practice.
- Implementing partner - World Bank staff at HQ and country office level involved with programme implementation including any consultants supporting the programme.

METHODOLOGY

It is expected that a mixed methods design combining analysis of primary and secondary quantitative and qualitative data will be appropriate to respond to the evaluation questions. The framework used to analyse both quantitative and qualitative data should be determined by the evaluator. It should be rigorous and sufficiently robust in order to identify changes that may be plausibly associated with the project and that may contribute to the desired outcomes and impact. The analytical framework should identify pathways through which these changes have and could happen.

Quantitative data may be derived from a range of sources including but not limited to publications, project monitoring records, planning documents, programme results, impact evaluations, meeting reports, results framework, annual reviews, country reports and case studies. Qualitative data may be derived from sources such as key informant interviews. A preliminary list of available sources of data is included as Annex B and this will be updated prior to the start of the evaluation.

The following data collection methods are encouraged:

⁶⁶ In line with DFID's evaluation policy, findings will be published on the DFID website.

⁶⁷ The previous evaluation covered the period between 2009 – 2011.

- A desk review using available data from current literature, programme and financial reports, workshop reports and results from the completed impact evaluations to analyse the current evidence, key achievements, lessons learnt and challenges both within and across all pilot countries.
- Analysis of evidence and key lessons from key informant interviews with the World Bank, donors, relevant stakeholders and recipient country governments at headquarter and country level. It is encouraged that the evaluators contact at least 10 countries to solicit information using a structured interview approach and visit at least 2-3 countries for a 'deeper dive' as outlined below⁶⁸.
- A deeper dive analysis in the form of case studies involving country visits to 2-3 countries including countries where impact evaluations have been completed to synthesize the results, impact, sustainability, key achievements and challenges of designing, implementing, monitoring and evaluating an RBF approach. Currently Democratic Republic of Congo, Cameroon, Gambia, Nigeria and Zimbabwe are being proposed but the consultants can make suggestions to include different countries which can then be discussed and agreed upon during the inception period.
- Based on the analysis, top line recommendations should be presented on operational and programmatic issues moving forward for (a) for donors/WB to inform management of the remainder of the HRITF programme (b) for recipient countries to consider improvements or address challenges; and (c) for the GFF secretariat and investors group to inform future implementation and activities.

Administrative considerations: Countries are at different stages of implementation of the RBF pilots – some have completed impact evaluations and have transitioned the pilots, where as other countries have less implementation experience of an RBF approach. The evaluators will need to be cognizant of this fact as they design an evaluation framework and undertake their analysis as data availability and experiences in terms of implementation will vary accordingly.

Representativeness, generalizability: The HRITF activities support countries with diverse social, political and health contexts. Different types of RBF approaches have been designed to address country needs but also to specifically build the evidence base to see how different mechanisms perform. Given the time and budget constraints, the evaluation will only be able to look at a relatively small portion of the evidence *in-depth*. Given these factors, generalizability will be difficult. Common themes may however become apparent and these should be highlighted.

Travel: Will be limited by budget and logistical feasibility. It is desirable that evaluators conduct country visits to countries where impact evaluations have been undertaken to give the greatest chance of evaluating all the DAC criteria. Final selection of countries will be agreed upon during discussions on the inception report. Evaluators will not be expected to visit countries facing any political disturbances or global health outbreaks and final decisions on country visits will depend on latest developments. In addition, the evaluators are encouraged to meet with relevant personnel in the World Bank/donors and travel to their offices should be factored into the budget and the inception report.

Access to data and technical resources: The evaluator will have access to a number of detailed documents that will primarily be provided by the donors and WB (but not limited to). Preparations will be made prior to the start of the evaluation, to have as much data ready for sharing so there are no delays. A list of data that is immediately available is included in Annex B. Information is currently also available on the RBF website which gives 'real-time' results for many of the HRITF supported countries. Access to additional data such as through the donor-portal will be facilitated by DFID, Norad and key personnel within the Bank depending on the type required. This evaluation is not expected to re-analyse primary datasets from impact evaluations as this is likely to be duplicative of work already undertaken, although the evaluators will be able to review methodologies from these. Any additional data requirements proposed by the evaluators will be discussed during the inception phase of the evaluation.

⁶⁸ Countries will be selected in consultation with the Bank, DFID and the Norwegian Ministry of Foreign Affairs/Norad

Relevant donor/WB personnel will cooperate with the evaluators and be available for interviews and consultations. Day-to-day communication will be coordinated through the DFID focal point person but the evaluators can expect to have regular direct communication with relevant personnel from the World Bank. The evaluators will be able to meet and spend time with personnel from the WB including the principle investigators of the impact evaluations.

During the inception phase, the evaluator will propose a list of key informants to interview which will be discussed with evaluation steering committee and contact information will be provided where this is available. Organising dates and times for interviews with key informants will be the responsibility of the evaluators.

Country personnel and technical resources: The WB will work closely with the evaluation team to draw up this list and provide necessary contact details of relevant country focal point personnel. It is likely that conference calls with country teams will be required and again the Bank will help to facilitate these meetings but the evaluators will be expected to coordinate and chair these discussions. During country visits, the WB will support introductions with relevant country officials, stakeholders and technical partners in country. The evaluator will however be responsible for collecting qualitative or quantitative data from countries outlined in the inception report and for covering the costs for field visits and in-country meetings within the proposed budget.

During the inception phase, a detailed discussion on the data required given the proposed methodology will be further addressed. Specific requests for data or problems in accessing will be brought to the DFID focal point person who will resolve any issues if they arise.

Ethics: The evaluator will be expected to adhere to the DFID Ethics Principles for Research and Evaluation. This will include but not be limited to the following:

- Information gathered e.g. financial reports, interview responses will be treated confidentially.
- Individual respondents (officials from Ministry of Health and Finance, implementers, WB staff etc.) will be informed of the purpose of the research and have the option to voluntarily participate in the evaluation.

Code of conduct: The evaluation of DFID assistance is guided by the core principles of independence, transparency, quality, utility and ethics. The evaluator will be expected to work according to these principles⁶⁹.

Fieldwork: The evaluator is encouraged to gather data directly from programme partners and beneficiaries through in-depth interview questionnaires and data collection in country as described above.

GOVERNANCE ARRANGEMENTS

The assessment will be coordinated by the DFID Human Development Department and be guided by a Steering Group that comprises representation from DFID, Norad and the World Bank⁷⁰. Representatives from both DFID and Norad's evaluation departments will participate in this Steering Group. The purpose of the Steering Group will be to guide the design of the evaluation and assure the evaluation outputs. The group's input should ensure that the evaluation has credibility across the range of stakeholders.

Inception, work-planning and review meetings

Meetings with evaluators and the steering group will take place as required to ensure that the provider has all the necessary advice and guidance they require.

⁶⁹ See DFID Evaluation Policy 2013, pp6-7.

⁷⁰ TOR for steering committee available on request

Commenting on study outputs (including timescales)

The Steering Group will provide comments on the evaluation work plan and inception report (4-6 weeks), the draft final report (months 6) and the final report (month 7). Feedback will be provided within 2 weeks.

Quality Standards/Performance Requirements

The evaluation of DFID assistance is guided by the core principles of independence, transparency, quality, utility and ethics. Quality pertains to personnel, process and product in evaluation. Independent quality assurance is mandatory during the 'entry' design phase and at the 'exit' (draft final report) stages. Quality Assurance is currently conducted by SEQAS, a contracted service. There is a 10 working day turnaround, provided that the programme team is able to notify them in advance about the delivery of the outputs. The Evaluator's services and performance will be assessed using DAC Quality Evaluation Standards.

In addition to quality assurance requirements, a formal management response to all findings, conclusions and recommendations from an evaluation is required, and will be published with the evaluation.

REQUIREMENTS

The evaluation will be commissioned through a competitive tendering process which may include going through existing DFID evaluation frameworks. The assessment should be carried out by an organisation or a group of consultants with the following expertise:

- Experience in conducting quantitative and qualitative evaluations of results-based financing health sector programmes
- Knowledge of global health financing strategies and understanding of the different modalities for funding the health sector in different contexts.
- Knowledge and experience in RMNCH in low and middle-income countries especially the Africa context as well as knowledge of health systems and health system strengthening.
- Experience in analysing and determining the quality of impact evaluations, programme performance assessments and qualitative research.
- Experience in primary qualitative and quantitative data collection and analysis.
- Strong analytical skills and ability to think strategically and concisely analyse and integrate information from a diverse range of sources into practical and realistic recommendations.
- Effective communication skills, written and spoken, in English required and French strongly recommended.

Bidders must include CV's of proposed consultants and their role in delivering this TOR as part of their bid.

OUTLINE OF PROPOSED WORK PLAN

1. Month 1-2: Draft inception report that includes:
 - Suggested evaluation questions and sub-questions, evaluation methodologies, with their strengths and limitations, concluding with recommendations for evaluation approach.
 - Identification of data needs, including what can be drawn from HRITF monitoring and what will be required from primary data collection (based on discussions with stakeholders).
2. Month 2-3: Final inception report that includes: country selection, evaluation methodology with data collection instruments, including sampling framework, analysis plan, coding framework for primary data and reporting plan (to be QA'd following DFID Evaluation policies).
3. Month 6: Draft final report (to be QA'd following DFID Evaluation policies) with findings, lessons learned and recommendations.
4. Month 7: Final report, incorporating Steering Group comments, and, upon completion, primary data cleaned, labelled and with identifying information removed.

REPORTING & DELIVERABLES:

1. An inception report outlining the evaluation framework, questions to be asked, selected countries, references to past performance.
2. A draft final report (max 30 pages excluding annexes) for preliminary circulation to DFID, Norway and WB for feedback.
3. A final report completed after the incorporation of comments from DFID, Norad, WB and some key stakeholders as defined by HRITF working group, including a detailed executive summary of no more than 5 pages
4. A presentation to DFID, Norway, the Bank and relevant stakeholders, and accompanying shareable set of slides for circulation.
5. A learning brief of 2-4 pages summarising key findings and recommendations of the evaluation.

DFID and members of the Steering committee will be responsible for onward sharing of findings from the evaluation to relevant stakeholders and pilot countries.

CONSTRAINTS AND DEPENDENCIES (IF ANY EXIST)

The evaluation will start in the last quarter of 2016. The duration is expected to be approximately seven months from start to final completion of all evaluation output requirements.

It is not expected that the evaluator will need to work with other evaluation or M&E suppliers. The evaluator will be expected to engage closely with the implementing partner World Bank. The evaluator will have to plan field trips in collaboration with WB to ensure that the scheduling is appropriate for all parties.

Management of risks/challenges

The evaluator will perform appropriate risks assessments for the project including field visits. DFID/WB will provide information on risks and risk management at country level as requested by the evaluator.

TIMEFRAME

This contract will commence in the last quarter of 2016, with the final report completed (including QA) within 7 months. No extension is anticipated, but there will be an option to extend for 1-3 months and will be subject to the DFID programme Officer's discretion

DFID CO-ORDINATION

The following people will support the development of this evaluation and its requirements: Human Development Department – SRO for the HRITF, Health advisor, Evaluation advisor, Programme manager and Procurement department. The DFID focal point person for the evaluation will be the Health advisor from the Health Services Team within the Human Development Department.

BUDGET

The budget for this evaluation is between £150,000 - £250,000 and it is expected to cover the costs of evaluation staff, primary and secondary data collection, data analysis, field and office visits, meeting costs, travel, report writing, presentation material for final report and VAT.

DUTY OF CARE

The Supplier is responsible for the safety and well-being of their Personnel and Third Parties affected by their activities under this contract, including appropriate security arrangements. They will also be responsible for the provision of suitable security arrangements for their domestic and business property.

DFID will share available information with the Supplier on security status and developments in-country where appropriate. DFID will provide the following: A copy of the DFID visitor notes (and a further copy each time these are updated), which the Supplier may use to brief their Personnel on arrival.

The Supplier is responsible for ensuring appropriate safety and security briefings for all of their Personnel working under this contract and ensuring that their Personnel register and receive briefing as outlined above. Travel advice is also available on the FCO website and the Supplier must ensure they (and their Personnel) are up to date with the latest position.

Bidders must develop their response on the basis of being fully responsible for Duty of Care in line with the details provided above. They must confirm in their Response that:

- They fully accept responsibility for Security and Duty of Care.
- They have made a full assessment of security requirements.
- They have the capability to provide security and Duty of Care for the duration of the contract.

If you are unwilling or unable to accept responsibility for Security and Duty of Care as detailed above, your Response will be viewed as non-compliant and excluded from further evaluation.

Acceptance of responsibility must be supported with evidence of Duty of Care capability and DFID reserves the right to clarify any aspect of this evidence. In providing evidence, Suppliers should consider the following questions:

- a) Have you completed an initial assessment of potential risks that demonstrates your knowledge and understanding, and are you satisfied that you understand the risk management implications (not solely relying on information provided by DFID)?
- b) Have you prepared an outline plan that you consider appropriate to manage these risks at this stage (or will you do so if you are awarded the contract) and are you confident/comfortable that you can implement this effectively?
- c) Have you ensured or will you ensure that your staff are appropriately trained (including specialist training where required) before they are deployed and will you ensure that on-going training is provided where necessary?
- d) Have you an appropriate mechanism in place to monitor risk on a live / on-going basis (or will you put one in place if you are awarded the contract)?
- e) Have you ensured or will you ensure that your staff are provided with and have access to suitable equipment and will you ensure that this is reviewed and provided on an on-going basis?
- f) Have you appropriate systems in place to manage an emergency / incident if one arises

The latest DFID/FCO risk assessment data on countries that may require visits as part of the delivery of the project is provided in Annex C. Once these countries have been selected and agreed upon, these can be updated. For any immediate information on travel please consult the FCO travel advice: <https://www.gov.uk/foreign-travel-advice>.

Annex to TOR BACKGROUND

The Health Result Innovation Trust Fund (HRITF) is a World Bank-managed multi-donor trust fund, which was established in 2007 with initial support from the Government of Norway and then DFID from 2009, to support countries to design, implement, monitor and evaluate results-based financing (RBF) interventions in the health sector. Through Country Pilot Grants (CPGs), HRITF was designed for low income and lower middle-income countries to make progress towards goals outlined in their national health plans, and accelerate achievements towards the Millennium Development Goals (MDG) for women's and children's health (MDG 1c: nutrition, MDG 4: child mortality and MDG 5: maternal mortality). A primary output of the HRITF is to support a variety of Impact Evaluations and programme assessments to contribute to the global evidence base and knowledge on RBF. The value of donor pledges to the fund is \$480.3 million of which \$396 million is for RBF programmes in 30 countries. Countries have also linked this funding to \$2.2 billion from IDA. The HRITF programme ends in 2022.

A primary objective of the HRITF programme is to build the evidence base for different RBF mechanisms, support countries to decide whether to continue using these mechanisms, or not, and where they are shown to be successful, support countries' ability to maintain and expand RBF mechanisms. Building the evidence base will contribute to our understanding of how/if an RBF approach leads to better performance and efficiency and how/if RBF strengthens the underlying health system in a sustainable way. This will build evidence for what works best in different contexts and about both the performance and impact of the different instruments.

The five expected outputs of the HRITF Trust Fund are:

Output 1: Low and lower middle-income countries develop increased awareness of and capacity to design and implement RBF approaches in health

Output 2: Effective design and implementation of RBF in low- and lower middle-income countries

Output 3: Evaluation of RBF programmes is supported

Output 4: Countries have access to a robust evidence base on RBF and institutional capacity for sustainability

Output 5: HRITF is administered efficiently and effectively

To build the evidence base, a variety of RBF approaches have been designed based on country needs and include: (i) health facility performance-based financing (29 grants) (ii) performance-based financing at higher levels than the health facility (e.g. in administrations) (35 grants), (iii) community-based performance-based financing (7 grants) (iv) conditional cash/in-kind transfers or voucher schemes (6 grants), (v) performance for results (cash on delivery) (1 grant), (vi) disbursement linked indicators (3 grants), and (vii) social health insurance schemes (3 grants).

Table 1: Overview of type of RBF approach by country

Type of RBF approach	Countries involved
Health facility performance (29 grants)	Afghanistan, Argentina, Armenia, Benin, Burkina Faso, Burundi, Brazil, Cameroon, China, Democratic Republic of Congo (1 and 2), Republic of Congo, Gambia, Ghana, Haiti, India, Kenya, Kyrgyz Republic, Lesotho, Liberia, Mexico, Nigeria, Rwanda, Senegal, Tajikistan, Tanzania, Yemen, Zambia, Zimbabwe
Performance-based financing at higher levels than the health facility (e.g. in administrations) (35 grants)	
Community based financing (7 grants)	Burundi, Cameroon, Ghana, Gambia, Senegal, Rwanda, Zambia 2
Conditional cash/in-kind transfers or voucher schemes (6 grants)	Burkina Faso, Nigeria 2, Pakistan, Senegal, Yemen, Zimbabwe 2

Performance for results (cash on delivery) (1 grant)	Ethiopia
Disbursement linked indicators (3 grants)	Laos, Nigeria 2, Zambia
Social health insurance schemes (3 grants)	Armenia, Kyrgyz Republic, Tajikistan

Since inception, 36 Country Pilot Grants (CPGs) have been approved and RBF pilots are being implemented in 30 countries⁷¹. The HRITF pilot grants range from between \$0.4million to \$20 million and in most cases countries have linked these grants to IDA loans to allow broader implementation.

Alongside these, the programme has provided a number of evaluation grants that include: 29 quantitative impact evaluations with mixed methods and 4 qualitative impact evaluations; 5 programme assessments; and 5 enhanced programme assessments. The impact evaluations measure the causal impact of the intervention in question, using a rigorously identified counterfactual and a handful of econometric techniques that allow it to identify the causal impact of the programme, while the programme assessments do not typically involve a counterfactual. In addition, three standalone impact evaluations, where the RBF approach itself was not implemented by the World Bank, have also been carried out⁷². Thirty 'Knowledge and Learning' grants have been provided to support technical dialogue and learning about RBF design and implementation in all IDA-eligible HRITF countries⁷³.

Details of the types of questions that each of the impact evaluations plan to answer are outlined in the HRITF Learning Strategy⁷⁴. All these evaluations are at different stages of implementation. Countries with completed impact evaluations include: DRC, Argentina (stand-alone), India (stand-alone), Rwanda, CAR (only baseline), Zambia, Zimbabwe, Afghanistan (only baseline) with China and hopefully Burundi due to finalized in 2016.

Implementation of the CPGs is also at different stages in each country but the majority of the pilots will be completed by the end of 2019 with plans to consolidate all the findings from the programme and impact evaluations in the subsequent years of the programme⁷⁵. The World Bank is in the process of developing an evaluation framework to guide the consolidation of these results.

In addition to formal evaluations, regular data is being collected for all 36 pilots using data from either routine national reporting systems or project specific information systems. An overview of the progress of the CPGs and their evaluations is attached in Attachment B⁷⁶. Between 2013 and the end of 2015, the RBF pilots had *contributed* to a cumulative⁷⁷:

- 6,300,166 one-year old children being fully immunised;
- 4,916,517 women delivering their babies with a skilled birth attendant;
- 4,783,504 pregnant women receiving postnatal care; and
- 17,332,087 women aged 15-49 using modern family planning methods.

⁷¹ Afghanistan, Armenia, Benin, Burkina Faso, Burundi, Cameroon, Central Africa Republic, Chad, Democratic Republic of Congo, Djibouti, Ethiopia, Gambia, Ghana, Haiti, India, Kenya, Kyrgyz Republic, Lao, Lesotho, Liberia, Nigeria, Pakistan, Republic of Congo, Rwanda, Senegal, Sierra Leone, Tajikistan, Yemen, Zambia and Zimbabwe

⁷² Standalone impact evaluations have been undertaken in Argentina, China, and India (Karnataka).

⁷³ Countries have used these grants to explore and analyse whether RBF is the right approach for their country context and health system challenges.

⁷⁴ <https://www.rbhealth.org/resource/learning-agenda-results-based-financing-health-sector-health-results-innovation-trust-fund>

⁷⁵ Ghana is the only country with a closing date after 2019.

⁷⁶ This is due to be updated at the beginning of September 2016 in time for this evaluation

⁷⁷ Individual country results and scorecards can be found on <http://www.rbhealth.org>

Evidence from the initial impact evaluations is slowly emerging and is highlighting variable results which are dependent on the country context⁷⁸. Evidence and lessons learnt are being shared through publications, websites, at conferences and through exchange visits. Some governments e.g. Rwanda, had already adopted RBF approaches before this programme began. Other governments and donors are developing increased confidence in Results-Based Financing (RBF) methods as demonstrated by a number of RBF projects being scaled-up and transitioning into national control, governments co-financing projects, and additional donors pledging commitments⁷⁹. This has enabled some countries to scale up HRITF activities to cover additional districts.

Learning from the experiences of the HRITF, another major development has been the establishment of the Global Financing Facility (GFF)⁸⁰. The GFF was launched in July 2015, as a key financing platform of the UN Secretary-General's updated Global Strategy for Women's, Children's and Adolescents' Health. It is a country-driven financing partnership that brings together, under national government leadership, stakeholders in reproductive, maternal, newborn, child and adolescent health (RMNCAH), to provide smart, scaled and sustainable financing to accelerate efforts to end preventable maternal, newborn, child and adolescent deaths by 2030. The GFF is partly funded by the GFF Trust Fund and these funds are likely to be mainly results based. It is important that lessons learnt from the HRITF to date are incorporated.

⁷⁸ Results from completed evaluations can be found on <http://www.rbhealth.org>

⁷⁹ By March 2015, a total of 7 countries were receiving financing from the national governments (including Burundi, Zimbabwe, Sierra Leone, Republic of Congo, Nigeria, Cameroon and Tanzania) and 13 countries were receiving financing from other donors (including Afghanistan, Benin, Burkina Faso, Burundi, CAR, DRC, India, Nigeria, Ethiopia, Tanzania, Haiti, Senegal, Pakistan, and Cameroon)

⁸⁰ For more details go to: <http://globalfinancingfacility.org>. There are currently 12 frontrunner countries, all at different stages of implementation.

ANNEX A: Outline of relevant stakeholders who will be interested in the findings from this evaluation

Audience	Relevant information	Format required
Donors: Norway, DFID	<ul style="list-style-type: none"> All findings and recommendations from each of the Objectives of the evaluation 	<ul style="list-style-type: none"> Full final report Presentation
World Bank: as implementer	<ul style="list-style-type: none"> All findings and recommendations from each of the Objectives of the evaluation 	<ul style="list-style-type: none"> Full final report Presentation
Governments, policy makers and implementers at country level	<ul style="list-style-type: none"> Findings under Objective 1 of the evaluation; Recommendations related to design, implementation, monitoring and evaluation of an RBF approach from a country perspective 	Final report and presentation excluding: <ul style="list-style-type: none"> Findings from review of previous evaluation Recommendations specifically related to internal programme management
GFF investors group	<ul style="list-style-type: none"> Findings under Objective 1 of the evaluation; Recommendations related to design, implementation, monitoring and evaluation of an RBF approach from a country and GFF perspective 	<ul style="list-style-type: none"> Full final report Presentation
Research community, community of practice	<ul style="list-style-type: none"> Findings under Objective 1 of the evaluation; Recommendations related to design, implementation, monitoring and evaluation of an RBF approach from a country perspective 	Final report and presentation excluding: <ul style="list-style-type: none"> Findings from review of previous evaluation Recommendations specifically related to internal programme management

Annex 2: Evaluation framework and questions

Criterion and definition	Evaluation questions at Trust Fund level: HRITF as a programme	Evaluation questions at Country level: RBF as a development modality	Data sources
Relevance The extent to which HRITF and RBF activities and outputs are consistent with achieving the intended outcomes and impact. The extent to which HRITF and RBF design and implementation are relevant (fit-for-purpose) to achieve their respective outcomes and impact.	<p>Is a multi-donor Trust Fund an appropriate mechanism to implement RBF at a country level?</p> <p>To what extent does HRITF provide appropriate support to countries to implement RBF?</p>	<p>How are the RBF mechanisms aligned with and relevant to country policies, systems, initiatives?</p> <p>How are the RBF mechanisms aligned with and relevant to other development assistance and partnerships e.g. GFATM, GAVI, existing bilateral programmes?</p>	Interviews with global stakeholders Interviews with country stakeholders, TTLs, country development partners in virtual and deep dive case studies Document reviews including World Bank documentation and reports e.g. Project Approval Document (PAD), Implementation Status Reports (ISR), country national health strategies and policies, development partners' country plans. Results Framework reports
Efficiency The extent to which HRITF is managed and governed to deliver quality outputs in a timely and economic manner. The extent to which RBF pilots at a country level are designed, managed and implemented to deliver quality outputs in a timely and economical manner.	<p>How efficiently has the HRITF been managed by the donors and the World Bank?</p> <p>How effective were the governance structures?</p> <p>How effective and efficient have the financial management and reporting processes been?</p> <p>Have resources been allocated to the right priorities?</p> <p>Were there sufficient human resources to deliver the tasks?</p> <p>Have a sufficient number of different RBF mechanisms been introduced and tested?</p>	<p>How effective and efficient have the RBF management, contracting and procurement processes been? Does the programme purchase right services at the right prices?</p>	HRITF Results Framework reports and annual financial data reports; World Bank documentation and reports (Project Approval Document (PAD), Implementation Status Reports (ISR); Additional Financing reports; IDA data. Government/implementation agency project implementation units' reports and data. Interviews with: <ul style="list-style-type: none"> Global stakeholders HRITF donors HRITF Secretariat Interviews at country level with: World Bank, Government

Criterion and definition	Evaluation questions at Trust Fund level: HRITF as a programme	Evaluation questions at Country level: RBF as a development modality	Data sources
	Have there been any significant changes in the way HRITF has been managed or implemented over time? If changes were made, why? What if any has resulted from these changes?	Have the RBF mechanisms led to improvements in efficiency in converting inputs to outputs?	counterparts; subnational health staff; health facilities staff, implementing agencies, development partners.
		Have the RBF mechanisms lowered/increased the transaction costs for the recipient compared to other programmes?	
		Have there been any significant changes in the way RBF has been managed or implemented over time? If changes were made, why? What if any has resulted from these changes?	
Effectiveness The extent to which HRITF is likely to achieve its outcomes, and key factors that influence the achievement or non-achievement of TF outcomes. The extent to which RBF is likely to achieve its outcomes, and key factors that influence the achievement or non-achievement of health outcomes.	The extent to which the HRITF has achieved fund-level results as assessed by the HRITF results framework	What have been the key achievements and challenges in establishing and evaluating an RBF approach and building institutional capacity at a country level?	Interviews and Focus Group Discussions with global and country stakeholders, TTLs, country development partners Annual reviews by HRITF secretariat and DFID Results Framework reports Reviews of country RBF and HRITF documentation, financial and activity data, evaluations, Visits (in deep dive countries) to health facilities.
	How did the HRITF respond to any challenges in establishing and evaluating an RBF approach and building institutional capacity at a country level?	What factors are critical or a hindrance to, the successful design, implementation and monitoring of both the pilot projects and the impact evaluations?	
		What factors are critical to build institutional capacity and awareness about RBF approaches?	
		Have the RBF mechanisms lead to improvements in effectiveness – in converting outputs to health outcomes?	
The extent to which the evidence and lessons from	How relevant, rigorous, of good quality and timely has the current and completed generation of	How well are the country RBF evaluations/assessments going to support key policy decision making points as they are	Interviews with global stakeholders, country stakeholders,

Criterion and definition	Evaluation questions at Trust Fund level: HRITF as a programme	Evaluation questions at Country level: RBF as a development modality	Data sources
HRITF are being used, how and at what level.	evidence been from the programme?	currently designed, in terms of timing and evidence needs?	TTLs, country development partners. Reviews of impact evaluations and the HRITF Learning Strategy and plans Review of the development of the RBF website and publication/dissemination of evidence Review of learning and evidence sharing workshops and conferences Review of country level research and reports, evidence, use of findings
	Are the learning and evaluation frameworks fit for purpose including the consolidated evaluation framework?	How has evidence or lessons learned been used at the different stages of design, implementation and transition by countries?	
		Have RBF lessons positively or negatively influenced country policies, perceptions, decision making, practices including addressing gender or implementation course (short and medium term)?	
Impact The extent to which HRITF succeeds in building an evidence base and institutional capacity for RBF to catalyse health systems development and transformation in low-income and lower middle-income countries.	To what extent are programme outcomes (and hence assumed impacts) are likely to be achieved based on available evidence?	Have there been (positive or negative) effects or consequences of the instruments on country health systems?	Interviews with global stakeholders, DFID, Norad Interviews with World Bank HRITF and Health Nutrition Population teams. Interviews with country stakeholders. Review of evidence from impact and other evaluations; Review of country documents and RBF reports; ISRs and Results Framework data.
		Have there been (positive or negative) effects or consequences of the instruments on the implementer, and/or on beneficiaries, and/or health outcomes?	
		What evidence has emerged as to whether RBF incentives impact (positively or negatively) on behaviour of implementer and / or beneficiaries?	
		What impact has the RBF approach had on health outcomes in different contexts?	

Criterion and definition	Evaluation questions at Trust Fund level: HRITF as a programme	Evaluation questions at Country level: RBF as a development modality	Data sources
The effects (positive and negative) that HRITF may have on: the World Bank's ways of working; on the availability, quality, access and utilisation of health services, as well as on health systems more broadly.	How have lessons learnt been used by the World Bank and how has the HRITF affected the way, the World Bank operates in countries e.g. GFF?		Interviews with global stakeholders; with DFID, Norad Interviews with World Bank HRITF and Health Nutrition Population teams. Interviews with country teams and stakeholders. Review of evidence from impact and other evaluations.
	How well is RBF integrated in the broader World Bank programmes including on Health, Nutrition and Populations?		
	How has the HRITF affected the role of World Bank in MNCH globally, including work with partners?		
Sustainability The extent to which RBF has influenced the Bank and other donors' aid mechanisms.	How the global health financing and aid context has changed since RBF was introduced; how this might affect the design, implementation, monitoring and evaluation of RBF processes in future?	What is the evidence of the extent of country ownership for the supported activities?	Interviews with global stakeholders; DFID, Norad. Interviews with World Bank HRITF and HNP teams. Review of HRITF results framework reports. Interviews with country stakeholders including CoP members, development partners. Document review – country plans, strategies, documents and RBF reports; GFF governance and programme documents.
		Are there plans to expand the use or coverage of RBF and/or to integrate the RBF modality with country health systems?	
The extent to which countries succeed in sustaining and scaling up RBF. The extent to which countries can develop, fund and integrate RBF within their own health systems.	What areas of support are required to sustain or transition RBF mechanisms from pilots?	Where are the gaps in institutional capacity required to sustain or transition RBF mechanisms from pilots and how best should these be addressed moving forward?	
	What technical assistance is needed in future, what may be the role of the GFF, role of other partners?	Is provision being made in national health budgets to sustain and scale up RBF? Are countries mobilising additional resources from donors to sustain and scale up RBF	
Equity	To what extent does the RBF design and World Bank guidance and	To what extent are the programmes designed to reach marginalized, harder to reach, poorer and	Review of HRITF documentation, results framework, publications,

Criterion and definition	Evaluation questions at Trust Fund level: HRITF as a programme	Evaluation questions at Country level: RBF as a development modality	Data sources
The extent to which RBF contributes to equitable changes and improvements in the availability, quality, access and utilisation of health services.	processes ensure that equity is addressed?	most vulnerable populations including women and girls?	Interviews with HRITF Secretariat; global stakeholders. Interviews with country stakeholders, PBF COP members, development partners Review of country documents and HRITF reports
		Does implementation of RBF lead to increased access/demand/use among most vulnerable groups?	
		Was there beneficiary involvement in design, implementation and monitoring and if so what level of participation was there and how effective was this?	

Annex 3: Summary of HRITF country grants

Key: Entries in *italics* = deep dives Entries shaded grey = virtual case studies

Country	Dates Effective	HRITF (USD m)	IDA (USD m)	Supply Side	Demand Side	Project objectives	Components	Impact evaluation completion status
Afghanistan (Afghanistan Reconstruction Trust Fund co funding)	09/2013 - 06/2018	12	100	✓		Expand the scope, quality and coverage of health services provided to the population, particularly for the poor, in the project areas, and to enhance the stewardship functions of the Ministry of Public Health.	1. Sustaining and improving BPHS and EPHS services (\$530.90 m) 2. Building the stewardship capacity of MoPH and system development (\$107 m) 3. Strengthening programme management (\$16 m)	Complete 2015
Argentina (stand-alone evaluation, no CPG) Closed						Impact evaluation 1: identified the impact of Plan Nacer programme as a whole on selected health outcomes Impact evaluation 2: investigated the effects of temporary incentives paid to clinics for early initiation of prenatal care using a more restricted experimental approach in one province.		Complete 2014
Armenia	09/2013 - 12/2019	1.8	35	✓		Improve (i) Maternal and Child Health (MCH) services and the prevention, early detection, and management of selected Non-Communicable Diseases (NCD) at the Primary Health Care (PHC) level; and (ii) the efficiency and quality of selected hospitals in Armenia.	1. Performance-based incentives to improve MCH and NCD services in primary care facilities (\$5.03 m) 2. Hospital modernisation (\$38.17 m) 3. Project management (\$1.80 m)	Pilot of evaluation tools complete 2017
Benin	09/2011 - 06/2017	11	32.8	✓	✓	(i) To increase coverage of quality maternal, neonatal and child health care services in the targeted areas, and (ii) to strengthen the institutional capacity of the MoH.	1. Improvement of health facilities performance through RBF (\$25.70m) 2. Support to improved financial accessibility (\$12.10m) 3. Technical Assistance for institutional strengthening (\$6.00m)	Midline evaluation complete

Country	Dates Effective	HRITF (USD m)	IDA (USD m)	Supply Side	Demand Side	Project objectives	Components	Impact evaluation completion status
Burkina Faso	10/2012 - 12/2018	12.7	29	✓	✓	To improve the utilisation and quality of reproductive health services in the Recipient's territory, with a particular focus on selected regions of the Recipient.	1. Improving the delivery and quality of a Reproductive health service package through RBF (\$ 43.30 m) 2. Supporting critical inputs for reproductive health and HIV/AIDS services (\$33.30 m)	Baseline complete 2014; endline due 2017; completion due 2018
Burundi 2	04/2013 - 06/2017	20	25	✓	✓	To increase the use of a defined package of health services by pregnant women and children under the age of five.	1. Increased financing for a redefined free package of services (\$67.55 m) 2. Strengthening capacity of the MoPH and entities involved in RBF 9\$17.25 m)	Endline surveys in progress
Cameroon	06/2008 - 12/2017	20	45	✓	✓	<i>To increase utilisation and improve the quality of health services with a particular focus on child and maternal health and communicable diseases.</i>	1. District service delivery (\$20 m) 2. Institutional strengthening (\$ 5 m)	Complete 2016
Central African Republic	10/2012 - 03/2018	11.2	17	✓		(a) Increase utilisation and improve the quality of maternal and child health services in targeted rural areas of the Recipient's territory; and (b) provide emergency health services to the general population	1. Improvement of health facilities performance through PB contracting and PBF (\$20.60 m) 2. Strengthening of the capacity of the recipient's MoH and Min of Population (\$5.60 m) 3. Emergency health services (\$ 14.00 m)	Baseline complete 2012
Chad	09/2014 - 09/2018	5	15.7			Increase the utilisation and improve the quality of maternal and child health services in targeted areas	1. Improving accessibility and quality of MCH services through PBF and community health (\$12.80 m) 2. Strengthening the institutional capacity to implement and sustain PBF and community-led health care services (\$2.20 m)	Evaluation design agreed 2014
Djibouti	07/2015 - 12/2018	7	7	✓		To improve the utilisation and quality of maternal and child health services and communicable disease control programmes (i.e., HIV/AIDS and tuberculosis) across Djibouti.	1. Improving health service delivery performance \$8.850m 2. Strengthening health system management \$0.8m 3. Strengthening project management and monitoring and evaluation capacity \$4.350m	None planned

Country	Dates Effective	HRITF (USD m)	IDA (USD m)	Supply Side	Demand Side	Project objectives	Components	Impact evaluation completion status
DRC 1	2010 - 2013	0.4	105	✓		Ensure that the target population of selected health zones has access to, and use, a well-defined package of quality essential health services.	1. Expand access and utilisation of a proven package of essential health services to selected District and Health zones (\$193.50 m) 2. Boost Malaria control intervention (\$103.30 m) 3. Strengthen capacity for oversight and evidence-based management of the health system (\$30.20 m) 4. Project coordination (\$4.00 m)	Complete 2013 (?)
DRC 2	05/2016 - 12/2019	6.4	220	✓	✓	Ensure that the target population of selected health zones has access to, and use, a well-defined package of quality essential health services.	As above	
Ethiopia (P4R)	06/2013 - 06/2018	20	100	✓		To improve coverage of basic maternal and child health services, enhance accountability and transparency and strengthen the health management information system.	N/A	None planned
Ghana	02/2015 - 06/2020	5	68	✓	✓	Improve utilisation of community-based health and nutrition services by women of reproductive age, especially pregnant women, and children under the age of 2 years	1. Community-based MCH and Nutrition interventions (\$62.00 m) 2. Institutional strengthening, capacity building, M&E, and project management (\$7.50 M) 3. Epidemic preparedness and control (\$3.50 m)	Baseline complete 2016
Haiti	09/2013 - 12/2018	20	70	✓		To increase the access and use of maternal and child health services, strengthen cholera control, and improve targeting of social services in the Recipient's territory, with a particular focus on areas affected by Hurricane Matthew	1. Providing MCH, Nutrition and social services (\$92.82 m) 2. Strengthening the stewardship and management capacity of Govt (\$11.46 m) 3. Piloting vulnerability indicators for more targeted social service delivery (\$5.00 m)	Baseline completed

Country	Dates Effective	HRITF (USD m)	IDA (USD m)	Supply Side	Demand Side	Project objectives	Components	Impact evaluation completion status
India (Closed)	10/2011-08/2014	0.7	142	✓		To improve health service delivery, public-private collaboration, and financing, particularly for the benefit of underserved and vulnerable groups in Karnataka.	1. Strengthening existing government health programmes (\$75.30) 2. Innovations in service delivery and health financing (\$ 115.80 m) 3. Project management, M&E (\$ 20.70 m)	Complete
Kenya	03/2014 - 06/2018	20	42	✓		To increase the delivery, use and quality of maternal and child health services in rural areas and reduce inequities in access to healthcare through health insurance	1. Scale-up of RBF to improve delivery of quality health services for women and children in rural areas (IDA credit - US\$11 million; HRITF grant US\$14 million) 2.a: Supporting the Health Insurance Subsidies to the Poor (HISP) to reduce inequities in access to health care IDA credit - US\$14 million and HRITF grant - US\$6 million) 2.b: Capacity building of counties to develop sustainable institutions to effectively manage the devolved health system (US\$16 million from the IDA credit)	At design stage
Kyrgyz Republic	07/2014 - 06/2017	11	0	✓		(1) Pilot performance-based payments and/or enhanced supervision for quality of maternal and neonatal care in randomly selected rayon hospitals; and (2) strengthen the Government's and providers' capacity in performance-based contracting and monitoring and evaluating for results.	1. Pilot Performance-Based payments and enhanced supervision for Quality of Care 9\$9.59 m) 2. Strengthen the Govt's and providers' capacity in PB payment reform and M&E for results (\$1.41 m)	Midline survey complete
Lao PDR	10/2011 - 12/2015	2.4	15	✓		Assist Lao PDR to increase utilisation and quality of health services, particularly for poor women and children in rural areas in Project Provinces	1. Improving the quality and utilisation of health services (\$10.15 m) 2. Strengthening institutional capacity for health service provision (\$12.28 m) 3. Improving equity, efficiency, and sustainability of health care financing (\$2.57 m)	None planned

Country	Dates Effective	HRITF (USD m)	IDA (USD m)	Supply Side	Demand Side	Project objectives	Components	Impact evaluation completion status
Lesotho	02/2014 - 07/2019	4	12	✓		(i) Increase utilisation and improve the quality of primary health services in selected districts in Lesotho with a particular focus on maternal and child health, TB and HIV; (ii) improve contract management of select PPPs; and (iii) in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency.	1. Improving health service delivery through PBF (\$11.45 m) 2. Capacity building support to the MoH (\$3.73 m) 3. Enhance PPP management capacity within the Govt. of Lesotho (\$0.82 m) 4. Contingent Emergency response	Baseline complete 2015
Liberia	03/2013 - 05/2018	5	10	✓		Improve the quality of maternal health, child health, and infectious disease services in selected secondary-level health facilities	1. Support to quality service delivery systems (\$19.70 m) 2. Support to strengthening fit-for-purpose health workforce (\$2.70 m) 3. Project management (\$2.00 m) 4. Support to strengthening critical services and support systems (\$6.6m)	Baseline complete 2014
Nigeria	11/2012 - 06/2018	20	150	✓	✓	<i>To increase the delivery and use of high impact maternal and child health interventions and improve quality of care at selected health facilities in the participating states</i>	1. RBF using (i) PBF for outputs at health facilities and LGA PHC Departments (ii) DLI at State and LGA levels (iii) DFF at the health facility level to compare with PBF (\$122.20 m) 2. Technical Support that will support reforms; institutional strengthening; implementation of PBF and DLI at the state, LGA and facility levels; and monitoring and evaluation (\$34.00 m)	Endline surveys in progress
Republic of Congo	01/2015 - 06/2019	10	10	✓	✓	Increase utilisation and quality of maternal and child health services in targeted areas	1. Improve of utilisation and quality of health services of health facilities through PBF (\$107.50 m) 2. Strengthening health financing and health policy capabilities (\$ 12.50 m)	At design stage
Rwanda (Closed)	04/2009 - 06/2012	12	18	✓	✓	Support the government of Rwanda's (GoR's) social protection and health reforms designed to reduce extreme poverty, initially in 30 pilot sectors, and to expand access to high-impact		Complete: evaluation 1 2011

Country	Dates Effective	HRITF (USD m)	IDA (USD m)	Supply Side	Demand Side	Project objectives	Components	Impact evaluation completion status
						health, nutrition and population interventions at the community level.		evaluation 2 2015
Senegal	11/2013 - 06/2018	20	20	✓	✓	Improve health and nutritional outcomes among women and children in regions among the poorest	1. RBF for health and nutrition services and capacity building (\$22.30m) 2. Improvement of accessibility to maternal, nutrition, and children health services (\$14.00 m) 3. Institutional strengthening and project implementation (\$6.00 m)	At design stage
Sierra Leone (Closed)	10/2013 - 10/2016	5	13			To increase utilisation of a package of essential health services by pregnant and lactating women and children under the age of five, and support the emergency response needed to contain and control the Ebola crisis.		None undertaken
Tajikistan	12/2013 - 12/2018	4.8	15	✓		Improvement of the coverage and quality of basic primary health care (PHC) services in rural health facilities in selected districts.	1. PBF (\$ 13.96 m) 2. Primary health care strengthening (\$14.30 m) 3. Project management, coordination and M&E (\$ 4.81m)	Baseline complete 2015
The Gambia	05/2014 - 07/2019	5	8.7	✓	✓	Increase the utilisation of community nutrition and primary maternal and child health services in selected regions in the Recipient's territory	1. Community mobilisation for social and behaviour change (\$5.15 m) 2. Delivery of community nutrition and PHC services (\$11.53 m) 3. Capacity building for service delivery, RBF, food and nutrition security and cash transfers (\$ 4.00 m) 4. Ebola preparedness and control (\$ 0.5 m) 5. Contingent emergency response	Baseline completed 2015
Zambia 1 (closed)	2008 - 2014	17	34	✓	□	To increase coverage of interventions for malaria prevention and treatment and other key maternal and child health interventions	1. Strengthening the health system to improve service delivery \$44m 2. Community response to malaria \$3m 3. Programme management \$3m	Complete 2014 (?)

Country	Dates Effective	HRITF (USD m)	IDA (USD m)	Supply Side	Demand Side	Project objectives	Components	Impact evaluation completion status
Zambia 2	03/2015 - 06/2019	15	52	✓	✓	To improve health delivery systems and utilisation of maternal, newborn and child health and nutrition services in project areas.	1. Strengthening capacity for primary and community level MNCH and nutrition services (\$27.50 m) 2. Strengthening utilization of primary and community level MNCH and nutrition services through RBF approaches (\$24m) 3. Strengthening project management and policy analysis (\$15.50 m).	None planned
Zimbabwe 1 (closed)	9/2011-7/2014	15	0	□	□			Complete 2016
Zimbabwe 2	09/2013 - 02/2017	20	0	✓		Increase coverage of key maternal and child health interventions in targeted rural and urban districts	1. Delivery of packages of key maternal, child and other related health services (\$22.10 m) 2. Management and capacity building in RBF (\$11.90 m) 3. Monitoring, documentation, and verification of results under PB contracts (\$1 m)	
Zimbabwe 3	12/2015 - 02/2017	10	0	✓		as above	as above	

Annex 4 HRITF Results Framework

Summary of indicators in the Health Results Innovation Trust Fund (HRITF) Results Framework

1. Country-level objective: to accelerate the progress toward achieving Millennium Development Goals (MDGs) 1c, 4, and 5

Indicators
Number of 1-year old children fully immunized with support from Results-Based Financing (RBF) Country Pilot Grants (CPGs)
Number of women delivering their babies with a skilled birth attendant with support from RBF CPGs
Number of pregnant women receiving at least 1 ANC visit with support from RBF CPGs
Number of pregnant women receiving postnatal care with support from RBF CPGs
Number of HIV+ pregnant women receiving antiretroviral therapy for Prevention of Mother-to-Child Transmission (PMTCT) with support from RBF CPGs
Number of women aged 15-49 using modern family planning methods with support from RBF CPGs

2. Fund-level objectives: to support RBF approaches in the health sector, for achievement of the health-related MDGs, particularly on MDGs 1c, 4 and 5

Objective 1: Low and lower middle-income countries develop increased awareness of and capacity to design and implement RBF approaches in health

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Indicators
1.1 Total number of K&L, CPG or Evaluation Grant (IE/PA/EPA) approved proposals
1.2 Number of countries with K&L grants that assess the feasibility and appropriateness of RBF and were provided with recommendations on whether to adopt RBF
1.3 Percentage of HRITF-funded teams who participated in HRITF technical training or capacity building events
1.4 Number of countries that took action (either within country or outside) linked to RBF and/or IE in line with recommendations produced through HRITF support

Objective 2: Effective design and implementation of RBF in low and lower middle-income countries

Indicators
2.1 Number of countries with a World Bank board-approved CPG
2.2 Number of different RBF approaches in approved CPGs. The different RBF approaches typically include but are not limited to: (i) health facility performance-based financing, (ii) performance-based financing at higher levels than the health facility (e.g. in administrations), (iii) community-based performance-based financing, (iv) conditional cash/in-kind transfers or voucher schemes, (v) P4R (cash on delivery), (vi) DLIs, or (vii) social health insurance.
2.3 Percentage of Board approved CPGs that are disbursing for results payments
2.4 Number of CPGs making the decision to continue or discontinue RBF based on the evidence produced

Objective 3: Evaluation of RBF programmes supported

Indicators
3.1 Number of approved impact evaluations designs that include rigorous experimental or quasi experimental methodology
3.2 Number of impact evaluations with baseline surveys completed and data/documentation submitted to HRITF
3.3 Number completed impact evaluations that include rigorous experimental or quasi experimental methodology
3.4 Cumulative number of articles in peer reviewed literature on impact evaluation results from HRITF financed evaluations

Objective 4: Countries have access to a robust evidence base on RBF and institutional capacity for sustainability

Indicators
4.1 Number of country level RBF programmes that receive financing from: a) the national government, or b) other donors

4.2 Number of downloads per year of key documents on different RBF technical areas from RBF website, by continent
4.3 Number of impact evaluation reports disseminated in forms other than peer review articles, per year
4.4 Percentage of different types of global audiences who would recommend the website to a peer as a resource for information on RBF
4.5 Cumulative number of (i) unique visitors to the RBF partnership website (www.rbfhealth.org) and (ii) “Facebook likes” of the RBF Facebook page, by continent

20 Objective 5: HRITF is administered efficiently and effectively

Indicators
5.1 Percentage spent on administration, global advocacy and reporting
5.2 Percentage total funding committed for recipient executed
5.3 Average HRITF disbursement ratio is equal or better than the average IDA disbursement ratio
5.4 Ratio of forecasted disbursement at the beginning of the fiscal year and actual disbursements at the end of the fiscal year

Annex 5: Global stakeholders interviewed

Name	Organisation
Amanda Glassman	Centre for Global Development
Julia Watson	DFID
Donald Menzies	DFID
Sally Waples	DFID
Grace Wood	DFID
Terri Starch	DFID
Michael Borowitz	GFATM
Bruno Meessen	University of Antwerp
Ingvar Olsen	Norad
Tore Godal	Norwegian Government adviser
Mickey Chopra	World Bank
Supriya Madavan	USAID
Joe Kutzin	WHO
Agnes Soucat	WHO
Claude Meyer	WHO
Paul Gertler	University of California, Berkeley
Sophie Witter	Queen Mary's University, Edinburgh
Jack Langenbrunner	Bill and Melinda Gates Foundation
Jean Kagubare	Bill and Melinda Gates Foundation
Cheryl Cashin	Joint Learning Network
Godelieve van Heteren	Rotterdam Global Health Initiative
Olga Bornemisza	GFATM

Annex 6: HRITF Country Pilot Grants Projections, Actuals and Disbursements between 2010 and 2019 for case study countries

	Afghanistan (2009-2018)			Benin (2011-2017)			Burkina Faso (2012-2018)			Burundi (2012-2014; 2013-2018)			Cameroon (2014-2017)			DRC (2010-2013; 2014; 2015-2019)		
	Nov, 2013 Projections*	Dec, 2016 Actuals	% Disbursement rate	Nov, 2013 Projections*	Aug, 2017 Actuals	% Disbursement rate	Nov, 2013 Projections*	Aug, 2017 Actuals	% Disbursement rate	Nov, 2013 Projections*	Aug, 2017 Actuals	% Disbursement rate	Jan, 2014 Projections*	Aug, 2017 Actuals	% Disbursement rate	2013, 2014 and 2016 Projections*	Aug, 2017 Actuals	% Disbursement rate
2010	1.026	1.026	-													0.099	0.099	-
2011	1.476	1.476	-													0.147	0.147	-
2012	1.089	1.089	-	1.638	1.638	-										0.318	0.318	-
2013	2.333	1.671	72%	2.100	0.637	30%	1.632	1.333	82%	11.076	10.076	91%				0.292	0.292	-
2014	1.250	2.844	227%	2.500	2.820	113%	1.500	4.741	316%	7.700	5.750	75%	0.200	0.000	0%	6.000	8.934	149%
2015	1.250	1.691	135%	2.500	2.286	91%	2.500	5.287	211%	5.000	5.195	104%	2.800	3.600	129%	4.000	1.028	26%
2016	1.250	1.217	97%	2.200	2.511	114%	3.500	1.319	38%	4.000	8.856	221%	6.000	13.821	230%	3.000	0.000	0%
2017	1.250	0.225			0.874		3.568	0	0%	4.600	3.913	85%	6.000	1.272	21%	3.500	0.788	23%
2018	1.075									2.400			5.000					
2019																		
Total of the CPGs Projections and Actuals	12.0	11.2	94%	10.9	10.8	98%	12.7	12.7	100%	34.78	33.79	97%	20	18.69	93%	17.36	11.61	67%
	*As Aug 10, 2017, Revised Projections are \$300,000 in 2017 Q3 and Q4 and \$460,000 in 2018			*Revised Projections are \$230,000 in 2017 Q3&Q4.			*All the CPG have been disbursed between 2013 and 2016			*Revised Projections are \$540,000 in 2017 Q3&Q4			*Revised Projections are \$1,3 million in 2017 Q3&Q4			*Revised Projections are \$5,71 million until 2019; Note that the 2010-2013 Projections are from Nov 5, 2013, 2014 and 2015 Projections are from Sept 10, 2014 and 2016-2017 Projection as from April 2016 Data		

	Ethiopia (2013-2018)			Gambia (2014-2019)			Haiti** (2013-2018)			Liberia (2014-2018)			Nigeria		
	Nov, 2013 Projections*	Aug, 2017 Actuals	% Disbursement rate	Sept, 2014 Projections	Aug, 2017 Actuals	% Disbursement rate	Nov, 2013 Projections	Aug, 2017 Actuals	% Disbursement rate	Sep, 2014 Projections	Aug, 2017 Actuals	% Disbursement rate	Nov, 2013 Projections	Aug., 2017 Actuals	% Disbursement rate
2010															
2011															
2012															
2013	6.000	6.000	-										1.000	0.000	0%
2014	11.800	7.800	66%	0.300	0.232	77%	2.000	0.000	0%	0.300	0.000	0%	4.000	4.805	120%
2015	2.200	0.000	0%	0.500	0.726	145%	6.500	0.000	0%	1.200	0.000	0%	5.500	4.225	77%
2016	0.000	0.000	0%	1.500	1.519	101%	6.500	0.000	0%	1.200	0.000	0%	5.200	4.135	80%
2017				1.500	0.736	49%	5.000			1.275	0.180	14%	4.000	3.595	90%
2018				1.200						1.025			2.000		0%
2019															
Total of the CPGs Projections and Actuals	20	13.8	69%	5.000	3.213	64%	20.000	0.000	0%	5.000	0.180	4%	21.700	16.760	77%
	*Revised Projections are \$6,2 million in 2017 Q3&Q4			*Revised Projections are \$400,000 in 2017 Q3&Q4, \$900,000 in 2018 and \$490,000 in 2019			*The project has not yet disbursed; the revised 2017 Q3&4 Projections are \$2 million, and \$8 million the two subsequent years, in 2018 and 2019			*Revised 2017 Q3&Q4 Projections are \$2 million and \$2,82 million in 2018			*Revised 2017 Q3&Q4 Projections are \$2,4 million and \$2,54 million in 2018; Note that the Projections for the first HRITF grant in Nigeria are taken from Nov 213 Data and the second, from Oct 2015 Data		

	Senegal** (2014-2018)			Tajikistan (2013-2019)			Zambia** (2011-2014; 2015-2019)			Zimbabwe (2011-2014; 2013-2015; 2015-2017; 2018)		
	Jan, 2014 Projections	Aug, 2017 Actuals	% Disbursement rate	Jun 2014 Projections	Aug, 2017 Actuals	% Disbursement rate	Nov, 2013 Projections	Aug, 2017 Actuals	% Disbursement rate	Nov, 2013 Projections	Aug, 2017 Actuals	% Disbursement rate
2010												
2011							1.746	1.746	-			
2012							4.286	4.286	-	10.264	10.264	-
2013								3.968		7.236	9.956	138%
2014	1.700	0.170	1%	0.750	0.350	47%	5.740	6.725	117%	10.000	10.736	107%
2015	3.000	0.176	6%	1.200	0.406	34%	3.500	1.000	29%	7.500	3.966	53%
2016	7.600	1.217	16%	1.200	0.946	79%	4.000	0.418	-10%	6.700	8.970	134%
2017	7.600	0.835	11%	1.250	0.548	44%	4.000	1.078	27%	6.300	1.043	17%
2018	0.100			0.400			3.500			2.000		
2019												
Total of the CPGs Projections and Actuals	20	2.398	12%	4.800	2.249	47%	30.740	18.385	60%	50.000	44.936	90%
	*Revised 2017-2018 Projections are 14,3 million, i.e. 72 % of the total CPC grant			*Revised Projections in 2017 Q3&Q4 and 2018-2019 are \$2,55 million			Zambia 2017-2018-2019 Projections are \$2 million, \$4 million in 2018, and 7,34 million in 2019, for a total of \$13,34 million			*Revised Projection in 2017 Q3&Q4 are \$64,000 (from the 3rd CPG) and an additional \$5 million in 2017 Q3&Q4 and 2018 (4th grant) for a total of \$5,064 million		

**** Projects with possible partial cancellation at end disbursement date if project closing date is not extended.**

Source: HRITF CPG Disbursements (250817) WB

Note: Data between 2010 and 2013 are Actuals, except for 2013 Q4 that are Projections. The Disbursement rates in 2013 reflect the difference between the Projections and Actuals disbursements in 2013 Q4, if any; for each CPG, initial Projections were used to compare with the Actuals Disbursements and to calculate the Disbursement rates. Annual Projections have been largely revised over the years due to various factors such as delays starting the implementation, balancing out the financing of the sources (including IDA Credit) as the project moves forward, more expensive project or other contextual factors.

Explanations for the variance (Over disbursements in Afghanistan, Cameroon, Burkina Faso or Zimbabwe, or delayed in DRC, Ethiopia, Haiti, Senegal etc.):

-In Afghanistan: the last data are from Dec 1 2016, after the project disbursements are not reported in the Excel files.

-In Burkina Faso the CPG were disbursed faster than projected and according to a study, the trends in the monthly disbursement rate and operational activities, will inevitably lead to a funding GAP

-In Cameroon over disbursement was about balancing out the financing of the two sources according to the TTL: HRITF CPG and the IDA credit, as the project moves forward.

-In DRC, the HRITF grant was used while the IDA credit weren't yet available because the political context: the Assembly took one year to approve the credit (instead of the usual three months)

-In Senegal the HRITF mainly supported the preparation phase since the approval of the project, in 2014, because the lack of government's ownership that is causing delays

-In Zimbabwe, the project was more costly than projected (according to the TTL of Cameroon) -to be documented

Annex 7: HRITF Disbursements Summary by Activity Category

US\$ Million

Category	CY08- CY12	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018	CY2019	CY2020	Total
1. Preparation and Review of Proposals	.7	.5	.6	.6	.3	.0	.0	.0	.0	2.7
1a. RBF Seed Grants/K&L grants	3.9	1.0	.6	.2	.0	.0	.0	.0	.0	5.7
2. Recipient-executed Design and Pre-Pilot grants	1.8	3.1	3.9	3.3	.9	.1	.0	.0	.0	13.1
3. Bank-executed Preparation and Appraisal	4.5	1.8	2.0	.6	.0	.0	.0	.0	.0	9.0
4a. Implementation of RBF Programmes (CPGs)	34.3	34.7	61.4	35.8	61.8	65.4	59.3	26.3	1.8	380.8
5. Bank supervision	1.3	2.0	2.2	2.8	3.3	2.8	1.8	.5	.0	16.6
6. Monitoring, Documentation /Knowledge Sharing	.9	.8	.9	.6	.3	.7	.7	.7	.4	6.0
7. Evaluation of RBF projects	8.3	4.0	7.9	5.9	4.3	6.7	8.8	1.7	.2	47.8
8. Knowledge dissemination	7.6	.9	1.3	.5	.3	.0	.3	.2	.2	11.4
9. Administration and Resource Mobilisation	2.2	.4	.5	.4	.4	.5	.5	.4	.2	5.5
Grand Total	65.7	49.2	81.4	50.7	71.7	76.1	71.3	29.6	2.8	498.6

Source: HRITF Financial Update as of August 21, 2017, World Bank

Annex 8: Summary of completed impact evaluations

Country, and dates of evaluation publication	Evaluation design	Summary of evaluation findings
Argentina (2014)	Random sampling of women from relevant registration lists	The programme increases the number of perinatal care visits as well as the probability of receiving a tetanus vaccine. Beneficiaries also had a 19% lower probability of low birth-weight compared to non-beneficiaries. Beneficiaries have a 74% lower chance of in-hospital neonatal mortality in larger facilities, approximately half of which reduction is due to from fewer low birth weight babies and half from better postnatal care. Results also show that the financial autonomy provided to facilities by <i>Plan Nacer</i> allowed a better allocation of scarce resources, which in turns had positive impact on health outcomes of beneficiaries.
Afghanistan (2015)	Two groups: treatment group and control group	The first evaluation found no significant differences in any of the five RMNCAH coverage indicators (modern contraception, antenatal care, skilled birth attendance, postnatal care, and childhood pentavalent vaccination) or indeed on equity measures between the P4P arm and the comparison arm. However, substantial increases were observed in the quality of patient examinations and counselling, as well as in the time spent with patients. The second end-line results were largely similar, with few statistically significant differences between the treatment and control arms on utilization of health services. However, the study found improvements in staff training and the availability of medical supplies, as well as in facility-level management.
DRC Haut Katanga (2013?)	Two groups: treatment group and comparison group; comparison group received the same levels of funding as the treatment group	A 43% increase in the provision of preventive sessions for targeted services in the treatment group than in the comparison group, with no discernible impact on the quality of these services or associated patient satisfaction. However, these increases did not translate into higher levels of service utilization or better health outcomes. There were also design problems which weakened the pilot: there were interruptions in the payment schedule; the comparison group received substantially higher payment levels during the first six months of the two year-long intervention. As facilities in the treatment group were required to reduce the prices of their services but were unable to attract more patients, revenues were substantially lower in the treatment group than the comparison group, leading to 42% fewer resources for the treatment facilities, and 34% less income for health workers in the treatment group than in the comparison group.

Country, and dates of evaluation publication	Evaluation design	Summary of evaluation findings
Rwanda 1 (2011)	Two groups: treatment group and comparison group with comparable input funding.	A large and significant positive impact on institutional deliveries, the quality of prenatal care, and the utilization of preventive care for young children.
Rwanda 2 (2015)	Three intervention groups: (i) demand-side in-kind incentives for women, (ii) performance-based payment for community health worker (CHW) cooperatives, and (iii) combined demand-side & CHW cooperative performance payments, pure comparison group.	Demand-side in-kind incentives, on the other hand, had a significant positive impact on timely antenatal and postnatal care. Relative to the comparison group, women in the demand-side-intervention-only arm were almost 10 percentage points more likely to attend ANC during the first four months of their last pregnancy and 7 percentage points more likely to attend PNC within the ten days after delivery. Supply-side incentives to CHW cooperatives did not affect any of the outcome indicators.
Zambia (2014?)	Three-arm evaluation that tested RBF against an enhanced financing-only arm and a pure comparison arm.	Institutional deliveries and skilled birth attendance increased substantially in the RBF districts relative to the comparison arm, but rose by even more in the enhanced financing arm relative to the pure comparison arm. The first ANC visit was earlier by two weeks as compared to the two other arms. In addition, while full vaccination coverage declined in both, the enhanced financing and comparison arms, it remained constant or slightly higher in RBF districts. The enhanced financing arm also showed improvements and improvement in PNC was much faster in this arm
Zimbabwe (2016)	Two groups: treatment districts; matched districts without treatment or funding.	Key indicators such as delivery by skilled provider and in-facility delivery improved faster in RBF districts than in control districts. Findings suggest a largely positive message around quality (but not for all indicators): improvements were observed for selected measures of structural quality, as well as increased availability of certain equipment. For both the RBF and control districts, the availability of the majority of medicines, supplies, and equipment remained relatively unchanged, with minor fluctuations across products from baseline. A key indicator of the system-level effects was the strong evidence suggesting no neglect of non-incentivized services. None of the non-incentivized services investigated showed a decline in the number of cases treated. Key enabling factors included improved autonomy, decentralized decision-making, and strengthened facility-level governance. Findings also suggest greater positive effects for the lesser-educated groups and the poor.
Sources:	<i>Impact Evaluations and emerging lessons</i> , Kandpal, Eeshani, World Bank 2016; relevant country impact evaluations referred to	

Annex 9: Deep Dive Case studies summaries

Nigeria Case Study

Overview of HRITF grants and other financing sources in Nigeria

Source	Date effective	Closing Date	Amount
HRITF	15/11/2012	30/06/2018	\$20 million
IDA	15/11/2012	30/06/2018	\$150 million
HRITF additional financing	20/03/2014	30/06/2018	\$1.7 million

Context

As Africa's most populous country, it is crucial for Nigeria to make progress on health outcomes for Africa to achieve global health targets. At the project's start date, health outcomes were poor, and Nigeria contributed to 10% of global maternal deaths.

Relatively high levels of health spending in comparison to other parts of Africa. As of 2012, total health spending was estimated at around US\$30 per capita.

Complex federal arrangement in which individual states have considerable autonomy in managing the health sector. Revenue allocation and expenditure responsibilities are decentralised to Local Government Authorities (LGA), and health system responsibilities dispersed among the three levels of government (federal, state, and local government). Currently there are no direct lines of accountability for health between the different levels of government, and each has an independent budget. There is a lack of alignment in priorities and approach between the three levels, and no unified approach to primary care. The HRITF-supported project was implemented initially in three states with wide variation in key maternal health indicators.

Recent financial crisis due to crash in oil prices. Since mid-2014, "growth has been on a downward spiral, and the economy is currently in recession. In 2016, it continued to deteriorate further after recording negative growth in the first two consecutive quarters."⁸¹

Ongoing insurgency in the Northeast, including in Adamawa state where RBF is being implemented.

RBF Implementation Arrangements

RBF is integrated with existing health systems structures, and has developed processes which ensure that existing federal, state, and local government bodies are at the core of its delivery. The project uses supply-side RBF to support the delivery of a pre-defined package of healthcare services in Nasarawa, Ondo, and all North-eastern States. The Project Implementing Unit (PIU) is located in the National Primary Health Care Development Agency, which provides technical assistance to State Primary Health Care Development Agencies to contract primary and secondary healthcare facilities. RBF is also used to address demand-side constraints to boost service utilisation. Additionally, the project aims to strengthen institutional performance through financing to local governments and states through Disbursement Linked Indicators (DLIs) for performance in areas such as budgeting and HMIS reporting.

⁸¹ See World Bank Nigeria overview: <http://www.worldbank.org/en/country/nigeria/overview>

Ownership at the state level is strong, but ownership at the federal level is less clear. The PIU is located within the National Primary Healthcare Development Agency, which is independent of the Federal Ministry of Health. This provides an arm's length position which supports independence, but which is also seen to weaken the ownership felt by the Federal Ministry of Health.

Engagement and alignment with development partners appears mixed. While the RBF project does provide a platform for engagement, there is limited evidence of other partners buying in to the programme, for instance through funding indicators relevant to their work.

Implementation Effectiveness, Equity, and Efficiency

RBF in Nigeria has developed in a phased process, which has allowed it to learn and adapt its modality to increase its effectiveness, and its contribution is evident in pilot states. Learning from the initial pilots has been used to develop processes which are robust and effective, and there is frequent "learning by doing" to review and revise processes, including the recalibration of indicator fees and revisiting verification processes.

A key area has been capacity and institutional strengthening. Oxford Policy Management (OPM) is the technical assistance provider, and has assisted with developing processes, quality improvement plans, trainings and managing the ex-post verification of results. There remain a number of gaps in institutional engagement and capacity, in supervision skills and effectiveness, and in developing management capacity in the Local Government Areas. While each government level has a set of DLIs through which they are rewarded for improved management, hospital and Primary Health Care Boards, which play an important role in overseeing performance in facilities and hospitals, are insufficiently incentivised for their performance, and are not effectively engaged.

The effectiveness of RBF is demonstrated clearly at the facility level, where significant improvements have been noted in infrastructure, staffing levels, and consequent improvements in patients and resulting financial strength. RBF has contributed to greater staff accountability and reduced absenteeism. Greater autonomy for the facilities has enabled them to introduce and own the improvements that have been made. Facilities receive regular supervision by Local Government and this is seen to have a positive impact on the quality of care.

RBF has contributed to health systems strengthening in Nigeria, through improving the culture of data collection and utilisation, the development of the Drug Revolving Fund to help ensure a stronger supply chain, improved staffing levels, and the provision of a methodology that can support improved financing systems.

The RBF modality prioritises maternal and child health, and therefore is focused on meeting the health needs of women and girls. There is a mechanism to compensate facilities with higher needs levels, through the provision of a financial hardship weighting based on their remoteness from the relevant local government centre to help compensate for the additional difficulties of distance, recruiting and retaining staff, and more dilapidated facilities. An element of the programme also provides for free health care for the poorest of the poor to enable all to have access.

RBF has provided an efficient means of channelling funds directly to health facilities, and strategic purchasing has been an effective way of making course adjustments when necessary. Fraud, which is a widespread concern in Nigeria, is effectively detected and sanctioned through the counter verification system. Payment to contracted entities has been made in a timely manner, which is viewed as a significant achievement. This is attributed to the use of the online reporting portal, through which verified results are posted and commensurate payments made in real time.

A large volume of operational research has been undertaken throughout the implementation, and this has been used to make course adjustments. Examples of operational research include a study on the determinants of health facility performance

Detailed information relating to the administration and overhead costs of RBF has not been made available.

Impact

The impact evaluation for Nigeria has not yet been completed

Sustainability

Most stakeholders appear to be of the view that RBF and its associated reforms merit sustaining. Long-term financial sustainability is however a persistent and serious challenge. Whilst it is largely evident that institutionally there has been a sufficient degree of buy-in and ownership, at present it remains unclear how the supported activities will be sustained following the end of the programme in June 2018. That said, stakeholders are aware of this challenge, and there are indications that discussions have commenced to explore possible means of addressing it.

It is quite evident that at the facility, LGA, and State level, there has been a significant degree of buy-in with regard to the reform potential of RBF, and this has led to a strong sense of ownership. However, it is widely acknowledged by stakeholders that long-term sustainability will depend in some measure on uptake by the Federal level of government. The scope for engagement is broad, as both the National Health Strategic Development Plan and the National Health act “call for bold innovations and reforms that increase the focus on results and address ineffective incentive structures.” Nevertheless, the view is that efforts to raise the visibility of RBF at the Federal level have not been proportionate to the successes that it has registered at the State and LGA level.

Long term financial sustainability: prior to the implementation of Nigeria State Health Investment Plan (NSHIP), primary and secondary health facilities in Nigeria received extremely limited inputs from government beyond the (often incomplete) payment of salaries for health workers. The current RBF mechanism in the States is supported entirely by a grant from HRITF and a loan from IDA, with no government co-financing or in-kind contribution. At this stage, it appears unlikely that the government will have the necessary discretionary financing to continue to implement RBF beyond the duration of NSHIP. The implications of this are significant, as RBF has become the primary source of funding for facilities and supervision bodies in the intervention areas.

There is some indication that to some extent, RBF is seen more as a source of finance than as a fundamentally new way of doing business. In contrast to some other countries where stakeholders at the facility level stressed primarily the managerial changes brought about by RBF, discussions held in Nigeria were in general more focused on the importance of the presence of funding and its use for staff incentives

There are encouraging indications that the sustainability challenge is acknowledged by key stakeholders, and it is understood that there have been discussions to identify possible solutions. Some of the States covered by RBF, including Nasarawa and Adamawa have made concerted efforts to coordinate partners and bring them into the fold of RBF through the establishment of basket funds. State-supported health insurance schemes have also been mooted as a means of addressing the financial sustainability challenge, but it is unclear at what stage this is and whether state health insurance schemes will be sufficiently established before the end of the current World Bank funding and the planned GFF support.

Zimbabwe Case Study

Overview of HRITF grants and other financing sources in Zimbabwe

Source	Date effective	Closing Date	Amount
HRITF I	06/12/2011	31/07/2014	\$15 million
HRITF II	25/09/2013	28/02/2017	\$20 million

Context

- Legacy of a well-managed and efficient public health sector, but this has been weakened by protracted economic decline over the past two decades.
- High maternal (651 per 100,000 live births) and infant (50 per 1000 live births) mortality rates (2015).
- Results Based Financing identified by government as a desirable modality for public service delivery prior to the involvement of the HRITF.
- Zimbabwe remains ineligible for IDA support, and is the only country in which the HRITF is operating as the main financing source for RBF.

RBF Implementation Arrangements

RBF is well-aligned to government structures, but does not make use of government systems (at least in part because Bank rules in Zimbabwe proscribe the use of government fiduciary systems). Instead, a Project Implementing Agency (Cordaid) was contracted to serve as the fund holder for the project. Cordaid has contracted local government supervisory bodies and primary and secondary health facilities for participation in RBF. The second phase of financing, however, requires Cordaid to support efforts to establish and build the capacity of a Project Implementing Unit within the Ministry of Health.

Ownership appears strong at the ministerial level. This is evidenced by the Government of Zimbabwe's call for the adoption of the RBF operating model by the Health Development Fund (a separate multi-donor fund supporting the health sector in Zimbabwe), by Government co-financing, and the identification of a Project Implementation Unit within the Ministry of Health to assume management of the programme from Cordaid upon completion of the HRITF project. The Government appears to have maintained a pivotal role throughout implementation through the National Steering Committee, which provides guidance and strategic support, and through its decentralised structures, which are responsible for the supervision of healthcare service deliver.

Implementation Effectiveness, Equity, and Efficiency

The RBF mechanism appears to have been very effective in fostering organisational changes at the facility level. However, the impact evaluation does not determine whether this is due simply to additional resources, or to the nature of the modality itself.

Key organisational changes observed at the facility and supervisory level include but are not limited to; improved autonomy and decentralised decision making, revitalisation of community governance and oversight structures and routine supervision by local government, improved data quality, improved structural quality, and improved staff satisfaction.

Challenges encountered in implementation have included increased workload for staff, the inability of health facilities in small catchment areas to attract sufficient volumes, severe delays in RBF payments, and downward revisions to indicator prices due in part to resource availability.

With regard to efficiency, the cost of the programme appears high, but there are indications that this is improving. Overhead costs were initially as high as 50% of the total budget but have since been reduced to between 23% and 25% of overall cost. Third party verification is considered expensive, and efforts are underway to develop a leaner, risk-based approach to verification.

Impact

The impact evaluation of the RBF programme found that “many of the programmes intended consequences have been achieved while, unexpectedly, some unintended changes and effects have also occurred.” In terms of coverage, significant increases were observed in both RBF and non-RBF districts. However, because resources were not matched across intervention and control sites, some of these results may have followed from increased resources rather than RBF as a payment mechanism. Not all indicators showed improvement. For example, there was no significant improvement in ANC services or in family planning services.

Sustainability

Sustainability emerges as a key challenge, with crucial outstanding questions regarding long term financing. Significant efforts will be required to ensure that the approach is sustained. There are positive signs, including the Government’s commitment to maintaining the approach, and willingness to contribute resources despite government fiscal constraints. Other development partners, including the Global Fund, have indicated interest in supporting RBF in Zimbabwe, and RBF has been identified as key area of cooperation in the Medium-Term Framework between the World Bank and the Government. As a result of the experience in the HRITF pilot, Zimbabwe has elected to scale up RBF in the rest of the country.

Even (and perhaps especially) so, the issue of sustainability is rendered more problematic by the high levels of dependency that RBF has engendered. While RBF payments were never designed to cover the full costs of service delivery, but instead aimed to serve as subsidies, they have become in many cases the only source of funding for health facilities’ operational costs (though the Government does continue to cover the costs of human resources and pharmaceuticals, albeit intermittently). Whilst limiting the scope for the type of service innovation for which the programme was originally designed, this also implies a level of dependency which may constitute a sustainability risk. This is evidenced by the disruption resulting from downward revisions to subsidy prices.

Cameroon case study

RBF and HRITF in Cameroon

	Date effective	Closing date	Revised closing date	Amount USD \$ million
IDA	March 2009	March 2014	December 2016	25
HRITF	September 2014	December 2017		20
IDA	June 2014	December 2017		20

Performance Based Financing (PBF) in Cameroon began with a pilot in East region in 2006, supported by an NGO. In 2008, the World Bank approved a \$25 million loan to Health Systems Support Investment Project (HSSIP) which supported pilots in Littoral region. In 2012 the PBF programme was extended with Bank funding as part of the HSSIP programme and covered 26 districts in four regions by the end of 2012, implemented by other NGOs. In 2014, contracting, verification and payment responsibilities transferred from NGOs to the Regional Funds for Health Promotion (RFHP), regional-level organizations. The purpose of the 2014 HRITF funding and additional IDA funding agreed in 2014 was to support continuation of PBF in the first 4 regions and to extend it the three regions in the north.

Relevance

Maternal and child health in Cameroon is in critical need of improvement. Cameroon is one of the few countries with high maternal mortality where maternal mortality did not decrease at all between 1990 and 2015. One possible explanation is that the proportion of women delivering in health facilities has remained unchanged over much of the last decade; and antenatal visits rates are low. Government spending on health is also low. In 2012, government spending only accounted for 21.7% total spend, and much of the remaining 70% is paid for by user fees. Much of the health budget is spent on administration and infrastructure so that there is inadequate resource to run and supply the day to day health services. It is highly centralised: 70% of the health budget remains at central level with only 10% allocated to regions, excluding external financing. Funds are not targeted towards the most under-served populations, or to more challenging socio-economic or security contexts. Health staff are very unequally distributed across the regions, with the poorest and more remote regions being understaffed. The drugs supply chain managed by the public-sector agency CENAME is weak; drugs can be obtained using the private sector market; however there remains a need for better regulation and more reliable access to supplies.

There is good alignment between the PBF programme and with national health strategies and policies and processes are in place, to develop and strengthen health systems to align with and support PBF. The PBF programme is now being integrated into the national health system and is integral to the Plan National de Developpement Sanitaire (PNDS) health financing strategy and proposals for financial reform (in development). In 2016, the Government committed to scale up PBF to cover 100% of the country by 2020 and has instructed regions to do so in 2017.

PBF is seen to offer a highly relevant tool to enable public health facilities to improve the quality and quantity of health services provided through strategic purchasing, and to increase availability of resources to the health facilities. The PBF programme has also engaged with the private sector. This is particularly important in Cameroon given the high proportion (40%) of private or confessional health facilities. Through the PBF programme there is now more effective regulation and incentivisation of the private/confessional sector and this is improving quality standards and coverage nationally, given the sector's size.

PBF is now widely integrated with health policies and strategies in Cameroon. The PBF programme is explicitly included in the National Health Strategy 2016-20 and seen to provide a method for improving health coverage and quality standards in Cameroon. PBF has also been selected in the Global Financing Facility (GFF) Investment Case as one of the key service delivery platforms for improving health outcomes in the four priority regions for GFF (East, Adamaoua, North, and Far North).

There is now a stronger ownership for PBF by the Ministry of Public Health, although this has been a developing journey from earlier years when PBF was seen as a parallel system external to the MoPH, and was perceived as a separate programme. The Project Implementation Unit (PIU) for PBF, previously hosted outside the MoPH by the World Bank, has been developed into the Cellule Technique Nationale (CTN), a larger support unit which is based in the MoPH. The CTN is responsible for the technical management of PBF, managing and allocating funding, verification, monitoring and evaluation at national level. The CTN is, however identified as lacking sufficient capacity and political weight to meet its task

The other development partners are generally supportive of the PBF programme as a model for health care and health financing. Initially partner engagement was slow. The PBF programme was initially seen as a vertical programme, working in parallel with the Government of Cameroon (GoC) and others, and is still viewed that way by some partners despite the alignment of the project with the government program and policy. Over time partners have realised the PBF programme's potential to reduce parallel working and integrate activities, especially UNICEF and UNFPA who have been formally engaged since 2015 and use PBF indicators to assess progress on the health areas they support (family planning and nutrition), and CDC/PEPFAR since 2017 for HIV/AIDS indicators. There was however been a decision in 2017 by UNICEF to reduce their contribution to PBF funds for nutrition services, since the nutrition indicators were not improving well and UNICEF did not have the financial resources to continue supporting the programme. A demand-side project providing vouchers run by AFD is not yet fully aligned with PBF implementation although the PBF unit and voucher programme have jointly agreed upon measures related to quality measurement and payment for better harmonization of the two approaches on the ground.

Efficiency

The US\$20 HRITF Country Project Grant (CPG) has been used between 2015 and 2017 in conjunction with \$20 million IDA, to scale-up the activities of the 2008 original project and to fund the impact evaluation. US\$ 15 million of the HRITF was allocated to service delivery, and \$5 million to institutional strengthening. The HRITF CPG accounts for 85% of the HRITF funding in Cameroon; the remaining funding covers the evaluation of the project (9%), preparation and supervision, administration and recipient design and pre-pilots (6%).

As showed in the Table 1 below, 93 % of the HRITF CPG grant was disbursed as of 30 June 2017. The grant was disbursed faster than anticipated, according to the HRITF projections, as the HRITF funds were used to balance the IDA expenditure on PBF. Both funds were used to support PBF and have effectively been used as two elements in a combined budget.

Table 1: HRITF Disbursements Projections and Actuals Disbursements in Cameroon

	Projections USD\$	Actuals as of August 1, 2017 USD\$	% of Actual Disbursements on Projections
2015	3, 603, 000	3, 603, 054	100%
2016	3, 566, 000	13, 820, 823	388%
2017	6, 000, 000	1, 271, 929	21%
2018	6, 830, 000	-	-
Total	19 999 000	18 695 806	93%

Source: HRITF Financial updated as of September 1, 2016 (Annex 4) and the WB, as of August 1, 2017

The majority of the project funds were used to reward the performance of the facilities in the four regions, increasing to 64%, in 2015 (see Table 2). Overhead costs varied according to the model of management: in Littoral region where the Performance and Payment Agencies (PPA) responsibilities were implemented by the RFHP, it took half the funds on operating costs while they were limited to 14% in the other regions in their contracts with AEDES. The remaining funds paid for goods, equipment and pharmaceuticals (15%), operating costs (20%) and consultants (5%) (See Table 2)⁸².

Table 2 : Project Expenses, 2014 and 2015 - Projet d'appui aux investissements dans le secteur de la Santé (PAISS)

	2014	% of Disbursements 2014	2015	% of Disbursements 2015	Total	% of Disbursements (2014-2015)
Service Delivery	7 548 870	53%	17 551 088	64%	25 099 958	60%
Operating costs	2 155 184	15%	6 139 323	22%	8 294 507	20%
Goods Equipment and pharmaceuticals	3 355 880	24%	2 751 593	10%	6 107 473	15%
Consultants	1 128 330	8%	1 095 813	4%	2 224 143	5%
Total	14 188 264	100%	27 537 817	100%	41 726 081	100%

Source: Unité de gestion du projet, Comité de pilotage, PAISS (2014, 2015)

In the South West RFHP, 60% of resources are used to pay for performance of the health facilities and 40% was allocated to the Regional Fund to cover operational costs, including training and coaching (2017).

In 2016, the World Bank introduced changes to reduce transaction time between validation of results and receipt of PBF subsidies, to reduce operational costs and to separate payment from contract management and verification. The PIU fiduciary and coordination responsibilities of the project were transferred into the CTN-PBF and technical direction from MoPH was transferred to the CTN. The responsibilities of the PPA, previously managed by International Non-Government Organisations (INGOs), were allocated to the newly established ACVs, hosted by the RFHP, to focus efforts on contract management, verification and coaching. Health facility payments were transferred to the RFHP, although the AVCs still pay the Community-Based Organizations (CBOs) directly for community verification activities. Health facilities are required to have an independent bank account and are directly paid by the CTN.

Delays in disbursements of up to 10 months have been experienced which have had a negative impact on performance. Delays have become more serious since 2016, partly due to the increase in the volume of payments without adequate staffing within the PBF Unit to meet increased demand, compounded by lengthy payment processes. For instance, in the region of the South West Region of Cameroon, indicator payments were only paid for two months in 2016. The lack of finances led to staff demoralisation, which undermined performance⁸³. Community feedback scores for health facilities were lower following the delays. A new portal for payment was launched in August 2017 which should reduce the number of processes required to approve payment, and the time required for processing claims significantly. In November 2017, after a lengthy procurement process the PBF unit hired four additional accountants in order to increase the speed at which payments for PBF subsidies were processed.

As part of regular review of performance, the tariffs for indicators have been adjusted to optimise their impact and focus health workers' activities on the harder to achieve indicators, such as institutional deliveries and ANC visits, and rather than on low hanging fruit, such as immunisations.

⁸² The evaluation team received no data to analyse the project expenditure for implementation for 2015 and 2016.

⁸³ Cameroun Endline Qualitative Study 2017, World Bank

This should increase the efficiency and effectiveness of the PBF resources, but also had some initial negative impacts on local health systems, as facilities adjusted their budgets to accommodate changed incomes levels. There have been efficiency gains associated with the RBF, such as increased productivity as assessed by numbers of people seen by nurses, and reductions in payment fees for patients.

Effectiveness

PBF has contributed to strengthening governance and accountability for performance and funds. PBF has provided a stronger framework for results, with a clearer regulatory role at regional and district levels, as well as the independent verification and contracting function of the AVC. This has been reinforced by the recent development of PBF contracts with performance objectives for the CTN, Regions, District and AVC as well as for facilities. Central-level performance contracts were signed in August 2017 with the Directorate of Family Health, the Directorate of Health Promotion, the Health Information Unit, and the National Programme to fight Maternal and Child Mortality, contributing to greater integration of the PBF principles in the central-level administration of the Ministry of Public Health. Building on the publication of results data and costs required by PBF, there is also greater transparency. The use of CBO community surveys provides direct feedback on quality of care from local communities, increasing health facilities' awareness of community priorities and perceptions of the quality of care.

The transfer of PBF implementation, verification and contracting from the PPAs to the AVCs was used as an opportunity to separate the verification and supervisory roles. AVCs now have a specific focus on verification and payment to ensure greater independence and a more manageable workload for the AVCs, and the supervisory role has been transferred to the district and regions. The transfer to organisations within the country health architecture and away from INGOs also builds greater sustainability.

At district level there is a clear responsibility for overseeing and supporting improvements to the quality of health care, and enabling facilities to deliver results which is leading to changes. At facility level, PBF is seen to have changed the morale of staff through introducing greater autonomy and transparency. The use of community feedback through the validation surveys has introduced a greater focus on quality and increasing patient satisfaction. The increased politeness of nursing staff, greater cleanliness of facilities, as well as increased numbers of qualified staff, were frequently cited as the most evident impact of PBF.

The original plans, for external counter-verification for the programme's results to be conducted by the University of Douala, were not successful and after two years, an alternative approach has been developed. The CTN, with partners and other MoPH directorates, undertake quarterly performance evaluations and counter-verification. This method provides verification, but with a smaller sample of facilities than originally planned. A proposal has been made to replace the planned contract with the University with a process of peer evaluation by regions for third party evaluation. This has been piloted, and is an effective way of learning about good practice as well as providing verification. The counter-verification using the new approach was conducted in November 2017.

The effectiveness of the programme is affected by resource constraints. There are reported low levels of resourcing for coaching and supervision, which are critical to the success of PBF. Despite the importance of data management and analysis to the model, regional data manager posts were deleted in 2017 while additional data management positions were created and staffed in the national PBF unit.

Learning and knowledge

Review and analysis of data has been used iteratively to inform PBF development, revise processes and tariffs, and improve the guidance (implementation manual). At facility and district and regional

level learning is shared with peers and used to improve performance. Cameroun shares its performance data on the www.rbfhealth.org website.

The HRITF Knowledge and Information Team organised a writing workshop for stakeholders in Cameroon to support writing skills and dissemination of evidence and learning. This was well attended, and led to the production of several publications. There are however, relatively few nationally generated learning products beyond this.

There has been other learning from other countries, for instance, the MoPH is reviewing the UHC model developed by Gabon; and experts from Burundi were key players in early PBF development in Cameroon. The World Bank plays a role in proposing countries to visit and sourcing relevant materials from other countries. Several countries in the region have also come to visit the PBF programme in Cameroon and learn, for example how to engage with private sector providers.

A summary of the draft Impact Evaluation (IE) was presented to country stakeholders by the Bank at a session chaired by the Minister for Health in 2016 which was found useful. It is not clear if the evaluation informed the subsequent decision to scale up PBF. The IE was published as a World Bank working paper in August 2017. Two rounds of qualitative studies were also conducted as part of the IE and have been submitted for publication in peer-reviewed journals.

Impact

The Cameroon PBF IE 2017 found mixed results: that there were “significant increases in coverage (child and maternal immunisation, family planning, HIV testing)”, but there was an absence of change in indicators such as skilled deliveries and ANC visits, which are key indicators to improve to have impact on maternal mortality. There was an improvement in the structural quality of care, and an increase in providers and supplies in health. There was also a reduction in out of pocket payments, suggesting that care was more affordable. Differences between the two groups of PBF facilities and non-PBF facilities receiving additional financing were not significant.

A major contribution of PBF has been to strengthen information systems and data management, which has been a weakness in Cameroon. The requirement to have regular reporting, establish baselines and targets has improved use of data and also generated considerable data on health service use. It is also contributing to a culture of recording and using data regularly which will support the development of Health Management Information Systems, identified as a priority in the GFF Investment Case. The recently appointed Director of Health Information at the MoH is seeking ways to integrate PBF with wider health information improvement plans.

Health staff resourcing at local level has been a major challenge. One of the main benefits of PBF cited by health facilities is that they can use the PBF funds to recruit and pay additional qualified staff. This is particularly important in areas with low staff levels; over the period of PBF there has been a reported increase in qualified staff in the North region from 30% of facilities to 90%⁸⁴.

The autonomy provided by PBF helps facilities to improve staffing, which in turn increases capacity to improve the quality and quantity of services. This is also key to the financial viability of health facilities, which are vulnerable to closure if income streams from cost recovery are too low. Access to services is increased; although it is not evident that equity of access has been increased⁸⁵. Financial management in facilities is improving⁸⁶.

⁸⁴ Reported by the World Bank, in interview

⁸⁵ Analyse des indicateurs de suivi de projet, au cours de l'année 2016, Ministère de la Santé Publique, Cameroun

⁸⁶ Rbfhealth.org portal for Cameroon <http://www.fbrcameroun.org/data.html>

The RFHP are working with pharmacies and drugs suppliers to improve standards and help regulate supply, to tackle the supply chain weaknesses in Cameroon. PBF facilities have the resources and buying power to exert pressure on local suppliers; the quality indicators require health facilities to manage the quality and storage of drugs to a higher standard. However, the quality scores for the availability of tracer drugs and medicines management do not show improvement 2013 – 2017⁸⁷.

Equity

Under the PBF programme, there is provision for free health care for those categorised poor or vulnerable. The exemption mechanisms for the poor aim to cover health care provided at the community and health facility levels. PBF budgets provide for up to 10% of budget to be allocated to these groups; in practice if there is greater need, the region can allocate additional funding for care for the poor. However, while increasing over time, there remain low reported numbers of poor people receiving free treatment in certain regions. The Endline Qualitative Study 2017 found that access for the very poor to health was not substantially changed by the PBF programme⁸⁸. A study of the Cordaid-financed RBF programme in the Far North region on the impact of targeting services to the poor in the North region found that it only reached a tiny proportion of the target population, reflecting challenges in design and implementation⁸⁹. While this programme was not supported by the World Bank and did not receive financing from IDA or HRITF, the results may still be relevant for programme design in Cameroon.

PBF pays an equity bonus in areas using criteria of remoteness, difficult access, low socio-economic indicators, security issues and where health facility provision quantity and quality is weak. This, coupled with enhanced autonomy of facilities to hire and fire staff, has resulted in a significant increase in the presence of qualified staff in the northern regions, increasing from less than 50% before the programme to close to 100% after six months of implementation.

Social and cultural demand barriers to using health services are being addressed to some extent by facilities undertaking outreach work. Some health facilities are also using demand side financing (vouchers) to pay for transport to the facility and to secondary care when required, using their facility bonus. Cost barriers to demand have been addressed by the PBF programme through a reduction of some costs charged to service users, for instance the cost of an institutional delivery has been reduced from c. 20,000 CFA to c. 8,000 CFA. The challenge of very high maternal deaths and low uptake of services is associated with low rates and levels of schooling, and there is now a linked programme of PBF in schools to retain young girls in education.

Sustainability

The GoC has a very strong commitment to PBF, as evidenced by its commitment to scale up the PBF programme to the whole country by 2020, and to integrate PBF within its strategic health financing model. The sustainability of PBF in Cameroon is strengthened by the extent of the system wide commitment to PBF as a way of doing business, rather than as a programme, and the extent to which it is now being integrated with the wider health system. However, there are still many reforms which are needed to align the programme with the national priorities and legislative frameworks.

The advent of the GFF which includes support to PBF will assist with the short-term sustainability of PBF until 2020. The work currently being undertaken by the government under the auspices of the GFF to develop Health Financing and Universal Health Coverage strategies is aligned with the PBF model and will further embed it in the Cameroon health system. These different strands of work, if

⁸⁷ Rbfhealth.org portal for Cameroon <http://www.fbrcameroun.org/data.html>

⁸⁸ Cameroun Endline Qualitative Study 2017, World Bank

⁸⁹ Targeting the poorest in a performance-based financing programme in northern Cameroon, Ilse J.E. Flink,¹Roland Ziebe,² Djebba Vagai², Frank van de Looij, Hilda van 't Riet and Tanja A.J. Houweling, Health Policy and Planning, 2016, 1–10

successfully implemented, should help build improved financial sustainability for PBF in the longer term, but risks remain.

The MoPH in July 2017 required all the regions to scale up PBF to all districts on a phased timescale with the intent of 100% coverage by PBF by 2020. The regions are now planning the roll out of PBF. There are however risks of inadequate staff and financial capacity to train, coach and verify twice increased numbers of health facilities.

There are questions regarding long-term financing. The Government's commitment to funding the PBF in Littoral region has only been met in 2014 and 2017 but not in 2015. 2016, showing risks to sustainability of funding. The health budget is low at 6% of the total government budget. There is a wider risk to sustainability, since more than half of the central budget is from external sources. These factors throw doubt on the GoC's capacity to support PBF, unless there is a significant increase in health budgets. The Development Policy Operation (DPO) supported by the World Bank which is expected to be approved by December 2017 includes several key legal reforms that will contribute to the financial and administrative sustainability of the PBF programme in Cameroon. These include measures related to financial autonomy of health facilities, liberalisation of the pharmaceutical market for more efficient procurement from private wholesalers, the geographic and administrative extension of the PBF programme, and increases in allocations of the public budget to periphery-level service providers through a budget line for PBF payments.

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