Using Results-Based Financing to Achieve Maternal & Child Health

PROGRESS REPORT

THE WORLD BANK
HEALTH RESULTS INNOVATION TRUST FUND
Ensuring that every woman and every child can survive and thrive is a priority for the World Bank Group, and is central to our global goals to end extreme poverty and boost shared prosperity. Poor health and high out-of-pocket spending for health care are among the leading causes of poverty. Access to quality, affordable care is both a basic human right and a key condition for sustainable, inclusive economic growth. Over the past several years, the Bank Group has stepped up support to help developing countries to reach Millennium Development Goals 4 and 5, saving women’s lives and improving child health. Helping drive this effort is our Health Results Innovation Trust Fund (HRITF), working together with the International Development Association (IDA), the Bank’s fund for the poorest.

Since HRITF was created at the end of 2007, with generous support from the Governments of Norway and the United Kingdom, results-based financing (RBF) is improving access and quality of health services for women and children in the poorest countries. HRITF's portfolio has grown from the first program in Afghanistan to 27 country programs around the world. This innovative fund has had a powerful catalytic effect in the resources available for maternal and child health in developing countries: $400 million has been linked to $1.2 billion of IDA financing approved or in the pipeline as of April 2013.

This report outlines the successes, challenges, and lessons learned over the past five years, as part of our ongoing commitment to transparency and improving development effectiveness. In particular, preliminary results from RBF programs in Afghanistan, Burundi, Democratic Republic of Congo, Nigeria, Zambia, and Zimbabwe are very promising. Although the final results from the impact evaluations are still outstanding, we are excited to see the operational data of the programs showing improvements in coverage and quality of maternal and child health services across the different countries. The experience so far indicates that RBF approaches can help to strengthen core health systems, making them more accountable and delivering greater value for money, by shifting the focus from inputs to results.

Consistently monitoring program data has also enabled us to see variations in performance across facilities, regions and countries. This information is being used to make program adjustments to strengthen implementation and learn more about the factors that are influencing success or failure of programs in certain settings. For example, in Benin, implementation progress has been slower than in other countries. By constantly monitoring and adjusting this can be addressed. To better understand the behavioral, organizational and contextual changes that cause the effect of RBF programs, many of the country programs are now incorporating qualitative methods in program monitoring and evaluation.

RBF programs in some cases have also helped to reduce the fragmentation of donor support, becoming an effective platform for partner collaboration and harmonization.

As the global RBF experience continues to grow, documenting and sharing knowledge has taken on even greater significance. In addition to developing tools for practitioners, such as the new Impact Evaluation Toolkit, we have embraced online platforms to make information, technical content, and lessons learned from programs under implementation more easily accessible. Please visit www.rbfhealth.org to learn more about the many events, videos, and tools that are supporting engagement and knowledge sharing across borders.

An independent evaluation of HRITF, in June 2012, provided an opportunity to reflect on the strengths and achievements but also to identify and address weaknesses. Going forward, the Bank Group, clients and partners will continue to learn and share the experiences of the past five years and new lessons coming in from projects that support a broad range of interventions, including demand-side and community approaches, and that also seek to leverage impacts on other sectors critical to better health.

When Ministers of Health and Finance from across Africa gathered at the April 2013 Africa Health Forum in Washington DC, many spoke of the important contribution RBF programs are making to their efforts to improve maternal and child health outcomes. With the continued leadership from countries and continued support from our development partners, the Bank Group is optimistic about the opportunities to scale up RBF approaches nationwide in more countries – and the enormous boost this can provide in our collective efforts to reach the MDGs by 2015.

Keith Hansen
ACTING VICE PRESIDENT, HUMAN DEVELOPMENT NETWORK
THE WORLD BANK
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Overview
HRITF BACKGROUND AND OBJECTIVES

The Health Results Innovations Trust Fund (HRITF) is a World Bank-managed multidonor trust fund established in December 2007. It is supported by the governments of Norway and the United Kingdom, with a total commitment of US$535 million equivalent through 2022. The main objective of the HRITF is to support results-based financing (RBF) approaches to achieving the health-related Millennium Development Goals (MDGs), focusing particularly on MDGs 1c (nutrition), 4 (child mortality), and 5 (maternal health).

The specific objectives of the HRITF are to:
- Support the design, implementation, and evaluation of RBF mechanisms
- Develop and disseminate the evidence base for implementing successful RBF mechanisms
- Build countries' institutional capacity to scale up and sustain RBF mechanisms within the national health strategy and system
- Attract additional financing to the health sector.

Results Based Financing is defined as a cash payment or non-monetary transfer made to a national or sub-national government, manager, provider, payer or consumer of health services after predefined results have been attained and verified. RBF is an umbrella term that encompasses various types of interventions that target beneficiaries (for example, conditional cash transfers), providers (for example, performance-based financing), and country governments (for example, cash on delivery).

A key element of the program is funding for country pilot grants (CPG) to design and implement RBF programs. A rigorous impact evaluation is embedded in each CPG, in order to evaluate the effectiveness of the approach. In addition, HRITF also supports capacity building and knowledge and dissemination activities, to ensure scale up and sustainability of the successful country programs.

To achieve these specific objectives, the HRITF finances four main pillars of work, see Figure 1.1: building awareness and capacity, piloting RBF approaches, evaluating, and disseminating knowledge. The progress and achievements of each pillar are covered in detail in sections 2 through 5.

Because this is the first annual report available to the public since the inception of the HRITF, it provides an overview of progress against the four specific objectives as well as an update on the fund's portfolio and financial performance during the last reporting period (April 1, 2012, through March 31, 2013).

FUNDING STRUCTURE

CPGs are the core of the HRITF program and 80% of the funding is allocated to the design and implementation of country programs. The HRITF funding mechanism provides support throughout the CPG life cycle: from the early conceptual stage, during project design and appraisal, and throughout the implementation phase (which typically runs for three to five years), as well as during the final stage of evaluating the

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1 Donor commitments are converted to US$ equivalent every six months, taking into account disbursements and cash contributions received. As of March 31, 2013, the US$ equivalent of the contributions from the two donors are: US$362 million from the Government of Norway and US$173 million from the United Kingdom.
2 Philip Musgrove, Financial and Other Rewards for Good Performance or Results. World Bank May 2011
impact and the lessons learned from project implementation. To explore the technical feasibility of RBF and the interest in using it as a mechanism for improving health outcomes, the HRITF facilitates technical dialogue, stakeholder consultation, and peer-to-peer learning with potential beneficiary countries.

All HRITF CPGs provide co-financing for grants or credits financed by the International Development Association (IDA)\(^{3}\) and therefore require approval by the World Bank’s Board of Executive Directors. After a potential recipient country indicates an interest in preparing and implementing a pilot grant, a proposal for a CPG is prepared jointly by the recipient country and the Bank within the operational framework of the World Bank. At the time that the HRITF approves a CPG, the proposal is typically at an early conceptual stage; it takes nine months, on average, until the project has been designed, appraised, and approved by the Bank’s Board of Executive Directors. During this stage, the country has access to pre-pilot funding to field-test the operational design and build local capacity to jump-start implementation.

To support this series of activities, the HRITF channels its funding through three funding streams:

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\(^{3}\) IDA is the International Development Association (IDA), the World Bank’s fund for the poorest.
Funding stream 1: CPGs for amounts up to US$20 million are awarded to recipients, usually governments, through dollar-to-dollar matching of the proportion of the IDA amount for the RBF component of the project. All low-income or lower-middle-income countries that have a new or existing IDA-financed project with an RBF component in the health sector are eligible to apply. Under this stream, the HRITF also provides funding for preparing, implementing, and evaluating the CPG projects. The grants are prepared and supervised within the World Bank’s operational framework, ensuring regional and country oversight of management and support for rigorous design, implementation, monitoring, and evaluation.

Funding stream 2: Knowledge and learning (K&L) grants support technical dialogue and learning about RBF design and implementation in IDA-eligible countries. K&L grants help grant recipients make informed decisions in their health policy choices by exploring and analyzing whether RBF is the right approach for addressing the issues of their health system and improving maternal and child health in their country. K&L grants also help build capacity in RBF, so that countries interested in the approach can learn how to design and implement RBF programs successfully.

Funding stream 3: Evaluation grants support RBF program evaluation efforts to learn from successful and unsuccessful experiences around the world, while contributing to local and global
evidence-based policy making. Whereas funding for the individual impact evaluation of each CPG is provided under funding stream 1, under funding stream 3 the HRITF finances stand-alone impact evaluations of non-HRITF-financed programs, the study of which can contribute to global knowledge about RBF.

As of March 31, 2013, the HRITF has approved funding for 27 CPGs, 27 K&L grants, and 11 stand-alone evaluation grants (Table 1). In addition, it supports a robust analytical and capacity-building program intended to bolster the global knowledge base on RBF and increase the technical capacity and expertise of RBF program implementers within and outside the Bank.

As shown in Table 1, CPGs represent a substantial share of the HRITF’s approved portfolio. Sixteen of the 27 CPGs approved (US$181.9 million) have been approved by the Bank’s Board of Executive Directors—leveraging an additional US$779.5 million of IDA financing for the recipient countries—and are at various stages of implementation. The remaining 11 CPGs (US$115.5 million) are expected to be approved and start implementation by the end of June 2014, leveraging some additional US$189 million of IDA financing. Another seven proposals (about US$107 million) are in the pipeline at various stages of preparation. Counting the additional projects in the pipeline, the total CPG commitments amount to US$404.4 million or about 75 percent of all contributions to the HRITF.

The majority of the CPG funding (75 percent) benefits countries in the Africa Region (AFR), but overall the portfolio of approved grants and the existing pipeline are well diversified and include IDA-eligible countries from all Bank regions (Figure 1.2). The complete list and descriptions of approved CPGs is provided in the Annex.

**FINANCIAL OVERVIEW**

Between the fund’s inception and the end of March 2013, HRITF donors contributed US$138.7 million in cash, of a total commitment of US$534.6 million equivalent. Over that period, US$77.7 million has been disbursed for eligible activities. Disbursements have accelerated in the past year and are expected to increase further as more CPGs are approved and start implementation. Figure 1.3 shows the current disbursements and future disbursement projections.

![Figure 1.3: CY08-FY12 ACTUAL DISBURSEMENTS & CY13-22 DISBURSEMENT PROJECTIONS (USD MILLIONS)](image-url)
Building Country Capacity and Awareness
To support the HRITF objective of building country awareness and capacity, the trust fund provides funding through knowledge and learning grants to specific countries or regions. Additionally, support is provided for capacity building activities for Bank teams and country clients. This section describes the results and achievements of the K&L grants and the capacity building activities.

A K&L grant typically consists of several activities. Country and regional K&L grants financed the engagement of the World Bank with governments in policy dialogue on RBF; consultations with key stakeholders including donors, Non-Governmental Organizations (NGOs), and communities; study tours from countries considering or starting RBF to those already implementing it; knowledge- and lesson-sharing events on RBF; technical training workshops for policy makers and stakeholders; and peer-to-peer exchange forums to learn from implementations of RBF.

Since the inception of the HRITF, the fund has financed 21 country K&L grants (see Figure 2.1), of which 12 continue—in Bhutan, Côte d’Ivoire, Djibouti, India, Kosovo, Madagascar, Mali, Mozambique, Senegal, Tanzania, Togo, and Yemen. Two of them were approved since March 2012—Côte d’Ivoire and Tanzania. Six regional K&L grants have supported groups of countries in exchanging knowledge and learning from each other’s experiences with RBF—in Africa, South Asia, East Asia and the Pacific, Latin America and the Caribbean, and the Middle East. Five are still in progress.

As a result of the interest raised through these grants and the increased capacity to design or implement RBF programs, K&L grants in 10 countries—the Central African Republic, Djibouti, Haiti, India, Kenya, Liberia, Senegal, Sierra Leone, Tanzania, and Yemen—have resulted in applications for CPGs. In other countries, such as Mali and Madagascar, K&L grants have been followed by the implementation of RBF programs through sources of financing other than the HRITF.

K&L grants have produced demand for program implementation funds in 10 countries since 2008

**FIGURE 2.1: KNOWLEDGE AND LEARNING GRANTS**
Several multicountry and individual K&L grants have financed analytical work to address the technical feasibility of RBF and its appropriateness in given countries, and to explore program design options. In some cases, as in Kenya, K&L grants were linked to existing RBF pilots and financed learning during program design and piloting. In the East Asia and Pacific Region, a multicountry K&L grant enabled the examination of evidence from successful RBF interventions to improve sexual, reproductive, and child health around the world, in order to gain an understanding of the factors or preconditions that explain success stories, and relate lessons learned to low- and lower-middle-income countries and fragile states, especially Papua New Guinea, the Solomon Islands, and Timor-Leste. A working paper on demand-side schemes produced as a result of this grant concludes that where financial barriers to use predominate, schemes with easily measurable outcomes are more likely to work.

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**KENYA:** “SUCCESS IS NO LONGER BEING MEASURED IN TERMS OF THE INPUTS, SUCH AS MEDICAL EQUIPMENT OR SUPPLIES, BUT IN TERMS OF THE QUANTITY AND QUALITY OF ACTUAL SERVICES THAT HEALTH FACILITIES DELIVER TO PEOPLE.”

G N V RAMANA, LEAD HEALTH SPECIALIST, WORLD BANK

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**Learning from the Kenyan RBF Program**

The 2010–12 K&L grant in Kenya aimed to undertake a comprehensive assessment of performance-based financing (PBF) in the context of the reforms under way at the time. It also aimed to mobilize stakeholders through a policy workshop; develop a comprehensive operational manual for the implementation of RBF in the pilot county of Samburu; train implementers and independent verifiers, including civil society organizations; and support the implementation of the pilot, which started at the end of 2011.

In Samburu, PBF is being tested in a range of facilities, from tiny village dispensaries to larger health centers, run by both public and nongovernment providers. The PBF scheme builds on the Health Sector Services Fund, which the Kenyan government set up to channel funds directly to health facilities. The Samburu experience provides a rich learning ground and lessons that will inform a potential scale-up of the PBF approach across Kenya, enabling the country to sharpen its focus on health results.

The analysis of operational data shows that PBF is achieving results. Reported data verified by NGOs show that the number of children fully immunized before age one rose by 28 percent between October–December 2011 and January–March 2012. In the same period, 30 percent more women received family planning services, 20 percent more pregnant women received at least four prenatal checkups, and 15 percent more deliveries took place with skilled attendants in health facilities. The results of this assessment, including lessons learned from the design of the current pre-pilot, are being used to develop a larger pilot financed by IDA and HRITF.
respond well to demand-side financing approaches—as long as preconditions such as supply-side capacity and quality are present. Demand-side RBF schemes could be successful in a variety of settings as long as attention is paid to designing service packages and the payment distribution system, and to determining the appropriate size of the transfer.

**K&L grants have also financed consultations among multiple actors.** The grants have proven very useful in providing a platform for informed decision making. HRITF-financed countries stress the importance of engaging both the central and local governments, as well as a variety of other stakeholders such as the nonprofit sector and other donors, early in the dialogue about RBF to maximize the success of the chosen policy in improving maternal and child health outcomes. For that reason, many of the K&L grants have funded workshops and discussion forums where participants can weigh options and assess the appropriateness of RBF.

In the East Asia and Pacific Region, after producing results on the enabling conditions and feasibility for RBF programs, the K&L grant sought to create a dialog within the region to increase understanding and improve RBF initiatives through stakeholder workshops discussing these results. Through a multicountry K&L grant in the European and Central Asia Region, a study tour to Turkey by Uzbekistan government officials from the Ministry of Health, the Ministry of Finance, and the Ministry of Economy was organized in May 2012. A follow-up roundtable discussion was organized to share experience in other countries, including Turkey, and discuss the potential application of RBF in the Uzbekistan health sector. In Haiti, a national consultation was held in June 2012 to start a dialogue between the Ministry of Public Health and Population and its partners on RBF institutional arrangements and agree on a way forward. Among the 50 attendees were not only technical teams from the Ministry, but also representatives from the Haiti Social and Economic Assistance Fund as well as other governments, bilateral aid agencies, United Nations agencies, and NGOs.

**K&L grants have made it possible to build technical capacity in designing, implementing, and evaluating RBF programs in a variety of actors**, including central and local government policy makers, NGOs, donors, health practitioners, and academicians.
In the past, K&L grant activities have targeted health workers—through a practitioner-to-practitioner learning workshop in 2011 in India, for example, and a training workshop for policy makers and health professionals the same year in Chad. In 2012, academicians in the health sector, government officials, and NGOs benefited from capacity-building activities in Cameroon and the Central African Republic.

Regional K&L grants provide opportunities to build regional and global capacity in RBF. A K&L grant in the Africa Region has built capacity in the “francophone and anglophone community of RBF practitioners” in relation to RBF implementation, through joint face-to-face and virtual hands-on learning sessions. In 2012, a workshop in Ghana called “How RBF Could Help Achieve Universal Health Coverage” was held to improve knowledge of the relevance of RBF as an instrument to help achieve universal coverage through its impacts on the efficiency, quantity, and quality of service delivery, as well as knowledge of the opportunities and challenges of implementing RBF. The workshop covered different RBF approaches, fiduciary and legal procedures in RBF operations through the World Bank, and the use of building capacity through Public Health Professors.

**Building Capacity through Public Health Professors**

**The Idea.** A K&L grant was implemented in Cameroon in the last two years to tap into local professors’ openness to new ideas and use local universities as avenues to build local capacity in RBF and facilitate quality implementation of RBF.

**The Results.** In Cameroon, where RBF is being piloted through another source of funding, the K&L grant was used to hold workshops for 65 faculty members from two public medical schools. Six of them attended a two-week course in Rwanda. They later developed an RBF curriculum for their respective schools, building in country capacity to successfully design and implement RBF programs now and in the future. The K&L grant, through the close cooperation among stakeholders that it fostered, also led to the creation of a partnership to oversee RBF program funding.

**Cameroon:** “When they are convinced that RBF works, they teach it at the university. When the students graduate, they can work on RBF programs and help spread the word at hospitals and clinics.”

Gaston Sorgho, Lead Public Health Specialist, World Bank Africa Region.
of practical tools such as financial risk forecasting for RBF programs. A workshop called “Challenges of Implementing Results-Based Financing in Health in Anglophone Africa,” held in Zambia, focused on peer-to-peer knowledge exchange and technical assistance among 80 central and provincial members of ministries of health, as well as representatives from ministries of finance and NGOs from nine countries, and from the World Bank.

In addition to these workshops, the HRITF has organized several technical workshops over the last year. Some of these workshops were internal to the World Bank, and some were also targeted to members of local governments and to research and technical assistance partners implementing and evaluating HRITF programs. Although measuring the impact of knowledge-generating and -sharing events can be challenging and results sometimes limited, we make a point to get participants' feedback on and ratings of technical workshops so as to ensure we respond to the demand for capacity building appropriately, on the right topics, and in the right manner.

- The HRITF’s fourth “Annual Results and Impact Evaluation Workshop” in November 2012 aimed to build capacity in World Bank staff, government counterparts, and other local partners from 14 country teams in designing, implementing, monitoring and evaluating RBF programs.
- The HRITF’s third one-week “RBF for Health Workshop for World Bank Task Teams” in June 2012 aimed to enhance understanding of RBF; to equip task teams with the technical knowledge, experience, and tools to inform their operational projects; and to foster a community of practice in RBF at the World Bank.
- A few months later, a one-day “Workshop on RBF Implementation Challenges” within the World Bank followed up on pending issues from the RBF for Health Workshop and progressed on technical issues such as tackling the fiduciary aspects of financing RBF and using preliminary evidence from program implementation.

Overall, the versatile portfolio of K&L grants, and learning and capacity-building activities financed by the HRITF have made a difference in the policy dialogue on improving health systems, and maternal and child health. They have equipped key stakeholders with the skills and information needed to decide whether and how to pursue a RBF strategy.
Financing Design and Implementation of Country Pilot Grants
CPGs finance the design, preparation, implementation, and supervision of RBF programs for health in IDA eligible countries. This section describes the status of the CPG portfolio, results achieved across countries under implementation, and the HRITF’s approach to monitoring and learning throughout the life of a program. It also highlights several new developments since March 2012:

- **Sharp increase in the number of CPGs and diversification of program design:** The portfolio of CPGs grew by 40 percent. This increase was coupled with diversification of the types of RBF programs implemented: for example, more programs focused on demand-side incentives, RBF at the hospital level, and the inclusion of the community in program design or monitoring.

- **Acceleration of program implementation and initial results from operational data:** Several countries progressed into the implementation phase. Operational data from performance payments show initial positive results related to improvement in service delivery and broader positive changes in the health system, such as increased accountability or efficiency gains.

- **Learning from implementation:** with so many CPG’s starting implementation over the last year, emphasis was given to new ways to monitor programs to adjust and improve implementation and learn about the organizational, behavioral, and other contextual factors that determine good performance.

**HRITF PORTFOLIO OF COUNTRY PILOT GRANTS**

The HRITF currently finances 27 CPGs in 24 low- and lower-middle-income countries, Figure 3.1. Since March 2012, the HRITF has approved CPGs to seven new countries: Armenia, the Republic of The Gambia, Haiti, Kenya, Senegal, Sierra Leone, and Yemen.

Ongoing monitoring of RBF payments made to health facilities in Burundi and Zimbabwe identified tangible improvements in the delivery and coverage of health services to mothers and children. As a result, governments in these two countries requested continuing work with the World Bank to scale up RBF. Both programs have been granted additional financing from the HRITF for their existing CPGs, to expand the geographical

**FIGURE 3.1: COUNTRY PILOT GRANT PORTFOLIO**

- New CPGs from April 2012 – March 2013
- CPGs as of March 2012
scope or duration of the RBF programs, and to respond to new challenges with additional interventions such as vouchers and PBF incentives focused on nutrition.

The CPG portfolio grew by 40 percent between March 2012 and March 2013.

CPG recipients are at different stages of designing, preparing, or implementing their RBF programs:

- Of 27 CPGs, 11 are in the preparation stage, as recipients work with the World Bank to reach agreement on RBF program design, institutional arrangements, and monitoring and fiduciary mechanisms. Work at this stage includes assessing readiness, designing the program, determining who will benefit from it, and identifying how it will be implemented and monitored.
- Four CPGs, in Armenia, Ethiopia, the Kyrgyz Republic and Nigeria were approved by the World Bank’s Board of Executive Directors and have moved into the implementation phase.
- Another 12 CPGs are currently under implementation. That is four more than in March 2012, through the addition of Burkina Faso, Burundi (with two CPGs), and the Central African Republic. One CPG in Rwanda has been fully implemented and disbursed, and the government is now funding the program.

RESULTS AND ACHIEVEMENTS

Since 2008, many HRITF-financed countries have tested RBF on a small scale, then expanded their program as RBF showed potential for improving the delivery of maternal and child health services. All programs under the HRITF collect operational data on services provided; the data are verified and used as the basis for results-based payments. This year, the analysis of these data across countries has provided an overview of the initial results and achievements of the RBF approach across countries. The data shows that RBF programs strengthen key health system functions as well as improve the quantity and quality of services. It is important to keep in mind that operational data are not “gold standard,” therefore the patterns depicted are more suggestive than conclusive of the true impact of the programs on the studied outcomes. The impact evaluations will provide conclusive evidence of the impact. Here are highlights of the results:

RBF strengthens key health system functions

Efficiency. RBF can be used as an instrument to improve efficiency in the health system, Figure 3.2. For example, by

![Figure 3.2: RBF Promotes Efficiency Gains](image-url)
setting the payments high for services (such as deliveries) that are delivered performed at health centers, RBF increases efficiency by allowing hospital resources to be used for complicated care. This has been the experience in Zimbabwe (Figure 3.2). The RBF program there does not reimburse for normal deliveries in secondary hospitals unless they were deemed to be difficult cases and referred from lower-level facilities. Data from two front-runner districts clearly show an increase over time in the number of deliveries handled by the health centers, against a sharp decrease in the number of hospital deliveries reimbursed by the program.

**Equity.** There are multiple channels by which RBF programs can improve equity. On the demand side, programs use various methods with well-demonstrated effectiveness to directly target vulnerable groups to enable their access. Examples include voucher and conditional cash transfer schemes. Yemen and Zimbabwe plan to implement HRITF-financed voucher schemes. On the supply side, PBF programs targeted to health facilities use various mechanisms to direct financing to the most vulnerable groups:

- Geographic targeting, as in Burundi (Figure 3.3) and Nigeria, where more of the performance-based financing budget is allocated to remote and difficult-to-reach regions
- Rural-hardship grading and bonuses for health facilities in certain areas
- Higher incentives for serving traditionally excluded population groups, as in Burundi
- Fee exemptions for the poorest population group

**Accountability.** RBF programs make the health systems more accountable by shifting the focus from inputs to the results. Linking payments to performance strengthens the governance of the system and allows ongoing monitoring of the results that government and partner resources are ‘buying.’ There is strong evidence that linking financing to results produces better outcomes than as compared to providing similar financial resources without the linkage to results. In the Democratic
Republic of Congo, operational data show much higher coverage of modern family planning methods supplied at facilities receiving RBF than at facilities receiving an equivalent but inputs-based monetary transfer. The difference is explained by the fact that health centers that were paid based on outputs were more proactive in planning and developing strategies for dealing with erratic supplies of commodities. Using data from routine health management information systems, similar patterns are found in the case of institutional deliveries in Zambia (Figure 3.4).

The RBF program design feature of the verification of reported results also crucially enhances accountability for actual results achieved. The very existence of the verification process is a key improvement in the governance of the health system. In Burundi, providers open their doors to public scrutiny. In Argentina the verification of results has enabled dialogue between federal and provincial level to focus on results and their accuracy.

In line with greater accountability for results, RBF programs also foster greater social accountability of health care providers toward their patients and their communities through systematic design features. Through the contractual design of programs, communities have been more engaged in monitoring and verifying results in several countries. In some countries, patient satisfaction is accounted for in the definition of the quality of care that is rewarded. To align provider practice with community needs, the community is also engaged in the definition of indicators that are eligible for RBF rewards.

The analysis of operational data across the eight countries under implementation shows an increase in coverage of key interventions as institutional deliveries and preventive care visits for children in the facilities with performance-based financing as compared to the control facilities. This includes data from Burundi, DRC, Zimbabwe, Zambia and Afghanistan. Although the level of change in service provision varies by program and indicators, across the board some high-impact indicators show positive improvements in service coverage—for example, in Afghanistan, Burundi, the Democratic Republic of Congo, and Zimbabwe, see Figure 3.5. Key progress indicators include institutional deliveries and postnatal care, both critical for reducing maternal mortality.

The evidence from operational data will have to be validated by the upcoming results of the impact evaluations.

Beyond service coverage, initial results also suggest that RBF increases the quality of care, Figure 3.6. In most HRITF-financed PBF programs, performance-based payments to health care providers are based not only on the number of services provided but also on their quality, which is measured and compiled into a quality score. An analysis of quality score trends suggests that quality of care improves with the implementation of RBF. Health facilities under performance-based financing contracts are generally found to be more responsive to client demand and to be improving clinical care standards. This finding is very important as it shows that under RBF both quantity of services and quality can improve at the same time.
Verification in Results-Based Financing Programs

Verification of results is an integral part of any RBF program. The main objective of verification is to ensure that the results reported by health care providers were indeed achieved. It also allows supervisors to identify problems or areas for improvement, and can prevent over-reporting from occurring. Verification can be conducted by personnel involved in the payment or provision of services, or it can be done by an independent agency such as a consulting firm, local NGO, or local university. Verifying results can include ensuring the consistency of routinely collected data, directly observing the conditions of service delivery and care, conducting patient surveys either at the facility or later at home. Most RBF programs introduce sanctions for reporting errors over a certain percentage.

In most countries, initial performance reporting errors can be high, but as people learn how to report, fewer mistakes are made. This was the case in the Cameroon RBF pilot where the error rates declined substantially and quickly after some initial challenges. In addition, other geographical areas that were added later learned from the experience in the pilot region and saw fewer errors. Verification therefore has the added benefit of strengthening the data reporting in the health system.

![Error reporting rates by month and Region](image.png)
FIGURE 3.5: INCREASE IN COVERAGE OF KEY INTERVENTIONS

Increase in the number of postnatal care visits over time, compared with first quarter

Note: Data for Zimbabwe are from two front-runner districts

FIGURE 3.6: QUALITY OF CARE

Overall Quality Scores

NOTE: Overall quality scores in health centers and hospitals in Nigeria improved steadily over time.

NOTE: Increase in average quality of care scores at health centers and hospitals in Cameroon5

5 Cameroon receives an HRITF evaluation grant to evaluate its RBF program which is financed by IDA.
Zimbabwe

Changes on the Ground and No Crowding-Out of Other Services

THE PROGRAM. Zimbabwe’s RBF program was launched in July 2011. Cordaid, a Dutch international NGO, was contracted to implement it. The program began in two front-runner districts and was later scaled up to 18 of 62 rural districts by March 2012. It currently covers 387 health facilities serving a population of approximately 3.5 million. The program provides subsidies to rural health clinics and hospitals based on their performance in delivering a package of free health services to pregnant women and children under five (16 primary care services and 5 secondary care services).

INCREASED COVERAGE AND QUALITY OF CARE. Verified operational data from the March to December 2012 show major increases in the coverage of key maternal and child health indicators. For example, the coverage of institutional deliveries increased from 50% to 75% between March and December 2012 (Figure 3.7); and immunization increased from 33% to 62% between March and November of the same year. Quality of care measured through a technical score of quality and by client perception also follows a positive trend.

NON-REWARDED SERVICES DO NOT RECEIVE LESS ATTENTION. A common concern for all RBF programs is that participating health facilities will focus on delivering incentivized services and neglect the services that RBF does not reward. In Zimbabwe, health management information system (HMIS) data monitors a number of non-incentivized indicators, which belong to the most frequent conditions for outpatient contacts with a health facility: diarrhea, malaria, and acute respiratory infection, among both children and adults. In districts that benefit from RBF and districts that do not, the trends in the number of acute respiratory infections per 10,000 population are identical not only in the period before the project started, but also for the whole nine months into the project, Figure 3.8. The patterns are similar for other non-incentivized indicators: there is no evidence that the improvement in RBF performance was achieved at the expense of the non-incentivized services.
The significant increase in the demand for RBF funding signals growing interest in replacing traditional input-based approaches with a stronger focus on results. This increased buy-in for a results-based approach is evident at all levels of decision making and service delivery, from ministries of finance and health to local authorities, communities, and health centers. In Nigeria for example, the government made significant progress on mainstreaming the RBF approach across the health sector.

Science of Delivery: Learning from and Improving Implementation

The move from paying for inputs to paying for performance and results has changed the way we are able to monitor the effectiveness of the programs during implementation. The focus on results and assessing performance on an ongoing basis is an unprecedented opportunity to better monitor programs and use the results to strengthen implementation. Furthermore, it provides an opportunity to learn about the factors that influence performance which in turn will help make adjustments to improve implementation and shape the design of future programs. The focus on assessing performance on an ongoing basis creates “virtuous cycles” of learning, in which task teams and governments continuously “test innovations, capture results”, and use these results to modify existing and design new programs. The field of delivery science provides an excellent framework to further develop this approach to monitoring, evaluation and implementation. The objective is to track and analyze delivery, capture the factors that made it possible (or not), improve implementation and transmit the lessons of that experience in forms that others can use. “The key is interactive problem-solving, with a laser focus on results” (Dr. Jim Kim, Keynote Speech to World Knowledge Forum, Seoul, Republic of Korea, October 8, 2012).

To encourage primary health care, the Zimbabwe RBF program set a target for the share of reimbursement to rural health centers (RHCs) as a % of total spending on output indicators to be at least 60%, leaving 40% for hospitals. However, operational data from the first 6 months of the program showed that 54% of spending went to hospitals. Moreover, the biggest cost item in hospitals was “normal deliveries”. A Technical Review Mission conducted jointly by the Government, Implementing Agency Cordaid and the World Bank in June 2012 recommended that the price structure be revised. Unit subsidy for normal deliveries in hospitals decreased from $50 to $25 and in RHCs increased from $6 to $12.5. The new price structure was applied in October 2012. Furthermore, normal deliveries without referral would not be eligible for reimbursement at the hospital level. As a result, the share of total output spending by RHCs increased dramatically starting October 2012, reaching 70%. Thus, by closely monitoring the payment data and adjusting incentive structure accordingly, the program has contributed to prioritizing primary health care and improving efficiency in the system.

Understanding how and why RBF programs work or do not work is as important, if not more important, as determining whether they work. Experience with CPGs shows that the performance of RBF can vary across contexts, indicators, types of health facilities, their degree of remoteness, health-seeking behaviors and cultures, attitude toward producing results, and other characteristics. The

HRITF seeks to create and disseminate knowledge about which organizational, behavioral, and other contextual factors determine good performance and successful results, how to measure these factors, and what drives results in RBF programs.

To comprehensively assess what determines success and failure in RBF programs, specifically the ones using PBF, the HRITF has developed a conceptual framework that delineates what PBF brings about in terms of behavioral, organizational, and contextual changes see Figure 3.9. The framework is used to identify areas for learning about RBF, linkages between the design features of RBF programs and the individual and systemic responses to those programs, and consequently to apply the most appropriate methods in designing, monitoring, learning about, and evaluating RBF programs.

Going down the stream from what to learn about RBF to how to best learn about it, several CPG recipients are embarking on using the conceptual framework to pinpoint the learning area most relevant to their country context. They are doing so using both quantitative and qualitative methods, with technical and financial support from the HRITF. For example, Nigeria has used the conceptual framework in conjunction with results from operational data analysis to identify factors that may explain variations in performance and to inform further analytical work.
Evaluating RBF Programs
To support the HRITF objective of building the evidence base for RBF, the trust fund provides support to country programs for evaluating RBF programs. This section describes the status of these evaluations, the research themes and outcomes of interest, and some country examples of ongoing work. It also highlights several new developments over the past year:

- **Diversification of research topics:** The HRITF evaluation questions have become more varied with the diversification of CPG designs and the interest from middle-income countries in evaluating RBF. They now include, for example, a stronger focus on managerial skills and supervision linked to RBF, demand-side interventions and community-based RBF programs.

- **Learning from baseline data:** Several countries are promoting learning at the early stages of impact evaluation through the use of baseline survey data.

- **Large demand for capacity building from policy makers:** The release of the [online Impact Evaluation Toolkit](http://www.worldbank.org/health/impactevaluationtoolkit) has made the accumulated knowledge and tools more widely available and is contributing to meeting the large demand for capacity building among impact evaluation practitioners and policy makers.

- **Qualitative evaluation methods:** A growing number of countries have embarked on the addition of a qualitative dimension to their evaluations, to contribute to a better understanding of why and how RBF works.

“NO MATTER IF WE SOUGHT SUPPORT FOR INCREASED DOMESTIC BUDGET ALLOCATIONS.... OR ... FUNDING FROM DEVELOPMENT AGENCIES, WE FACED THE SAME QUESTIONS: COULD WE SHOW RESULTS? COULD WE SHOW IMPACT? COULD WE PROVE THAT WE WERE GETTING GOOD VALUE FOR THE MONEY...? THE NEED FOR SOLID EVIDENCE AND RESULTS HAS INCREASED FOR BOTH GOVERNMENTS AND DONOR AGENCIES.”

DR. MUHAMMAD PATE, MINISTER OF STATE FOR HEALTH, FEDERAL MINISTRY OF HEALTH, GOVERNMENT OF NIGERIA, IN AN INTERVIEW WITH THE HRITF IN MARCH 2012.

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Figure 4.1 Impact Evaluations

Evaluations in the HRITF portfolio consist of impact evaluations (IEs) and program assessments (PAs), see Figure 4.1. Impact evaluations follow best practice standards, i.e. randomization, credible comparison group, etc. Since implementing impact evaluations is not always feasible, the trust fund also finances program assessments, which can be costing, cost-effectiveness or qualitative studies.

As of March 2013, the HRITF finances 31 impact evaluations in 29 countries. 25 of these impact evaluations accompany CPGs.8 The HRITF finances six stand-alone impact evaluations of RBF programs in Argentina, Cambodia, Cameroon, China, India, and Turkey. Since March 2012, the HRITF has approved impact evaluation grants to nine new countries that benefited from CPGs: Armenia, Burundi, the Republic of the Gambia, Haiti, Kenya, Senegal, Sierra Leone, Yemen, and Zimbabwe. In addition, new stand-alone impact evaluation grants were awarded to Cambodia and China.

8 In the exceptional case of Burundi, because RBF was implemented at a national scale, the impact evaluation initially planned was cancelled. However, an impact evaluation will be linked to the country’s second CPG, which finances the expansion of the package of services rewarded through RBF to include nutrition services. In the exceptional case of India, the impact evaluation is funded by 3ie.
FIGURE 4.2 IMPACT EVALUATION STAGES

<table>
<thead>
<tr>
<th>DESIGN</th>
<th>BASELINE</th>
<th>FOLLOW-UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armenia</td>
<td>Argentina</td>
<td>Afghanistan</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>Benin</td>
<td>Rwanda</td>
</tr>
<tr>
<td>Burundi II</td>
<td>Central African Republic</td>
<td>DRC</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Cameroon</td>
<td></td>
</tr>
<tr>
<td>China</td>
<td>Kyrgyz Republic</td>
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<tr>
<td>Ethiopia</td>
<td>Nigeria</td>
<td></td>
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<tr>
<td>Gambia</td>
<td>Zambia</td>
<td></td>
</tr>
<tr>
<td>Haiti</td>
<td>Zimbabwe</td>
<td></td>
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<tr>
<td>India I</td>
<td></td>
<td></td>
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<tr>
<td>Kenya</td>
<td></td>
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<tr>
<td>Lao PDR</td>
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<td>Liberia</td>
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<td>Lesotho</td>
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<td>Senegal</td>
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<td>Sierra Leone</td>
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<td>Tajikistan</td>
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<td>Turkey</td>
<td></td>
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<tr>
<td>Yemen</td>
<td></td>
<td></td>
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<tr>
<td>Zimbabwe II</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FIGURE 4.3: HRITF EVALUATIONS ARE RICH IN THEIR THEMATIC DIVERSITY

<table>
<thead>
<tr>
<th>INTERVENTION EVALUATED</th>
<th>COUNTRIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply-side RBF payments</td>
<td>Afghanistan, Argentina, Armenia, Benin, Burkina Faso, Burundi, Cambodia, Cameroon, Central African Republic, China, Democratic Republic of Congo, Ethiopia, Gambia, Haiti, India, Kenya, Kyrgyz Republic, Lao PDR, Lesotho, Liberia, Mexico, Nigeria, Philippines, Rwanda, Senegal, Sierra Leone, Tajikistan, Turkey, Yemen, Zambia, Zimbabwe</td>
</tr>
<tr>
<td>Demand-side RBF payments</td>
<td>Gambia, Lao PDR, Rwanda, Senegal, Yemen, Zimbabwe</td>
</tr>
<tr>
<td>Community-Based RBF</td>
<td>Gambia, Haiti, India, Senegal, Rwanda</td>
</tr>
<tr>
<td>RBF for quality of care</td>
<td>Afghanistan, Armenia, Argentina, Benin, Cambodia, Cameroon, Central African Republic, China, Haiti, Kyrgyz Republic, Lao PDR, Nigeria, Senegal, Tajikistan, Turkey, Zambia, Zimbabwe</td>
</tr>
<tr>
<td>RBF in hospitals</td>
<td>Afghanistan, Armenia, Burundi, China, Kyrgyz Republic, Lao PDR, Liberia, Nigeria, Philippines, Senegal, Sierra Leone, Turkey</td>
</tr>
<tr>
<td>Additional financing</td>
<td>Benin, Nigeria, Zambia, Zimbabwe</td>
</tr>
<tr>
<td>Differential incentive levels</td>
<td>Argentina, Central African Republic, China</td>
</tr>
<tr>
<td>Enhanced monitoring and supervision</td>
<td>Argentina, Cameroon, Kyrgyz Republic</td>
</tr>
<tr>
<td>RBF and training of providers</td>
<td>Zimbabwe</td>
</tr>
<tr>
<td>Negative Incentives (sanctions)</td>
<td>Zimbabwe</td>
</tr>
</tbody>
</table>

Last update: April 2013
The five program assessments in the HRITF portfolio are in India, Kenya, Mexico, the Philippines, and Turkey. The program assessment in Kenya was awarded this year to inform the design of the ongoing CPG in that country.

**The evaluation portfolio is expanding**

The 31 impact evaluations are at different stages in the impact evaluation cycle (see Figure 4.2 on page 27). Afghanistan, the Democratic Republic of Congo, and Rwanda will be the front-runners in completing their follow-up surveys, with preliminary results on the impact of RBF on health outcomes expected in early 2014. With the approval of a significant number of CPGs since March 2012 came a significant number of impact evaluations in the early design stage.

HRITF evaluations are reaching the final stage of producing results

**The focus of interest across impact evaluations has grown more diverse.** This year in particular, that diversity has intensified. A majority of HRITF evaluations examine supply-side incentives; nonetheless, several new evaluations this year aim to study the impact of demand-side RBF, Figure 4.3. There is a lot to learn about RBF in hospitals, and certain evaluations focus specifically on hospital effects, such as those in Liberia and Sierra Leone. Testing the impact of RBF in communities is also of interest to a growing number of countries, Figure 4.4. Finally, RBF is paying not only for producing health results but also for strengthening accountability, increasing supervision, and monitoring results. Some impact evaluations intend to

### FIGURE 4.4: HRITF EVALUATIONS LOOK AT DIVERSE OUTCOMES

<table>
<thead>
<tr>
<th>Outcomes of Interest</th>
<th>Countries (Impact Evaluations only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning</td>
<td>Afghanistan, Armenia, Cameroon, Central African Republic, Democratic Republic of Congo, Ethiopia, Lesotho, Rwanda, Zambia, Zimbabwe</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Burundi, Gambia, Senegal</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>Afghanistan, Armenia, Benin, Burundi, Cambodia, Cameroon, Central African Republic, Democratic Republic of Congo, India, Kyrgyz Republic, Lesotho, Liberia, Nigeria, Senegal, Tajikistan, Turkey, Zimbabwe</td>
</tr>
<tr>
<td>Out-of-pocket Payments</td>
<td>Afghanistan, Benin, Cambodia, Cameroon, Central African Republic, Democratic Republic of Congo, India, Lao PDR, Tajikistan, Zimbabwe</td>
</tr>
<tr>
<td>Tuberculosis, Malaria, HIV/AIDS</td>
<td>Afghanistan, Benin, Liberia, Nigeria, Rwanda, Zambia, Zimbabwe</td>
</tr>
<tr>
<td>Staff Motivation</td>
<td>Benin, DRC, Zambia, Zimbabwe</td>
</tr>
<tr>
<td>Non-communicable diseases</td>
<td>Armenia (cervical cancer), China, India (tertiary care), Turkey (prevention)</td>
</tr>
</tbody>
</table>

Last update: April 2013
A WORKSHOP TO EXPLOIT BASELINE DATA. In February 2013, the World Bank held a multicountry workshop called “Baseline Data Analysis of the Impact Evaluation of Results-Based Financing”, in Yaoundé, Cameroon. A number of the recipients of HRTF impact evaluation grants have completed their baseline data collection; they include Benin, Cameroon, and the Central African Republic. For these three countries, the next step is to write a baseline report addressing both households and health facilities that validates the design of the evaluation and describes the sample. The four-day workshop aimed to build capacity among the three country teams to manage and analyze the baseline data and to write and disseminate reports. The workshop also aimed to facilitate exchanges and South-South learning among the three country teams. The main audiences of the workshop were key members of the data collection team and key policy makers, most of them based in the three countries.

THE LESSONS. Several types of learning can be done from baseline data: analyzing topics relevant to national and international policy making; analyzing the validity of survey methods and instruments, and developing recommendations on best survey practice (for example, identifying the most truthful instruments for measuring the quality of care); and conducting multicountry analysis of the same topic. Multicountry workshops such as this create momentum for exploiting more of the potential of the data. They foster collaboration in data analysis across countries and collective problem solving, which can produce globally relevant evidence.

RESULTS AND ACHIEVEMENTS

Grant recipients are designing and implementing their impact evaluations to determine the impact of RBF on health outcomes. In that process, they maximize opportunities to learn. For example, they take the opportunity to exploit the results of the baseline surveys they carry out before program implementation. These surveys, conducted usually among households and health facilities, describe the health system and health outcomes in areas that will benefit from the RBF program and in comparison groups that will not receive payments on the basis of results achieved. Although on their own baseline surveys cannot be
Afghanistan

Operational Data with Treatment and Comparison Groups Tell a Much Richer Story

**THE PROGRAM.** Since the end of 2010, NGOs competitively selected in eleven provinces, and health facilities operated by the Ministry of Health in three provinces are contracted by the Government to deliver services. They receive an additional performance bonus for good performance on quality of care and service coverage.

**WHAT TIME SERIES ANALYSES SAY ABOUT RBF.** The health management information system collects information on the delivery of prenatal care and on skilled attendance at births, and the quality of the data is fairly good. System data for areas benefiting from RBF show a positive trend in the number of prenatal care visits and in the number of births attended by skilled workers. However, it is impossible to determine whether this trend reflects an improvement that is due to RBF or to any other factor.

**WHAT RANDOMIZED CONTROLLED TRIAL ANALYSES say about RBF.** These analyses enable one to look at the same trend and distinguish the treatment group, which was randomly selected to receive the RBF program, and the comparison group, which was randomly assigned not to receive it. The picture becomes much more interesting. While both groups evolve with a similar trend, the difference between them increases over time, suggesting a positive impact of RBF on service delivery.

**FIGURE 4.5: NUMBER OF WOMEN COMPLETING 4 PREGNATAL VISITS AND BIRTHS OCCURRING WITH SKILLED BIRTH ATTENDANTS**

![Graph showing number of women completing prenatal visits and births](image)
used to infer a causal impact of RBF; they do produce a wealth of information that can be exploited to inform policy making in the health sector.

Similarly, because end-line data are usually collected at least 18 months after program implementation begins, the design characteristics of the impact evaluation, such as the structure of the study arms, can also be taken into account in the analysis of operational data in the meantime, by comparing treatment (RBF) and comparison groups of the impact evaluation when data is available for both, for example, through the health management information system (HMIS).

Among recipients of impact evaluation funds, there is a strong demand for HRITF support to build their capacity to successfully design, implement, and monitor impact evaluations. Along with conducting in-person capacity-building activities such as the Annual Results and Impact Evaluation Workshop held in November 2012, the HRITF has developed an online Impact Evaluation Toolkit. The toolkit consolidates current knowledge and tools, and helps impact evaluation practitioners through all the steps of this complex exercise. Since the launch of the toolkit website in October 2012, web statistics have been increasing steadily, with users accessing it from a large variety of countries.

EXPANDING KNOWLEDGE: ADDING A QUALITATIVE DIMENSION TO EVALUATIONS

One area of growing interest since March 2012 has been the use of qualitative methods to enrich impact evaluations. The HRITF will continue to support the accumulation of rigorous quantitative evidence on RBF programs. At the same time, it is also important to use qualitative methods to supplement quantitative findings from impact evaluations at different stages of the evaluation.

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The Impact Evaluation Toolkit

The toolkit aims to respond to the needs of country teams working on evaluations of the impact of RBF. Technical advice and the collective knowledge of recipient teams are shared in the toolkit in the form of best practice guidelines for each stage of an impact evaluation. There are over 70 tools, which can be downloaded and edited. Some tools are specific to impact evaluations of RBF, but most can easily be adapted to other sectors, and therefore be useful to a wider audience. The toolkit guides users from defining the research questions of the impact evaluation and assembling the team, through conducting survey fieldwork, analyzing data, and disseminating results. The toolkit features country spotlights that highlight experiences of Country teams.

The toolkit website, was launched in October 2012, and demonstrations were held for multiple audiences both inside and outside the World Bank, ranging from research and government practitioners on the ground to international partners. An average of 600 unique visitors a month from 82 countries looked at the site and downloaded the guidelines and tools.

This toolkit is a living document. The HRITF is adding to and improving it based on feedback received through the website and through the HRITF network of supported impact evaluation teams.

The toolkit is available at www.worldbank.org/health/impactevaluationtoolkit.
Qualitative methods can reinforce quantitative evaluations over time

Several countries have started to design qualitative studies this year to complement their impact evaluations and learn more about RBF. Among them, the Kyrgyz Republic added a qualitative component to its baseline survey, which was conducted in the last quarter of 2012. The results from both quantitative and qualitative data collection are analyzed concurrently, to build a complete picture of the initial conditions in which the RBF program will operate and inform the early implementation of the program.

In the past year, improved communications played a critical role in the sharing of evidence and RBF knowledge from the maturing project portfolio with key stakeholders and global audiences. This section describes key communication, dissemination, and outreach activities—including targeted messaging and tailoring of content to stakeholder needs. These activities underpinned two key objectives:

- **Capturing and documenting high-quality technical content and lessons learned** from the programs being implemented
- **Making information widely available to different audiences** and draw on the experience of the RBF community to discuss and share knowledge
Kyrgyz Republic

Why Use Qualitative Methods in the Impact Evaluation?

THE PROGRAM AND THE IMPACT EVALUATION. The Performance-Based Payments project is a three-year pilot focused on improving the quality of maternal and neonatal health care. In this three-arm randomized control trial, district hospitals will be randomly assigned to three groups:

• Those that will receive both enhanced supervision through a balanced-scorecard approach and a performance-based payment
• Those that will receive only enhanced supervision using a balanced-scorecard without performance-based payments
• Those that will receive no additional inputs.

The impact evaluation includes both quantitative and qualitative data collection components at baseline, before implementation of the RBF pilot program.

WHY QUALITATIVE? The motivation for including the qualitative component was to gain insight into how rayon (district) hospitals function. While the quantitative evaluation component will provide a snapshot of maternal and neonatal health care service conditions in district hospitals, the qualitative component will provide information about the health system and health facility dynamics that may have influenced the delivery of maternal and neonatal care. For example, the quantitative assessment may demonstrate poor quality of care during the postpartum period, but the qualitative assessment should tease out how different factors—policies, supervision, health worker performance, commodity supplies, and so forth—may have worked together to result in poor quality of care.

USE OF RESULTS. Results from the qualitative baseline study will be used to establish perceptions of the quality of maternal and neonatal health and the functioning of the health system, to inform policy makers and health system managers about the state of maternal and neonatal health service delivery, and to inform the development and/or revision of tools and procedures for the performance-based payments pilot program.
Disseminating Knowledge and Evidence
HRITF KNOWLEDGE AND EVIDENCE BASE PORTFOLIO

The HRITF’s integrated communication strategy now spans the Web, social media, video, email outreach, and traditional knowledge products, producing and sharing interesting technical content. These efforts contributed to a vibrant conversation on RBF, as well on universal health coverage, Beyond 2015, and global health debates. The primary channels included:

- **RBFHealth.org**, the partnership website and flagship external communications tool
- **All Things RBF**, the popular blog on the website
- Social media channels, including Facebook
- **RBF Bulletin**, the flagship (subscription-based) communications tool
- Events such as public Web-based seminars.

RESULTS AND ACHIEVEMENTS

**Website.** The partnership website was restructured in 2012 to improve the user experience, align with the results framework, and facilitate more engagement through comments and social media sharing. As the first contact with HRITF, the website is the standard-bearer and the hub for information on RBF programs and CPG projects. The addition of project pages was an important step toward more proactive sharing of experiences and best practices. An increase in the numbers of feature stories, blog posts, resources, and event notices published on the website helped to drive more traffic and downloads of information. Compared with March 2012, page views increased by 69 percent and monthly unique visitors increased by 56 percent. The top three countries from which visitors accessed the site were the United States (41 percent), the United Kingdom (8 percent), and India (4 percent). Almost half of all visitors made return visits within a day, indicating that new content and resources are helping to make the site a trusted source of credible information on RBF. The Home page remains the most popular page, with 15 percent of all visits, closely followed by the pages called **Our Projects** (4 percent) and Search (3 percent).

**RBF blog.** *All Things RBF*, launched in 2012, is one of the top 10 most visited pages on the website. The blog is proving to be a valuable resource for informal peer-to-peer learning through posts and comments generated by practitioners. It provides an opportunity to exchange knowledge and views on a range of topics including impact evaluations, conceptual frameworks, field experiences, and partner experiences with RBF. Unlike the rest of the website, the blog offers readers the opportunity to engage with bloggers through comments. This feature is helping to build and foster a transparent, vibrant community that is engaged in global conversation about RBF.

**Social media.** The new, more interactive and engaging website was complemented by several social media channels, which helped transcend borders to offer the global RBF community different ways to connect with HRITF and each other. The RBF Health community on Facebook grew from 44 followers in December 2012 to over 4,000 by the end of March 2013, as a result of compelling posts, including videos and photos of beneficiaries, and targeted messaging about maternal health in developing countries. The sharing options available to Facebook users—approximately one-seventh of the world’s population—as well as the peer influence fostered by the platform made the creation and dissemination of high-quality and engaging RBF content a priority for the HRITF. The Facebook page also allowed for greater engagement with people in the global south, see Figure 5.1, helping balance the website’s mostly global north audience. A diversity of countries and languages engage in the RBF conversation through the RBF Health page.

Popular posts on the Facebook page included videos from Burundi, Ethiopia, and Zimbabwe; and an International Women’s Day posting of “Bernadette’s Story,” which illustrates how the loss of a mother’s life affects families. That post reached over 12,000 people, 118 of whom clicked the Like option.

**RBF Bulletin.** Like the website, the RBF Bulletin is a flagship communications tool, valued by the HRITF and subscribers as a regular source of timely RBF content. Bulletin subscriptions increased by 53 percent; subscribers come from 28 countries. Despite the popularity of social media, e-mail is still the most effective way to engage with stakeholders. Each transmittal of the Bulletin had a direct, positive impact on website traffic, as recipients clicked links to the website from Bulletin content.
The level of engagement, measured by the percentage of recipients who opened the e-mail message, was high for this medium—23 percent.

Events. Events also played an important role in offering the RBF community, governments, and policy makers opportunities to discuss key current issues such as financial sustainability or quality of care within the context of RBF approaches for health. With initial results from programs starting to come in and key topics of interest arising, it was important to provide avenues to share the knowledge and experience as widely as possible. To reach the widest audience, RBF seminars were hosted over the Internet, available to participants around the world. Presenters this year included policy makers such as Dr. Gerald Gwinji, permanent secretary of Zimbabwe’s Ministry of Health and Child Welfare, and technical experts such as Dr. Kalipso Chalkidou, founding director of NICE International.

Going forward, strategic communications will continue to play a key role, enhanced by mutually beneficial dissemination partnerships with other organizations and the PBF community of practice, as well as by greater use of social media tools. In the coming months, the HRITF will focus on sharing results and facilitating opportunities for discussion with government clients and other priority audiences to ensure that the knowledge gained through the country programs is widely available and well integrated in RBF programs, to support the further scale up and sustainability of successful country programs.
### Annex: Description of Country Pilot Grants

<table>
<thead>
<tr>
<th>Country</th>
<th>Project Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>RBF is implemented at two levels - primary care and hospital. In both cases, health facilities are provided performance bonus of up to ten percent of the value of their existing contract with the Government for good performance based on quantity and quality of services. Performance payments are made available for the volume of services conditional on the quality of care at the primary health facility level. Similarly, performance payments are made available for quality of services to hospitals. While payment on the volume of services are made based on self-reported but independently verified performance, payments to quality are done based on performance reported by an independent agency. A third-party firm is contracted to verify self-reported performance as well and collects data on quality of services from hospitals. The health facility level RBF was introduced to provide a further push for improving performance, particularly in maternal and child health service. It is being implemented in 11 provinces for basic health services and in 5 provincial hospitals.</td>
</tr>
<tr>
<td>Armenia</td>
<td>In 2010, Armenia introduced Performance-Based Incentives in family medicine for public primary health care facilities in the country’s 11 regions (marzes). Under current performance contracts with the State Health Agency, primary health centers receive performance bonuses annually as a percentage of capitation rate based on targets met for selected indicators. The HRITF-financed RBF activities under the Disease Prevention and Control Project build on and expand Armenia’s current contracting scheme by adding performance indicators for reproductive health aspects, adding payment based on conditions to provide quality care, increasing the amount and frequency of payment of the performance bonuses, and strengthening the institutional arrangements, monitoring and evaluation as well as independent verification of results under the scheme. The project RBF activities include primary health care providers in all 11 marzes of the country.</td>
</tr>
<tr>
<td>Benin</td>
<td>To strengthen the quality and utilization of healthcare services, health facilities receive quarterly payments based on achieved results, especially those regarding maternal and child health and malaria free health care. All public and private not for profit health centers and hospitals in the 8 pilot health districts are contracted by the Ministry of Health and receive a fee-for-service, adjusted based on the quality of care. Payments take place after the quality and quantity of care reported are verified both internally and externally. Half of the health facilities have autonomy to decide how to use the RBF payments. An additional incentive to health providers for treating the poor is planned to be provided in the near future to enhance the utilization of these services by the poorest. The program is jointly financed by the Global Fund and GAVI.</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>The RBF component of the project will be piloted in 5 regions and will target the rural and urban poor. In the prepared project, on the supply side, the project supports performance-based incentives for health facilities for the delivery of packages of basic health care services, focusing mostly on maternal and neonatal health, but also including child and adolescent services, tuberculosis and malaria. Payment is on a fee-for-service basis and takes place every three months after their assessment by external reviewers and verification for quantity and quality of care. Facilities have autonomy to decide on how to use the RBF payments. On the demand side, the project supports cash incentives and transport vouchers for rural women to encourage utilization of services.</td>
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<td><strong>Burundi I</strong></td>
<td>The Performance-Based Financing program is nationwide and involves a total of 513 health centers and 50 hospitals. The largest contributor to the program is the Government of Burundi via its national budget. Health facilities are contracted for the delivery of a package of services under the Free Health Care policy for pregnant women and children under five. Payments are provided based on the quantity, through a fee-for-service, the quality of care, as well as an equity markup whose size depends on the extent to which the facility is considered disadvantaged in its ability to provide services. Up to a pre-determined fixed percentage of the total cash receipts of health facilities (from RBF and user fees) can be used to provide monthly performance-based incentives to the personnel. The remaining amount can be used to improve the performance of the facility.</td>
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<tr>
<td><strong>Burundi II</strong></td>
<td>The additional financing to the project described above (Burundi I) will support the continuation and expansion of the national Performance-Based Financing strategy. The project will finance incentives to healthcare providers for the provision of additional services particularly vital for the development of the country. These services are those directly related to nutrition and contraception.</td>
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<td><strong>Central African Republic</strong></td>
<td>The RBF project will be implemented in nine prefectures located in four out of seven health regions in Central African Republic. It will cover close to two-thirds of the total population. The government will contract with performance purchasing agencies to provide maternal and child health services through a RBF approach. The performance purchasing agencies themselves contract rural public, faith based and non-governmental organization-run health facilities for the delivery of a specified package of essential maternal and child health services, based on achieved results. Facility payments are made quarterly after service volumes have been verified and quality of care has been assessed. The results payments are used for incentives for health workers, as well as to improve service delivery.</td>
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<td><strong>Democratic Republic of Congo</strong></td>
<td>The RBF project involves performance-based contracts between implementing partners, such as Non-Governmental Organizations, and the Ministry of Health. Payment of performance-based subsidies to health centers and referral centers is on a fee-for-service basis and takes place after verification for quality and quantity of care. Contracts are monitored and evaluated by an external evaluation agency recruited competitively. Facilities have autonomy to decide how to use the RBF payments.</td>
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### Country Project Description

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<th>Country</th>
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<tr>
<td>Ethiopia</td>
<td>Using the new Program for Results (PforR) lending instrument of the World Bank, the IDA and HRITF will disburse upon achievement of a set of Disbursement Linked Indicators (DLIs) at the national level which aim to improve coverage of basic maternal and child health services, enhance accountability and transparency and strengthen the health management information system. The program is a collaboration on country level with several other development partners including DFID. The program has targets for increases in coverage of key maternal and child health services. It also support the development and implementation of a Balanced Score Card on facility level that assesses health facility performance. Regular national level surveys will be implemented to track the performance of the different indicators which will be the basis for the program disbursement.</td>
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<td>The Gambia</td>
<td>The objective of the project is twofold. First it aims to tackle demand-side socio-cultural and knowledge barriers, and improve household practices related to maternal and child health. Second, it aims to improve the quality and accessibility of maternal and child health services. The proposed program will incentivize both communities and health care providers, and focus on nutrition improvements. It will seek to promote and incentivize community-based service delivery and is exploring RBF strategies to influence behavior change. It will also define demand-side indicators to enhance timely utilization of health services.</td>
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<tr>
<td>Haiti</td>
<td>The Project seeks to support the national performance-based contracting program to improve use and quality of health services. Eligible public and non-public providers are contracted for a defined package of health services. Payments are adjusted for the quality of care provided, verified, and remote facilities benefit from a remoteness bonus. The project also intends to scale up the community agents (Kore Fanmi) network throughout the country and pay them for health-related results through the use of performance-based incentives.</td>
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<td>India</td>
<td>The project provides financial incentives to eligible private obstetric care providers under output-based agreements between the Ministry of health and health care providers. One payment is made upon signing the performance agreement, one payment takes place three months later as a continuation incentive, and a final payment is based on measured improvements in key health outcomes among pregnant women and infants in the catchment area regarding post-partum hemorrhage, preeclampsia, sepsis, and neonatal death.</td>
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<td>Kenya</td>
<td>In 2011, Kenya started a RBF pilot in Samburu county. A program assessment was funded by the HRITF to assess the results of this pilot. Based on early signs of success of the pilot, the Kenya Government has embarked on scaling up the approach, whereby the HRITF-funded CPG, along with a US$ 30 million IDA Credit, will provide performance based incentives to primary care facilities for the achievement of pre-defined targets in maternal and child health services, and HIV-related services.</td>
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<tr>
<td>Kyrgyz Republic</td>
<td>The RBF project is a pay-for-quality scheme which comprises two interlinked pilots. First, the project provides quarterly performance-based payments to 20 rayon hospitals on the basis of quality performance assessed through a Balanced Score Card. Second, a pre-pilot of performance-based payments at the primary clinic level will be implemented in one rayon starting in the second half of the project.</td>
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<td>Lao People’s Democratic Republic</td>
<td>The project supports RBF interventions which build on the original Health Services Improvement Project (HSIP) and pilot various innovative payment mechanisms. The three broad interventions involved are (i) continued support for Health Equity Funds, which provide output-based payments for key health services delivered to the targeted poor; (ii) support for the National Free Maternal and Child Health Policy, which provides output-based payments, on behalf of patients, for key maternal health services; and (iii) piloting of variable quality-based additional payments for these key MCH services, contingent on the achievement of certain quality measures. An existing pilot uses conditional cash transfers for maternal and child health. The possibility to merge these two programs is being explored.</td>
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<tr>
<td>Lesotho</td>
<td>Performance-based financing will be implemented in public clinics and clinics run by the Christian Health Association of Lesotho (CHAL). Facilities will have the management autonomy to use PBF payments based on priorities identified in their business plans, including to offer health worker performance or retention bonuses or to purchase inputs, within limits defined by their contracts with the performance purchasing technical assistance.</td>
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<td>Liberia</td>
<td>The project consists in performance-based incentives at the secondary hospital level, incentives to improve the referral chain, and support to improving health-worker skills and competencies. The project focuses mostly on paying for quality, while linking this feature with provider training. The objective is to improve in target counties the utilization and quality of medical interventions under the Essential Package of Health Services, which is targeted mainly but not only to maternal and child health. Performance-based payments made to health facilities will be adjusted to reflect their geographical location so that facilities located in remote areas can earn more.</td>
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<td>Nigeria 1</td>
<td>In a decentralized health care system, the project aims to intervene at three levels: state, local government; and health facility. At state and local government levels, the project is to provide annual funding after verification of the achievement of a series of pre-agreed Disbursement Linked Indicators (DLI’s). The performance of local governments is assessed through a scorecard. At the health facility level, performance-based incentives will be paid for the quantity and quality of care provided, on a fee-for-service basis after verification of reported results. Facilities will be given autonomy in how they use the performance payments, and payments will be adjusted for remoteness. Results will also be counter-verified. A similar performance-based financing approach will be tested in hospitals.</td>
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<td>Nigeria 2</td>
<td>Additional financing to Nigeria 1 to add the demand-side incentives which were not included in the original project.</td>
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<td>Rwanda</td>
<td>The Community Living Standards Grant Project supported a number of policy actions, including the development of the Community Performance-Based Financing program. It provides demand-side in-kind incentives targeting women, and complementary supply-side incentives targeting community health workers, with the overall goal of improving demand for reproductive and maternal health services to reduce fertility and maternal and child mortality. On the supply side, community health workers are organized into cooperatives and incentives are paid to the cooperative based on the overall performance of the member community health workers. 70% of the payments must be reinvested in the cooperative for income generating activities, and the remaining 30% is paid to community health workers.</td>
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<td><strong>Senegal</strong></td>
<td>The project will finance a community-based platform funded through RBF and strengthening both demand and supply of health and nutrition services. It will incentivize health facilities for improving quality and accessibility of key social services and households for changing their behaviors or for seeking institutional health care. Local councils will become the purchasers of results by the end of the project and select the interventions that will be incentivized, depending on the needs of their population. Indicators will include not only supply-side indicators, but also indicators for boosting demand for health and social services. Performance-based financing will also be piloted in hospitals. The project will be developed in close collaboration with USAID.</td>
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<tr>
<td><strong>Health &amp; Social Financing</strong></td>
<td><strong>HRITF amount:</strong> US$ 20.0 million <strong>IDA amount:</strong> US$ 44.0 million</td>
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<td><strong>Sierra Leone</strong></td>
<td>The project will strengthen the existing primary health care performance-based financing program for maternal and child health, by extending to private primary health care facilities. It will also scale up performance-based financing from two hospitals to six hospitals to improve quality of care at the tertiary level. In the primary health care performance-based financing scheme, payments for the quantity of each service is adjusted for the quality of care, and results verified both internally and externally.</td>
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<td><strong>Reproductive and Child Health Project Phase 2 (RCHP2) Additional Financing 2</strong></td>
<td><strong>HRITF amount:</strong> US$ 5.0 million <strong>IDA amount:</strong> US$ 7.0 million</td>
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<td><strong>Tajikistan</strong></td>
<td>The project aims to provide result-based payments to primary health care facilities to begin with. Demand side incentives may be introduced at a later stage of the project. Supply-side performance-based incentives are added as a top-up to the existing capitation payment for primary health care, based on achievements in the quality of care, with a focus on maternal, child health, and prevention and management of selected chronic diseases such as diabetes and hypertension. The project would also support the introduction of a collaborative quality improvement process focusing on the management of three priority areas- preliminary acute respiratory illness, child under-nutrition, and hypertension. This will involve strengthening the capacity of primary health care managers and head nurses to provide supportive supervision to providers, and the introduction of provider peer-to-peer learning groups to learn and exchange about quality improvement activities at the facility level on the three priority areas.</td>
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<td><strong>Tajikistan Health Services Improvement Project (HSIP)</strong></td>
<td><strong>HRITF amount:</strong> US$ 4.8 million <strong>IDA amount:</strong> US$ 15.0 million</td>
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<td><strong>Yemen</strong></td>
<td>The project is a community-based maternal and newborn health program using demand-side financing approaches, including a voucher for safe delivery services and neonatal care, together with a cash benefit for women living in rural areas towards the cost of transport, food and possibly other opportunity costs. Targeted services are free at the health facility. They will be mainly provided by contracted private profit and non-profit organizations who will be reimbursed an agreed price for services provided according to the agreed package of voucher services. Public providers will be resorted to in areas lacking providers or tertiary services that require hospitalization. All these providers will also be the principal conduit for distributing the cash contribution for transport to women at the community level. Verification both in the facility and among beneficiaries will be conducted.</td>
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<tr>
<td><strong>Maternal and Newborn Voucher Project</strong></td>
<td><strong>HRITF amount:</strong> US$ 10.0 million <strong>IDA amount:</strong> US$ 10.0 million</td>
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Zambia
Malaria Booster Project
HRITF amount: US$ 16.76 million
IDA amount: US$ 20.0 million
The project supports contracting of health facilities for the delivery of a specified package of essential maternal and child health services. Facilities are paid on a fee for service basis, adjusted for a quarterly quality score, which translates into significantly lower incentives for health facilities providing poor quality services. Reported results undergo internal and external verification. Staff at the district medical offices are also contracted to enforce regular quality supervision by the hospitals to the health centers; to conduct regular quantity audits; and to maintain a constant supply and optimal distribution of health systems inputs, including human resources. The performance incentive payments are used to pay incentives for health workers as well as for activities to improve service delivery at the health center. To trigger demand, neighborhood health committees decide on activities to spend money on so that solutions are designed to meet local needs.

Zimbabwe I
Health Results Based Financing Project
HRITF amount: US$ 15.0 million
IDA amount: None
The project supports contracting of health facilities for the delivery of a specified package of essential maternal and child health services with no user fee. Facilities are paid on a fee for service basis based on quality and quantity achieved in a given period. An internal and external verification process audits the reported data. Quarterly quality audits verify the quality of services provided based on a standard protocol. At the district level, hospitals receive performance based contracts to improve the quality of emergency obstetric care and district health management teams are contracted to strengthen quality of supervision. Remote facilities receive higher payments for the delivery of the package of services. The project is implemented by Cordaid, under the guidance of the Ministry of Health and Child Welfare (MOHCW). Performance-based subsidies are used for incentives for health workers as well as for activities at the health center to improve service delivery.

Zimbabwe II
Health Sector Development Support Project
HRITF amount: US$ 20.0 million
IDA amount: None
Based on preliminary positive results of the above RBF project (Zimbabwe I), the Government of Zimbabwe has requested the support of the World Bank in collaboration with other donors to sustain and expand this program. This additional financing will support the expansion of the above project (Zimbabwe I), through expanding the package of primary and secondary services, introducing demand-side interventions on a pilot basis for the urban poor, and lengthening the project implementation period by at least twenty months.
No mother should die from childbirth. It is time to accelerate progress on maternal, newborn and child health in developing countries.

“NOT MANY CHILDREN ARE DYING ANYMORE, I WOULD LIKE TO THANK RBF.”

TECLAR GOHORI, A BENEFICIARY OF AN RBF PROGRAM NOW COVERING 387 FACILITIES IN ZIMBABWE - MAINLY RURAL CLINICS - IN 18 HEALTH DISTRICTS.