Norad Evaluation Department

Evaluation of the Health Results Innovation Trust Fund

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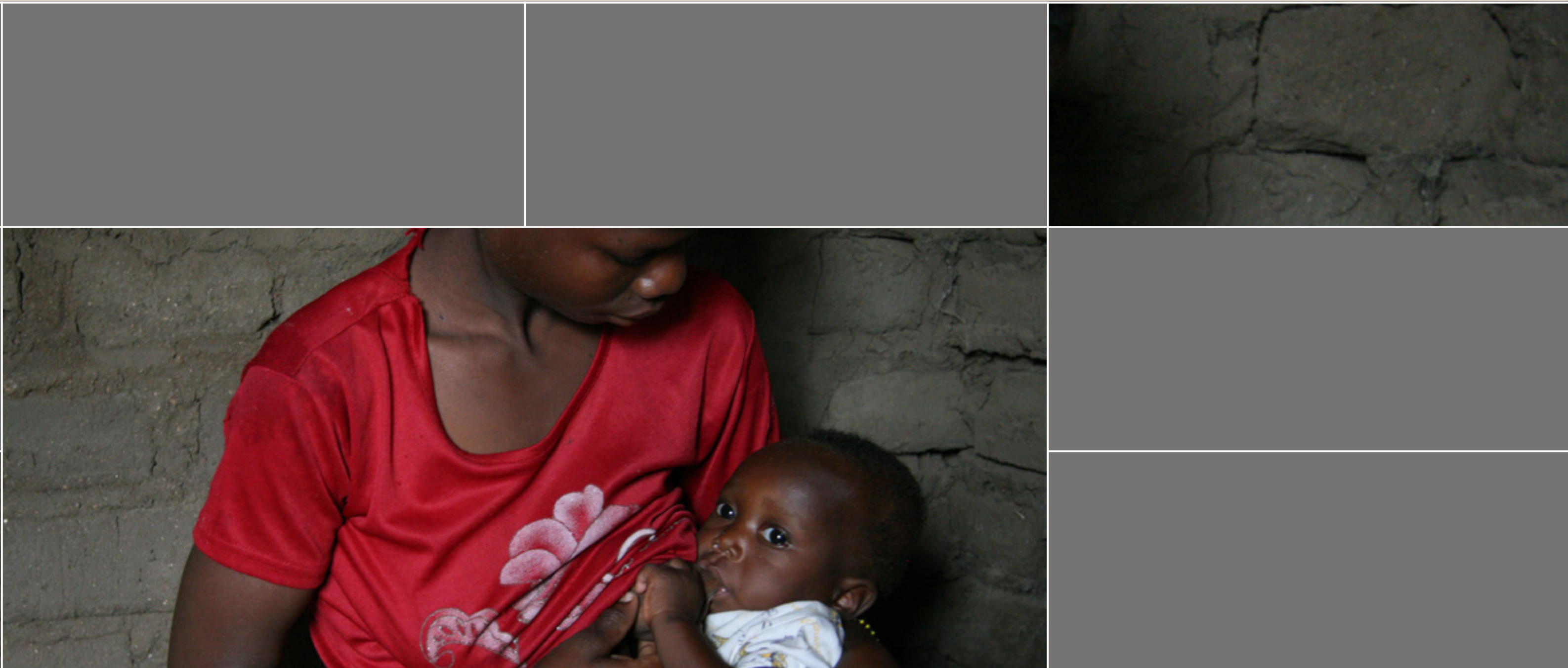

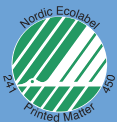

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Evaluation of the Health Results Innovation Trust Fund

June 2012

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The report is the product of its authors, and responsibility for the accuracy of data included in this report rests with the authors. The findings, interpretations and conclusions presented do not necessarily reflect the views of Norad Evaluation Department.

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Note on layout and language

The layout of the document has tried to conform to guidelines for accessibility and ease of reading, which require Arial font and left (not full) justification of the text.

The report has tried to avoid unnecessary use of acronyms and abbreviations.

An easy-read version of the final report will be made available on www.norad.no

Preface

Deficiencies in the quality of care, caused by lack of knowledge, insufficient resources, organizational rigidities, and inappropriate incentives for providers, impede the ability of health systems to improve health outcomes for the poor. In addition, too often, poor people do not utilize essential preventive, curative and life extending primary care services, even when those services are available. Distance to health facilities, lost wages associated with illness, costs of care-taking and care-seeking, facility fees and other out of pocket costs all contribute to limit access to health care and information by those who need it most.

The main problem with traditional aid is that it provides inputs without verifying results. Of course, donors have always cared about results. But funding for health has traditionally been directed toward inputs—salaries, construction, training, equipment. Improved health was assumed to follow, but this has not always happened. Despite pouring billions of dollars into health programs in Africa over the last decade, and despite some significant successes, many countries in Africa are still falling tragically short.

Results-based financing emerged as a reaction to these challenges. RBF for health refers to any program that rewards the delivery of outputs or outcomes with incentives (financial or otherwise), upon verification that the agreed result has been delivered. The incentive may be directed to either patients when they take health-related actions (such as having their children immunized) or to healthcare providers, when they achieve performance targets (such as immunizing a certain percentage of children in a given area), or both. While the World Bank uses the term "results-based financing" (RBF) to describe this concept, other donors call it performance-based incentives (PBI) or pay for performance (P4P). But they all essentially describe the same concept of linking incentives with results.

In 2007 the Norwegian Government was very keen to accelerate progress towards the Millennium Development Goals (MDGs) for health, and decided to support the creation of a trust fund dedicated to piloting Results-Based Financing (RBF) initiatives which could play an important role in achieving this. At the same time, some African governments became acutely aware that their countries were unlikely to achieve MDGs 4 or 5, which call on countries to reduce the under-five

mortality rate by two-thirds and the maternal mortality ratio by three-quarters between 1990 and 2015.

With supply of new approaches and potential demand assured, the Health Results Innovations Trust Fund (HRITF) was created. It is a multi-donor trust fund managed by the World Bank and financially supported by the governments of Norway and the United Kingdom (since 2009). It is the largest trust fund operated within the Health, Nutrition and Population portfolio of the World Bank, with total commitments of over US$575 million. The purpose of the fund is to help develop the evidence base on RBF approaches in health and their ability to increase the usage, provision and quality of reproductive, maternal, neonatal and child health services.

The Evaluation Department of the Norwegian Agency for Development Cooperation (Norad), upon request by the Ministry of Foreign Affairs, commissioned an evaluation of the Health Results Innovation Trust Fund (HRITF) covering its first four years (2007 to March 2011). This is the first of three evaluations which will take place over the course of the programme (2007-2020).

The objective of this evaluation, conducted between November 2011 and May 2012, was to assess HRITF performance against its objectives, and make recommendations to improve its operations, programming and governance. Impact to date was not assessed, as it is still early in the implementation phase, but this will be a key focus of the subsequent evaluations.

The report provides a rich read. The evaluation finds that in the four years since its launch the Fund has contributed to increasing the awareness about RBF both within the World Bank and in the health sectors of more than 45 countries where it has supported a range of initiatives. It argues that without the fund there would have been less RBF activity globally, and that what would have been implemented would probably have been evaluated in a less rigorous fashion, thus limiting the important learning aspect of this incentive-based financing mechanism. Nevertheless, the report calls for the development of a solid results framework and more strategic annual reporting. It observes that the Fund is a programme focusing on results, yet it does not have a theory of change, results framework and indicators defining how success will be measured.

We are happy to be able to include the World Bank's management response to this report (annex 8), and commend them for the good practice of preparing such official responses.

Oslo, June 2012

Marie Gaarder
Director of Evaluation

Acknowledgements

This report was produced by HLSP (http://www.hlsp.org) , a company of the Mott MacDonald group.

The evaluation team comprised Dr Javier Martinez (team leader, evaluation & health systems specialist), Mark Pearson (deputy team leader, health economist & health financing expert), Birte Holm Sørensen (MNCH expert), Barbara James (gender specialist) and Claudia Sambo (knowledge management and dissemination expert). The team were closely supported by Catriona Waddington (health economist, responsible for quality assurance of evaluation products), Emma Denton (health economist, project manager for the evaluation contract on behalf of HLSP), and Eva Hannah (project officer, administration and logistics support to the evaluation team).

Evaluators wish to express their gratitude to the Norwegian Agency for Development Cooperation -Norad for commissioning this work to us, and very specifically to Norad's Evaluation Department (EVAL) for extremely efficient and helpful oversight of the entire evaluation exercise. We are also thankful to staff and advisers based in Norad, in the Ministry of Foreign Affairs of the Kingdom of Norway and in the Department for International Development of the United Kingdom –DFID for sharing their views and experience with us and for helping us shape the focus of the evaluation.

As the organisation managing the programme that was being evaluated we are thankful to many staff and consultants from the World Bank, in the Washington headquarters and in several country and regional offices. We are particularly thankful to the HRITF Team in Washington and to Rama Lakshminarayan, the Interim HRITF Project Manager who provided so much support and clarifications to the evaluation team.

In undertaking the evaluation we talked to many colleagues from Ministries of Health, Development Agencies and the communities of practice for Results Based Financing from around the world. We are particularly indebted to the Ministry of Health and the World Bank team of the **Kyrgyz Republic**, and to the Ministry of Health of the **Republic of Rwanda** for allowing the evaluation team to conduct a case study in these two countries and for supporting the evaluation team so efficiently. In other countries such as **Benin, Burundi, Cambodia, Democratic Republic of Congo, Ethiopia, India, Mozambique, Nigeria, Senegal, Tajikistan, Zambia** and **Zimbabwe** we talked to selected persons from ministries

of health, world bank offices, academia and independent consultants as part of the process of preparing and undertaking five desk reviews that would complement the two case studies.

We tried our best to include the names of all the above in Annex 1 and we apologise if we have unwillingly forgotten or misspelt any names.

Statement:
This report is the product of its authors, and responsibility for the accuracy of data included in this report rests with the authors. The findings, interpretations, and conclusions presented in this report do not necessarily reflect the views of EVAL.

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List of Abbreviations and Acronyms

AfDB	African Development Bank
CAS	Country Assistance Strategy
CDC	Centres for Disease Control
CHW	Community Health Worker
CLSG	Community Living Standards Grant
COD	Cash on Delivery
COP	Community of Practice
CPBF	Community Performance Based Financing
CPG	Country Pilot Grant
CPR	Contraceptive Prevalence Rate
DFID	Department for International Development
DPT3	Third Dose of Diphtheria, Tetanus and Pertussis Vaccine
DRC	Democratic Republic of Congo
DTL	Deputy team leader
EDPRS	Economic Development and Poverty Reduction Strategy
EmOC	Emergency Obstetric Services
FRA	Fiduciary Risk Assessment
FTI	Fast Track Initiative
GAVI	Global Alliance for Vaccines and Immunisation
GBS	General Budget Support
GoN	Government of the Kingdom of Norway
GoR	Government of Rwanda
H&A	Harmonisation and Alignment
HFA	Health Financing Agreement
HMIS	Health Management Information System
HNP	Health Nutrition and Population
HRITF	Health Results Innovation Trust Fund
HSBS	Health Sector Budget Support
HSSP	Health Sector Strategic Plan
IDA	International Development Association
IE	Impact Evaluation
IWG	Inter-Agency Working Group
JHSR	Joint Health Sector Review
KM	Knowledge Management
KM&D	Knowledge Management and Dissemination
M&E	Monitoring and Evaluation
MFA	Ministry of Foreign Affairs
MNCH	Maternal, Neonatal and Child Health

MoH	Ministry of Health
MoF	Ministry of Finance
MINECOFIN	Ministry of Finance (Rwanda)
MSH	Management Sciences for Health
MTEF	Medium-Term Expenditure Framework
NGO	Non-Governmental Organisation
NORAD	Norwegian Agency for Development Cooperation
NURSPH	School of Public Health from the National University of Rwanda
OBA	Output based Aid
PAD	Project Appraisal Document
PBF	Performance Based Financing
PFM	Public Finance Management
PID	Project Implementation Document
PM	Performance Management
PRSP	Poverty reduction Strategy Paper
QA	Quality Assurance
RMNCH	Reproductive, Maternal, Newborn and Child Health
RBF	Results Based Financing
SBS	Sector Budget Support
SISCOM	Community Health Information System
TF	Trust Fund
The Bank	The World Bank
TL	Team leader
TTL	Task Team Leader
UNICEF	United Nations Children´s Fund
WB	The World Bank
VfM	Value for Money
WHO	The World Health Organisation

Executive Summary

Executive Summary

Background

The Health Results Innovations Trust Fund (HRITF) is a multi-donor trust fund supported by the governments of Norway and the United Kingdom and managed by the World Bank. The total commitments to the HRITF are US$ 575 million equivalent (this fluctuates according to exchange rates), making it the largest trust fund operated within the Health, Nutrition and Population portfolio and one of the largest operated by the World Bank. The Trust Fund is unusual in its lengthy - 15 year - implementation period to 2022.

The purpose of the HRITF is to help develop the evidence base on Results Based Financing (RBF) approaches in the health sector and their ability to increase the quantity and quality of Reproductive, Maternal, Neonatal and Child Health services used or provided.

RBF is a generic name given to any programme that rewards the delivery of one or more outputs or outcomes by one or more incentives, financial or otherwise, upon verification that the agreed-upon result has actually been delivered. Incentives may be directed to service providers (supply side), program beneficiaries (demand side) or both.

The goal of the HRITF is to support (RBF) mechanisms in the health sector to accelerate progress towards the health-related Millennium Development Goals (MDG), particularly MDGs 1c (nutrition), 4 (child health) and 5 (maternal health). It has *four specific objectives*: (1) to support design, implementation, monitoring and evaluation of RBF mechanisms; (2) to develop and disseminate the evidence base for implementing successful RBF mechanisms; (3) to build country institutional capacity to scale-up and sustain the RBF mechanisms, within the national health strategy and system; and (4) to attract additional financing to the health sector. The vast majority of funds are to be spent in implementing country RBF pilots and their associated impact evaluations.

A key feature of the HRITF is that it explicitly links Trust Fund activities to IDA credits thus bringing to bear the full weight of World Bank processes and procedures to the approach. This was intended to ensure that the RBF work becomes part of the Government-World Bank policy dialogue ensuring it fits with national requirements, and that the dialogue on results forms part of the broader dialogue on financial reform and sustainability. Other expected benefits include leveraging IDA resources for RBF and ensuring implementation readiness of the

operation. The Trust Fund is managed by a HRITF Team within the Health, Nutrition and Population (HNP) Hub, based in Washington DC.

The evaluation
The Evaluation Department of Norad (the Norwegian Agency for Development Cooperation) has commissioned an evaluation of the HRITF covering the period from the programme's beginning in 2007 to March 2011. The main objective of this evaluation is to assess the performance of the HRITF with regard to its above mentioned objectives, and to provide recommendations that can improve current operations and future programming and governance of the initiative. It is the first in a series of evaluations that will take place over the course of the programme.

The evaluation is based on five evaluation criteria - relevance, effectiveness, efficiency, sustainability and process capability. It considers questions (shown in Annex 4) that bring together the evaluation criteria with HRITF's objectives, and aims to consider both processes (e.g. how were programmes selected, designed, approved and implemented) and experience to date, including lessons with design and implementation of impact evaluations (baselines, models, verification, etc). Given the early stage of the evaluation there will be no attempt to look at impact of RBF activities or pilots to date.

The findings
The evaluation has covered a large range of issues in a relatively short period of time. There are many findings, observations and interesting features complemented by recommendations that we have brought together in Chapter 5 of this evaluation report, a chapter aimed at the agencies funding or implementing the HRITF. **Readers looking for the full set of recommendations are referred to chapter 5.** In this executive summary we will not attempt to summarise the main conclusions and recommendations any further. Instead, evaluators will use this executive summary to convey a general statement and five key messages that summarise what evaluators consider should be done to build on the achievements of the HRITF to date and to make it more relevant, effective, efficient and sustainable in the near future.

Overall statement
In the four years since its launch the HRITF has contributed to increasing the awareness about RBF both within the Bank and among the health sectors in the more than 45 countries where it has supported RBF-linked initiatives such as knowledge grants and products, seminars, publications, analytic pieces, design of pilots or rigorous evaluations, to just mention the main ones supported by the HRITF. Demand and interest have been generated among country governments, donors, NGOs, academia and civil society as a result of HRITF. The knowledge base on RBF is also increasing and will increase further as the almost 20 RBF pilots and linked impact evaluations that are being supported by the HRITF begin to deliver results over the next few years. Nonetheless the evidence base for RBF remains narrow and there is still a huge potential and opportunity for the programme supported by the HRITF to draw and learn key lessons by just using

the information that is being already generated by the pilots at country level and soon to be generated by impact evaluations supported by the Fund.

Case studies undertaken for this evaluation in Rwanda and the Kyrgyz Republic and reviews of country evidence (including five intensive desk reviews) suggest that while the pilots are likely to generate useful knowledge, they also emphasised the importance of the country and health sector context to explain results (and hence why the same RBF approach may work differently in different settings). We are satisfied that most existing pilots have a clear focus on reproductive, maternal, neonatal and child health services and the potential to improve outputs and outcomes. The impact evaluations that have been put in place to assess each RBF pilot are generally well designed and have achieved a reasonable balance between scientific rigour to test innovations, country relevance, feasibility of measuring impact in fast changing health sectors, and ownership. However, since RBF is not a standardised intervention much of what we need to learn is at what cost and with what level of effort can those improvements be achieved or sustained. We are confident that two or three years from now, when the results of RBF pilots and linked impact evaluations from HRITF application rounds 1 and 2 become available, the evidence on the feasibility of RBF will begin to grow in a way that would not have been possible without the Trust Fund.

Five key messages

For all the reasons above it is imperative for the Fund to concentrate its efforts on learning from the RBF pilots that it is currently supporting, with particular emphasis on the pilots that will complete the impact evaluations over the next three years. This work should set the pace and focus for the Fund in the future and help it consolidate its strategic direction. What interventions will help the Bank and its partners deliver on the four HRITF objectives?

1. **A solid results framework for HRITF and more strategic annual reporting.** For a programme focusing on results the Fund does not yet have a theory of change and linked results framework and indicators to define how the success of the Fund will be measured. Linked to this, the current focus of implementation and reporting is almost exclusively activity and input driven. There is a risk that the multitude of activities being reported worldwide could mask a more thorough assessment of progress. Results cannot be just the sums of activities undertaken, and while many activities are encouraging the real question is are these the right activities and are these being implemented in the right way, as per HRITF objectives? The only way to answer this question is to define clearly and explicitly the results that the HRITF expects to achieve over time for each of its four objectives, and to include indicators to measure such progress. Such a results framework is not yet in place and, we feel, it should be developed as a matter of urgency (please refer to section 3.2.3 for more details).

   A clear results framework would contribute to providing direction to the HRITF at a crucial time of rapid growth. By defining results at programme

level the results framework should also enable such results to be reflected and further described in annual work plans. Work plans should become the basis for assessing progress and addressing gaps year on year, and by being captured in annual reports they should lead to a more transparent and constructive policy dialogue among HRITF partners in the annual donor consultations, which should become much more strategically focused and be able to respond to questions like: Has the HRITF delivered on its work plan? Which parts of the results framework require additional attention? Developing the results framework may be challenging as it will force the partners to agree on what they expect to achieve, but this is the only way to put the programme on a stronger platform for results focus and for future evaluations. In sum, a programme focusing on results cannot delay any further the definition and application of the same methods to itself.

In line with all those suggestions these evaluators have made specific recommendations. Annual reporting and annual donor consultations should be adapted towards a more streamlined reporting and strategic engagement, with annual reports focusing on the four objectives and on the (yet to be defined) results; with activity reporting being brought to the annex section; with substantially strengthened financial reporting better capturing expenditure versus forecast and reasons for deviations; and with all the above being placed in the context of the annual work plans.

2. **Demand driven but strategically positioned.** Evaluators appreciate the demand driven approach by which countries apply for HRITF support. This was a sound way to generate demand and interest in RBF. Now that demand for RBF has increased markedly there is a need for the Bank to become much more selective, particularly with regard to country pilot grants (CPGs). We recognise the challenges this imposes as the HRITF Team effectively plays a brokerage role with the Bank's Task Team Leaders ultimately responsible for implementation. Country Pilot Grants should be subject to rigorous feasibility analysis, and while such analysis has improved as a result of linking the RBF pilots to the IDA credits the distinct features of the Fund and of RBF interventions (see 3.3.1 and 5.1 d in the main report) call for additional caution that the HRITF team should ensure across the range of RBF pilots. Also, the process of communicating HRITF funding decisions should become explicit and transparent in all cases: this may have already improved in rounds 3 and onwards (when compared to Rounds 1 and 2) as a result of the IDA link, but attention is drawn to the need for systematic feedback to be provided in all cases and for the HRITF team to closely oversee the process.

   The range of RBF mechanisms the Trust Fund is supporting is quite narrow. It is not clear whether this is what the donors had in mind. What is needed is a clear mapping of the current portfolio (evaluators have been told that such mapping has been recently commissioned) and a debate among HRITF partners on how any perceived gaps might be covered. For example, should the Trust Fund invest in a wider range of mechanisms (how, since the

models are largely country chosen?) or should donors pursue these through their bilateral programme? In terms of ongoing investments the next four years –at the end of which the next HRITF evaluation is planned – will be crucial, as the first results from the impact evaluations will become available.

Because the RBF is so context specific we have recommended a stronger focus on continuous documentation of existing pilots to serve various purposes: to identify and possibly deal with emerging issues affecting RBF; to ensure there is no contamination of pilot sites for impact evaluation purposes; to develop a better understanding of the costs involved in design and implementation, particularly those that are harder to assess through baseline and end line surveys alone; and to learn from all these and share the knowledge effectively.

3. **Strategically oriented and more hands-on HRITF Team.** We do not necessarily suggest that the HRITF Team have not been strategic to date. Rather we see this as a natural progression – interest has been built up, a range of activities and a portfolio of pilots schemes has been developed – now is the time to step back, assess the programme as a whole from a knowledge generation perspective and ask whether country demands are likely to meet the overall Trust Fund goals. (If this programme were simply about implementing a proven intervention the current approach would be fine. It isn't - it's also about investing in a global public good: knowledge). The point is rather that for the programme to respond to the challenges of the next four years and ensure that the pilots and evaluations deliver knowledge and that this is effectively analysed and disseminated, it will need to become more proactive and it will need to receive additional and regular analytic and, perhaps, managerial support. More proactive engagement by the HRITF team does not necessarily mean changing the ways in which the Bank implements its operations or increasing the size of the HRITF team (these options are for the Bank to consider). However, more proactive engagements will imply strengthening the HRITF team for it to cope with a larger portfolio of RBF pilots and impact evaluations, some of which will be delivered at about the same time. For example;

    3.1. There should be more regular (at least once a year) and systematic (a set of key points to cover) de-briefings and updates between the TTLs and the HRITF Team on the countries that are receiving support through Country Pilot Grants (CPG);

    3.2. RBF can take many forms or "models" – if the intention of the HRITF is to test as wide a range of models as possible there is a need to map out in more detail the current RBF portfolio as a means of identifying gaps;

    3.3. improved mapping should be linked to improved documentation of pilots at country level, and make sure the issues and lessons -even if preliminary- are swiftly captured and discussed;

3.4. continue the focus on training Task Team Leaders (TTL) and Bank staff but provide more opportunities at country and regional levels to discuss progress with pilots and to tap into regional communities of practice;

3.5. countries where pilots are taking place should be guaranteed a continued presence by Bank teams, to the extent that if Bank effective country presence (involvement in sector reviews and policy dialogue included) cannot be guaranteed the case for letting the country apply for pilot funding should be revisited. Alternatively other approaches could be considered e.g. a bilateral donor or multilateral donor taking forward the programme – either independently using the Trust Fund tools and technical support or even using Trust Fund resources (to be discussed among the TF partners);

3.6. steps should be taken for the HRITF Team to explore funding and sustainability issues linked to the RBF pilots well before these come to an end – this is being done more systematically in some countries than in others and, for example, key health donors and decision makers in each country where an RBF pilot or impact evaluation are being supported need to be systematically targeted with the right information and capacity building interventions;

3.7. every HRITF pilot should be effectively documented for both design and implementation, and a clear knowledge programme should be built focusing on many of the issues above and reflected in explicit questions that should lead to analytical pieces for the Bank and the international community to learn from;

3.8. there should be a stronger and more clear link between the learning activities at country level and the regional and global HRITF learning programme, with the focus of the learning programme being far more visible than it is to date in the RBF website, in annual reports, etc.;

3.9. all the above information should continue to be placed on the RBF website with a stronger focus on emerging evidence on RBF - the option for an RBF website committee that used to be in place may need to be revisited but with a stronger involvement of countries and regions rather just a group or “global experts”;

3.10. the knowledge programme will need to reach out to countries where RBF/PBF type approaches are being piloted or implemented without HRITF involvement –the HRITF should capture knowledge from those initiatives too- and it should establish stronger links with the RBF/PBF “communities of practice” that exist in Africa and Asia to explore possible avenues for collaboration and possible Fund support to interesting opportunities for mutual learning;

3.11. for many of the activities above the Bank may need to strengthen the human resource base of the HRITF Team that appears way too narrow to respond to the challenges ahead –this phase of the HRITF characterised by growth requires a stronger, more sophisticated approach to certain management functions undertaken by the HRITF team, and therefore a re-assessment of capacity of the HRITF team in the context of the functions it should perform and of its links with other parts of the Bank have been recommended.

4. **The full implications of the RBF pilots should be better assessed and reflected in existing reports.** The complexity and costs of RBF were often described to evaluators as very significant. Impact evaluations, in particular, are a costly, technically complex and risky activity. Sound implementation will play a crucial role in ensuring they are successful and it is important that resources are not spread too thinly. For example, given the dilemma it would be better to do fewer studies well than do a lot badly (while we are not saying any are being done badly right now). Clearly they should demonstrate value for the money invested but we would propose a more flexible approach allowing additional funding to be provided – especially for impact evaluations - where a strong case can be made for doing this. At the same time we recognise that countries are not a laboratory and that the most feasible option for design may need to be made. There needs to be greater clarity on what constitutes an acceptable design. Linked to this the Bank through the HRITF should have a stronger work programme to assess financial, operational and transaction costs linked to RBF implementation, and should use this information for learning purposes and to improve its own financial management and forecasting of financial needs linked to the HRITF programme.

5. **Work harder to ensure that successful RBF pilots can be scaled up and sustained.** As the results from ongoing pilots are released several countries may consider scaling up, but the funds required to financially support that effort may be simply not available. The original HRITF programme envisaged the development of a funding platform for RBF. While the HRITF has indeed become a focal point for RBF the number of donor agencies familiar with what Norway, the United Kingdom and the World Bank are attempting to do remains quite limited. In line with the point made in 3.6 above it would be desirable to expand the reach to other donors using a combination of country, regional and global activities. Since the HRITF is not expected to cover the costs of scaling up attracting additional funding from other sources will be key, particularly in countries where the likelihood of moving from pilot to national implementation already appears to be quite high (Rwanda).

Concluding remarks - performance against the five evaluation criteria
Overall, at this stage our assessment of the Trust Fund against the evaluation criteria is:

Relevance – the Trust Fund is relevant as it is exploring an approach – RBF- that offers considerable promise yet the evidence base remains thin.

Effective – as they stand the pilots will test a rather narrow range of interventions with an acceptable if not maximum degree of rigour (which is a major achievement) which are likely to generate a large body of knowledge. A more proactive approach is needed to seek out key knowledge outside the TF pilots.

Efficiency – partially. Progress has been relatively slow. This is due to a range of factors – some can be justified - initial expectations were unrealistic, RBF is complex and dialogue is likely to be prolonged and external factors have played a role. However, we found evidence that progress, in some cases, has been slower and less effective than it could have been.

Sustainability – it is too early to tell whether the pilot will be sustained. More importantly it is yet to be demonstrated that the pilots will be worth sustaining. We found a number of promising signs. The close link between the Bank and Ministries of Finance offers the potential that the issue is discussed. Problems may be greater in aid dependant countries where funding for scale up is more likely to come from donors who may not have been fully engaged to date (hence why the fifth key message is important).

Process Capability – partially. A number of steps need to be taken to tailor governance and implementation capacity with the realities of a fast growing programme. For example, a clear theory of change and results framework need to be developed, a more strategic approach to annual planning and reporting should be put in place, and efforts are required to increase the managerial capacity of the HRITF team and its access to technical capacity especially in the area of impact evaluation.

The counterfactual

No evaluation is complete without an assessment of the counterfactual. It is, of course, impossible to know what would have happened had the Trust Fund not been established. A reasonable assumption, though, would be that in the absence of the Trust Fund:

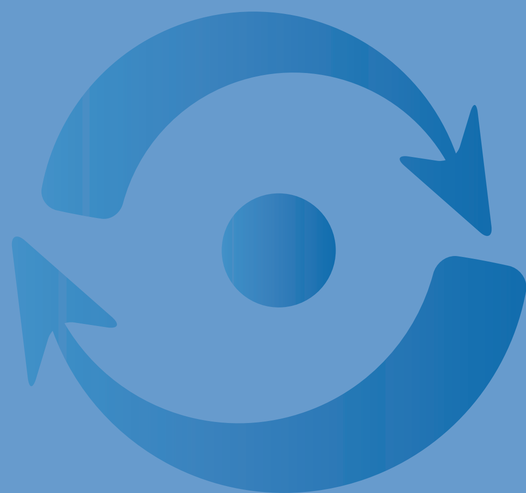
- there would have been less RBF activity globally (compared to what has happened)
- should the activity have taken place it might have been implemented more rapidly and probably at lower cost (using less rigorous evaluation methods)
- the activities would have been implemented in more opportunistic manner – with little planning or effort to ensure a balance between types of approaches and countries covered
- there would have been much less of a focus on assessing impact
- the approaches to assessing impact would have been much less rigorous and relied less on experimental designs incorporating randomisation

- there would have been less effort globally to develop and synthesise the knowledge base and build capacity in, and awareness about, RBF and impact evaluation

It is also possible that other actors might have been willing to accept greater fiduciary and other risks (though one cannot say that such risks would necessarily materialise) and might have faced greater challenges in accessing funds for scaling up from Finance Ministries (though they might have found it easier to attract resources from other sources).

Our conclusions in relation to the Trust Fund need to be seen against this background. For example, whilst we argue that the range of mechanisms addressed has been quite narrow there has at least been an attempt to achieve a balance between approaches which might not otherwise have taken place.

Main Report



1. Introduction and Background

1.1 Background to the evaluation

The Health Results Innovations Trust Fund (HRITF) is a multi-donor trust fund supported by the governments of Norway and the United Kingdom and managed by the World Bank. The total commitments to the HRITF are US$ 575 million equivalent (this fluctuates according to exchange rates), making it the largest trust fund operated within the HNP portfolio and the one of the largest operated by the World Bank. The Trust Fund is unusual in its lengthy - 15 year - implementation period to 2022.

The purpose of the HRITF is to help develop the evidence base on Results Based Financing (RBF) approaches in the health sector and its ability to increase the quantity and quality of Reproductive, Maternal, Neonatal and Child Health (RMNCH) services used or provided. RBF is a generic name given to any programme that rewards the delivery of one or more outputs or outcomes by one or more incentives, financial or otherwise, upon verification that the agreed-upon result has actually been delivered. Incentives may be directed to service providers (supply side), program beneficiaries (demand side) or both.

The goal of the HRITF is to support (RBF) mechanisms in the health sector to accelerate progress towards the health-related Millennium Development Goals (MDG), particularly MDGs 1c (nutrition), 4 (child health) and 5 (maternal health).

The Evaluation Department of Norad (the Norwegian Agency for Development Cooperation) has commissioned an evaluation of the HRITF covering the period from the programme's beginning in 2007 to March 2011. The main objective of this evaluation is to assess the performance of the HRITF with regard to its objectives, and to provide recommendations that can improve current operations and future programming and governance of the initiative. It is the first in a series of evaluations that will take place over the course of the programme.

This evaluation is based on five evaluation criteria - relevance, effectiveness, efficiency, sustainability and process capability. It considers questions that bring together the evaluation criteria with HRITF's objectives and aims to consider both processes (e.g. how were programmes selected, designed, approved and implemented) and experience to date, including lessons with design and implementation of impact evaluations (baselines, models, verification, etc). Given the early stage of the evaluation there will be no attempt to look at impact of RBF activities or pilots to date.

1.2 Report structure

This evaluation covers a large programme supported by the Trust Fund that in its first four years has already provided support to more than 45 countries in all regions of the world. It contains many new features, some of which are innovative and untested. Capturing this wealth within a manageable report has been very challenging, so we have had to compromise on a few structural and contents issues to keep to the specified length. For example:

- We have maintained the confidentiality of information provided by our key informants, as we told them we would, but we have included a few of their statements in order to illustrate certain points. These statements are captured in shaded boxes. All quotations (unless stated otherwise) should be seen as one person's opinion, but are given because they provide a specific insight to illustrate a point, so they are not necessarily or meant to be "representative" of a common view (the actual points and findings are made in the text of the report, not in the shaded quotations)
- In some sections a different type of box (not shaded, with line border) has been inserted to bring together key messages.
- Whenever possible we have included text from various HRITF documents and progress reports in the way of an opening statement or introduction to the topic being discussed.

The structure of this report is as follows:

The **executive summary** provides a quick glance at some of the main findings and recommendations of the evaluation, presented in the form of an opening and concluding statements and 5 key messages.

Chapter 1, this chapter, **introduces the study**, the concept of Results Based Financing (RBF) and the programme being supported by the trust Fund.
Chapter 2 discusses the **evaluation approach and methodology**, in a simplified form. It makes an important point, which is the need for a more clear and explicit theory of change for the HRITF, and a linked results framework.
Chapter 3 presents the main study **findings organised as per the four HRITF objectives**.
Chapter 4 presents **additional findings** in the area of **HRITF organisation, management and governance.**
Chapter 5 presents the **main conclusions and recommendation** of the study in table form.

The evaluation is supported by the following annexes:

Annex 1 lists all the **people met or approached** for this evaluation.
Annex 2 lists the main documents consulted and referenced.
Annex 3 contains the summaries of the cases studies, desk reviews and informal enquiries undertaken in a sample of countries.
Annex 4 includes all the hypotheses and questions explored as part of this evaluation to ensure a focus on the five evaluation criteria: relevance,

effectiveness, efficiency, sustainability and process capability. **Annex 5** contains the terms of reference for this evaluation.

1.3 What is RBF?

Results-Based Financing (RBF) is a generic name given to any programme that rewards the delivery of one or more outputs or outcomes by one or more incentives, financial or otherwise[1], upon verification that the agreed-upon result has actually been delivered. Incentives may be directed to service providers (supply side), program beneficiaries (demand side) or both. A more detailed definition – based on work commissioned by the Trust Fund is shown below.

> Results-Based Financing, RBF, is any program that rewards the delivery of one or more outputs or outcomes by one or more incentives, financial or otherwise, upon verification that the agreed-upon result has actually been delivered. Incentives may be directed to service providers (supply side), program beneficiaries (demand side) or both. Payments or other rewards are not used for recurrent inputs, although there may be supplemental investment financing of some inputs, including training and equipment to enhance capacity or quality; and they are not made unless and until results or performance are satisfactory. Payment can take any form so long as it does not simply purchase inputs. Verification that results were actually obtained is an essential feature. The ideal is perhaps for verification to be undertaken by a neutral third party, even if the principal pays the corresponding costs, but many arrangements are possible. Ex ante verification (before payment) can be complemented by ex-post assessment. The definitions of results or objectives and rewards are embodied in contracts between one or more principals who provide the incentives and one or more agents who contract to deliver the specified results, outputs or outcomes. The contract may also specify varying degrees of collaboration between principal and agent, supervision of the latter by the former, or other aspects of how the results are produced, such as protocols to be followed or targets to be met.
>
> Source: Musgrove, 2011.

Key features of RBF approaches include:

- **Who** funds**?** (the principal)
- **Who** delivers the results? (the agent)
- **What:** Which results are targeted?
- **How:** Which levers are used?

1 Please note that under the HRITF only financial incentives are being provided following a decision made by the World Bank in 2010 not to provide in-kind incentives. In-kind incentives have only been provided in Rwanda because its application for HRITF support predated such decision. Clarification provided by the HRITF team.

The table below (taken from Musgrove 2011) illustrates the types of results supported (the what) and possible approaches to funding (the how).

Table 1: Overview of Results Based Financing – How are results paid for?

	Results			
	Input	Output	Outcome	Impact
Locus	Provider or Facility		Individual Patient	Population
Example of "Result"	People, Drugs, Building, Equipment	Services, Interventions, Procedures, Tests	Survival, Birth Weights, Reduced Pain or Disability, Better quality of life	Life Years/ QALYs/DALYs gained
Financial	Input Based: Salary, Purchase, Leasing Capitation	Fee for Service DRGs, Bundled Pay by Condition, Capitation	Incentive payments for: coverage, targets, protocols, compliance	Incentive payment according to impact

RBF is not a new approach. It has gained major impetus through the availability of additional donor funding (before the current economic crisis), following growing concerns that traditional input based approaches were not delivering optimal results and in the context of greater emphasis on results as set out in the Paris Declaration.

Whilst considered a promising approach the evidence base is seen to be weak (see for example the boc below). This has been recently reconfirmed by a Cochrane systematic review of Performance Based Funding (Witter et al 2012).

Weak Evidence Base: Experiences with RBF in the health sector in low and middle income countries are increasing, but formally published evidence in this area is still limited. Methodologically sound studies of RBF are few; with the result that documentation about effects is weak.

Source: DFID Project Memorandum.

1.4 What Is the HRITF?

The Health Results Innovations Trust Fund (HRITF) is a multi-donor trust fund that was initially supported by the Government of Norway since December 2007 with a commitment equivalent to US$ 104 million. In December 2009, the Government of Norway increased its commitment by a further US$ 264 million equivalent. Following recommendations of the High Level Taskforce for International Innovative Financing for Health, the United Kingdom committed the equivalent of US$ 190 million equivalent to the HRITF in 2010. The total commitments by the Governments of Norway and the United Kingdom to the HRITF are US$ 575 million equivalent through 2022 (please note this figure is a rough estimate – actual figure will vary according to exchange rates).

The Trust Fund (TF or HRITF will be used interchangeably) supports a programme managed by the World Bank and its mandate is set out in the Grant

Agreement signed by the Norwegian Government and the World Bank on December 4th 2009. The HRITF is the among the largest trust funds operated by the World Bank and the largest in the Health, Nutrition and Population programme. The HRITF is unusual in its lengthy - 15 year - implementation period, which implies a recognition that introducing, piloting and testing a range of RBF approaches requires a sufficiently long implementation period. Taking the total programme length into consideration the period under evaluation (2007-2011) is a relatively short time and marks the launch of the programme and the development of its modus operandi, systems and instruments.

The HRITF is fully integrated in the World Bank´s structure and follows strictly the Bank´s operational procedures. This means that the implementation of the HRITF is the responsibility of its country, regional and central office staff and departments, exactly in the same manner as any other World Bank operation. Furthermore, a key feature of the HRITF approach is that since 2010 it explicitly links most Trust Fund activities to International Development Association (IDA) credits and grants, thus bringing to bear the full weight of World Bank processes and procedures to the approach. This was intended to ensure that the RBF work becomes part of the Government- World Bank policy dialogue ensuring it fits with national requirements and that the dialogue on results forms part of the broader dialogue on financial reform and sustainability. Other expected benefits include leveraging IDA resources for RBF and ensuring implementation readiness of the operation.

The TF is managed by a Team (referred to in this document as “the HRITF team”) based in Washington DC which plays a key brokerage role between the donors and the respective Bank Task Team Leader and sector leaders responsible for implementing any Bank initiated result based financing (RBF) programmes. The size of the team is quite small (less than 10 persons) and is integrated within the Health, Nutrition and Population hub of the Bank, which comprises 9 units (1 General unit, 6 Regional Units, 1 Research unit and the World Bank Institute).

The goal of the TF is to support RBF mechanisms in the health sector to accelerate progress towards the health-related Millennium Development Goals (MDG), particularly MDGs 1c (nutrition), 4 (child health) and 5 (maternal health).

The TF has *four specific objectives*:

1. support design, implementation, monitoring and evaluation of RBF mechanisms;
2. develop and disseminate the evidence base for implementing successful RBF mechanisms;
3. build country institutional capacity to scale-up and sustain the RBF mechanisms, within the national health strategy and system; and
4. attract additional financing to the health sector.

These objectives are operationalised through nine activities, as defined in the administration agreement signed between the Bank and the funders. It is important to note that "activities" in this context are the administrative categories used by the Bank to classify expenditures incurred by the TF, and for reporting and budgeting purposes. The TF does cover several other activities –capacity building, leveraging resources, etcetera- that may not exactly fit in any of the 9 "activities" or that could be assigned to more than one activity line. Out of the 9 administrative activities 6 will be implemented by the Bank, two by the recipients, and one jointly by the Bank and the recipient (see Table 2).

Table 2: HRITF Activities as per the Administration Agreement

Responsibility	Activity
World Bank	3: Preparation and Appraisal of RBF projects / components 5: Supervision of Bank and recipient projects 6: Monitoring and Documentation of projects 7: Evaluation of Bank projects 8: Dissemination and knowledge sharing 9: Trust Fund Management and Administration
Recipient Country	2: Design of RBF Projects /components 4: Implementation of Bank/Recipient RBF projects
Dual Responsibility	1: Preparation and review of proposals/RBF Seed Grants

The Trust Fund is in its early stages: as of March 2011 it had received $93m from donors and spent some $22.6m – 3.9% of its total funds. In march 2011 the Fund was operational in 40 countries with 24 countries have receiving grants for preparation of proposals/seed money (activity 1 above) and 11 countries receiving project preparation and appraisal support (activity 3) with 3 of those in the implementation stage (activity 4). All countries for which so called country pilot grants (CPGs) to pilot RBF approaches have been approved automatically receive financial support from the HRITF for an impact evaluation (IE) to be conducted. Just over 40% of spending to date has been on the implementation of RBF pilots.

The HRITF is growing quite rapidly, and while most of this evaluation will cover the period from 2007 to March 2011 it is worth noting that by the time this evaluation was being conducted in early 2012 the number of country pilot grants (all stages included) had already increased to 19 countries, which also implies that 19 baseline studies for impact evaluation were at different stages of design, not to mention the exponential growth in knowledge and dissemination activities that the programme is experiencing.

Why did HRITF happen?

In 2007 the Norwegian Government was very keen to accelerate progress towards the MDG 4 and 5 goals, and regarded GAVI ISS as a positive experience and also felt the approach had worked well in Norway (where a large share of payments to health providers – around 40% - are results based). With the Janani Suraksha Yojana (JSY) experience in India (demand and supply side

incentives for institutional or skilled assisted deliveries) Norway also spotted some opportunity for taking forward the so called diagonal approach when much of the additional funding being allocated to the health sector over the last decade was taking place in a rather vertical manner.

DFID supported the approach from 2009 following the report of the Taskforce on Innovative International Financing for Health Systems (see boxes below), which suggested an important role for RBF in helping accelerate progress towards the health MDGs.

Taskforce on Innovative International Financing for Health Systems Clearly link financing for health to defined outcomes and to measurable results in broader programmes as well as in projects, building on the specific experiences from performance-based funding and SWAps.

Source: Working Group 2 Recommendation

Overall Taskforce Evaluation of RBF: The value added of RBF is to create incentives within recipient countries to deliver results. RBF is a relatively flexible approach that could be supported though a multi-donor trust fund. Several billion dollars annually could be channelled through RBF. Potential disadvantages include upfront costs, including the need for carefully designed programmes to avoid the creation of inappropriate incentives, and the fact that funding would have to come from conventional ODA or from one or more other financing mechanisms. Ultimately, RBF's success would depend on well-designed programmes that take into consideration country systems and capacity for implementation. If properly implemented, RBF could score high on aid effectiveness criteria. It is designed to support strong results and could be used to target funding to the poor. Since RBF channels funds through country systems, funding is expected to be well aligned with country priorities. Positive externalities could arise from the additional data collected, the high motivation to report, and monitoring and evaluation requirements. Predictability may be viewed either as a disadvantage (in that flows depend on results) or as an advantage (in that recipients can to some degree control the flow of funds by their own actions).

2. Metholodology and Analytical Framework

The Administration Agreement of the HRITF grants allows for periodic, donor initiated independent external evaluations to be undertaken in 2011 and 2016 with a final evaluation to take place in 2022 when the Trust Fund is due to close. This evaluation is the first of these; its main objective is to assess the performance of the Trust Fund with regard to its above mentioned objectives, and to provide recommendations that can improve current operations and future programming and governance of the initiative. The evaluation covers the time period 2007 – March 2011, although the evaluators could not in all cases stop the watch and some of the findings have been reported up to the first quarter of 2012 (we will mention when such is the case).

To keep the report short we will just summarise the main steps taken to develop and apply the methodology for this evaluation. The main questions and hypotheses that we have attempted to address are included as Annex 4 and these are specifically referred to in our Chapter 5 of conclusions and recommendations.

2.1 Approach and methods

The methodology for this evaluation was first presented in a technical proposal during the evaluation bidding stage (October 2011), which was subsequently refined during the inception phase (November 2011 to January 2012). The original terms of reference for the evaluation have been appended as Annex 5.

2.1.1 Developing hypotheses and study questions

We took the following steps:

- We first developed questions to evaluate each of the four evaluation objectives by using five pre-defined evaluation criteria: Relevance, effectiveness, efficiency, sustainability and process capability. Those questions were included in the original technical proposal submitted to Norad. Definitions for the first four evaluation criteria were taken from the OECD/DAC evaluation guidelines. Process capability was added by the evaluators to cover any issues relating to the performance of the implementing agency in delivering the programme as per the administrative agreements.

- The questions developed (as above) where then added to and set in the context of broad evaluation questions that had been included in the original Request for Proposal, and additional questions that we gathered through informal meetings held with Norad, DFID and the World Bank between November 2011 and January 2012. We then developed a set of hypotheses to be tested and added new questions to respond to these. This process led to a table linking HRITF objectives, big evaluation questions, main hypotheses and more detailed questions. The table can be found in Annex 4.

- We used the table in annex 4 to build up our understanding of current HRITF processes and how they are supposed to work. We used the table, for example;
  - to understand the process through which countries apply for HRITF financing and the processes involved in assessing those application and approving the funding;
  - to assess the products for which countries apply for funding, such as the learning grants, the RBF pilots, the impact evaluations, etc. What range of RBF pilots is being implemented? What approaches are being tested? What types and range of incentives are being used? Which indicators will trigger payments? How will results be verified? Etc.
  - to understand issues relating to the design of impact evaluations being designed to assess the impact of RBF: What impact evaluation designs are being used? What hypotheses are being tested? What indicators will be used? Etc.

2.1.2 Data collection strategies and sources

To meet the evaluation objectives this evaluation has been highly dependent on the reviewers´ ability to document and analyse available information linked to two main types of processes:

- The **programme design and implementation** arrangements for HRITF, and the tools, procedures and protocols developed to support it; the discussions held in the Bank between the HRITF implementation unit and other departments and units of the Bank, at headquarters and country levels; the interactions between all the above with key stakeholders such as the governments of the UK and Norway and with the members of the inter-agency working groups and other institutions and donors with an interest in or expertise about RBF; to mention the main ones.

- The second set of processes relate to the **implementation of HRITF activities in specific countries**, including; initial discussions, agreements and other interactions held between the World Bank country offices and those responsible for the national health system in each country, namely the governments of those countries, selected development partners and, in some cases, private sector organisations (NGOs; for profit and not-for-profit providers, etc.) and civil society organisations. All the above would be linked

in different ways to specific HRITF activities such as reviews of available evidence and practice on RBF. As we have indicated earlier in this review we are also interested in **evidence from countries where there are ongoing RBF initiatives not supported by the HRITF** that are still interesting from a lesson learning and dissemination perspective (objectives 2, 3 and 4 of HRITF).

- The team is aware of the important relationships between the first and second sets of processes mentioned above.

We mapped the methods to collect information to answer the hypotheses and question, and we assigned responsibilities among team members for these. In a nutshell, the following data collection strategies and sources were used:

- **Documentation.** We gathered a large number of documents from then HRITF partners and from internet (mainly RBF website) that were classified, distributed among team members and used to prepare interim analytic document to help team members better understand the HRITF. For example, a "countries folder" was prepared summarising information on HRITF support to countries contained in the HRITF annual reports. A "timeline folder" was also prepared depicting main HRITF milestones. A "persons to meet folder" was also prepared listing a set of key informants. These documents helped the team to prepare more detailed data collection tools. The main documents used can be found in **Annex 2**.

- **Case studies**. The RFP established that the evaluators should, in consultation with the Bank, DFID, the Norwegian Ministry of Foreign Affairs/ Norad "propose two country case studies for analysing the recipient country level issues in this study. The proposed cases should be selected using the criteria actual disbursement, length of support, geographic coverage (one country from Africa and another country from outside Africa), and type of activities". The proposals were presented and justified in the inception report and **Rwanda and the Kyrgyz Republic** were proposed and accepted. Details on reasons for selection can be found in the inception report and will not be included here to keep this report to the required length. The intention was to attempt to answer as many as possible of the hypotheses and questions (Annex 4) in each of the two countries. The summaries of the case studies undertaken can be found in **Annex 3.**

- **Desk reviews**. Evaluators proposed to the HRITF partners that in order to maximise the learning on the practical implementation of the HRITF it would be desirable to explore a larger number of countries than the two selected for case studies. It is thus that a proposal was made to conduct a series of six desk reviews in countries that offered interesting features for the evaluation. The process of selecting the countries was totally driven by the evaluators following their own review of HRITF annual reports, and informal consultations with the HRITF partners and with the World Bank task team leaders (TTL) responsible for those countries. In the end five countries were

covered with desk reviews (**DRC, Benin, India, Nigeria and Zambia**). The intention was to cover in the desk reviews as many questions from our main research table (Annex 4) as possible. Summaries of these desk reviews can be found in **Annex 3**.

- **Other countries covered in less detail by evaluators**. In addition to the desk reviews the evaluators approached key informants in a few additional countries where interesting features –identified in documents or by key informants- might contribute to the evaluation. Countries that were covered in this way included **Cambodia, Ethiopia, Mozambique, Senegal, Tajikistan and Zimbabwe**, for some of which the team prepared some "vignettes" or text boxes to include in the evaluation report. A couple of examples of vignettes for Senegal and Tajikistan have been included in **Annex 3.**

- **Key informants.** In addition to people interviewed for the case studies and desk reviews the evaluation team leader and deputy team leader interviewed more than 40 key informants throughout the evaluation using a range of tools (personal interviews; phone/skype interviews). Briefing notes were prepared to approach informants. Email questionnaires were used to explore views from the former Project Manager of the HRITF (Darren Dorkin) and to obtain information from a range of TTLs. When the names of people approached as part of the case studies and desk reviews are added to those mentioned above more that 120 people were interviewed as part of this evaluation. Their names have been included in **Annex 1**.

- **Additional focus on knowledge management and dissemination (KM&D).** The HRITF has an important responsibility to synthesise and disseminate knowledge on RBF mechanisms in health. During inception the evaluators identified the need to strengthen the team with an additional person, a professional with KM&D expertise tasked with looking at the products and processes supported by or delivered through the HRITF (workshops, publications, RBF website, etc.).

The main data collection strategies and sources have been summarised in table format and can be found as **Annex 6**.

2.1.3 Data analysis - bringing together the evaluation findings

Desk reviews, case studies and the assessment of KM&D were written in an analytical manner so as to feed answers and evidence to the questions and hypotheses included in Annex 4. In addition, the evaluation team conducted a series of cross cutting analyses of all those products of the evaluation and assigned individual responsibilities for this. For example:

- Looking across issues and lessons linked to the Impact Evaluation studies commissioned through the HRITF (leader: Mark Pearson led);
- Looking across gender, equity and poverty focus in design and implementation of pilots (leader: Barbara James)

- Looking across the focus on RMNCH aspects and the alignment with MNCH national strategies (leader: Birte Holm Sørensen)
- Looking across HRITF management, skills mix needs and gaps and governance arrangements (leader: Javier Martinez)
- Looking across procurement arrangements (staff, goods & services) for HRITF (leaders: Javier Martinez and Mark Pearson)
- Looking across knowledge management and dissemination aspects linked to HRITF (leaders: Claudia Sambo and Javier Martinez)
- Looking across planning, forecasting, budgeting, resource allocation and expenditure reporting issues, and sustainability (leader: Mark Pearson)

The main tasks and responsibilities undertaken by team members in this evaluation in relation to both data collection and analysis have been summarised in table form at Annex 6.

2.2 Limitations and lessons for future evaluations

The team had to process a lot of information within a short period of time and by a small team. While we think that the approach and methodology used have delivered answers to most of the hypotheses and questions the following issues are worth noting to contextualise the findings and to design future evaluations:

1. **Information availability or accessibility**. The evaluators were only able to access data from the secure donor connection at a very late stage of the study. This data was provided indirectly through a donor (and we appreciate their willingness to do this). Without having had direct access to the website we cannot guarantee we have made full use of this source. The secure connection is helpful but still only provides limited information. For example, monthly financial statements are only available from May 2010. Data is not provided on expenditure by activity. Also, detailed grant by grant expenditure figures can only obtained for the period up to the date on which the report is run. It is not possible to look at expenditure prior to the current date meaning it is difficult to say anything about trends in spending over time. The site only provides aggregate level breakdowns of spending. It is not possible for example to breakdown spending by use grant by grant. Although this is, in principle, possible the HRITF team argues that this would provide little added value (see the footnote) given the effort involved, and that such a detailed focus on inputs makes little sense give the results focused nature of the programme.[2] As a result we were unable to address some of the issues set out in the Terms of Reference. **Lesson**: it would save time and resources in future evaluations if data needed by the evaluators is either prepared well in advance of the beginning of the evaluation or, alternatively, if the length of the inception period is increased considerably. Given the size and complexity of the HRITF programme

2 The following response was received from the Bank following the request of information: “for central monitoring purposes, we only look at the aggregate expenses and only drill down further if we feel something is off-track. However, routinely trying to track expenditures by the above expense categories would be extremely time-consuming (drilling into numerous child TFs) and, in our opinion, will not yield much more useful information. ….we do monitor by activity under the TF at the country level, since this is something that we think needs to be looked at closely from a central monitoring standpoint and serves as an early warning system if something is off-track”

preparing the information well in advance makes sense. If information cannot be prepared in advance then we suggest that a longer inception period is allowed, during which evaluators would approach the agency responsible for the programme being evaluated, assess data availability, request the necessary data and only formally begin the evaluation when data is made available to them. However, this approach has disadvantages to the contractor (uncertainty about dates for delivery of evaluation products) and to the evaluator (time from the members of the evaluation team cannot be guaranteed beyond a limit, so there is risk of losing key staff if the inception period is too long). This is why it is proposed that resolving access to information before launching the evaluation saves time and resources to everyone.

2. **Relying on institutional memory.** People move on and important pieces of information may be lost in the process. This affected our ability to acquire information regarding: how were the original applications for HRITF prepared; what decisions were made by the review committees in each case; how were decisions communicated to countries; what changes were made to the original proposals and budget, and why. Some of the institutional memory loss in unavoidable, but evaluators could not help perceiving that in many cases the documentation of HRITF ongoing processes was not being systematically done by the World Bank. In our country visits or in phone conversations with TTLs we often asked for a "logbook" or "timeline table" outlining key dates and key processes linked to HRITF implementation, but it was the evaluators who had to produce these most of the times. Lesson: simple timeline tables can be very useful to keep institutional memory and, in the process, to help evaluators understand what happened when. It is recommended that every CPG pilot should have a timeline description linked to it – this could be also quite useful for hand-over purposes.

3. **The range of countries to cover.** In the time and with the resources available evaluators feel that a sufficient number of countries were covered, but two case studies proved insufficient in terms of range, particularly when 19 country pilot grants are currently being supported by HRITF. To compensate for that evaluators suggested a compromise approach through the desk reviews, but these had to be done from desks and where therefore, by necessity, more superficial than case studies in terms of properly assessing aspects like ownership, quality of institutional arrangements in place, fitting with the policy context, etc. Evaluators would have also liked to spend time in some regional offices and better understand the regional learning grants and the regional issues linked to supporting RBF pilots and impact evaluations. Of course, these issues only became apparent to evaluators towards the end of the inception phase, at which time it would not have been appropriate to substantially modify the evaluation design (although we did adapt it considerably and our contractor was very flexible and supportive of such adaptation). **Lesson:** future evaluations should allow for a wider sample of countries for case studies to be conducted. Since the "right" numbers of case studies can only be known following a better understanding of the programme than is possible at bidding stage we suggest that the RFP should require bidders to use the inception phase in order to come up with a proposal on range of countries

to cover. In such case all staff and logistics costs associated with the case studies (time for consultant to lead each case study, time for national consultants, travel, accommodation and transport) should be excluded from the financial proposal, where only core evaluation time would be costed.

3. Findings – progress achieved on the HRITF objectives

We begin the section on findings with a brief review of the HRITF programme, its main milestones and the way it works. We then proceed to explore the results chain underpinning the HRITF programme, as a first step towards analysing progress. Then each of the four HRITF objectives is analysed in detail. Each objective is analysed following the hypotheses and questions included in Annex 5, which cover each of the four evaluation criteria: relevance, effectiveness, efficiency and sustainability. The dimension process capability has also been analysed and is covered mainly in chapter 4.

As mentioned in the introduction evaluators have inserted shaded text boxes along the way to illustrate certain points. Text boxes include either text from documents reviewed (source is referenced) or statements from key informants interviewed (anonymity is maintained as per agreement with informants). All quotations (unless stated otherwise) should be seen as one person's opinion, but are given because they provide a specific insight to illustrate a point, so they are not necessarily or meant to be "representative" of a common view (the actual points and findings are made in the text of the report, not in the shaded quotations. In some sections a different type of box (not shaded, with line border) has been inserted to bring together key messages.

3.1 Overview – how the Trust Fund has functioned

The original idea behind the multi-donor trust fund for health results innovation (HRITF) is a concept note produced by the World Bank in 2007 and submitted for funding consideration by the Government of Norway (GoN). An administrative agreement for HRITF –the first administrative agreement- was signed between the GoN and the World Bank in 2007. In 2009 the Government of the UK, through DFID decided to join the HRITF and a new administrative agreement was signed with the World Bank by the GoN and DFID in 2009.

Chronologically the main milestones in the implementation of the HRITF are summarised in the table on the next page.

Table 3: Timeline of the HRITF implementation

2007	Proposal (concept paper) submitted by WB to GoN Admin Agreement for HRITF signed between Norway and WB. In December Norway commits $104m to the trust fund as the sole donor.
2008	Trust Fund established; Procedures for fund allocation developed; In February **Round** 1 receives 9 proposals. Of these 5 countries (Afghanistan, DR Congo, Eritrea, Rwanda & Zambia) are approved for funding. Interagency working group (IWG) on RBF is established. First meeting in March, Washington DC In October **proposals from HRITF Round 2** are received**.** Regional WB management nominates 10 potential countries (all IDA countries eligible except those from Round 1) to compete for 3 pilots grants. Each candidate country receives $50K to support RBF proposal development (linked to an IDA credit). Following Norway´s request for focus on Africa decision is made that of the three countries to be provided funding 2 should be from Africa and 1 from another region. 9 countries submit proposals: Benin, Burkina Faso, Burundi, Djibouti, Ghana, Kyrgyz Republic, Madagascar, Senegal and Vietnam. Mali was invited but did not submit on time. RECOMMENDATIONS for support by HRITF made for Ghana, Benin and Kyrgyz republic. July and November – First and second Impact Evaluation workshops held in Washington DC Annual report for Jan-Dec 2008 submitted.
2009	In July 2009 after a short trial period the new RBF website is launched: www.rbfhealth.org In February the WB Board approves Round 2 In March Amie Batson the first HRITF Project manager leaves the Bank and hands over management of HRITF to Daniel Cotlear. Towards end of 2009 Darren Dorkin takes over as new Project manager for HRITF. April – third meeting of the IWG in Eschborn, Germany November – UK government joins HRITF – commits £114m ($189m). Norway commits an additional $264m (to $368m). Total HRITF is now circa $558m. November 2009, 1st Annual IE Workshop in Capetown. 23 November – Fourth Meeting of IWG in Oslo. Interesting PBF examples reported in Philippines, Bangladesh and Pakistan (Greenstar vouchers); health systems 20/20, a USAID project, producing case studies on PBF; WHO conducts review of PBF experience in 5 African countries.
2009-10	Annual report submitted covering June 2009-March 2010. Zimbabwe is granted a pilot in spite of not having submitted an application: a special case. Many workshops in countries and regions to raise awareness and clarify concepts.

2010	The Bank introduces a fundamental shift in the way countries access HRITF funds. Under the new approach countries themselves do not apply for RBF grants directly: they apply for IDA credits that include an RBF component that may then also include HRITF grant support. June 10-11: Annual donor consultation on HRITF. There is no mention in it to the new "IDA link". September – Following the UN General Assembly (every woman, every child) the World Bank commits an additional $600m to support PBF for MDG 1c, 4 & 5 (this is not the HRITF presumably). September – Launch of **Round 3** – a "new and improved process" is introduced using the 3 "funding streams". 57 proposals submitted from all regions for the 3 streams. Funding stream 1 supporting the country Pilot Grants is formally linked to the country having an active health IDA in place. October 2010, 2nd Annual IE Workshop, Tunis.
2011	Annual report April 2010-March 2011 is submitted. Results of Round 3 are formally communicated: **Funding Stream 1**: Country program Support Pilot Grants: Burkina Faso, Burundi, Ethiopia, Laos, Nigeria, Sri Lanka and Tajikistan. **Funding Stream 2**: Regional RBF Knowledge and Learning Grants. Bhutan; Cameroon; Central African Republic; Chad; Haiti; India; Kenya; Liberia; Madagascar; Mali; Mozambique; Niger; Senegal; Sierra Leone; Togo; Multi-country Regional Grant for the African Region 1 (Cameroon, Chad, Cote d'Ivoire, Kenya, Liberia, Lesotho, Madagascar, Mali, Mozambique, Senegal, Sierra Leone and Togo); Multi-country Regional Grant for the African Region 2 (Cameroon, Chad, Cote d'Ivoire, Kenya, Liberia, Lesotho, Madagascar, Mali, Mozambique, Niger, Senegal, Sierra Leone and Togo); Multi-country Regional Grant for the East Asia and the Pacific Region (Papua New Guinea, Solomon Islands, Timor-Leste); Multi-country Regional Grant for Eastern Europe and Central Asia Region (Kosovo, Uzbekistan); Multi-country Regional Grant for South Asia Region (India, Bangladesh, Maldives, Nepal, Pakistan, Sri Lanka). As evidenced in the past under the HRITF, this work is expected to increase IDA financing for RBF for health and concomitant demand for Country Pilot Grants. **Funding Stream 3**: Country RBF Evaluation Grants. Argentina, Cameroon, India, Mexico, Turkey. **Program Assessment Grants**: India, Mexico, Philippines, Turkey. October. 3rd Annual IE Workshop, Bangkok, 5 November – Meeting of the IWG in London. November - beginning of the HRITF Evaluation. Darren Dorkin leaves the Project manager position – Rama Lakshminarayan appointed as HRITF Interim Project Manager. Sources: HRITF Annual Reports, interviews with HRITF partners.

From a developmental perspective the following phases of the HRITF life were usefully described to us in the following way[3]:

Initial phase – 2008: Very unstructured, developing the concept into a programme and putting in place the first features: 9 activities can be funded; demand driven; how the evidence will be built; how it will fit World Bank policies and instruments; focus on building the demand up, and quickly; big workshops and meetings to generate interest in the Bank and within the international community.

Consolidation phase – 2009/10: Working out operational arrangements, reviewing experience to date, responding to increased funding and new administrative agreements, whilst still learning by doing.

Scaling up phase– 2010/11: Establishing a basket of approaches and funding modalities (funding streams), further developing the link with IDA credits, establishing regional networks of practitioners to support ongoing activities – multi-country regional grants invited during Round 3, HRITF becoming more systematic at forecasting financial needs and use of available funds.

Strategic learning 2011/12: Addressing the gaps; stronger links IE & results chain, first and second generation questions; initial results start to emerge from pre-pilots e.g. what are the lessons from design? What is the best model for TA (handholding/learn from mistakes?); links between thoroughness of design, time involved, consequences for ownership; beginning to do a landscaping before the HRITF can become more strategic.

3.2 Measuring results of the HRITF

3.2.1 Rationale

The ToR for this evaluation specified that “it will be part of the assignment to develop a methodological and conceptual framework to ensure an objective, transparent and impartial assessment of the issues to be analysed in this evaluation”.

To respond to this expectation the first steps that evaluators took were to gather evidence about the existence of a results framework, results chain or similar defined for the HRITF since its launch. We did not find such a framework, and the closest that we came to it was a HRITF log frame defined by DFID in 2009 that partners admitted to not using for implementation and monitoring purposes. In the circumstances we

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3 The ideas belong to Christian Baeza during our meetings at the World Bank in Washington DC, in January 2012. Those ideas have then been adapted by the evaluators.

considered two options: 1) either to put in place a notional results framework, get this endorsed by the HRITF partners and then use it for our evaluation; or, 2) failure of that, use a notional framework to underpin our evaluation but in a very flexible and open manner. We had to go for the second options for obvious reasons:

– Developing a framework required an understanding of the HRITF that the evaluators did not have when they began the evaluation. It would not have been appropriate for them to propose what the HRITF is or should do when that was part of what the evaluators were expected to address.

– Getting a HRITF results framework endorsed before beginning with the evaluation would have also delayed the evaluation by several months, and this was not an option either;

– In the circumstances evaluators decided to opt for a simple and open results framework, and use it as a reference rather than as guidance for the evaluation. This is what the evaluators communicated to HRITF partners in the February 16th Inception Report.

The absence of a results' framework is an issue per se that is discussed later, but evaluators do not think that it has compromised the findings or rigour of this evaluation in any way. The reason is that the evaluation has used a pre-defined methodology using a set of agreed hypotheses and questions, inspired in the ToR and presented to (and agreed by) the HRITF partners in our Inception Report.

3.2.2 What is the HRITF's Theory of change

The objectives and results to be expected from the HRITF have evolved with time. At the outset the Trust Fund focused on three specific objectives (2008 Annual Report): Support governments to design, implement and sustain results-based financing (RBF) mechanisms; increase learning and sharing of country and global knowledge about RBF, including through monitoring and rigorous impact evaluation of RBF programs; and explore the feasibility and value of an "IDA-friendly financing platform" that links a focused health trust fund to broader IDA operations.

These objectives were reframed in the 2009 Grant Agreement that led to the existing four HRITF objectives used in this evaluation. This rephrasing suggests that greater emphasis was being placed on the need to build institutional capacity to support RBF initiatives. It also placed more emphasis on attracting funding as a whole to the sector and dropping any explicit reference to the link between HRITF and IDA (see box below with text taken from the 2008 and 2009 annual reports). Regardless of the changes in objectives nine activity areas had been defined in 2009 as part of HRITF implementation that have remained roughly the same since design (these are shown earlier in this report – see 1.4).

Key Features of the Trust Fund Design

Crucial Role of M&E: “robust M&E” “baseline, target and intermediate progress data” “allows for regular review of successes, shortfalls and bottlenecks thereby enabling midstream adjustments to implementation plans”

Focus on Equity: "Useful tool to promote equity because it can target incentives to improve the quantity or quality of services or encourage demand for specific populations or income groups – most notably the poor”

Emphasis on Priority Results: Focus on 5 core indicators (DPT3, HFA, % SBA, CPR, Access to EMOC)

Learning “support learning about finance reform and contracting design and establishing the systems critical to support the RBF (e.g. HMIS Cross country comparisons will help inform whether and how RBF can be successful in environments with different institutional capacities (both strong and weak) and in what circumstances they are most useful)”

Link to IDA “linked to IDA credits, thereby will be in the context of the PRSP and national health plan and will leverage the Bank’s mechanisms for improving health systems, quality assurance and assessment” (p 4see IDA credit as complementing – providing predictable funding to build health systems with the TF funds used to get MDG 4 and 5 results)

“by linking the RBF grants to existing IDA projects, the RBF work becomes part of the government-Bank policy dialogue, helping to ensure its fit within the PRSP and national health plans”

Source: Annual reports 2008 and 2009-10.

RBF was seen as promising i.e. to be “a useful tool within the larger national health strategy complementing more traditional health financing structure”. Discussions by evaluators with key stakeholders suggest that the ultimate aim was to have a long term impact on health system development (see box 1 below).

Box 1 - Perspectives on what should the TF achieve from HRITF main partners met by the evaluation team

“HRITF should have an identifiable influence on health system reforms”

“main reason was to be structurally transformational - to have a lasting impact”

“to learn the lessons from a series of pilots on a significant scale, with thorough impact evaluation and the explicit objective of learning and sharing information. The evidence this produces is expected to provide a catalyst for a longer term shift in the way that international aid for health is delivered, once lessons are learnt from the pilots"

“want to test out the approach in substantial pilots. The priority is MDG 4/5 – we are flexible in terms of supply or demand side – depends what fits at the country level – but we are quite keen in the demand side"

Such specific expectations are helpful although difficult to quantify. Although three evaluations are planned for HRITF much of the above impacts may not be felt until after the project has finished and may not be picked up in the proposed

evaluations – especially where the pilots commence towards the end of TF implementation.

DFID uses a log frame approach for its programmes and it developed a log frame for the HRITF in 2009 (see Box 2 below). However, there was not a clear view or consensus among partners interviewed as to whether the DFID log frame might become standardised and adopted by HRITF partners. Some of the partners said for example that it is were to be adopted as a common framework more joint work would be required and some of the indicators included in the current DFID log frame (especially those linked to outcome indicators to be achieved such as numbers of lives saved, etc) should be removed or revisited in the understanding that HRITF is not a standardised intervention but rather a learning programme testing a series of hypotheses rather than implementing a proven approach.

Box 2 - DFID Log Frame
Goal: To achieve Health-related MDGs, especially MDGs 4 and 5, in the countries participating in the Result-Based Financing pilots. *RBF will contribute to anticipated reductions in under five and maternal mortality.

Purpose: RBF approaches implemented by governments and development agencies as a key mechanism to improve the demand for and utilization of health services, especially by pregnant women and children and increase the volume and quality of cost-effective basic health services, especially maternal and child health services.

Outputs:
- RBF Proposals prepared and reviewed (5%)
- RBF projects or project components designed, prepared and appraised (5%)
- Bank and standalone RBF projects or project components implemented (60%)
- Bank and standalone RBF projects or project components supervised, monitored and documented (10%)
- RBF projects and project components evaluated (10%)
- Knowledge sharing (5%)
- Buy Downs and Buy Ups (5%)

(% = relative impact weighting)

3.2.3 The need for a robust results framework for HRITF

Most members of the three HRITF partners interviewed seemed to agree with the importance of having a clearer and common results framework for the HRITF that should be used for progress review and reporting. Evaluators strongly agree with this and encourage the HRITF partners to develop a common results framework as soon as possible. In fact, evaluators and several interviewees found a strange disconnect in that there is a very clear results chain at the country level for the CPG but not for the Trust Fund as a whole. We feel that this warrants urgent attention for the credibility of the programme and because future HRITF evaluations will surely raise the same issue: Something cannot be measured unless we first agree on the measuring scale.

As part of the evaluation we have developed a tentative results chain diagram (see below) that we think could easily be developed into a more detailed and descriptive results framework, specific results and verifiable indicators –or proxies- for each of the four HRITF objectives.

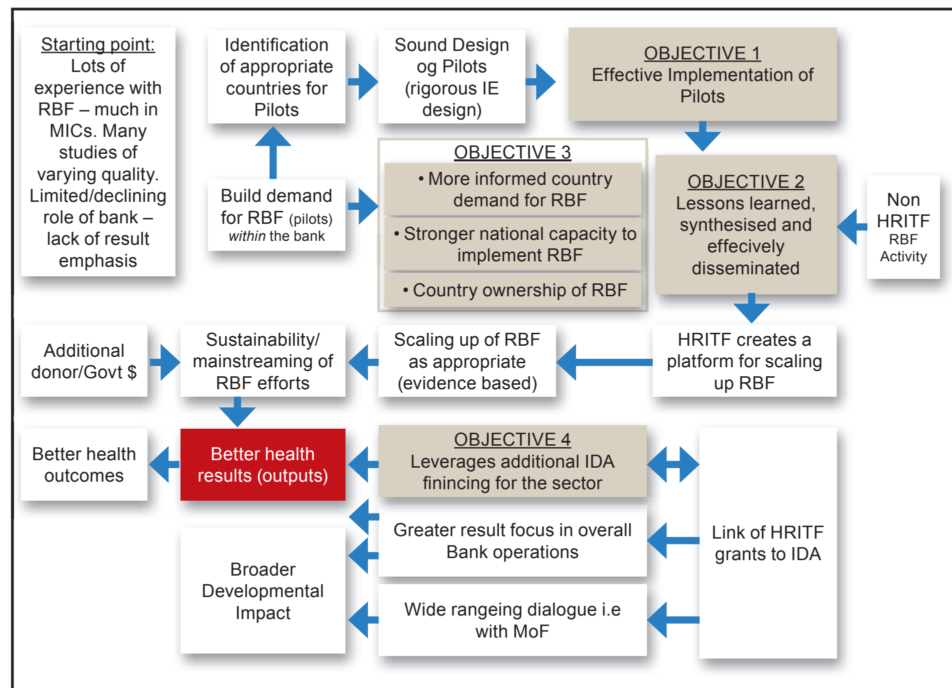
Key Messages

- Current reporting and monitoring approaches and focus of the HRITF could be substantially improved through the adoption of a clear, measurable HRITF results framework.
- If HRITF partners accept that a results framework is necessary they should first agree to this point and then ask the Bank to assist with developing such a framework. This could be done in weeks rather than months.
- Once the proposed framework is shared with partners and approved it should be adopted for all progress review and reporting purposes, beginning with annual reports and donors consultations, as is discussed next.

Developing the HRITF framework should crucially involve the TTLs who have been designing RBF pilots and IE. Their practical knowledge is essential at the time of developing feasible indicators. For example, it might be helpful for TTLs to set out their best estimates of the likely ultimate impact/ transformation brought about by the pilots and broader work of the Trust Fund (assuming that the pilots are successful). This might be revised once the results of the IEs become clear. Our case studies suggest that this might be feasible.
For example, in the case of the Kyrgyz Republic one might expect;

- nationwide uptake of a modified provider payment system at the rayon hospital level;
- the creation of demand for action to look at potential approaches in other settings (vertical programmes currently outside the single payer system, PHC, oblast hospitals);
- full integration of the approach into national systems.

Figure 4: Tentative results chain for the HRITF



Source: Mark Pearson

3.3 HRITF Objective One - Support design, implementation, monitoring and evaluation of RBF mechanisms

3.3.1 Application for funding process

Under HRITF, eligible countries are invited to apply for funds (this is often referred to as a “demand driven” process). Between 2008 and 2009 two rounds of applications were called that used the same 9 activity lines from the 2009 Administrative Agreement regulating the HRITF.

In 2010, when the third round[4] of applications was called, a new “rationale” began to be applied to the entire HRITF programme by which HRITF would become part of health credits and grants provided by the International Development Association (IDA) of the World Bank. Under the new approach **countries do not apply for o RBF grants directly; they apply for IDA credits that include an RBF component that may then also include HRITF grant support.** This aspect represents a fundamental shift in the approach to accessing HRITF funds that will be discussed in much more detail in chapter 4. In any case the new approach led the Bank to the definition of newly developed “funding streams” (see below) clarifying the application process and aligning it to the new IDA link. The three funding streams used since September 2010 and being used today are:

4 There was a fourth Round call for applications in 2011 that is not covered in this evaluation as it took place after March 2011.

Stream 1 - Country Pilot Grants – to provide financial support to country programmes funded by the International Development Association (IDA) for RBF projects for RBF projects;

Stream 2 - RBF Knowledge and Learning Grants – to support technical dialogue and learning around RBF design and implementation in IDA eligible countries (regional applications involving several IDA countries are also accepted);

Stream 3 - Country RBF Evaluation Grants – to support RBF programme evaluation efforts to learn "from successful (and unsuccessful) experiences from around the world and allow for learning in IDA eligible countries" (HRITF Annual Report, 2010-2011). According to the Bank this funding stream may be considered in some settings where the RBF may not focus on MNCH.

Applications are initially managed (and often written) by the World Bank country or regional offices, which are expected to demonstrate government commitment to exploring RBF. Since the funds are limited (particularly in Rounds 1 and 2) and in order to minimise opportunity costs to countries only a limited number of countries are invited to apply in each round. In Rounds 1 and 2 the applications received were reviewed by an Independent Review Panel (IRP) combining members from academia, NGOs, development partners and the World Bank, which makes recommendations to the HRITF Program Manager.

In terms of selection and eligibility criteria for the applications received during Rounds 1 and 2 (see later) the selection process for countries applying for RBF pilot support "was designed around three principles: (i) candidate countries needed to demonstrate government commitment to exploring RBF, (ii) only a limited number of countries were invited to develop proposals to minimize the opportunity costs to governments and Bank teams of developing and evaluating applications, and (iii) since country demand exceeded trust fund resources, country pilots were selected on a competitive basis, with strict criteria that measure likelihood of success. African countries were given priority: the goal was to have 75% of pilot programs in African countries" [5]

The review of applications and the eligibility criteria were modified in 2010 as a result of linking the RBF support to the IDA credits. For example, from Phase 3 onwards all applications are reviewed and approved by the HNP Sector Board (all managers in HNP of the Bank acting in collective review and assessment) with the support of the HNP Hub HRITF and other technical teams. Applications may be "approved as are", or approved with modifications, or turned down. In terms of eligibility criteria the clause requiring 75% of all CPGs to be in African countries no longer applies and each application is looked at on its own merit regardless of geographical location.

5 Source: World Bank HRITF team in comments to the evaluators

There were instances (see Box 3 below) where the country team considered that the feedback provided by the Bank on applications received was either not totally clear or included some inconsistencies, this suggesting that further effort may be needed for the HRITF team to clarify certain issues linked to the HRITF application process with the country teams.

Box 3: Problems with the Application Process – The India Experience
A number of proposals were submitted from India and experiences included:

Mixed Messages/Poor Communication. The India team were told that RBF would have to be paid against outcomes at the impact level and that since this was not the criteria for disbursement in the submitted proposal, the proposal could not be funded. This was communicated to the India World bank team by phone. Apparently, the possibility of improving the submitted proposal or receiving support from the HRITF team was not mentioned even though this approach had been used in some other countries to improve the proposals received by the Bank.

The pros and cons of rounds for HRITF applications
Being "demand driven" was a clever way to generate interest and awareness of the HRITF, but the longer term value and relevance of this approach should be reviewed, *particularly in relation to applications for CPG funding as pilot grants are expected to account for just under three quarters overall HRITF funding*.

There are several potential risks linked to the rounds approach, some of which are only incipient at this early stage in the programme but may become more important with time. For example:

- The risk of generating too much demand. Our impression is that new CPGs should only be approved following more thorough feasibility assessments than were done, particularly in some countries from Rounds 1 and 2 (the thresholds for feasibility are relatively high; e.g. strong financial management and monitoring systems. One might expect, therefore, that some assessments might find the approach to be unfeasible in some setting. Although we were informed that this has happened we could not find any example of an approved application that had been turned down on the basis of poor results in the feasibility assessment).

- Whilst a demand led approach might be useful to a certain point this may serve to undermine the strategic aim of building a knowledge base on RBF as a whole. (i.e. funding what is needed to learn versus funding what countries want).

- The risk of spreading resources too thinly and of not being able to provide sufficient long term support –financial or technical - to some country pilots where circumstances so require. It must be remembered that as per current Bank rules (written or practice) countries are allowed to apply only once for a stream (for each IDA grant), yet there may be unusual circumstances that merit continued support by the Bank on a case by case basis. Examples of

circumstances that may present (some have already presented, for others it is far too early) include:

- Delays in pilot implementation for which the country cannot be held fully responsible where a promising pilot requires additional funding (might happen in Zambia where the pre-pilot meant to last for 6 months took 3 years, so the pre-pilot will take longer than the pilot itself).

- Under-estimation at design of the costs involved in fully developing the pilot or in providing sufficient technical or documentation support to it. The case of Rwanda –where the Bank is no longer providing any external monitoring or support to documentation of the RBF pilot comes to mind. India, a huge country that has received some funding from HRITF but may need much more given its size and the diversity of PBF schemes taking place is several Indian states. The bottom line is the rules governing the HRITF on how much can a country receive or how many times it may apply for funding should be adapted to country circumstances.

- Successful pilots where scaling up is not guaranteed because there has been insufficient focus on mobilising resources and attracting additional funding at country level (either from IDA or from other sources). Many pilots may fall into this category in the next three years if results from impact evaluations are favourable and countries would like to scale up yet no additional funds are available. We are not suggesting the HRITF should fund the scale up costs but might it work with the country government and donors to develop a funding strategy?

All the risks above can be effectively mitigated as long as the HRITF team are made aware of these matters and can take a proactive approach to resolving the issues. However, as the HRITF program grows there is a risk that the issues above receive insufficient attention due to several possible reasons: limited capacity by the HRITF team to appraise and oversee these matters; inability of the country team to forecast these issues and communicate these to Washington; limited communications and insufficient proactive stance on the matters above between Washington and the country teams.

A second condition for risk mitigation is effective forecasting of HRITF financial needs, and while efforts have been made to improve this we could not establish whether these have been effective. Also, it is not clear from reviewing the annual reports, annual work plan for 2011 or annual donor consultations whether the issues and risks above are receiving sufficient attention by the HRITF team or the Bank.

Linking pilots to IDA grants in covered elsewhere in this report (Chapter 5). An important point to raise here in relation to such link is the possibility that the Bank may exclude important and interesting examples of RBF approaches requiring support or attention because these countries do not have or plan to

have an IDA health grant. Cambodia comes to mind as an example of a country that never applied for any HRITF funding stream for reasons unknown (no interest on IDA health credit?) in spite of having large RBF-type schemes in place (supply side incentives and Conditional Cash Transfers) that it might have been worth supporting or exploring for learning and dissemination purposes. We feel that the Bank should proactively explore interest for HRITF support in these countries rather than using the "demand driven" approach. In fact, exceptions to the eligibility criteria have been already applied by the HRITF as in the case of Zimbabwe where there was no IDA health grant in place and where no country proposal for CPG had been received, yet a proposal for an RBF pilot was put together by the Bank team that was eventually approved for funding.

Transparency and consistency of funding decisions

There is room for improvement in communicating funding decisions to countries by the Bank. In several instances evaluators could not find proof that the funding decision had been effectively communicated to the country (a formal letter similar to the one used by the GFATM or GAVI would be desirable). In one case (Senegal) we found that there had not been proper follow up of the recommendations made by the reviewers suggesting that funding for a proposal should be considered as soon as funds became available (see Box 4 below). In another case (India – see box 3) we found that the decision not to fund had been communicated to the country team just by phone, and that the reasons provided for the proposal rejection were not totally clear to the India-based World Bank team. Evaluators feel that after all the work involved in developing a proposal the least the country team deserves is a letter containing all information justifying the decision made. It would appear (as is argued by the Bank) that communications on funding decisions have improved as a result of linking the RBF to the IDA credit. Therefore, all that evaluators are asking is continued attention by the HRITF team on ensuring that countries get detailed feedback on submitted applications.

Box 4: Institutional memory – an example from Senegal: Funding rounds require strong follow up on the part of the HRITF team to ensure that successful applications can be funded immediately or in the near future: this has not always been the case. In Senegal the IRP made a positive recommendation for pilot funding that could not be honoured due to limited funds at the time. The IRC recommended that the Senegal proposal be supported as soon as funds became available, but the Senegal proposal was not followed up from 2009 when more funds became available (though the increase in funding by Norad and DFID) and, as a result, the proposal was never reconsidered for funding . We enquired with the existing TTL about this matter. He was not aware that a proposal had been submitted by his predecessor or that it was supposed to be followed up when funding became available. We think this point illustrates a loss of "institutional memory" that may not be representative but which should have been more closely followed up by the HRITF Team or the Bank.

Stronger description of planned feasibility assessment in applications
While the Bank has argued (Annual Report 2009) that funding decisions were based on “a rigorous assessment of the likely feasibility of the proposals received” the reality is that such feasibility cannot be realistically assessed ex-ante. In fact, we feel that the feasibility of some pilots should have followed a much more rigorous feasibility assessment (see later 3.4.2 – supporting design). We recognise that this might not have been possible in the original rounds 1 and 2 where the Bank had to figure out the funding modalities and criteria, but it should become much more rigorous in future. The Bank seems to have already captured the importance of stronger feasibility assessment and is using the IDA triggers to ensure that essential pre-conditions for RBF implementation are in place in all the new CPGs.

3.3.2 Supporting design of RBF mechanisms

Most of this section will refer to supporting country pilots. The focus of HRITF support to country pilots has consisted mainly on developing new pilots rather than supporting existing ones. The only exceptions to this pattern from the countries reviewed in this evaluation seemed to be Rwanda, where a community PBF predated the HRITF application, and to a lesser extent Kyrgyz and Burundi where the pilot built on pre-existing incentive schemes. Focus on designing new pilots was not in most cases a choice but a reflection of the fact that few countries had RBF schemes between 2007 and 2011, the period covered in this evaluation.

In general, evaluators found that the support provided by the Bank for RBF design was quite relevant and well delivered, particularly in the context of a HRITF that had to develop all systems from scratch and learn by doing. Against this general background we wish to discuss some specific issues uncovered in this evaluation that respond to questions from our evaluation framework (Annex 4).

The contents of RBF pilots
The table below summarises information on country pilot grants as of January 2012 facilitated by the HRITF team in Washington.

Table 5: Summary of HRITF supported RBF pilots

Cells shaded like this are CPGs approved after the beginning of this evaluation and not included in the analysis.

Cells shaded like this indicate CPGs where the evaluation team conducted case studies, desk reviews or spoke to the concerned TTLs.

Country and Round Nº	US$ IDA & HRITF	RBF approaches to be piloted	Implementation status as of January 2012
Afghanistan R1	IDA: $30m HRITF $12m	Supply side	Pre-pilot done, baseline survey completed and full scale up of pilot to 12 provinces (Source: annual report 2011 – no updated information ever since).
Benin R2	IDA: $1m HRITF $11m	Supply side	Grant effective in September 2011. About to begin implementation in April 2012

Country and Round Nº	US$ IDA & HRITF	RBF approaches to be piloted	Implementation status as of January 2012
Burkina Faso R3,	IDA: $14m HRITF $12m	Demand and supply side	Board approved in December 2011
Burundi R3	IDA: $18m HRITF $14.8	Supply-side	Design completed. Implementation to begin shortly
CAR R4	IDA: $12m HRITF $9.6m	Supply-side	HRITF approved in July 2011. Negotiations and expected Board approval in March and May 2012.
DRC	IDA: $2m HRITF $1m	Supply side	Pilot commenced in 2010. Duration being extended to achieve longer exposure period.
Ethiopia R3	IDA: $135m HRITF $15m	Supply side	Board approval expected October 2012
Ghana R2	IDA: N.A. HRITF $11m	Demand and supply side	Very slow. Concept note and draft Implementation manual just approved.
Kyrgyz Rep. R2	HRITF: $11m	Supply side	Grant agreement due to be signed March 2012
Lao PDR R3	IDA: $3m HRITF $2.4m	Supply-side	Grant agreement signed in October 2011. Slow start.
Lesotho R4	IDA: $5m HRITF $4m	Demand and supply	Board approval expected in September 2012; HRITF approval in January 2012
Liberia R2	IDA: $7.5m HRITF: 6m	Supply side Incentives	Expected Board approval date in March 2013.
Nigeria R3	IDA: $60m HRITF $20m	Supply side	Board approval expected March 2012. Preparation quite advanced.
Rwanda R1	IDA: $18m HRITF $12m	Community PBF supply and demand	Builds on pre-existing facility PBF. Implementing Pilot (2010-2012). IE expected in 2013.
Sri Lanka R3	IDA: $20m HRITF: $15m	Supply side	Board approval expected September 2012. HRITF grant signed December 2011. Impkementation expected shortly.
Tajikistan R3	IDA: $6m HRITF: $4.8m	Demand and supply-side	Project preparation in very early stage.
Vietnam R4	IDA: $40m HRITF: $15m	Supply side	Expected approval March 2013. Regional grant. Not listed among the winning CPGs in Round 3
Zambia R2	IDA: $50m HRITF: $16.7m	Provincial, district and hospital level supply-side incentives (fee for service)	Pre-pilot from Jan 2009 to march 2012. Pilot implementation expected April 2012.
Zimbabwe No Round	IDA: $0m HRITF:$15m	Supply-side	Grant became effective in 2011.

Source: Annual reports and HRITF team.

Thoroughness of RBF designs – feasibility studies
The complexity of RBF approaches and the need for key preconditions such as effective fiduciary and monitoring systems to be met suggest it unlikely that RBF approach would be feasible in all interested countries. Although we were informed that there were case(s) where a study had found the approach to be unfeasible we could find no example of this. The important point in terms of recommendations from this evaluation is that future applications for pilot grants should ensure that existing feasibility criteria –linked to HITF and linked to IDA operations – are fully applied before full funding for the country pilot would be released.

Likewise, there should be a more realistic assessment of how long a feasibility study (often referred to as "pre-pilots") might take and how much it will cost, particularly in terms of Bank and MoH staff time in a real world scenario. Examples from Zambia (3 year pre-pilot) and Rwanda (2-year pre-pilot) suggest the need to develop a much more thorough design cum feasibility phase and to avoid quick designs that may then become difficult to pilot in practice, as in the case of DRC, where high turnover and limited capacity resulted in the need for revision. The Bank (HRITF team) should, on the basis of experience to date, prepare much more thorough guidelines for pilot design and for pre-piloting based on a more realistic assessment of costs. If one key lesson emerges from the case studies and desk reviews to date – strongly backed by all TTLs interviewed- it is how extremely challenging, time consuming, expensive and absorbing pre-piloting can be. The pre-pilot in Nigeria was prefunded by government (with the Bank reimbursing retrospectively) and enabled many key design issues to be addressed at an early stage. In the Kyrgyz Republic (which lacked the funds to prefund the pre-pilot) a number of interviewees felt that there was an element of over design in the preparation process and that early testing on the ground through a pre pilot would have been better

Focus on RMNCH
In the HRITF Agreement between the Ministry of Foreign Affairs of the Government of Norway and the World Bank it is stated that the intention of the Trust Fund is to strengthen the achievement of the health-related MDGs, particularly MDGs 1c, 4 and 5.

An overview of the proposals indicated that this is followed for most of the proposals in that they primarily address achievements of MDGs 4 and 5, with a few also addressing MDG 1c, 6 (i.e. TB, HIV and malaria outcomes). The only country that deviates from this trend is India, where the proposal for funding stream 3 (impact evaluation) – which was funded - focuses on tertiary care including cardiology, oncology, neurology, nephrology, neonatology, burn care, and trauma care.

The finding of this review is that funded proposals have generally adhered to the agreed focus on RMNCH and accelerating achievements of MDGs with a focus on MDGs 1c, 4 and 5. One may question however why India has received so little HRITF funding in spite of submitting three RNMCH related proposals for

CPG funding and given that India accounts for the largest concentration of poverty in the world.

Which Outputs/Outcomes are the Pilots Addressing?

Table 6: What outputs and outcomes are the pilots addressing?

Country	Primary Maternal Outcomes	Primary Child Outcomes
Afghanistan	Skilled prenatal care, skilled birth attendant, postnatal care and family planning utilization	Fully immunized children < 1 yr
Argentina	Utilization of prenatal care, quality of care, immunization rates (tetanus and VDRL), early pregnancy detection.	Birth weight, low birth weight rates, utilization of post natal health care, quality of care, anthropometrics for 0 to 6 year old (z scores)
Benin	(i) quality of maternal care and (ii) equity of maternal care utilization as measured by indicators detailed in concept note.	Rate of child visits, vaccination rate of children
Cameroon	Skilled birth attendance; Contraceptive prevalence; ANC coverage; Tetanus toxoid vaccination coverage during pregnancy	Fully immunized children; Bed net use; Vitamin A coverage; Participation in growth monitoring; Exclusive breastfeeding
DRC	Curative care, institutional delivery, obstetric referral, tetanus toxoid vaccination, family planning, caesarean section, blood transfusion	Curative care, full immunization, blood transfusion
Ghana	Quality of prenatal care, institutional delivery and postnatal care, and quantity of prenatal visits	Birth weights, nutritional status, anaemia, vaccination
Kyrgyz Republic	Quality of prenatal care, institutional delivery, postnatal care	Birth weight, nutritional status, anaemia
Laos	Utilization of MNCH services (various Indicators to be defined)	
Nigeria	Skilled birth attendance ITN distribution ANC	– Immunizations – ITN distribution – ANC – Curative care for children
Rwanda	Prenatal care, institutional delivery, postnatal care, family planning	Nutritional status, anaemia, vaccination
Tajikistan	Quality of MCH/ RH services	
Vietnam		Quality of child growth management; quality of malnutrition rehabilitation

Country	Primary Maternal Outcomes	Primary Child Outcomes
Zambia	Curative Consultation, Institutional Deliveries, ANC prenatal and follow up visits, Postnatal visit, Third dose of Malaria IPT, New Acceptors of FP users of modern methods at the end of the month, Pregnant women counselled and tested for HIV Hospital level incentive package that focuses on obstetric emergency and referral from lower levels	Curative Consultation, Fully vaccinated child, HIV exposed pregnant women in labour administered Niverapine and AZT
Zimbabwe	ANC; PMTCT; Tetanus toxoid vaccination among pregnant women; syphilis screening among pregnant women; malaria prevention among pregnant women; skilled delivery; referral of dangerous cases; PNC; family planning	Children fully immunized; vitamin A coverage; growth monitoring

Focus on poverty, equity and gender

"I told Gates, if you want to improve gender equity and you have 10 indicators, you increase the points for the gender sensitive ones – but you need training – and commodities".
Source: Government interviewee, DRC

"Sex disaggregated data – that's a luxury... These are practically emergency services."
Source: Interviewee, DRC

As noted above, HRITF was born out of the desire of the Norwegian government to accelerate progress towards MDG 4 and 5 goals. This was alongside DFID's support of the approach following the report of the Taskforce on Innovative International Financing for Health Systems suggesting an important role for RBF in helping accelerate progress towards the health MDGs. With this emphasis – which, as noted above, has largely been adhered to in country proposals – HRITF sets out strong potential to have an impact on gender inequality and wider equity issues.

The case studies and desk reviews have shown that the majority of countries have focused on gender, poverty and equity issues. In some countries this focus was explicit while in most countries the focus may have been implicit in the specific MNCH strategies at country level or the linked poverty reduction strategies underpinning the health sector and MNCH national strategies. A number of interviewees pointed to relevant indicators as a clear sign that gender and equity issues were being addressed, or the fact that the pilot was located in the poorest districts. Fewer, however, were clear as to what actions were being systematically taken to tackle issues that may be preventing access to services, such as Behaviour Change Communication campaigns to ensure baby girls and

boys equally benefit from nutrition or malaria prevention and treatment, although some of the wider IDA initiatives may involve such activities .

Some country examples:

- In Kyrgyzstan, equity is recognised as an issue (e.g. hospitals in remote areas may struggle to do well on the balanced score card) but is not explicitly mentioned. It is assumed that the provider payment system that the RBF pilot will support has pro-poor design features.
- Zambia has a specific focus on gender and equity (e.g. data are disaggregated by sex and other variables). A commissioned equity assessment found that since more than 90% of rural Zambia is poor, the RBF should avoid the urban areas and focus on services that would provide the greatest benefit to poor rural women, such as MNCH services.
- In India, while some proposals targeted only women, others focusing on poor people did not plan to collect sex disaggregated data to allow for analysis of gender equity issues arising.
- In Rwanda the poverty focus was clear, with initial 30 sectors selected for pre-piloting being the poorest.
- In Benin, the IE will improve identification of poor people and use sex disaggregated data to understand gender issues, such as whether boys and girls have equitable access to services.

Recommendations:

- The effectiveness of HRITF interventions can be enhanced by a focus that explicitly addresses gender and equity barriers to access. It may be helpful to have central checklists and other tools to ensure, for example, the involvement of prioritised communities in planning and monitoring or that IE systematically assesses how RBF contributes to gender equality.
- As noted by a range of country interviewees, it may be possible to increase the gender or pro-poor sensitivity of RBF programmes by increasing the weighting in the application review process given to gender- or equity-sensitive indicators.

Ownership, alignment and harmonisation at design

In our evaluation the degree of consultation and involvement of other donors and of government in designing the RBF pilots varied greatly from country to country, with much depending on the quality and characteristics of individual TTLs and on the existence of pre-existing donor coordination arrangements and the extent to which the Bank used those platforms for HRITF purposes. Little of this has been documented to date in the countries we visited and we were surprised that no analysis seems to have been conducted or commissioned to date by the HRITF Team on alignment and harmonisation issues in relation to RBF: it would have been very useful to find a World Bank (internal or external) analytic document discussing the main lessons learnt from the designs of RBF pilots from rounds 1 and 2 that might illuminate future rounds.

The novelty of the RBF approach being designed and the initial “teething” problems to process some RBF grants through the Bank system were important

factors that affected the quality of the first RBF designs that the Bank supported. However, the two most important factors determining the extent of consultation and "stretching to others" identified in this evaluation were the qualities of the task team leaders (TTL) and their being or not based at country level, in which case the quality of staff at the country office to follow up on decisions made in Missions becomes crucial. We recognise that the Bank cannot always guarantee either the quality of the TTL leadership or where the TTL will be based, but it should be possible for the Bank to at least provide **stronger training, guidelines and support to TTLs for them to work more closely with health partners at country level.**

Some MoH and donor representatives in countries emphasised the difficulties of designing and following RBF pilots with the Bank when the TTL is based far away and when there is no Bank country team (or a weak one) and no Bank presence in key sector and donor meetings. They also highlighted the fact that consecutive Bank missions often involved different people, which caused gaps in communications and made policy dialogue more complicated. This was captured in our case studies, with several expressions like the Bank "*reinventing the wheel at every mission", or* "*making it look like a vertical programme from Washington"* or "*forgetting what we agreed on*", or "*different people coming in with different ideas"* etc. We believe that these issues may affect the quality of designs or lead to sluggish pilot implementation and oversight.

As practical implications for the future of the HRITF (we accept this may not have been possible in the past) we would strongly recommend the Bank only supports RBF pilots – even if the approach is technically feasible from the country perspective - where;

- there is a TTL with practical experience on RBF or the TTL is less experienced but will receiving close support (coaching) from more experienced colleagues in the Bank and will undergo all the required training;
- the TTL is based in country (preferable) or the country has a strong country team knowledgeable on RBF to whom oversight responsibilities can be delegated and who will maintain close links with key stakeholders (the Zambia team was an excellent example of efficient team work in pre-piloting the RBF pilot);
- all new TTLs receive close follow up from HRITF team in Washington and/or in the region during the two years following CPG grant approval to ensure that effective links with partners and government are maintained;
- the Bank missions will be given the time and the resources for them to effectively engage with the MoH and with donors (and not just to invite them to meetings) and to report on progress;
- the Bank will be able to attend regular donor and sector meetings and use these to leverage support to the CPG and its future.

Where these criteria cannot be met other approaches should be considered. This might include inviting bilateral donors to take forward the programme using HRITF funds (recognising that there will be legal implications) or for them to do it

independently whilst still drawing on HRITF tools and human resources. It should be understood that failure to engage with other donors at country level during RBF design and implementation might significantly affect the chances of future financial support to, and buy in of, the RBF pilot or its eventual scale up – especially in lower income settings where donor funding is likely to remain a key funding source.

Use of National Systems

The Trust Fund aimed to make as much use as possible of national systems in line with best practice on aid effectiveness. For example, it saw opportunities for working in SWAp environments and the use of agreed performance indicators and possibly even through channelling resources in an un-earmarked manner into any existing SWAp pooled arrangements (see Box 5 below). Whilst it recognised that it might be necessary to adopt systems and approaches which were not completely in line with national approaches it envisaged a fairly short transition to a greater/full use of national systems (Box 6).

Box 5 - HRITF and Aid Effectiveness By working with development partners and countries to build and use country systems, wherever possible, the HRITF aims to be consistent with the principles of the IHP+, and Global Consensus on Maternal, Newborn and Child Health Proposal. Agreement has been reached between DFID, Norway and the World Bank that the HRITF will be consistent with the International Health Partnership (IHP+) principles working with development partners and countries to build and use country systems for results, wherever possible. DFID and Norway have insisted that country selection criteria should be based upon the World Bank aim to pursue a sector-based approach. This will be monitored closely.
Source: DFID Project memorandum

Box 6 - Gradual Alignment with National Systems/SWAP “In its initial start-up the RBF may require additional indicators (for example the core MDG 4/5 indicators) and/or baseline data by a different date than envisioned in the framework”. Within 1-2 years the data needs of the RBF would be incorporated into the SWAp framework “RBF grant might … be released into the pool after the results are achieved”.
Source: Initial Proposal by the World Bank to the Government of Norway, October 24, 2007.

We would question how realistic these well intended objectives actually were. Although laudable, in principle, the interventions to be piloted are innovative, require the development of new skills not currently available in country, require the specific tracking of funds (for the purposes of the impact evaluation) and should only be sustained if the results are positive. All of these factors would tend to make the case *against* a pooled approach and whilst one might not expect the pilots to bypass national systems where avoidable the case for full integration into national systems may not be strong. At the same time it is important that consideration should be given to how approaches might be integrated should they prove successful during the implementation phases.
A clear vision should be set out in the pilot design and a clear plan developed by the midterm of the pilot.

In the Kyrgyz Republic, which has a strong track record in implementing its SWAp, the pilot only makes partial use of national systems. A thorough analysis of the various funding options was carried out. Trust Fund support is to be allocated through the treasury system but through a Special Means Account which allows specific tracking of expenditure and also allows funds to be carried over from year to year. The former is important in terms of the impact evaluation and assessing how inputs are spent, and the latter is important for a new approach such as this where the supply side response is not known and budgets cannot be set prospectively. Similarly, the RBF Secretariat will be run as a quasi PIU – making use of national procurement and financial systems but recognising that different types of expertise – not available with the sector – are required and will need to be recruited externally. In Zambia country systems are used to ensure that the RBF is strengthening the overall health system. A PIU has been put in place in the MOH. Implementation and oversight is done by the MoH and the MOH is contracting two agencies under the grant, one to provide technical assistance support to implementation and the other to perform external verification. Funds will be channelled by the MOH to districts but using a special account created for RBF funds at district level to ensure accountability of funds. Each health facility will open bank accounts to which the MOH will deposit RBF funds directly. The only RBF pilot found to date that is fully using country systems is the one in Rwanda, although the MoH seems to consider it a special case and no regular reporting is being made within the MoH or at the time of the annual reviews in spite of the pilot covering 30+% of Rwandan sectors (administrative divisions).

It would be helpful to carry out a simple mapping exercise to show in a systematic way across CPG countries the extent to which national systems are used according to a range of key criteria (financing, M&E, management) compared to the most aligned donor(s). A failure to use existing national systems may be justified, but the reasons should be fully set out. We would also anticipate that in advance of the next evaluation – by which time there should be greater clarity on how well the pilots are working – plans will be developed for the integration of the intervention into the national system wherever this would make sense.

In the Kyrgyz Republic, for example, discussions with key stakeholders suggest that there is an intention to modify the existing provider payment mechanism in line with the finding of the pilot (if it proves successful) and likely funding though the overall funding pool, whether Government funded or through the SWAp pool. Similar intentions to modify national systems as per pilot results have been expressed in Zambia and Rwanda.

Key Messages

- It is quite easy to make ambitious statements about alignment at the outset. In practice, a pragmatic approach is needed.
- Whilst there should be compelling reasons not to use national systems the innovative and pilot nature of many of the TF activities suggest that it may not be possible/advisable to make maximum use of national systems during the pilot stage. Such reasons need to be set out fully.
- There should be a clear vision for integration at the outset and a clear plan at an early stage of the pilot implementation should the pilot prove successful.

3.3.3 Supporting implementation of RBF mechanisms

Few countries (at least from the ones we covered in our case studies and desk reviews) had made the transition from pilot design and pre-piloting to implementation at the time of this evaluation. It is therefore too early to say much in relation to pilot implementation.

Some of the issues to note in relation to implementation are similar to those raised earlier in relation to design: the importance of country ownership and close engagement between the Bank and the country government; the need for a thorough pre-piloting and assessment of country systems; the importance of competent TTL and strong country teams to support implementation; the need to involve other health donors from design, and to brief them regularly; the trade off between using country systems and efforts to guarantee solid design and implementation; etc. The following is a list of additional issues more specifically linked to implementation where evaluators wish to place emphasis.

Why documenting implementation is crucial

The point made earlier in relation to the importance of documenting designs is relevant in relation to documenting implementation too. The rationale for the need to document design and implementation is similar and well captured in both foundation documents (the HRITF Concept Note) and progress reports by the Bank (explicitly mentioned in both the 2008 and 2009 annual reports). In essence, impact evaluation is expected to measure the with and without situation through a set of indicators, but many things may not go exactly as planned or as assumed that may have an impact on the final results and that may not affect all intervention and control sites in the same way. Documentation is expected to capture processes and unexpected changes that might affect final results, and to do so on a regular basis. In some HRITF programmes the documentation function has been assigned to an external, independent entity (in Rwanda, the School of Public Health from June 2009- June 2010; in DRC an independent consultant) while in other programmes a firm contracted for supporting implementation may be assigned some documentation competencies (such as the TA firm to be soon appointed in Zambia and the TA firm in Benin).

What was of concern to the evaluators in that several RBF pilots being designed or implemented (Kyrgyz Republic, Nigeria, and to some extent Zambia) have not yet appointed anyone to perform the documentation function. In some cases the

reason given was that documentation would be done on an ad hoc basis, when the need is felt. In Rwanda, the cause was less clear: why did the contract with the School of Public Health that had come to an end precisely when pilot implementation was beginning in 2010 had not been renewed or an alternative firm appointed when, apparently, both the Bank and the country agreed to the importance of renewing the contract? In the case of Nigeria there was a documented application to the HRITF in 2011 by the Nigeria team requesting funding to appoint a documentation firm, for a value of $125,000. The proposal was turned down arguing that "*once you are a CPG - you cannot access funds in other streams*". Even accepting that funding for documentation should have been part of the original proposal we think that there is a case for treating these requests more flexibly.

Given that the evaluation has not systematically explored every country being supported or even every pilot we would not like to make issue of *why* support for documentation is not being provided but about *the fact that documentation is not taking place*, which we see as undermining the learning and piloting nature of an innovative scheme like the RBF that may or may not be scaled up depending on results achieved. We strongly recommend the Bank to look into this issue and ensure that every country where a pilot is being designed or implemented should have a documentation requirement built in it that collects, analyses and disseminates (it can be internally first) information on design, pre-pilot and pilot with an agreed periodicity and in a systematic manner. The evidence available from the countries that had such tasks performed at some point, like the lessons from the pre-pilots in Rwanda and Zambia, suggest that such information can be of high operational and strategic value. As we shall see under objectives 2 and 3 documentation can also be a very useful source of research and study questions that can then become part of a broader RBF learning programme at national, regional or global levels.

3.3.4 Supporting M&E of RBF mechanisms

There are three separate aspects involved in evaluating the HRITF support to M&E. One is the support to impact evaluations (IE) that HRITF provides as part of any CPG, under the principle that every CPG will have an IE linked to it, which evaluators strongly endorse. A second aspect is the HRITF support provided to evaluate RBF initiatives that are not supported by the Bank. The third element is how the HRITF team oversees, uses, learns from and disseminates monitoring and evaluation activities funded by the programme. The first and second aspects are covered under our review of HRITF Objective Two, while the third aspect is covered in section 4 (Implementation, governance and oversight arrangements).

3.4 HRITF Objective Two - Develop and disseminate the evidence base for implementing successful RBF mechanisms

The HRITF demonstrates a unique commitment to global learning and is building an evidence base on RBF for health through its support of rigorous, prospective impact evaluations (IE) on the causal effects, costs and operational feasibility of RBF.

Going forward, the key strategic direction of the HRITF will be to continue to achieve Health Nutrition and Population (HNP) results by supporting and expanding RBF in World Bank-financed IDA projects.

Country RBF Evaluation Grants will support RBF programme evaluation efforts to learn from successful (and unsuccessful) experiences from around the world and allow for learning in IDA eligible countries.
Source: HRITF Annual Report, 2010-2011.

3.4.1 Our approach to evaluating this objective

The HRITF is expected to have a strong focus on continuous learning and synthesis (see for instance the quotes taken from Annual reports in the box above). In addition, the 2009 Trust Fund Administration Agreement states that "RBF experiences will be continuously compared, contrasted, and considered; key lessons will be identified and synthesized periodically; guidance will be developed; and lessons and guidance will be widely disseminated. An existing RBF website supported by the Trust Fund will be used to disseminate information. An RBF Interagency Working Group (IWG) […] will contribute to global and cross-country learning". The "learning function" is primarily reflected in Objective 2.

Two interrelated aspects will be covered in this section:

- knowledge management, or the process necessary to generate new knowledge and evidence on RBF design and implementation that should rapidly and regularly feedback into the World Bank and the RBF community or practice with a view to improving the performance of the Bank in supporting RBF initiatives at country level, and;
- knowledge dissemination, or the process necessary to capture and make available the knowledge emerging from the HRITF programme.

Our evaluation of this objective is divided into three parts:

1. A review of the impact evaluations being undertaken on the pilots funded by HRITF CPG grants and potential evaluations targeting non-HRITF pilots.
2. A review of the strategy and approaches being used by HRITF to learn from ongoing design, pre-piloting or implementation of the RBF pilots.
3. A review of the instruments being used as part of the learning, knowledge management and dissemination activities linked to the HRITF.

3.4.2 Testing a Range of Results Based Financing Initiatives

Knowledge Generation through Impact Evaluations

The donors wanted the Trust Fund to implement a number of substantial RBF pilots and test them through rigorous impact evaluations (see box with objectives, below). The following section assesses the extent to which this has happened or is likely to happen.

Objectives of the Impact Evaluation Component

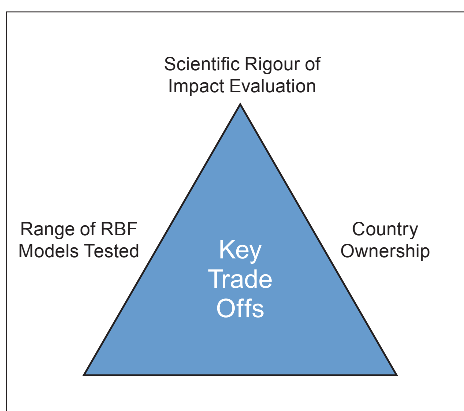
The specific objectives include the following:

1. Conduct rigorous, prospective impact evaluations on the causal effects, costs and operational feasibility of each RBF pilot scheme on the access and quality of preventive and curative health care, health expenditures, and health outcomes. We also propose to evaluate the distributional effects of the intervention and to the extent possible, the impact any resulting improved health outcomes on labour market outcomes and poverty. Depending on the nature of the pilot, each evaluation will look at the appropriate supply or demand side effects as well as anticipated and unanticipated consequences of the intervention such as supply side responses. If a pilot includes both supply and demand side interventions, the goal will be to estimate the separate impact of each as well as any from the combination of the two. The cost information will be used in estimates of cost-effectiveness of the intervention.
2. Coordinate and standardize as much as possible the evaluation methodologies across pilot sites to facilitate the comparison of alternative approaches, assess the external validity of impacts, and assess the feasibility of similar interventions across socio-economic and cultural settings.
3. Summarize and disseminate the lessons learned in materials that are accessible and relevant to country policy makers and other stakeholders, and address both the cost-effectiveness and operational complexity of alternative RBF mechanisms.

Source: Global Impact Evaluation Program for the Health Results Innovation Grant Concept Note Revised April 2008

3.4.2.1 What types of pilots are being implemented?

In developing a portfolio of country pilots the Trust Fund is trying to manage a balance between a number of competing objectives.
It is doing so in the absence of any specific guidance from donors on which of these objectives should be prioritised or perhaps a belief that there are no real tradeoffs to be made and that the different objectives can, in fact, be reconciled.



The Trust Fund is, on the one hand, trying to build up a body of knowledge on a *range* of RBF models (are we testing the right types of models? or are we just testing the same model in different settings?). It needs to ensure that those that it does pilot can be evaluated in a rigorous manner (are they valuable? will they provide answers to the right questions?). Lastly, they are trying to identify pilots

which fit within the individual country context. (are they appropriate to the country setting or are we just doing this because we can evaluate it?)

In Rounds 1 and 2 the choice of approaches to be piloted was also constrained by the restrictions on the countries which could benefit from the funding, particularly the requirement that the pilots should focus on MCH in low income countries with 80% in Africa. This appears to have resulted in countries like India with large MNCH needs and large numbers of poor people receiving little support, as the allocation formula prioritised allocations (on a per capita basis at least) to small, low income countries in Africa making no allowance for the needs of larger countries and the potential benefits and interest from outside the region.

The said allocation formula was dropped from Round 3 onwards, at which time all IDA eligible countries are equally able to access funds provided that they meet HRITF eligibility criteria (source: HRTIF Interim PC).

Approach

Investigating a Range of RBF Proposals will be achieved through “a series of four to six RBF pilots schemes – including both supply-side interventions (provider payment schemes, contracting out) and demand-side interventions (conditional cash transfers).

Source: Initial Proposal

The intention in the original documents supporting the HRITF application and agreements was to assess the potential of a range of RBF approaches (see box above). Whilst it is clear that this involves looking at both demand and supply side interventions there is little further detail on what specific RBF approaches should be tested. For those less familiar with RBF we have included a box below with several definitions and distinguishing features of RBF approaches, as proposed by Musgove (2011). Please note that some of the distinguishing features of RBF are not be mutually exclusive and hence RBF schemes tend to be “hybrids” that combine several features.

RBF – Definitions and Distinguishing Features
Results Based Financing (also known as Pay for Performance (P4P), Performance-based Payment and Performance-Based Incentives (PBI))

Distinguishing Features:

Performance Based Financing: "contracting in" Incentives are directed only to providers, not beneficiaries; awards are purely financial--payment is by FFS for specified services; and payment depends explicitly on the degree to which services are of approved quality, as specified by protocols for processes or outcomes

Performance Based Contracting: "contracting out" As above but adding a variable component that can reduce payment for poor performance or increase it for good performance compared to the standard defined in the basic contract

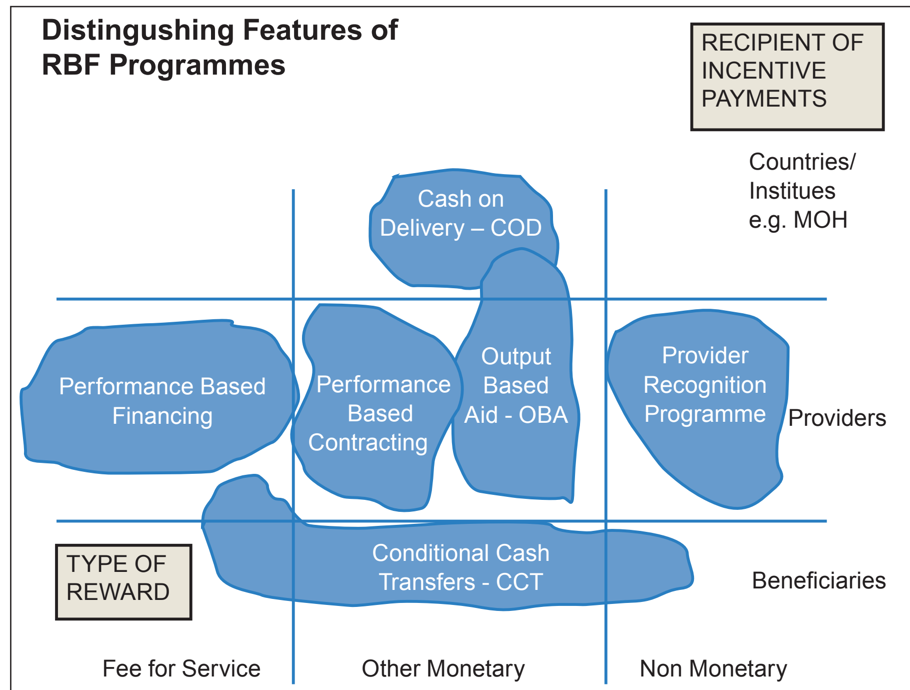
Output Based Aid (OBA) includes only financial rewards the principal is an aid donor; the agent is therefore typically a recipient government or public agency, although it could in principle be an NGO or private for profit organization if external assistance is provided directly to such an entity rather than passing through a government.

Cash on Delivery (COD): maximal degree of autonomy for the agent in deciding how to produce and deliver the results. Results may be outcomes or outputs.

Conditional Cash Transfers: incentives apply exclusively or primarily directly to the program beneficiaries rather than to the agent(s) delivering services. Results are defined by the enrolment of beneficiaries in the program and their compliance with required behaviours such as consuming specific services. Incentives to recruit and enrol beneficiaries or to provide them with services may also apply on the supply-side in these programs, as in RBF generally. For the name to apply there must be a financial payment to the beneficiaries for compliance. Such programs typically offer non-financial rewards, such as food packages, as well.

Source: Musgrove 2011

We used work commissioned by the Trust Fund - which helpfully seeks to provide clear definitions on the various RBF approaches – as the basis for our assessment. Table 7 and the schematic shown below set out how the various approaches can be distinguished. Essentially the schematic distinguishes between the method of payment (monetary or non monetary, different types of financial incentives) shown horizontally with the beneficiaries any PBF payments (countries, institutions, providers, individuals) shown vertically. The schematic then maps the various RBF approaches – their definitions and distinguishing features are shown in the table that follows - to these criteria. For example, Cash on Delivery involves payments to countries (not health providers or individuals) according to outcomes achieved.



Source: Musgrove

However, it is important to note that underneath these broad categories there are a range of key design features which can cause major variations between schemes taking the same overall approach. Clearly it is not possible to cover all design aspects of all mechanisms but the key question is whether the approach addressed a reasonable range of RBF program types.

3.4.2.2 Progress

Our rapid assessment of the pilots suggests that the focus has largely been on contracting out and contracting in methods with some focus on limited demand side initiatives. There has been no focus on Cash on delivery (COD) or Output Based Aid (OBA). It is not clear to us whether this was the intention or not. We could not find any evidence of the use of in kind incentives and were told by the HRITF team that these were excluded from the HRITF in 2010. This would explain why in-kind incentives are only being provided in Rwanda as its application predated the 2010 Bank decision. The quotation below reflects concerns about the rather narrow focus of the pilots approved.

> “the programmes are all very similar – in most cases just focus on better payment systems and on creating an industry to train NGOs to do audits/verification”?
> Source: Key informant

There has been no systematic mapping of approved pilots against the Musgrove framework though the table below presents a flavour of the different approaches although it presents a mix of approaches and research questions.

Table 7: Range of RBF pilots being supported by HRITF

Evaluate Impact of	Countries
Supply-side RBF payments	Afghanistan, Argentina, Benin, Burkina Faso, Cameroon, CAR, DRC, Ethiopia, Ghana, India, Kyrgyz Republic, Lesotho, Nigeria, Rwanda, Turkey, Zambia, Zimbabwe
Additional financing	Zambia, Zimbabwe
Linking RBF payments to quality of care	Afghanistan, Benin, Cameroon, Ethiopia, Ghana, Kyrgyz Republic, Nigeria, Zambia
Differential incentive levels	Argentina, Ghana
Monitoring and supervision	Argentina, Kyrgyz Republic, Cameroon, CAR
Demand-side RBF payments	Ghana and Rwanda
Interaction between RBF and training/knowledge of providers	Zimbabwe
Additional financing	Zambia, Zimbabwe
Differential incentive levels	Argentina, Ghana
RBF for hospitals and higher level providers of care	Kyrgyz, Argentina
Community-Based RBF	Afghanistan, Ghana, India, Rwanda, Tajikistan
Evaluate the Equity of RBF (by poverty, urban/rural)	Afghanistan, Benin, Burundi, India, Nigeria, Zambia, Zimbabwe

Source: HRITF Team

3.4.3 Degree of Scientific Rigour

Approach

The Importance of Impact Evaluations: A key element to the success of these pilots is a rigorous and well designed evaluation that fully documents the extent to which RBF policies are effective, are operationally feasible, and in what circumstances. The evaluations will not only add value by demonstrating how the pilot programs affect their intended outcomes (e.g. increasing coverage of MCH interventions, heath outcomes), but also the extent of any unintended consequences (e.g. encouraging providers to shift their attention from delivering interventions that do not provide compensation at the margin to the targeted interventions that do) as well as the costs associated with new methods of payment.

Source: Impact Evaluation Toolkit

As shown in the box above there was a clear aim to have a substantial number of rigorous impact evaluations to strengthen the evidence base on RBF. Whilst it was recognised that not all evaluations would be able to address all areas of interest, taken as a whole the portfolio of impact evaluations was expected to do so. Similarly, whilst it was recognised that it might not be possible to implement a “gold standard” evaluation in every setting the evaluations proposed should be of sufficient rigour to provide credible results (as stated in the two boxes below).

> We conclude that there are few robust studies of PBF available from a low- or middle-income context and it is premature to draw any firm conclusions on its effectiveness or factors that determine its effectiveness.
> Source: DFID HRITF Project Memorandum

> The current evidence base is too weak to draw general conclusions; more robust and also comprehensive studies are needed. Performance based funding is not a uniform intervention, but rather a range of approaches. Its effects depend on the interaction of several variables, including the design of the intervention (e.g. who receives payments, the magnitude of the incentives, the targets and how they are measured), the amount of additional funding, other ancillary components such as technical support, and contextual factors, including the organisational context in which it is implemented.
> Source: Witter et al 2012.

Progress

The Trust Fund has established a strong pipeline of impact evaluations. They all involve some form of randomised or experimental approach.

Do they address the right questions?

The evaluations focus on two broad questions.

<u>First Generation Question: Does RBF work?</u>

What is the impact of RBF on:

- Health care provision?
- Utilization of Services?
- Maternal and child health outcomes?
- Are there unintended consequences of RBF?
- How does RBF work differently for different populations?
- Are impacts cost-effective relative to other interventions?

<u>Second Generation Question: How can RBF work better?</u>

What components of the RBF “package” matter most:

- performance reward? Increased financing? decentralized decision making or autonomy? improved monitoring and supervision? better data and information?
- What are the right incentives?
- Who should be incentivized? Providers? Households? Communities?
- How to reduce reporting errors and corruption?
- What are the optimal provider capabilities?
- What are the key organizational building blocks to make RBF work?

Detailed guidance is set out in the Impact Evaluation Toolkit (which was under development during the timeframe of this evaluation but has since been completed)

Underrepresented Research Questions

> "Accountability will be enhanced through stringent monitoring of both quantity- and quality-related targets"
> Source: Burkina Faso CPG
> "RBF has the potential to … improve … accountability in both public and private sectors"
> Source: Grant Agreement

Whilst we believe that the IEs commissioned to date do meet necessary minimum standards of rigour we identified two areas which the IEs do not appear to cover fully. Both are important issues though neither is particularly easy to quantify. One of the key aims of RBF is to improve accountability (see box above) yet this aspect – despite being a stated objective in some of the pilots - does not appear to have been covered in any of the IE concept notes. A second issue relates to the question of transaction costs which has major implications for sustainability. Early documents referred to the high cost associated with RBF and the interest in doing full cost benefit analyses in some settings. (Brenzel, 2009). Although the various concept notes do refer to a cost effectiveness analysis of RBF compared to other approaches it is not totally clear which costs are referred to – whether this is just independent verification costs or other costs associated with RBF.

Potential Conflict between Country Priorities and Requirements of an Impact Evaluation?

> "This is not a laboratory – the approach must be country driven – but minimum standards need to be met "
> Source:Personal communication from a government officer based in a pilot RBF country

The need for rigorous IE and the emphasis on IE by the Bank was something strongly perceived in the countries covered by our case studies and desk reviews. This is, in itself, a great achievement by the HRITF and the Bank as it implies a change in mindset among many government and donor representatives, from the traditional expectation that results will hopefully be achieved to the need for focus on results and on their verification right from design. At the same time, some interviewees expressed the opinion that there was an excessive focus on impact evaluations (such as the stamen shown in the box above) at the expense of supporting implementation and documenting lessons from the RBF design and implementation process. Likewise, the point was made that more emphasis has been placed by the Bank staff on IE design than on making an effort to make available, explain and disseminate the findings from the baseline surveys at country level. Informants explained that this is often done through a dissemination workshop but that it takes much more than a workshop to bring key messages to the attention of key health policy makers and donors. In general, evaluators did not find a clear strategy in the countries for the Bank and implementers of IE to be more didactic in terms of delivering results from ongoing baselines to a set of key stakeholders, and then to target those stakeholders on a more regular basis. This is difficult, the evaluators are aware,

but quite crucial in preparation for the moment that IE results will become available.

It is not feasible or advisable to implement a rigorous impact evaluation which does not have the support of the country in question, and such support should go beyond a mere acceptance of IE towards developing a critical mass of nationals knowledgeable and supportive of the IE approach. Basic knowledge of impact evaluation methods was low in many settings and seems to have improved significantly among the health community partly through support provided by the Trust Fund. However, it must be accepted that the traditional approach in some countries to pilot in a district then scale up nationally does not fit naturally with an approach which randomly allocates interventions between beneficiaries. Countries such as Ethiopia, for example, are extremely reluctant to pilot interventions in regions on equity grounds and much prefers national approaches. Whilst, it may ultimately prove to be possible to adopt a rigorous randomised approach the dialogue to achieve this may be protracted. The current approach, as we understand it, is to try and identify potential agrarian, pastoral, and urban settings with comparable regions as controls.

In the case of the Kyrgyz Republic the initial plan to have four study arms in the IE which included one where providers were allocated an equivalent amount of funding to the intervention areas - was dropped. From an evaluation point of view this arm would have allowed one to assess whether any results were down to the RBF approach or whether they were just down to the money linked to the RBF (i.e. measuring the income effect). Government found such an approach to be extremely “damaging” and “sending out all of the wrong signals” and the arm was ultimately dropped. In this case country ownership prevailed and the evaluation was partially compromised. Whilst the study is probably still worth doing it does illustrate the potential tradeoffs between country ownership and having a rigorous impact evaluation. It would not be surprising if similar issues emerge during implementation of pilots in other countries such as Zambia where some of the control groups (for study questions 2 and 3) will not receive any additional benefits from the program: might this in itself cause an internal “migration” of service delivery staff from the less to the more resourced facilities?

HITF capacity to respond to and support IE

The task of implementing over 20 impact evaluations (with more to come) - the IE programme is enormous given the complexities and technicalities of the IE approach leaving aside the increasing demand that is originating in countries (in part through funding stream 3) who request increasing support from the Bank in this area.

The HRITF team that oversees evaluation is quite small. TTLs approached in many countries were quite aware of the limitations of the IE team to provide ongoing support, but they said so in a very polite manner as they appreciated the enormous effort that the IE team is making. In some cases (e.g. India)

reference was made to the slow response from the Bank for requests for support on IE matters.

These evaluators have not made a thorough assessment of capacity issues at the level of the HRITF team in Washington and its "satellite" staff based in the regions, but we wish to bring to the attention of the Bank the need to appraise capacity versus increasing demand issues within the HRITF team, in this case in relation to IE, but similar points will be made later in relation to improved support to documentation of pilot implementation. This "strategic phase" of the HRITF requires a thorough assessment of whether the HRITF team contains or has access to the necessary expertise and capacity.

Looking Forward

There is a need for donors and the HRITF Team to take stock of what has actually been funded to date. We believe that it was reasonable for the Trust Fund at the outset to be responsive to the requests it received. However, having built up a pipeline it will be necessary to take a more strategic approach to ensure that the Trust Fund has a balanced portfolio of RBF programmes. This raises the question of what the donors might consider a balanced portfolio to look like.

We would recommend as a first step that a mapping is carried out of the current pilots to set out the current situation. We understand that work is ongoing on this. This should map out not only the broad approach being applied but also consider the detailed design features. (We would suggest the Tajik table –at Annex 7- to be used as a starting point, to be further developed by the HRITF Team.

Donors need to consider how important it would be for the Trust Fund to widen its net to a broader range of RBF initiatives (or whether other mechanisms should be used for this e.g. Global Programme on Output Based Aid or through their bilateral programmes e.g. DFID is piloting Cash on Delivery in the health and education sectors in Uganda, Rwanda and Ethiopia). If this is the case the HRITF Team will need to be more proactive in identifying possible settings for such pilots or providing arguments why such approaches are not feasible (i.e. because the evidence base suggests they are not appropriate for the TF eligible countries or because the available instruments will not support them.) We are not necessarily proposing that Cash on Delivery is something that could be piloted through the Trust Fund. We are aware that the Bank has major reservations about whether this approach can work. We do feel, however, that this is a discussion which needs to take place.

Key Messages

- There are questions as to whether IE offers the best value for money in generating knowledge.
- There can be tradeoffs between reviewing a range of approaches, reviewing them rigorously and ensuring country ownership. It is essential that the IEs meet minimum standards of rigour. In our assessment they seem to. Donors need to be more explicit on their priorities especially in relation to the range of approaches they would like to see tested. The Bank needs to be more explicit in spelling out the trade offs.
- The TF support to IE appears to be effective but also appears to be under resourced.
- There is a need to map out in more detail the current RBF portfolio and identify gaps using the Musgrove framework.
- Donors to consider whether it would be appropriate for the TF to try and cover these gaps.
- Trust Fund to advise on appropriateness/feasibly of such actions
- Developing a strategy to fill gaps.

3.4.4 Learning by doing? The approach to knowledge management and dissemination

Documenting RBF pilot design and implementation – Learning-by-doing. Continuous documentation of RBF design processes, implementation activities, unintended events and consequences, and contextual factors provides data for the following objectives: improving project management, strengthening the internal and external validity of the impact evaluations, and keeping governments and partners informed of progress with "real-time" information. Bank staff is assisting countries with this task and efforts are also underway to document the evolution of project designs, beginning with logic models for each country. Operational challenges and questions arising during project execution will be addressed through impact evaluation or special studies.

Source: HRITF Annual Report, 2008.

Robust effectiveness evaluations should be complemented by in-depth process evaluations to uncover the mechanisms by which the intervention may or may not work, and to probe the motivational effects which are intended to be at the core of the intervention. It will also be important to study the changing effects of incentives over a longer-term time span. Performance based funding is not a uniform intervention, but rather a range of approaches. Its effects depend on the interaction of several variables, including the design of the intervention (e.g. who receives payments, the magnitude of the incentives, the targets and how they are measured), the amount of additional funding, other ancillary components such as technical support, and contextual factors, including the organisational context in which it is implemented.

Source: Witter et al, Cochrane PBF in health review, 2011.

The HRITF has been defined as a learning programme (a couple of statements confirming such focus are included in the box above), and as such the evaluators have been interested in understanding its approach to knowledge management and dissemination, and not just to emit an opinion of the various

instruments through which learning will take place (this will be done in the next section – 3.6.4).

Learning by doing
The concept of learning by doing was constantly emphasised to the evaluators since, as explained earlier, RBF is a new approach routed in a weak evidence base. The evaluators wanted to understand whether there was a clear knowledge management and dissemination strategy, knowledge or learning work programme underpinning the HRITF? The following points can be made in this regard:

- There seems to be a much more systematic approach to IE design and implementation of IE studies than there seems to be in relation to the issues and lessons emerging from the design and implementation of the RBF pilots. This is a problem since, as has been argued, IE will deliver key lessons linked to the ultimate impact of the RBF yet there are many contextual issues linked to RBF implementation that will ultimately affect impact, which need to be properly monitored and documented as part of the design and implementation of RBF pilots. Hence the recommendation by experts (quoted in the 2008 Annual Report) that impact evaluations should be complemented by process evaluations, which we interpret as regular stock taking of issues and lessons emerging from RBF design and implementation.

- While the impact evaluation toolkit incorporates a series of key questions to be covered much of the emphasis remains on the ex-ante and ex-post measurements, while the emphasis on "learning as we go" is much less noticeable. For example, evaluators could not find at either national or Washington levels a set of questions to be addressed in relation to RBF design and implementation matters that could be linked to specific contracts or to a pipeline of work - either as part of the IE component of HRITF or linked to the design and implementation of the RBF pilots.. Such effort should be an integral endeavour of the World Bank country and regional teams and of the implementers of the RBF pilots rather than something linked to a central work programme managed from Washington. Global learning will only happen if the national learning takes place first.

- "Learning as we go" relies crucially on regular, systematic and pro-active documentation of RBF design and implementation issues (similar to the ones quoted above from the Witter review). The evidence gathered in several countries suggests that there is insufficient focus on documenting design and implementation issues (see 3.5.3: why documenting implementation is crucial). Examples from Nigeria, Rwanda (see text box below), and Kyrgyz Republic -and to some extent Zambia- may not make for a representative sample but they tell a story: there is insufficient focus on documentation and ongoing lesson learning that is affecting national learning and the entire HRITF learning programme.

"The Bank has engaged with us to plan… but the Bank has not been very active in looking at programmatic issues in the field, being based in Washington and not having a very big programmatic presence in Rwanda made it quite difficult to make sure that the program is being implemented as planned. Even though some consultants have been hired on behalf of the Bank and a small contract given to the School of Public Health to document the program implementation, I feel that much has to be done in that regards."

Source:Written communication from a key informant in Rwanda.

Key Messages

- There is insufficient focus on documenting ongoing pilots supported by the CPG grants – this will reduce the value of IE and may also reduce the effectiveness of the RBF approaches being piloted.
- Documenting pilots should be an integral part of the pilot implementation strategy. Where this is not the case (and the documentation tasks are not clearly assigned or not assigned at all) the Bank should swiftly mobilise resources to enable documentation by persons and/or institutions (depending on context) based in the country. External documentation from persons or institutions that are not directly involved in implementation, monitoring or verification of RBF pilots should be probably the best option in most cases, but context should determine that.
- As part of renewed focus on documentation stronger links should be established between the Bank country team and those documenting to ensure that issues that are spotted are fed back swiftly to the implementers (MoH, TA firms, verification firms, etc.) and that documentation feeds into a national knowledge programme on RBF where specific questions lead to commissioning of studies and then feed into regional and global learning.

3.4.5 The instruments to manage and disseminate knowledge on RBF

In this section we review some of the instruments used by the HRITF to date to capture, generate and disseminate knowledge on RBF. Dissemination and Knowledge Sharing are covered under Activity 8 of the HRITF work plan which "supports the sharing of RBF experiences and lessons learned through the RBF website (www.rbfhealth.org), meetings, country dialogue, workshops, case studies, and the Inter-Agency Working Group on RBF." A Knowledge Management Officer in the HRITF team in Washington reports on this activity.

This activity has both internal and external audiences. Dissemination for internal audiences (TTLs, Bank managers and other staff) is mainly done through training workshops and the intranet.

The intranet (not reviewed as part of this evaluation) is an essential part of any knowledge management (KM) system. Since 2010 the HRITF-managed intranet plays a particularly important role in fulfilling the needs of country-based staff who need access to relevant internal guidance in one place. The KM Officer has put significant effort in sourcing these documents from WB databases.
The intranet site is said to contain a wealth of resources including:

- Information on how to access HRITF funds
- Guidance on designing programmes
- Examples of Bank documents (e.g. guidance, concept notes, Project Appraisal Documents, project Implementation Documents, financing and loan agreements, grant agreements and contracts, Terms of Reference, and legal agreements)
- RBF contacts
- Videos and presentations from TTL workshops
- Essential readings and other content from the external website

3.4.5.1 Knowledge and learning grants

Knowledge and learning grants can be provided to countries applying for them under HRITF Funding Stream 2. All countries –not just IDA- can apply for these funds, and both country and regional applications (where various countries are included) are accepted and have indeed been approved (see table in 3.2 – Funding stream 2 in 2011). The following points can be made:

- It was a good initiative to have knowledge and learning grants, and to open these to all countries. There has been a good uptake from countries and regions.

- It was also a good idea to allow for regional grants to support regional learning programmes, although several members from the RBF community of Practice in Africa who are not World bank staff were not aware of these grants when they spoke to the evaluators. As other HRITF funding streams much depends on the extent to which TTLs are themselves integrated within the communities of practice.

- The HRITF Team should be aware that increased demand for learning products will increase the need to verify the quality and relevance of those products, which would in turn have important resource implications. Evaluators could not see that the surge in demand for learning products has led to increased capacity at the level of the HRITF Team, whether in Washington or in the regions.

3.4.5.2 The RBF website and knowledge products[6]

Building a website that would function as a 'global knowledge centre and network' for RBF was the first dissemination priority of the HRITF team.This has largely been achieved, as demonstrated, among the rest, by consistently increasing usage since its launch in 2009. The level of usage over the evaluation period is very respectable for a (relatively new - at the time) technical topic such as RBF.

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6 This section does not include commissioning and development of analytical work, which is covered separately.

Table 8: Web statistics on the RBF website

	Page views (average per month)	Unique visitors (average per week)	File downloads
July 29, 2009 to March 2010	3,400	180	544
April 2010-March 2011	5,100	248	753

Source: HRITF annual reports.

The website is a rich source of information: it contains over 100 publications (both originating from HRITF and external sources) and over 30 presentations from learning events. There are a few other websites containing information on RBF, but none is comparable in breadth to www.rbfhealth.org.

Initially the KM 'team' (intended as Washington- based staff with direct involvement in Activity 8) focused on 'building traffic' to the website by populating it with existing materials, commissioning short pieces such as country snapshots and technical briefs in order to draw attention to the site and position it as the 'go to place' for RBF. Short, easy to read summaries of less accessible books, and practical tools and guidelines were also added (as well as more substantial working papers) and a blog was launched in 2010. An analysis of website content, and the content schedule provided by the KM team, shows that the website has been very much a live tool, with new content added frequently and regularly.

In its first year of existence (2009-10), 58 knowledge documents were added to the RBF. Of those, 30 were original pieces developed and written by HRITF RBF team members or commissioned experts and writers. More have been added since. The team has made great efforts to commission pieces at the time when existing available information on RBF was more limited. It continues to do so with regular blogs, background briefs and features article, and links to external publications when these become available. It is commendable that the KM team has continued to keep the site up to date with new material even though the team's focus shifted to training of TTLs in 2011.

A Bulletin, published since August 2009, has been an important marketing tool. Subscriber numbers grew from 359 (in the period from the launch in late July 2009 to March 2010) to 504 in the following year (April 2010-March 2011). Currently 40% of subscribers are made up of World Bank staff, and the remainder includes a good mix of external users from countries (particularly Rwanda and India), donors and others. It is impressive that the Bulletin has been issued consistently twice a month over its lifetime. The frequency has now been reduced to once monthly, which is appropriate and the website has become well known and established. At the beginning an occasional IWG Newsletter was also produced (following IWG meetings) to keep members and others informed on RBF. The newsletter was not considered particularly successful and has been discontinued; this is justified in terms of duplication and potential information overload.

The HRITF team has followed the standard good practice processes for developing and maintaining the website. They started by developing a strategic

communications plan for building the online RBF community and marketing the website. There is an explicit (written) QA process for all products that are included on the website, covering both suggestions for external resources (from staff, partners etc), and commissioned pieces. Again, this process follows good standard practice (i.e. team review-peer review-final approval; potential country 'sensitivities' vetted with TTLs) and covers various levels of review depending on product (e.g. external peer review and professional editing for formal pieces). There is also an annotated content schedule which is reviewed at weekly meetings, covering the website, intranet, blog, bulletins and marketing opportunities. The KM officer schedules a full review of the website once a year for maintenance purposes (such as weeding of old material and IT issues).

Initially, all content was approved by a Web Advisory Committee. Currently decisions on what is included are made during regular team meetings and follow a content schedule. The KM Officer is now responsible for final review and revision of products (after peer review), and for oversight of the website. This is entirely appropriate given that all products are vetted before reaching the website, or (in the case of external materials) suggested by technical experts. The KM Officer has intensive contact with in country and Washington-based experts, which provides a constant flow of ideas and suggestions for external publications. It is also understandable that a Web Advisory Committee is no longer felt as needed. A Committee is crucial in the initial stages of web development to gain consensus on the direction the website should take and to develop a communications strategy (which was also in place), or in the context of a complete website re-haul/redesign, or when particularly sensitive issues are at stake. There is however a risk of complacency now that the website has been 'achieved' as a key deliverable, and it has become a lower priority for the team after training. Some issues raised by some informers would require taking a fresh look at the website; this is discussed below.

One of the key roles of the website is to provide the latest thinking on evidence on the impact of RBF. We would propose that a separate – and highly prominent page – is developed to demonstrate this. At present, it is rather difficult to find key documents of this nature. We would propose that this page is kept updated on a regular basis and post relevant new documents on a timely basis (e.g. the Witter Cochrane review report on RBF that is not there).

3.4.5.3 Workshops and learning events

During the evaluation period HRITF staff have participated in or conducted over 20 knowledge sharing events, ranging from training workshops for practitioners on what RBF is and how to implement it, to international events reaching broader audiences.

Since 2011, in response to high demand from WB managers, the focus of KM activities has been on internal training for TTLs. In 2011 two four-day training workshops reached 60 TTLs. Two more workshops are planned for 2012, after which it is expected that internal demand from the Bank will decrease. The workshops take place in Washington DC. In addition to these, since 2008 HRITF

staff has actively participated in a variety of workshops, conferences and training events targeted at the international or country level health community – all important channels for sharing lessons and various types of knowledge and information. From the sheer number of events one can infer varied and extensive engagement with practitioners and policymakers. Key international events have been documented in the RBF website.

Table 9: RBF participation at international events

2008

- RBF workshop, June 2008 Kigali, Rwanda. Attended by delegations from 12 countries in Africa and South Asia.
- RBF workshop, October 2008, Gisenyi, Rwanda. Prompted by overwhelming demand and attended by delegations from seven countries in Africa and Central and East Asia.

2009

- Asia Pay-for-Performance (P4P) Workshop, Cebu, Philippines, January 2009
- RBF IE Network workshop December 2009, Cape Town, South Africa (combining intensive training in IE methods and hands-on clinics to further develop the RBF pilot countries' IEs.)
- Partners' Consultation Meeting, Kigali, April 2009 (41 participants from 15 institutions including UN Agencies, multilateral donor institutions, bilateral donors, international and Rwandan NGOs).
- Training of Trainers for the Francophone Community of Practice Network, Ouagadougou, September 2009

2010

- Community of Practice (COP) RBF Workshop, Burundi, Bujumbura, February 2010
- "Cloud Computing" for the Burundian National PBF model, Washington-DC, April 2010
- Provider Payment Toolkit, Washington-DC, May 2010
- Supply Side RBF/PBF Design and Implementation, Regional Health Level Forum on Health Financing, Maldives, June 2010
- Supply Side RBF/PBF, Design and Implementation, Global Health Council Conference, Washington-DC, June 2010
- Flagship Course on Health Sector Reform and Sustainable Financing: Drill Down on Results-Based Financing (Performance-Based Financing)-The Case of Burundi, Washington-DC, November 2010
- Two-week Training on PBF, Zambia, July 2010
- The Alphabet Soup of RBF, Washington-DC, September 2010
- Risk and Reward: How RBF Contributes to Health Project Design, Washington-DC, October 2010
- Flagship Course on Health Sector Reform and Sustainable Financing: Drill down on Social Health Insurance-Performance-Based Financing-The Case of Rwanda, Washington-DC, November 2010
- Two-week Training on PBF, Kenya, November-December, 2010
- IE workshop Tunis, Tunisia in October 2010 (80 participants at different stages in the process of rigorously evaluating their programs, including ten World Bank RBF teams from five of the six World Bank regions.)

2011

- Learning week Seminar: Results Based Financing in the Most Unusual Places (examples from AFR and SAR), Washington-DC, March 2011
- Flagship Course on Health Sector Reform and Sustainable Financing: presentation on RBF, March 2011
- Training on PBF in the African Community of Practice conference, Saly, Senegal, March 2011

Source: HRITF Team

3.4.5.4 Discussion of knowledge products

HRITF donors provided good feedback on the website during the 2011Annual Donor Consultation: "Donors highlighted the usefulness of the RBF website and emphasized that they often refer colleagues to the site. The website's neutrality was noted as a very positive quality and donors encouraged the World Bank to maintain open access and neutral branding."

The website is a key dissemination achievement. It is run professionally and it has become, as intended, a central place to gather and disseminate RBF knowledge and information produced not just by the Bank but by a wide range of actors.

A number of potential issues have been noted:

- As the website continues to grow, the sheer quantity of material makes it more difficult for users to find what they are looking for.

- The paucity of information about HRITF itself.
  The issue raised by some informants that the website leans towards collecting 'interesting features' rather than the 'hard' lessons emerging from experience (both in the sense of critiques and documentation of HRITF experience so far).

Whether analysis and documentation from HRITF pilots has taken place is discussed separately. In terms of the existing content, the site is comprehensive and includes well known critiques (though they may not be so easy to find). A key reported criterion for inclusion is the soundness of underlying data. The use of feature articles and the blog has been useful for both generating traffic to a new website and disseminating information about RBF. However the website is no longer in its early stages and it would be useful to rethink whether the current structure and content are still appropriate to a 'more experienced' RBF community. The Knowledge Library in particular (categorized by document type, e.g. technical briefs, technical working papers) with well over 100 documents has become difficult to navigate and important documents are hard to find (see Annex for full list). It would be useful to facilitate access to documents through additional entry points (e.g. by technical area, country, and through a search function), and to have a clearer separation between 'newsy' items and features, and the more technical documents including lessons and analyses. The blog is useful to keep the site active, but is not generating much discussion (a lot of which takes place separately in the PBF Community of Practice run independently from the Bank). A reason for this may be that the content tends to be descriptive rather than thought provoking.

Although it can be said that the site has become the 'global repository' for RBF material, it is not very clear about 'where it sits' – that is, its relationship to the HRITF and other parts of the Bank, and what other activities are going on apart from document collection and dissemination. RBF is a hot topic for many health experts worldwide from different backgrounds who are not familiar (or indeed do

not know about the existence of the Trust Fund) who would find the information valuable. More information about HRITF was also included following feedback from the 2010 donor consultation. Although donors have not made further requests, from the point of view of an external user this information remains minimal. There is indeed a technical brief (Contributing to Global Learning About Results-Based Financing (RBF): The Health Results Innovation Trust Fund, September 2009) but it is very hard to find. The site does not list the countries with RBF pilots. The Bulletin mainly focuses on 'what's new' on the website and does not give a particular insight on specific HRITF activities. Equally from all the documentation on the website it is not always easy to distinguish whether the examples of RBF discussed are funded by the HRITF or not, and where the lessons are coming from – this is very basic and essential information.[7] This issue is being addressed through the development of a global RBF map which will provide basic information about projects worldwide. This ongoing initiative is scheduled to be delivered in 2012 – unfortunately over three years after website launch.

Clearly, the website needs to be and is seen as a useful repository of available information and would not wish it to become a censor. The TF would, anyway, not have the resources to do this effectively the site relies on intelligent individuals being able to critically review the content on the website and adapt it for their own purposes. We would recommend that this is set out explicitly in the website.

This does however raise the question of what to do when different papers contradict each other. Some papers arguing for example that the RBF pilots in Haiti, Afghanistan and Cambodia have led to significant improvements in health outcomes. The USAID Blueprint8 reports for example that "remarkable improvements in key health indicators have been achieved over the six years that payment for performance has been phased in" and that "as many as 15,000 additional children were immunised in Haiti because of the changed payment routine" the Witter review excluded the study as unreliable on the grounds that "although there are before-and after data for NGOs that did and did not participate in the PBF scheme, the groups cannot be assumed to be similar, particularly since criteria for inviting NGOs to participate were "indicators of readiness". It also raises the question of what to do when the content contains things which fundamentally disagree with the HRITF approach. The USAID Blueprint (wrongly in our view) argues that evaluations are not critical when designing a P4P blueprint (but) can significantly augment your learning strategy"

One could argue that IEs are difficult for health systems reforms and that a Cochrane type review sets too high an inclusion bar. IEs for RBF clearly are challenging but the Rwanda experience, and the ongoing experience of the Trust Fund, is showing that they are feasible and this being the case there is no

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7 The Global Partnership on Output-Based Aid (GPOBA) for example, has an extensive database of its own activities: http://www.gpoba.org/gpoba/node/243

8 Eichler, Rena and Susna De. April 2011. *Paying for Performance in Health: A Guide to Developing the Blueprint. Version 2* Bethesda, MD: Health Systems 20/20, Abt Associates Inc

reason for adopting lower standards for RBF than for other interventions. This would emphasise the need to highlight the finding or rigorous, independent meta analyses on the website.

Key messages

- The need for a health warning for those using the website and that these will need to critically review the content – some of which may be contradictory – so assess what makes sense in their setting.
- The need to ensure the focus remains on understanding the impact of RBF and ensuring that the current thinking is displayed prominently alongside key documents.

3.4.5.4 Inter-Agency Working Group

> The IWG serves many purposes. It allows the Bank to share learning from countries, elicit advice from others, and work towards a better understanding of what this innovation can contribute. An Inter-agency Working Group (IWG) of development partners was therefore constituted and convened at the very beginning of the program.
>
> Annual Report, 2008

The Inter-agency working group (IWG) for RBF was created in 2008 and meets twice a year. It is largely made up of international agencies. Evaluators met a few members of the IWG who generally perceived the venue to be a good forum for information exchange on RBF. Some interviewees mentioned however that combining members from aid agencies and experts in RBF in the same group can at times generate tensions on what should be the primary focus of the group: to share information on RBF initiatives from an aid perspective and use the IWG also as a donor coordination forum; or to focus more on what the HRITF is doing and what emerging lessons can be learnt. Evaluators find these different perceptions quite normal in a group of this kind and suggest that in the next IWG meeting the HRITF project manager (who is the Chair of the IWG) could propose to participants the undertaking of a simple survey to assess the views of participants on what should be the primary focus of the group and how might the meetings be organised to make them more useful to members.

3.5 HRITF Objective Three - Build country institutional capacity to scale up and sustain the RBF mechanisms

This section is kept short as many issues linked to capacity have been already discussed elsewhere when reviewing earlier objectives.

In general evaluators could verify the existence of many capacity building efforts at country level (mainly linked to the training effort to launch pilots) with workshops and other activities being used and with participation from other national stakeholders. In this sense the approach to capacity building was more operational rather than part of a broader or systematic capacity building plan. It is recommended that all countries where an RBF pilot is being implemented should include an explicit, detailed and verifiable institutional development and

capacity building plan: where is capacity needed (MoH, providers, communities, research institutions, etc.)? Who will be targeted (managers, service providers, academics, technical agencies, etc.)? What approaches will be used? Etc. The HRITF team should ensure that this requisite is part of the feasibility analysis that precedes pilots, and there may be a need for more specific guidelines in this respect.

Bank engagement at country level is key for learning, the capacity building and the attracting additional financing objectives. Relying on "remote control" from a TTL somewhere else or permitting that a weak country team oversee a RBF pilot would compromise progress on all three objectives. Therefore points made elsewhere about the need to have a strong World Bank country team in all countries where an RBF pilot is being implemented, and to consider this factor when applications are received are just emphasised again in this section.

Points on using country systems for capacity building have also been made elsewhere. The Bank has been quite strategic in using inputs delivered by other donors and agencies (CORDAID, MSH, CDC, Global Fund, GAVI and USAID) to increase capacity around country pilots. In general, the Bank has made visible attempts to use country institutions as part of pilot design and implementation. However the complexities of RBF and IE design should not be underestimated and often country institutions are not familiar with these concepts and require a lot of technical assistance. Many of these issues cannot be detected or fully appraised during application and RBF contract negotiations.

Since the technical assistance inputs for bringing country institutions up to speed with RBF and IE design and implementation matters can be very substantial (cost and effort) it is recommended that capacity building plans become part of any pilot being implemented and that they are based on better capacity assessments during feasibility studies and pre-piloting, since the real capacity gaps cannot be fully assessed during the application process. This may require TTLs being allowed to apply for additional capacity building support funds, which in turn require the HRITF Team to be responsive and flexible in the way internal HRITF expenditure sanction norms are applied.

3.6 HRITF Objective Four – Attract additional financing to the health sector

3.6.1 Leveraging additional resources:

> **Leveraging Additional IDA Funds**. The trust fund grants are leveraging additional IDA funds for health. Large vertical donor flows for specific health goals such as HIV/AIDS and immunization may cause some governments to reallocate scarce IDA resources toward other priority sectors.
> Annual Report 2008

The fourth objective of the Trust Fund is to leverage additional resources for the health sector. No specific description or linked indicators were ever set for this objective at design (except for references to leveraging IDA funds – see box

above) so evaluators found little clarity about what it means in practice or on which potential funding sources were to be tapped. Because of such lack of clarity this section is based on assumptions, suggestions and findings that the evaluators put for consideration by the HRITF partners.

The additional financing could come from the Bank or other sources. Within the Bank it might take different forms:

- it could result in IDA credits being included in the Country Assistant Strategy (CAS) which would not otherwise take place
- increasing the overall size of any IDA credit
- increasing the RBF component of the IDA credit
- attracting support from other funding sources – donors, Ministries of Finance, others such as foundations
- support for RBF activities outside HRITF but drawing from the HRITF experience

Other sources might include:

- new donors contributing financial support to the HRITF or to some pilots being implemented in specific countries of their interest
- donors cofinancing the scale-up of RBF pilots at the country level whenever IE deliver positive results and country governments show interest in such scale up. RBF can be an ideal platform for this as the internal contracting approaches can allow for multiple payers allowing donors – even those who may not be able to pool their funds or participate on SWAps to agree to pay for defined results
- other initiatives related to RBF arising specifically from HRITF activitities

We will attempt to address the following questions:

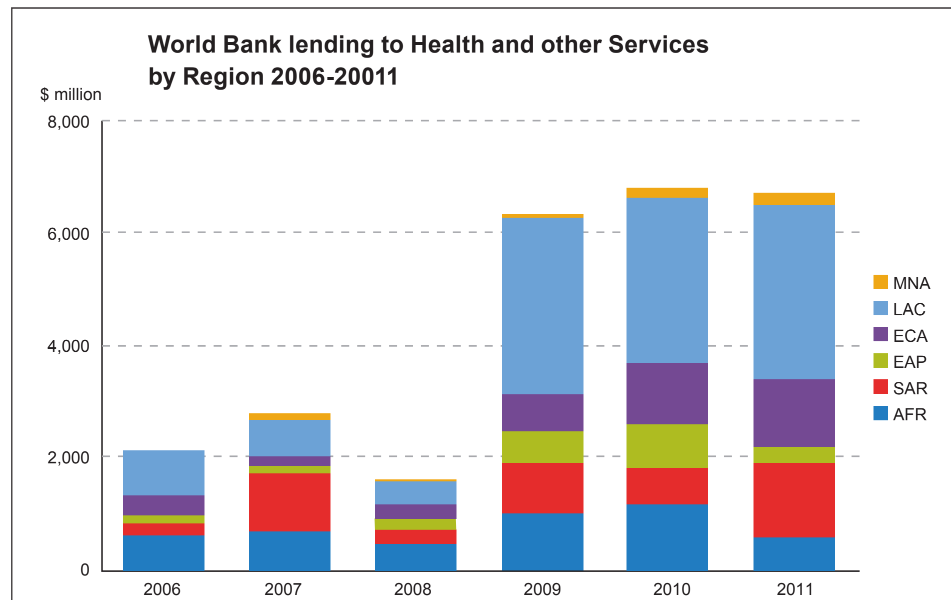
Were additional funds really needed? Whilst attracting additional resources is a stated objective some authors (including Gertler) have suggested that RBF is not generally expected to replace other funding streams, but rather leverage improved impact from the combined funding from RBF and non-RBF channels. As such it is less about requiring more resources – more about using existing resources better though additional resources are clearly required when the approach is being used to scale up coverage.

Is there more effective spending on RBF. This possibility is not referred to explicitly in HRITF programme objectives but we felt it was worth investigating. Firstly, one might anticipate that the HRITF might be able to ensure that support at the country level – including that provided by other development partners – could be delivered in a more harmonised and aligned way. Secondly, one might anticipate that donors or agencies implementing RBF initiatives independently from HRITF might draw lessons from the experience of the Trust Fund to improve the quality/cost effectiveness of their own programmes.

3.6.2 Progress – Leveraging Additional Funds from IDA

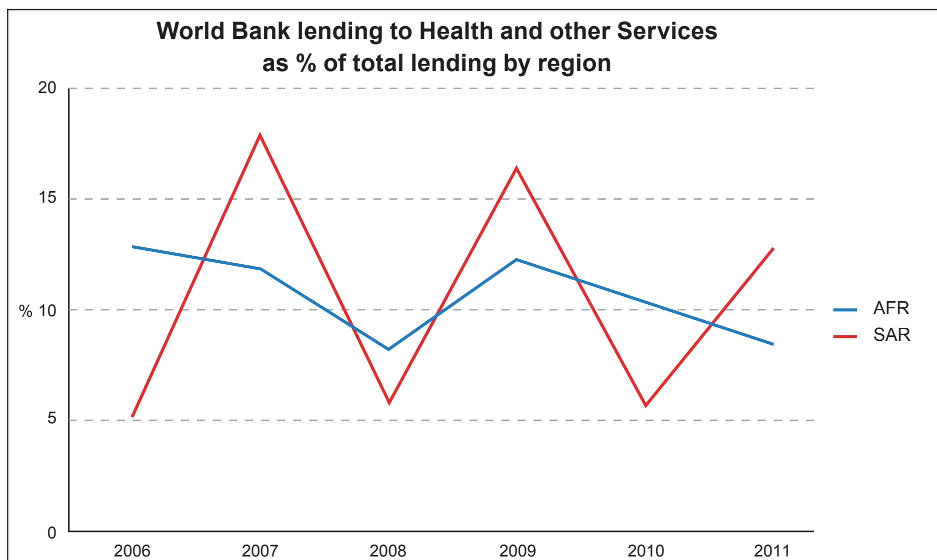
In terms of overall spending on health the Bank has been one of the few to increase support to health through the financial crisis with lending increasing from $2.1bn in 2006 fiscal year to $6.7bn in 2011. However, as the charts below show most of this is accounted for by spending in middle income countries. Lending for health in Africa region increased from $614m in 2006 to $1.18bn in 2010 before falling back to under $600m in 2011. Overall IDA support has increased steadily from $9.5bn in 2006 to $16.3bn in 2011. In terms of poorer regions the share of lending going to health in Africa region has declined whilst that in South Asia region has fluctuated with no discernible pattern. The share in some other regions – particularly Latin American and Caribbean – is much higher and has increased substantially over the period. HRITF flows are relatively modest in relation to overall Bank lending (the Trust Fund is expected to spend, on average, around $30m per annum over its 20 year life – around 5% of spending on health in Africa and around 0.5% of its overall health portfolio.

Figure 10: World Bank lending to health and other services, by region



Source: World Bank Annual report

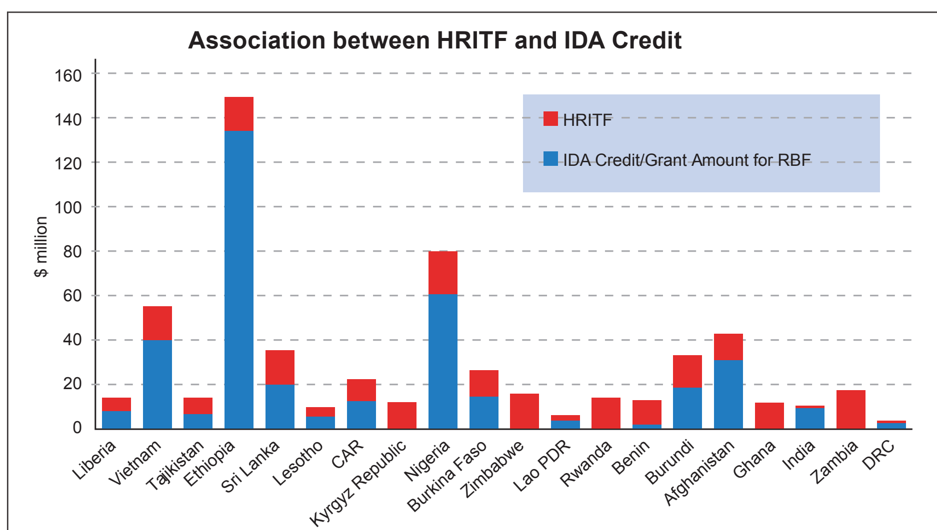
Figure 11: World Bank lending to health and other services, Africa and South Asia



Source: World Bank Annual Report

The HRITF grants are clearly *associated* with other IDA monies (except when the HRITF grant is stand alone). As the chart shows the $209m HRITF grants have been associated with some $363m of additional IDA RBF support. When the stand alone projects are excluded $143m of HRITF grants are associated with the $363m other IDA funding a ratio of 1:2.5. However, this does not imply that the other IDA funding actually *resulted* from the HRITF grant.

Figure 12: Association between HRITF Grant and IDA Credit



Source: HRITF Team (please see footnote[9])

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9 Evaluators consider that this table contains errors. In Rwanda, for example, the $12 million CPG and (approximately) $1.5 million impact evaluation grant were linked to 3 consecutive annual IDA Community Living Standards Grants worth $18 million total – thisa is not accounted for in the graph. In Zambia the HRITF money was always and is still linked to a pre-existing Malaria Booster IDA funded project. That project was restructured and its value went up from $19.4million to $50 million – this is also not showed in the graph. In both cases the IDA grant preceded the HRITF grant..

The 2008 Annual Report stated that “two governments reinstated support for health in the Country Assistance Strategy (CAS) and allocated IDA resources to health to be eligible to apply for the RBF grant funding. The $55 million in grant funding allocated from the trust fund in CY08 is estimated to have leveraged additional IDA allocations for health of roughly $30-50 million”. We were not able to verify these countries. This issue has not been reported on since.

The Trust Fund currently collects information on which IDA credits are *associated* with HRITF grant funds but does not necessarily assess which grants occurred because of the HRITF grants or their size was influence by it. For example we heard from the Nigeria TTL that the IDA credit would have occurred anyway and that the HRITF grant was a welcome addition. This information is not currently shared with donors.

To assess the issue of additionality we requested TTLs to provide us information on the extent to which the explicit link with IDA affected the type and volume of funding to the health sector. We received a response from around a third of them that included examples shown in the box below.

We found some examples where the HRITF grant led to increases in the additional IDA support (Tajikistan). We also found cases where the causality had gone the other way (Ethiopia - where the Government have been reluctant to take RBF forward

Examples from countries on leveraging resources
Would the IDA credit have happened without the HRITF credit?
It is the other way around. There would have been no RBF pilot without the IDA funded host project (Benin)
Probably. The grant was awarded in 2009, at a time when the IDA allocation was already agreed. That said, as the HRITF comes with funding for project preparation and supervision, it creates a huge incentive for our management to allocate IDA to HRITF-supported projects. It was not needed it at this time. (Benin)
It would get approved regardless of the HRITF. It was in the pipeline before HRITF grant was approved. (Sri Lanka)
In Rwanda the three annual IDA grants would have happened anyway
In Zambia the Malaria Booster grant preceded the HRITF application
Would the size or content of the IDA credit have been different without the HRITF grant?
Yes for Tajikistan, the IDA grant would likely have been less than the current $10 million without the extra funds leveraged from the HRITF. And most likely the focus of the project might have been a continuation of traditional investment project without any RBF component, as this would have been impossible to do without the additional HRITF funds both for the project itself as well as preparation etc.
Is the RBF component different to what it would have been without the HRITF grant? (Would there have been any RBF component without the HRITF grant? Or a smaller one?)
Probably not (DRC)
Maybe. The HRITF money was used to design the RBF program in Benin. Without this funding, the design might have been less suited to the context (Benin)
For Tajikistan, most likely there would not have been an RBF component with only the IDA funds.

Are there any other ways in which the HRITF grant supported/influenced the development of the IDA credit or has supported the Bank's programme?
Tajikistan – Funds leveraged from another source (see box below)
The HRITF grant supports the development of the project, which is expected to use a program approach. One of the key deliverables that the Government has indicated in its plan for the HRITF grant is a "results-based health sector plan". Thus the grant is expected to influence the overall nature of the sector-plan, rather than just a few pilots which would explore RBF concepts. But again, it is too early to tell, how far this is really going to happen. (Sri Lanka)

What lending instrument is likely to be used for the credit: Sector Investment, Development Policy Lending or Payment for Results?
Still under discussion. This is a CAS year and the CMU is still debating about the composition of the next portfolio (DRC)
Ethiopia – Country to use P4R – it would have been SIL otherwise
Sri Lanka - We are considering P4R; but it is subject to the approval of Regional Management (as there are limits to the amount of IDA credit that can use P4R in the first couple of years). If P4R is not permitted for this operation, we are likely to use IL with Disbursement-Linked Indicators
Source: Email responses from TTLs to a short questionnaire on leveraging resources

3.6.3 Progress - Leveraging Funds from other sources

The Trust Fund was set up to be able to accommodate other donors, and whilst there may have been some interest, no additional donor has yet come forward. The intention was also to have other donors piggybacking onto existing schemes: progress on this was described to us as "nascent". In practice, it might not make sense to have donors co-finance existing schemes where impact evaluations are in place. Instead, it might be more interesting for the Bank to focus on positioning new donors to fund the scale up effort if the evaluations prove positive.

In Tajikistan the Trust Fund activities have helped leverage funds from other trust funds (see box). In the Kyrgyz DFID had apparently shown early interest in supporting the approach but are now phasing out support in general to Kyrgyz Republic.

Tajikistan: Additional Resources for RBF: The Bank team successfully applied for 2 additional grants from separate TFs to finance work that will complement the RBF activities. The team was able to secure $400,000 from the Rapid Social Response Trust Fund to assess the feasibility of a demand side intervention and also $490,000 from the Institutional Development Fund to support capacity building for the MoH and Finance to effectively implement and monitor effect of health financing reforms including RBF (Tajikistan)

Collaboration with external partners is an ongoing challenge given that in many countries HRITF becomes virtually invisible (and this can be good when considering HRITF as the oil in the wheels of RBF) but can have a downside if

donors are not regularly kept informed by the Bank on what is going on. For WB staff on the ground there is the additional challenge that operational considerations linked to complex RBF designs can easily take preference over communications with other country donors. We saw evidence of the latter in desk reviews and in the Rwanda case study. For example, while donors may have been consulted at the onset of the RBF program they subsequently become uninformed or are not regularly briefed or involved in RBF discussions with the Bank – especially as many TTLs may not have the time to meet with other donors during the rather short and busy World Bank supervision missions or the donors may not be available for meetings. It is difficult and could be counter-productive to define general principles but communication about RBF and HRITF in countries should be improved (as emphasised in the 2011 Donor consultation – point raised by Nicole Klingen – page 4 bottom).

In the case of the Kyrgyz Republic donors have been involved in the design process. The approach has been discussed and presented at the SWAp meetings. As the process has begun to increasingly focus on issues of detailed design there has been somewhat less donor involvement. Some donors reported a lack of feedback from the last virtual appraisal mission. On the whole, though, they have a broad picture of what is going on without necessarily being fully acquainted with the details.

3.6.4 Channelling resources in a harmonised way

The key documents refer explicitly to the need to adhere to IHP principles. Our understanding is that initially, at least, the Trust Fund was seen as forming a core part of the Bank's contribution to the Joint Funding Platform (agreed between the Bank, GAVI and the Global Fund to channel resources in a more harmonised fashion to support systems strengthening). This issue is dealt with in more detail in the review of HRITF Objective One where we focus on the use of national systems. However, we would highlight the case of Benin (see box below) where support from the Trust Fund has been channelled through a harmonised arrangement with a number of other key donors.

Harmonised Support in Benin "The Benin HRITF helped to leverage RBF funding from other donors. Currently, GAVI, the Global Fund and Belgium have agreed (and have started) to fund the RBF program, through a harmonized arrangement (HSS platform). In other words, with a $11 million HRITF grant, the Government managed to mobilize $30 million more from other donors. The RBF principles (as funded by HRITF) were key to convince these donors to jump in".
Personal communication

Our interpretation of this example is not that the TF grant leveraged more resources – GAVI and Global Fund monies would have come anyway – but that the funds were channelled in a more harmonised way than would otherwise have been the case.

Key Messages

- HRITF has, in some cases, leveraged additional IDA monies including from other Trust Funds. In some cases causality appears to have run in the opposite direction.
- It would be useful to have more systematic reporting on this aspect as it is one of the key objectives and has not been mentioned since the 2008 Annual Report
- There has been no success in leveraging additional resources for the HRITF from other donors.
- There have been isolated cases where the TF has worked with other donors to harmonise resource flows.

3.6.5 Sustainability

The issue of financial sustainability is closely linked to the issue of attracting additional resources so is covered in this section. The Trust's Fund approach here has been to engage in dialogue with national governments and donors with the view that they will take over funding at the end of the programme and that this will be built into medium term frameworks and budgets (see box below). There was an expectation that it would develop a "platform" to support sustainable funding for RBF.

> "By the IDA negotiations Government will agree to gradually substitute budget resources for Grant financing for RBF and will include this commitment in the MTEF, beginning in the fifth year of the project".
>
> Original HRITF proposal from the World Bank to Norad in 2007).

Clearly a programme will only be *worth* sustaining if it delivers results in a cost effective manner. Prospects for sustainability are likely to be best if the issue is considered during the design process, the approach is integrated with national planning processes, that costs are modest in the context of overall financing for the sector and that the pilot is implemented efficiently thus keeping down costs (see box). This will require engagement with all potential funders at an early stage and throughout the design process. Whilst Finance Ministries are the main funders in many countries, donors are likely to play a key funding role in some countries for some time to come. This is why sustainability of the RBF requires a proactive engagement strategy right from day one.

It has also been argued that RBF should – in part at least – not necessarily require additional costs. Rather, it is about making better use of existing resources – channelling them in a different way (results based rather than input based budgets, or via consumers).

> "The limited scale of the RBF pilots (up to $15m per country in the first round) and the integration with the national health planning process (implied by working with IHP principles) should ensure that the fiscal impact is manageable".
>
> Source: DFID HRITF Project Memorandum.

Progress

It is too early to tell whether the pilots are likely to be successful, let alone sustainable. The pilots were intended to be substantial and the recurrent costs whilst not huge are also not negligible. The stronger links with Ministries of Finance supported by the IDA linkage (compared to alternative approaches) offer the potential to address sustainability issues in a more effective way but does not guarantee that this will be the case.

It is questionable whether it is realistic for all governments – especially low income countries - to take on the financing burden. We would, therefore, stress the need for long term plans for sustainability based on the country situation rather than assuming all governments can take over funding within a set timeframe.

There are some positive early signs

- **indication of commitment and ownership at the country level:** The RBF pre pilot in Nigeria was initiated using domestic resources with the expectation that the government will be reimbursed from the forthcoming credit;
- **impact evaluations are looking at value for money issues** which should help ensure that recurrent cost implications are lower than might otherwise be the case. In Zambia, for example, the IE is looking at the implications of different reward levels;
- **countries are looking for efficiency savings. I**n the Kyrgyz Republic the MHIF is actively looking for ways to improve its efficiency to increase its fiscal space to support ongoing RBF activities if there is a case for doing so
- **use of national systems:** as discussed in section 3.5.

But there is also a need for sustainability of funding to become much more of an ex-ante consideration i.e. at the time of pilot design and during implementation, where governments and health donors ought to jointly consider possible avenues for future funding. Our impression is that with some worthy exceptions (see an example in the box below) the Bank TTLs have not engaged in a systematic targeting of decision makers and key health donors to keep them informed of progress.

Consideration of Sustainability during the Design Process: Afghanistan

"The MoH, the Bank, and other participating donors have made a long-term commitment to Afghanistan's health sector. As such, we would explore multiple routes to sustaining and scaling one or both pilots if shown to be successful in increasing access to MDG 1b, 4, and 5 health services. For example, the MoF has publicly indicated that it will commit 7% of the Government's budget to health; hence as the economy grows and revenue collection improves, the Government should be able to afford the funded activities. Additional financing will be sought from bilateral and multilateral development partners already in Afghanistan. Excessive concern about financial sustainability might harm the focus on further improving the access to health services, particularly in rural areas".

Source: Afghanistan CPG.

Looking Forward

Greater emphasis should be placed on the issue of transaction costs as part of the impact evaluation to help clearly set out the institutional and financial sustainability challenges - this needs improved documentation of country pilots or/and process evaluations to help fully assess the costs of sustaining RBF approaches.

Key Messages

- It is too early to tell if the schemes are likely to be sustained (or if they are *worth* sustaining).
- There are some positive early indications.
- Close links with Finance Ministries will be important – the IDA link offers the potential for such dialogue to take place – though there is no guarantee that this will take place and result in additional funding.
- Domestic resources are unlikely to be sufficient in some settings.
- It will be important to focus on aspects such as transaction costs in the IEs, as these have a bearing on future sustainability.

4. Project Implementation, governance and oversight arrangements

4.1 Linking HRITF country pilots to International Development Association (IDA)

The Approach and Rationale

The Trust Fund is designed to provide RBF grants linked to IDA credits which can either be a new pipeline project or a restructured existing IDA-supported HNP programme (retrofitting). The link was made more explicit by the decision in September 2010 to set specific co financing requirements. In order to be eligible for HRITF funding the input-based and other non-RBF financing should not exceed 90% of total project financing. Of the remaining 10% or more that is RBF, CPG funding can be provided for up to 80% of RBF in the IDA project (up to US$15 million), in addition to the IDA amount.

By linking the HRITF grants to IDA credits the aim was to bring the full weight of the Bank's resources, processes and procedures to bear on the Trust Fund operations. The proposed advantages of this approach – set out in the 2008 Annual Report - are set out in the box below.

Implications of the IDA Link

Grants are designed and managed within the larger development and health portfolio ensuring that each grant is aligned with broader reforms and development policies under discussion between the World Bank and the Government, particularly the Ministries of Finance and Health.

The trust fund grant is prepared and supervised within the Bank's operational framework ensuring regional and country management oversight and rigorous design and implementation support. Because the trust fund provides incremental preparation and supervision funding, country teams can more easily take on the additional burden of managing the grants.

The trust fund grants help Bank staff coordinate multiple partners and engage Ministries of Finance, Planning and other critical sectors. Since the trust fund structure leverages IDA it can help ensure a continued or enhanced Bank presence (including staff) in a country's health sector

Source: 2008 Annual Report

This approach was designed to avoid problems experienced with some trust funds where grant funds simply substituted for IDA resources, and/or quality suffered as projects were designed and implemented separately from IDA operations. The Health Results Innovation Trust Fund explicitly requires that its grants are linked to existing or new IDA operations (with specific eligibility criteria). It also provides funding support to prepare and supervise the grants

requiring that this funding is additional to the Bank budget allocated for the IDA operation in question.

While setting co-financing requirements and ceilings is welcome there are instances when the principles should be applied flexibly and take account of the circumstances (such as the size of the country and IDA grant, the levels of poverty, etc.). For example, in a large IDA grant a 10% to RBF may be perceived as a lot of money to be locked into what the government may perceive as just an experiment, and the 10% might surpass the $15 million ceiling.

4.1.1 Bringing the Banks "full machinery" to bear

The core World Bank team working on RBF is small – to date it has managed quite successfully the large work program by engaging specialized staff from across the World Bank Group, and especially in the front-line operational units. Operational staff colleagues have increasingly integrated the RBF work into their core work programs and dedicating time to support national, regional and global demands on RBF.The core team has also leveraged time and expertise from non-health units in the Bank to contribute to the RBF work program. This includes the Bank's core research group, the World Bank Institute, the Global Development Learning and Network unit, the Global Program on Output-based Aid, and the Chief Economist's office'. HRITF Annual Report 2008.

The aim of the link to IDA was to make the best use of Bank's resources particularly in areas where they hold a comparative advantage. These were spelt out in detail in the Bank's recent HNP Strategy:

- technical capacity in health system strengthening, including its potential capacity to disseminate country experience with alternative innovations and reforms;
- its multi-sectoral approach to country assistance, which allows it to engage at national and sub national levels with all government agencies (but particularly Ministries of Finance);
- its capacity for large-scale implementation of projects and programs (including its financial management and procurement systems for extensive operations);
- its multiple financing instruments and products;
- its global nature, allowing facilitation of interregional sharing of experience;
- its core economic and fiscal analysis capacity across all sectors; and
- its pervasive country focus and presence.

(Source: Comparative advantages of World Bank as set out in HNP Strategy)

It should be noted that the donors funding HRITF can and do fund RBF initiatives outside the Trust Fund.

4.1.2 Importance of the IDA Link - Strong links with Finance Ministries

It is challenging to measure the impact of the link with IDA especially at such an early stage of the programme. However, we reviewed experiences of other similar approaches which did not formalise the IDA link – notably the Fast Track

Initiative. The extracts from the FTI evaluation – box below – highlight some of the shortcomings of not tying the approach to IDA. These relate mainly to the failure the engage effectively with Finance Ministries.

FTI Evaluation: Implications of Not Tying to IDA Process
Various factors were found to have limited the influence of the FTI processes on domestic budget allocations. These included a lack of engagement with Ministries of Finance and national Medium Term Expenditure Framework (MTEF) processes, and the choice of projects or pooled funds as aid modalities. There are some notable exceptions where the FTI has had a positive influence on domestic budget allocations, in particular when the (financial support) has been provided through sector budget support and Ministries of Finance have been actively involved.

Despite the requirement that countries have a PRSP as a pre-requisite for FTI endorsement, FTI processes (appraisal, endorsement, CF funding) have tended to focus principally on education sector entities and specialists, both within governments and within donor agencies. Finance ministries and other ministries (e.g. in charge of civil service reform), as well as macro and finance specialists in aid agencies in general, have not been sufficiently involved in FTI-related processes.

Both at global level and in-country it has mostly involved education specialists – typically those handling agencies' education portfolio and, in-country, the Ministry of Education. It has had less interaction with in-country Ministries of Finance, and with the macro-economists and generalists of aid agencies, than might have been anticipated from the original design.

The FTI has not been successful in strengthening the links between education sector specialists and macroeconomists. At country level there is commonly a strong relationship with the Ministry of Education and a much weaker one with the Ministry of Finance, although the latter has much more influence over the long term financing of education. Within donor agencies there is often much too little interaction between the education specialists and the staff responsible for budget support, although education as a sector is often a major beneficiary of budget support.

Source: FTI Evaluation

Evidence from case studies suggests that the TF has been successful in establishing strong relationships with Finance Ministries. In the Kyrgyz Republic, whilst the HRITF grant is a standalone operation, the requirement that Government increases the share of the budget going to health under the SWAp has formed a key part of the ongoing policy dialogue and is seen as one of the key preconditions of supporting the pilot.

However, the IDA link does not necessarily guarantee good follow up of the HRITF component, particularly if the IDA grant expires but the HRITF support is expected to continue supporting an RBF design or pilot, in which case there is a risk that HRITF-linked technical and documentation support might be stopped far too early, as reported in Rwanda. Much depends on the engagement by the TTL with the government of the recipient country (not just the Ministry of Finance but the Ministry of Health too) or, failing that, on the ability of the HRITF Team to

closely oversee that the end of the IDA does not lead to end of the HRITF oversight by the Bank.

Key Messages

- The IDA link offers the potential to improve the effectiveness and wider impact of TF programmes – especially through the links enjoyed with Finance Ministries
- But the IDA link does not necessarily guarantee good follow up of the HRITF component, particularly if and when the IDA grant expires before the HRITF does, in which case the TTL, the HRITF Team or both should closely oversee that HRITF continues to deliver technical and documentation support.

4.1.3 Leveraging other Bank Resources

The Approach

Given the Bank's matrix organisational structure in which those designing and implementing the RBF do not report to the HNP Unit (Anchor) which hosts the Trust Fund the HRITF Team plays a brokerage role with the Task Team leaders as their clients.

The linkage of HRITF grants with other HNP IDA programmes, and with funding from other agencies, is expected to demonstrate to a wide range of Bank and other agency staff how the RBF approaches can be linked to and improve results from more traditional approaches. It should help to convince those responsible for design of future programmes that the RBF approach has something to offer, as well as giving them direct experience of how to apply these mechanisms to complement other funding mechanisms. This should help to achieve the intended catalytic effect of building RBF into future health sector support (beyond the HRITF).

Source: World Bank, HRITF Annual Report 2010 – 2011.

Progress

We identified some examples of instances where leveraging has taken place. Some examples are captured in the boxes below - potential leveraging in relation to the P4R instrument is discussed after the boxes, in 4.1.4.

"Operational staff colleagues have increasingly integrated the RBF work into their core work programs and dedicated time to support national, regional and global demands on RBF. While challenging to manage, engaging operational staff has strengthened the work of the core team, built interest in and support for RBF interventions across the Bank and, most importantly, delivered the highest possible quality product to our client countries."

Source: Personal communication from a HRITF team member.

"We have tightened our links with Africa regional management, developed joint work programs and assigned members of the RBF team to work on, or engage with, each of the pilots. This arrangement is now working satisfactorily".

Source: HRITF Annual Report

Significant leverage of wider Bank resources – the Nigeria experience: The operation has received very substantial inputs and attention from the Country Director and the Sector Management i.e. 'it seems the Africa HD region 'own' RBF' as well as both very substantial additional preparation funding and 'free' technical assistance with a lot of experience in setting up RBF at facility level. This has clearly supported the planning of the combined IDA and HRITF operation.

4.1.4 Additional Consequences: Development of P4R Instrument

Although not explicitly referred to in the project documents the key donors have been keen to work with the Bank to strengthen its results focus. In the past the Bank has been rather limited in what it can do because of the inflexibility of its existing instruments (see box).

The Bank's ability to meet this demand (for a more results based approach) has been constrained by the limitations of its existing investment lending (IL) and development policy lending (DPL) instruments. Neither instrument fully allows supporting a government program of expenditure, building institutional capacity, and tying financing to achievement of results.

Source: P4R Board Document 2011

The Bank has recently introduced a new instrument – P4R (Programme for Results) which should help the Bank sharpen its results focus. Whilst the development of this instrument cannot be attributed solely to HRIFT activities, the P4R team reviewed the Bank's experience with RBF across sectors and found the experience in health to be particularly relevant, so it seems clear that the TF played at least some role (see box below). Going forward the P4R instrument offers those implementing HRITF activities an additional choice of implementation modality. It is expected that P4R will be used in Ethiopia and it is being considered elsewhere – although the plan is to use P4R in a limited way throughout the Bank in the short term in order to learn lessons on its effectiveness before scaling up more rapidly. At the same time RBF might not be suitable for some RBF approaches such as pure Cash on Delivery where fiduciary requirements are lower.

"The design of the Program-for-Results instrument benefited from the invaluable experience the Bank has gained in designing and implementing IL and DPL operations: specifically, technical and design issues, results definition, fiduciary systems, environmental and social impacts and risk management, and improving policy environments. It also built on decade-long experience—both within and outside the Bank—with sector-wide, program-based, and results-focused operations".

Source: Key informant

4.1.5 Adverse Consequences

We found cases in which strict adherence to the IDA planning cycle resulted in some delays – where an independent approach might have resulted in a more rapid approach, although the evidence for this includes mainly the Round 1 and

Round 2 countries where Bank systems were unprepared to house a new programme linked to a different way of working and measuring results.

Key Messages

- The IDA links bring potential benefits as well as costs – both intended and unintended. The Bank's strength in building links with Finance Ministries will be important but it will also need to engage with in-country donors. The Bank's systems and process are not intended for rapid implementation.
- Disbursement has been relatively slow – but evaluators are not sure how the rate of HRITF disbursements compares to Bank programmes as a whole. RBF is relatively new, is complex with multiple decision points and requires considerable dialogue the scale of which was underestimated at the outset.
- Disbursement delays have occurred for a number of reasons including external factors – however, the link to IDA appears to have been responsible in some cases. Such delays have in some settings caused considerable frustration and risk undermining ownership of the projects. Expectations at the outset appear to have been unduly optimistic.
- HRIFT activities have played some role in the development of the P4R instrument. P4R offers implementers an additional choice of instrument – and potentially a means of ensuring a greater results focus in the Bank's work – though its scope is set to be relatively limited in the short term.

4.2 Progress reporting

4.2.1 Reporting requirements: have they been met?

The Bank is required to submit an annual report to donors no later that 30th April each year outlining the work and activities undertaken during the previous calendar year with a focus on country progress. It should include a work plan for the following year's activities. The Bank is also required to give a midyear update no later than October 31st of each year to include actual expenditure by category over the previous 6 months.

Reporting on all components of progress is challenging. The Trust Fund is demand led and therefore already subject to considerable uncertainty. The technical content of the activities is also new and with no track record it is difficult to project requirements with any great degree of accuracy. We would also highlight the fact that a further dimension of uncertainty will be added as the pilots begin implementation – the extent to which the recipients of the rewards are able to secure the rewards on offer. That said we did identify a number of shortcomings in current reporting arrangements which need to be addressed.

Progress reports have been provided as set out in the Grant Agreement.

- World Bank Annual Report on the Health Results Innovation Trust Fund for the Period January 1, 2008 – December 2008
- No report submitted for the period between December 2008 to June 2009 though the World Bank did provide a progress report to the Government of Norway in August 2009

- Annual Report June 2009 – March 2010
- Mid-year April 2010 – November 2010
- Annual Report to Donors April 2010 – March 2011
- Mid Year Update to Donors November 2011
- Work Program July 2010-June 2011.

The approach to annual reporting has evolved over time as different HRITF managers have taken different approaches but, generally speaking, reporting has been based on the 9 HRITF activities and, more recently, it has used the three HRITF Funding Streams.

Progress to date

Annual reports do "outline the work and activities undertaken during the previous calendar year with a focus on country progress". They are well written and are highly informative. Only one year (July 2010-2011) was a work plan included, although annual reports have provided "indicative forecasts for expenditure by category over the following 12 months". Mid-year updates "no later than October 31st of each year to include actual expenditure by category over the previous 6 months" have been provided, although it is not clear that these were provided on time.

The annual report does not reflect progress in some key areas. For example, the issue of whether the Trust Fund is leveraging additional resources for health has not been discussed since the initial 2008 report. As a result this issue has been little debated and there is now some lack of clarity on what it actually entails. At the same time donors have been requesting ongoing information on impact which the Trust Fund is not, and was not set up to deliver. Though it is possible to "harvest information on numbers of lives saved" this was felt to be "incredibly difficult and contrary to business model ". While evaluators understand the requirement for donors to demonstrate results, the focus of this programme is on knowledge generation and this is what should drive the results framework rather than lives saved.

Reporting imposes a very heavy burden on a rather small HRITF Team. Members of the HRITF Team met by the evaluators reported that the Annual Report and Mid-Year report represented a heavy burden on staff with preparations beginning up to 4 months in advance. The burden is seen to have become heavier over time, with the programme growing rapidly, faster than the installed capacity at HRITF Team level. This is partly a reflection of the novelty of the approach and the (welcome) interest this raises which result in additional request for information, the relatively early stage of implementation and the growing range of activities supported by the Trust Fund. Donors report that the HRITF team have been responsive and that they believe the quality of reporting has improved. At the same time donors found that although the reports were useful they did not give a good overall sense of what had happened.

Proposed way forward
For a programme focusing on results we feel that the current reporting approach is too activity and input focused, although we recognise that the Grant Agreement requires the Bank to do this. While activity reporting may be informative it fails to answer the crucial question of whether and to what extent the HRITF programme is meeting its objectives. This is why our evaluation of reporting cannot be separated from the need for a more clear, consensus-based, realistic and measurable results framework for the entire RBF programme, discussed earlier.

We would propose that changes are made to accommodate the following changes:

- The Annual Report should report progress against the four key objectives including the (yet to define) specific results and indicators. There is no reason why the length of the report should increase just because the amount of activity has changed. In fact, the reporting against the pre-defined activities could be included either in the annex or as part of improved financial reporting (see later). It must be emphasised that in a large programme like the HRITF the multitude of activities being undertaken worldwide could easily mask a more thorough assessment of progress – many activities are encouraging, but are these the right activities and are these being implemented in the right way, as per HRITF objectives?

- The annual reports should more clearly state whether the HRITF is on track on each objective and provide supporting evidence/arguments for the same. Evaluators feel that this would be much more easily done if the Bank adopted the routine of presenting an annual work plan linked to its annual report (following the trend initiated in the July 2010-June 2011 work plan – see Box 7), and if the said work plan focused on areas where improvement is needed or increased attention required.

- Annual reports should include a specific section on issues linked to delivering the previous year´s work plan and on issues emerging from the previous year´s donor consultation. The argument that evaluators heard at times that work plans are difficult to put in place because this is a demand driven programme simply does not hold. For example, it should be clear at the beginning of the work plan year if there is going to be a call for proposals for the funding streams.

- Annual work plans do not need to be exceedingly detailed: Will there be rounds called? Will any pilot RBF be completed or IE end-line results delivered, and will that merit additional attention? How will global knowledge and evidence analysis and studies be linked to national documentation? Etc.

- Evaluators wish to suggest that a single annual report should replace the current annual AND mid-year reporting. The main reason, self admitted by some interviewees from the funding donors, is that that there does not seem

to be much point in producing a mid-year report that to a large extent tends to repeat or increase a little bit the information already provided in the annual report. For the relatively small HRITF team one less reporting need would free valuable time to be devoted to programme implementation – a message that was kindly delivered to the evaluation team during their visit to Washington.

- There is an alternative to a half-year report which is a short mid-year review of progress and actions taken on the decisions made during the annual donor consultations. This could be a very short report that the HRITF manager should be able to prepare quite easily highlighting the main steps taken.

Box 7 – The July 2010-June 2011 Work Programme
The only example of an annual work plan (called work programme) that the evaluators could review was the July 2010-June 2011 one. Apparently this was in response from a specific request made by a member from the funding partners. While the effort is noteworthy the following observations can be made:

The work plan reports by activity – donors may struggle to appreciate the link between a large number of activities planned and their contribution to each of the four project objectives (same issue as annual reports).

The work plan does not seem to link in any manner to issues raised in the previous annual report: is the work plan taking those issues into account?

The work plan makes an attempt to report against the DFID log frame. This is clearly challenging as the template is very different to the ones used in the annual report and mid-year report. There is no discussion on whether this form of reporting is possible or meaningful given that many boxes are left empty or under-reported or attribution seems to be an issue. Besides, if this is a work plan why include additional reporting on past rather than focus on next year? And can one realistically take some of the assumptions for granted rather than reviewing if these have indeed taken place as planned?

Key Messages
- Reporting is too activity focused – making it difficult to see the bigger picture.
- There is scope for improving the quality of annual reports and for better linking these to annual work plans .
- Annual reports and work plans should be sufficient for reporting purposes – the case for a mid-year report is hard to see.
- Work plans are essential for such a large program as HRITF, in part because of the risk to commit to too much with insufficient human resources at the level of the HRITF team.
- Financial data have not been presented in a consistent manner nor in a way which allows performance to be assessed.
- Expenditure planning (forecasts, scenarios)– though very challenging – has been weak and has not been much strengthened to date.
- The reporting burden is too heavy and should be streamlined.

4.2.2 Coordination with Donors

According to the Administration Agreement for the TF donors and the Bank are required to meet once a year after submission of the annual report. The meeting is to be held on a mutually agreed date and be organised by the Bank. Key issues for discussion were expected to include:

- key achievements,
- issues identified during the year and proposed mitigation,
- a qualitative assessment of progress against RBF indicators at the country level,
- assessment of the Trust Fund performance and budget execution,
- strategic direction for the Trust Find and the proposed annual work plan,
- preliminary annual; allocations and a reviews and
- an assessment of criteria used to identify countries for support

The results were to be reported in agreed minutes.

Progress

The Annual Donor Consultation is felt to be an increasingly useful exercise. There was a feeling that the onus was on donors to ask questions rather than the HRITF Team raising issues although, at the same time the HRITF Team were being responsive to what donors were asking for. Some members from the donor agencies who had attended at least one donor consultation meeting reported that while meetings were highly informative they did not necessarily cover all or most of the key issues above in a systematic manner. For example, it was felt that the link between annual reports, the annual work plan (the first one was only delivered for 2011 – so progress on it has not been reported yet) and the annual donor consultation meeting should be strengthened. It was also felt that there should be improved keeping of minutes on key issues raised and decisions made in a very executive manner, for easy follow up and reference.

It was felt that the agenda was often very ambitious and that it was not always possible to get a good overall sense of what was happening. One donor interviewee accepted that they needed to pay more attention and engage more actively in the run up to the meeting.

Looking Forward

Clearly this is an important programme which donors are investing significant amounts of money in. It is important, therefore that donors are well appraised on ongoing issues but that this is done in a streamlined way which keeps the burden to a minimum. We propose a number of approaches designed to improve reporting (see above) whilst minimising the burden of reporting.

The annual work plans linked to the annual reports should capitalise the dialogue between the Bank and its funding partners during the donor consultation meetings. It is also suggested that donor consultations should become a more structured process where annual report and work plan are discussed and then approved or modified accordingly. It should be better minuted focusing on key issues raised and decisions made.

4.2.3 Financial Reporting

A range of financial information has been provided in the various annual reports as set out below.

World Bank Annual Report on the Health Results Innovation Trust Fund for the Period January 1, 2008 – December 2008
Programmatic Financial Report presented. Includes a breakdown of spending by type of activity, investment income and Trust Fund fees though it is not clear how Trust Fund balance is arrived at. No forecasts are presented.

Annual Report June 2009 – March 2010
Financial Report provided. It does not cover calendar year - no work plan or indicative forecast for expenditure by category provided for following 12 months. It provides data on disbursement by activities to date (March 31). Also provides information on investment income and information on current Trust Fund balance though it is not possible to see how this was derived. The administration fee expenditure is mixed in with Trust Fund management expenditure.

Mid-year Update to Donors April 2010 – November 2010
HRITF Financial Report presented showing figures as at November 15, 2010 (US$). Forecasts of spending are provided for the period November to December 2010 and for following years not just the next 12 months by country and activity.

Annual Report to Donors April 2010 – March 2011
HRITF Financial Report presented showing figures as at November 15, 2010.
It provides data on actual spending to March 2011 with estimates for the period April to December 2011 by country and activity. It provides forecasts for spending to calendar year 2022 covering the full amount of the TF grants ($575m). It provides data on expected contributions from donors.

Summary: Data has not been provided fully in line with the requirements set out in the Grant Agreement. Reports have not been provided within the time frame set out in the Grant Agreement[10] and have not covered the period set out in the Grant Agreement (though no-one has suggested that this presented any great problem). Forecasts of future spending have been set out for the full period of the Trust Fund by activity and country (though not by category as set out in the Grant Agreement) but it is not possible to compare forecast expenditure with actual expenditure. Whilst the progress reports indicate why disbursements in some areas have been delayed, this is not done systematically.

Predicting Future Requirements. As noted above the various activities supported – and especially the RBF pilots - pose much greater challenges to financial planning than the standard five year investment lending project cycle. Whilst the concept notes do set out estimated funding needs, they do not form a basis for projecting resource requirements.

10 We infer this from the fact that the financial data for some of the reports is presented up to a date after the report should have been submitted

The timeframes were also significantly underestimated. In the initial stages of the Trust Fund operations the HRITF Team tended to rely on TTLs for their estimates of funding needs. These often proved to be highly ambitious. The HRITF Team have taken steps to develop a more systematic approach to linking required disbursements to the individual project timetable although much of the impact of this, if any, will have been felt outside the timeframe of this evaluation.

Real Time Reporting: Use of Secure Donor Website. We understand that the Norwegian MFA has made use of the secure Donor Website and found this helpful although it was suggested that the information was not always up to date. DFID did not report accessing this source.

The way forward

Financial reporting (linked to improved financial forecasting) is another area where improvements are desirable. As part of annual reports the HRITF Team could usefully provide a table showing the results which will be purchased if the supply response is sufficient to utilise available resources. This would be a one off exercise but should be updated as new pilots are confirmed. Donors could use this information in various ways to, for example, estimate impact on health outcomes.

We would also expect that the HRITF Team should report on results paid for in each of the pilots as such payments are made. Given the uncertainty about the supply side response (by this we mean the recipients of funds – could be beneficiaries under a demand side approach or a health provider under a supply side response) the Team might like to give some thought to how to respond to under-spends i.e. a failure of agents to achieve desired results. Should the pilots be rolled over i.e. extended? Would the funds be available to pump prime any scale up? If the money is not spent, will there be a case for scale up? Should any savings be channelled to the agents who exceeded their targets? (see the box below for the new GAVI approach). Should the HRITF Team over commit across its portfolio in the expectation that there will be under spends?

GAVI – New Performance Based Funding Approach:
Under the new approach approved by the Board in November 2011 any savings from countries which do not achieve the results necessary to achieve their indicative allocations will have their under spends recycled and made available to countries with lower coverage rates who perform particularly well.

In our view it would be helpful if a revised reporting format could be developed which sets out:

- the cash flow situation of the Trust Fund – clearly outlining revenues (investment income and donor contributions) and expenditures (by activity and by country)
- forecasts to be provided by activity and country by calendar year with a comparison of the previous year's expenditure with the actual one. Major discrepancies should be identified and a brief explanation noted.

Much of this is already in place but not yet incorporated into regular reporting.

The sector Donor Website should be advertised more actively among the donors agencies and made more easily available for external evaluations like this. If donors are interested in might be useful to run a short session on its use.

4.2.4 Financing HRITF – spending the money

Our analysis is based on financial data presented as part of the Annual Reports or mid year updates, through limited access to the secure donor connection and from data prepared by the Secretariat. Although the evaluation covers the period to the end of March 2011 we also present later information given its availability and the fact it provides useful data on trends which we affected by decisions made before March 2011.

Donor Contributions to HRITF

The 2008 Annual Report showed that Norway had contributed $43.9m and that, at the time, it was expected that further contributions of $15.8m would be required in 2009, 2010 and 2011. By March 2011 Norway had disbursed $83m and DFID $10m of their overall commitments (set out in table 13) below.

Table 13: Donor commitments to HRITF

Donor Name	Contri-bution Date	Contri-bution Currency	Contri-bution Amount	USD Equivalent(1)
United Kingdom - Department for International Development (DFID)	04/28/2010	GBP	114,000,000	182,934,027
Norway - Ministry of Foreign Affairs	12/04/2007	NOK	586,000,000	105,741,303
Norway - Ministry of Foreign Affairs	12/04/2009	NOK	1,500,000,000	260,793,372

Source: Secure Donor Website. (1) As at April 25th 2012 exchange rate

Expenditure to Date

By October 2010 the Trust Fund had spent some $16.57m (HRITF Financial Report 15/11/2010). This had increased to $22.61m at the end of the evaluation period (end March 2011). Since March 2011 there has been a major take off in spending. Total expenditure had almost doubled to some $45.5m by May 2012.[11] Spending data can be broken down by activity and economic classification as shown in the following table and chart.

[11] Source: Secure Donor Connection data collected May 2nd 2012

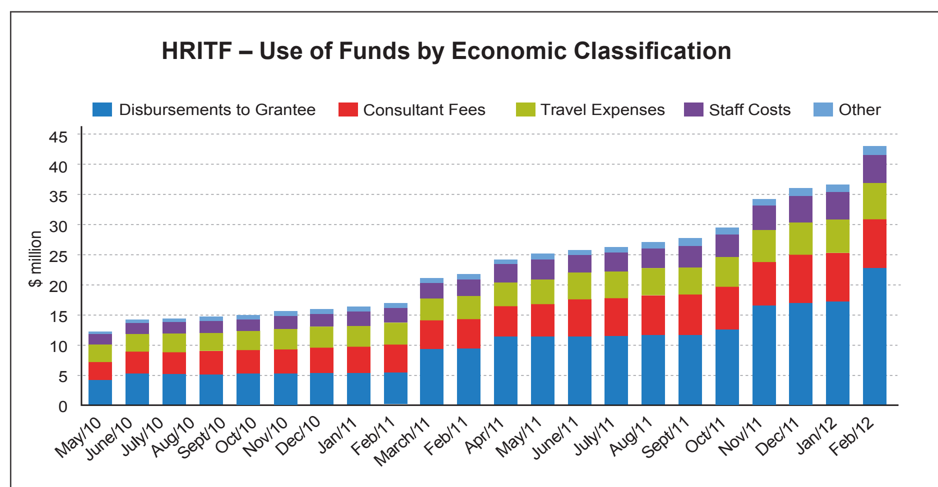
Table 14: Expenditure of Trust Fund by activity to March 2011

Activities as per the HRITF Administration Agreement	Actual 2008 - March 2011	%
1-Preparation and Review of Proposals	0.69	3.1
1a-RBF Seed Grants	0.41	1.8
2-Design of RBF Projects or Project Components	0.24	1.1
3-Preparation and Appraisal of RBF Projects or Components	3.56	15.7
4a-Implementation of Bank RBF Projects or Project Components	9.20	40.7
5-Supervision of Bank and Recipient-executed RBF Projects or Project Components	0.09	0.4
6-Monitoring and Documentation of Bank and Recipient-executed RBF Projects or Project Components	-	-
7-Evaluation of Bank and Recipient-executed RBF Projects or Project Components	2.15	9.5
8-Dissemination and Knowledge Sharing	5.33	23.6
9-Trust Fund Management and Administration	0.17	0.8
Admin Fee (0.83% of total contributions)	0.77	3.4
	22.61	100.0

Source: Annual Donor Report 2011

Table 14 shows that implementation of the pilots accounted for over 40% of spending at March 2011.

Table 15: Use of funds by economic classification



Source: Secure Donor Website: Monthly Expenditure Statements

In terms of economic category programme costs disbursed to the grantees (to implement the pilots) now accounts for the majority of overall spending. As shown in the table below its share has been growing at the expense of other cost components.

Table 16: Proportion of expenditure by spending category

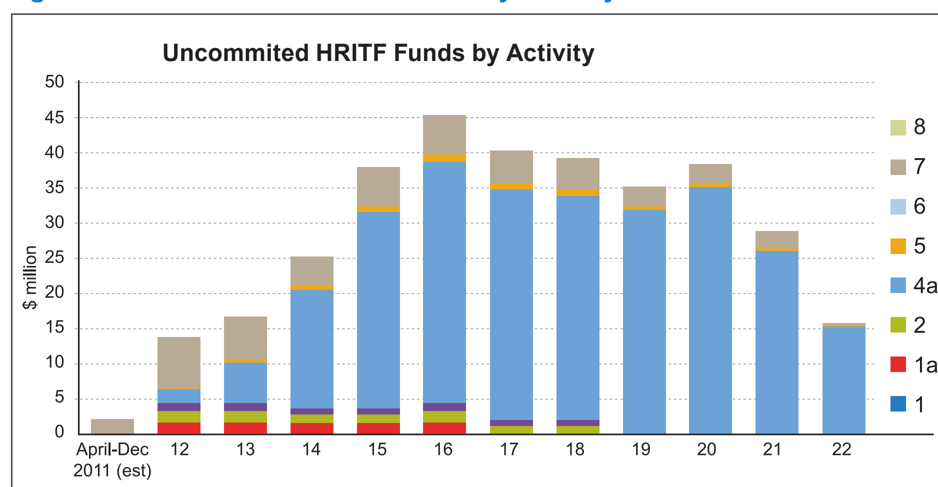
	Cumulative to end March 2011 (Evaluation Period)	Cumulative to end February 2012 (Post Evaluation Period)
Disbursements to Grantee	43.2	53.1
Consultant Fees	22.7	19.1
Travel Expenses	17.3	13.6
Staff Costs	13.2	11.0
Other	3.6	3.1
(excludes administration costs)	100.0	100.0

Source: Secure Donor Website: Monthly Expenditure Statements

Committed Funds

A substantial share of available funds have not yet been committed[12] suggesting there is still considerable scope for changing the allocation of resources within categories. Figure 16 below maps out the amount of funding yet to be committed by year and by activity (activity categories are set out in table 14). The vast majority of uncommitted funds relate to activity 4a – implementation of the country pilots. As at December 2011 45.6% of donor commitments had yet to be programmed.

Figure 17: Uncommitted HRITF funds by Activity

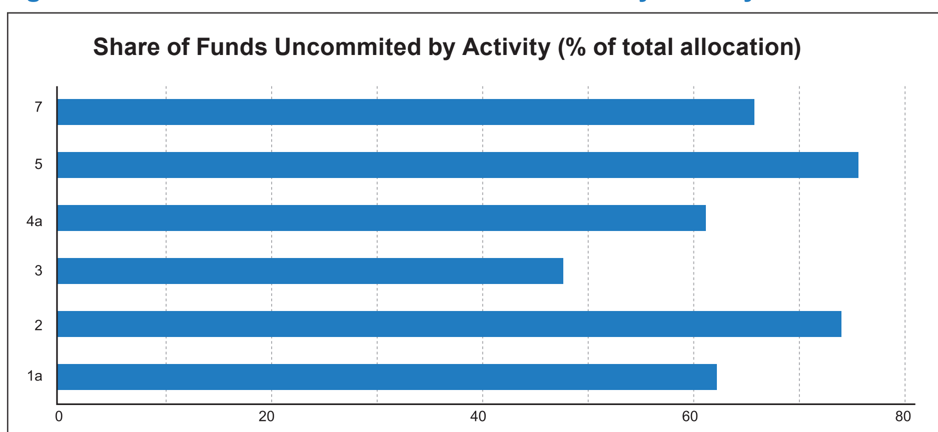


Source: April 2001 Donor Report. Activity categories from Table 14

As shown in figure 18 below there is variation in the degree of commitment by activity. Just over 60% of the allocation for implementation of the pilots had been programmed

12 Funds have been allocated by activity but not necessarily committed to countries *within* the activity. Such amounts are referred to in the Annual Report as TBD. It is not possible to identify this figure for activity 8 where spending is referred to as global

Figure 18: % Share of HRITF funds uncommitted by Activity

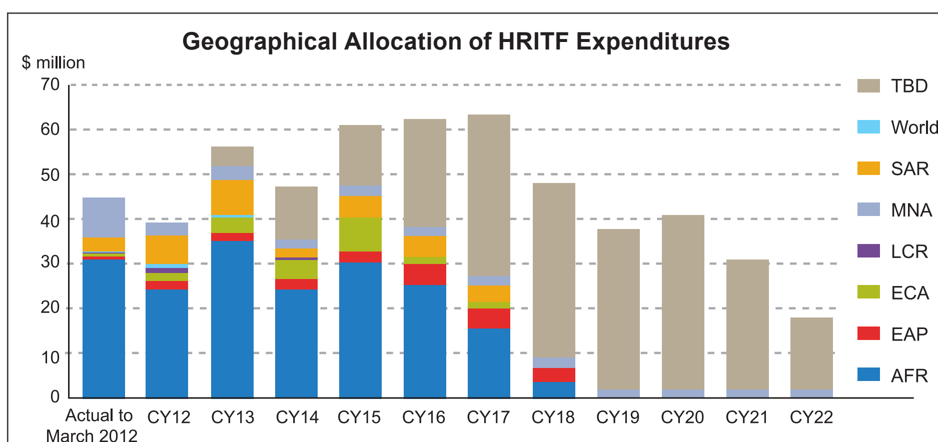


Source: April 2001 Donor Report. Activity categories from Table 14

Geographical Focus

As shown in the chart below the majority of funds have been spent in Africa and South Asia regions. Expenditure on the latter is expected to pick up in 2012. Of resources spent and programmed to date 62.6% are for Africa, 11.3% for South Asia and 10.6% for global activities. This appears broadly consistent with donor wishes to focus efforts in poorer regions.

Figure 19: Geographic Allocation of HRITF Expenditure



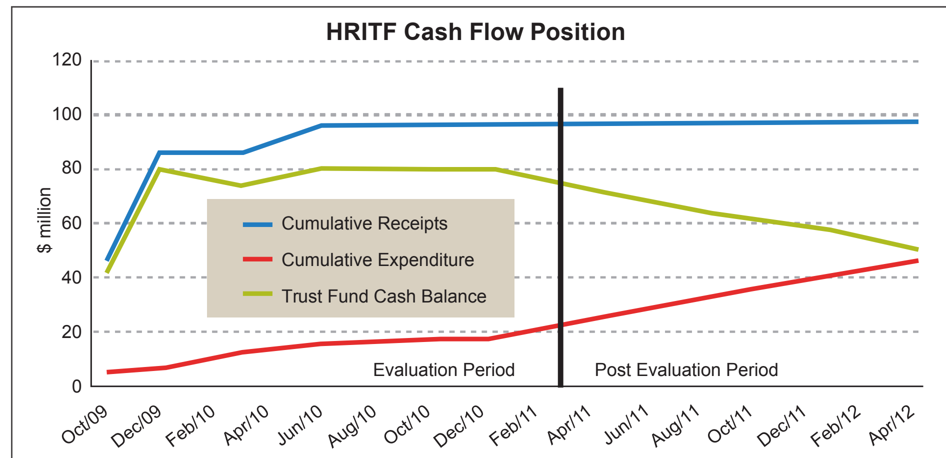
Source: Donor Report 2011. Key: TBD: To be determined, SAR = South Asia, MNA = Middle East and North Africa, LCR = Latin America and Caribbean, EAP – East Asia and Pacific, AFR - Africa

Cash Flow

Donor disbursements were shown earlier in table 13. No further disbursements were planned for 2011. Disbursements of between $55m to $65m per annum are expected between 2012 and 2016 with disbursements tailing off thereafter and ending in 2021. The balance held by the Trust Fund at the end of the calendar year was expected to remain at or above $30m until 2016 after which it is expected to decline. The Trust Fund also receives income from investing its cash balances. These are discussed later.

Figure 20 presents data on cumulative financial flows: it shows that the Fund has been holding large cash balances. This was due to large initial donor disbursements and lower than expected expenditures.

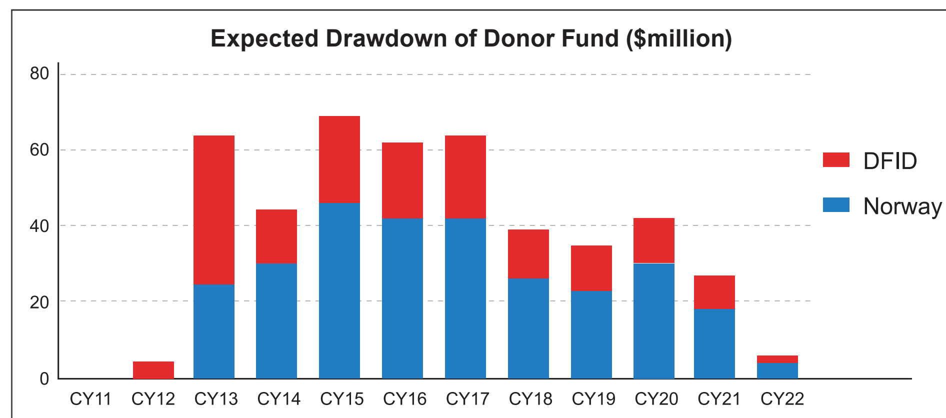
Figure 20: HRITF expenditure and revenue flows



Source: Secure Donor Website: Monthly Expenditure Statements

The Trust Fund cash balance remained at just under $70m at the end of the period considered by this evaluation – but has since reduced considerably. The Bank proposes to hold a buffer of 12 months of spending and anticipates drawing down some $4m this financial year suggesting that the balance is now down to an ideal operational level. Current expectations for future draw downs of donor support are set out in table 21 below. The issue of the Trust Fund holding an excessive balance appears now to have been largely resolved.

Table 21: Anticipated drawdown of HRITF funds from donors



Source: HRITF team

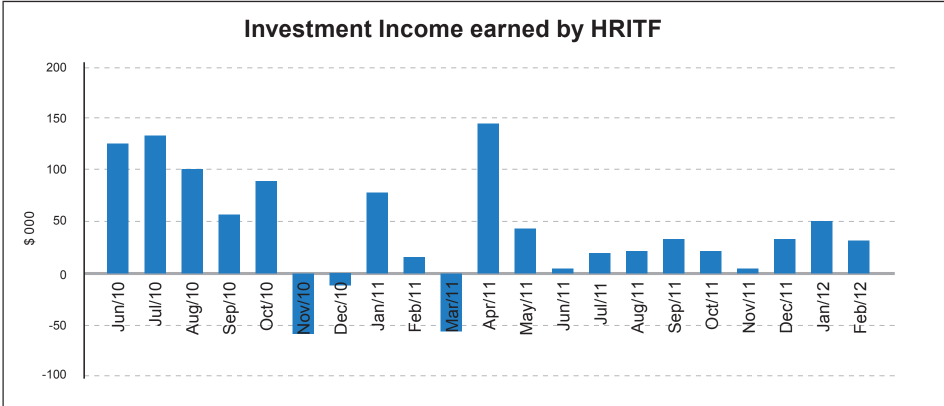
The Trust Fund clearly needs a cash balance to support its expenditures. The Trust Fund Administration Agreement makes no reference to the level of cash balances the Trust Fund *should* hold. The volatile and rather unpredictable nature of Trust Fund expenditures is one rationale for a substantial cash balance. Given ongoing donor concerns of paying in advance of need the HRITF team should justify its current 12 month cash balance policy - in terms of a) operational requirements of HRITF and the implications of not having a 12 month balance b) approaches the World Bank uses for other Trust Funds - at the next Annual Donor Consultation. In presenting projections about future expenditures and donor drawdowns the HRITF team should also express the projected cash balance as a proportion of expected expenditures.

One result of the early drawdown of donor support has been that the HRITF has received payment to cover its administrative expenses at an earlier date than might have been necessary. HRITF is entitled to receive 0.83% of donor contributions but it entitled to claim actual costs for a further 0.17%. The Bank should give early notice if it believes it will be making additional claims.

Investment Income

The Trust Fund is allowed to invest cash balances in line with general Bank procedures and invest funds accrued on the activities set out in the Trust Fund Administration Agreement. At the end the evaluation period (end March 2011) investment income returns amounted to some $2.83m; by the end of February 2012 this had increased to $3.23m. Figure 22 below shows investment income on a monthly basis. It shows major volatility - reflecting unsettled financial market conditions - and includes some months of negative returns. Overall - between June 2010 and February 2012 - returns averaged around 0.7% per annum (i.e. investment income in a month divided by average Trust Fund balance for a month.

Figure 22: HRITF investment income



Source: Secure Donor Website: Monthly Expenditure Statements

By the end of March 2011 investment income earned equated to 12.5% of total HRITF expenditure. As cash balances declined and expenditure accelerated this had fallen to 10% by February 2012. One would further declines over time. expect Investment income was four times the administrative expenses of running the Trust Fund.

Table 23: Investment income as share of key expenditure measures

Investment Income as % of:	Evaluation Period				Post Evaluation Period			
	Jun-10	Sep-10	Dec-10	Mar-11	Jun-11	Sep-11	Dec-11	Feb-12
Disbursements to Grantees	47.0	52.0	52.1	30.0	26.2	26.3	18.3	14.0
Direct Costs Disbursed by World Bank Group	27.4	28.4	25.0	22.8	20.7	19.3	16.5	15.9
Total HRITF Costs	16.4	17.5	16.1	12.5	11.2	18.4	12.4	10.0
Administrative Fees	321.8	359.2	361.2	365.8	390.5	399.9	407.4	417.9

Source: Evaluation team based on data from Secure Donor Website: Monthly Expenditure Statements

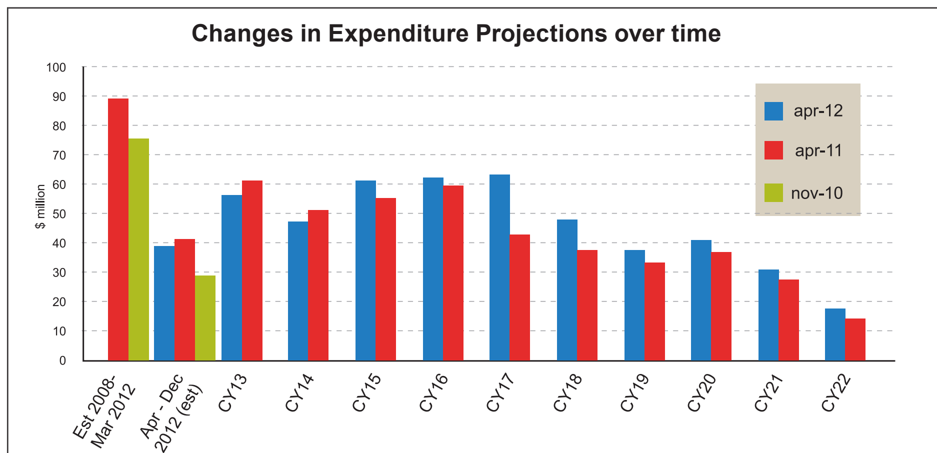
Expenditure Planning

Expenditure planning for HRITF is, and will continue to be, challenging. As RBF is a new approach there was no sound basis for projecting future expenditure and expectations were clearly overoptimistic. Looking forward future expenditure trends will depend to a degree on progress with the pilots and the extent to which those eligible for reward payments are able to secure them. Though the design of the pilots will play a role much of this is outside the control of Bank staff. This does raise an important question for donors – should they encourage the HRITF team to over commit their funds in the expectation that some pilots will not achieve their targets? Or, should they just commit available funds and run the risk of under spend. In our view, specific decisions do not need to be made now as a) a large proportion of funds still remain uncommitted and b) it would be useful to build up a better track record of progress under existing country pilots before making such decisions. However, donors should consider their approach and, possibly around the time of the 2015 evaluation, be prepared to make detailed decisions (on how much to over commit if this is the approach they wish to take).

Even allowing for this type of uncertainty expenditure planning has been extremely weak. The Secretariat has traditionally relied on often highly overoptimistic projections made by TTLs to estimate future spending. For example, the April 2010 – March 2011 Annual Report estimated that the Trust Fund would spend a further $36.79m in the period April 2011 to December 2011. In practice only a further $4.22m was spent over the period – only around 11.5% of that anticipated. Reasons include an under appreciation of the complexity of designing the RBF pilots, the need to follow Bank procedures (examples are presented in the case studies) as well as general over optimism.

Steps have since been taken to improve expenditure planning and the Bank recognises this as an area requiring specific attention over the next 18 months. An initial effect has been to change the expected disbursement profile (chart below). The overall expected breakdown of Trust Fund expenditure by activity is shown in the chart. It shows spending peaking during calendar years 2012 to 2016 then tailing off.

Figure 24: HRITF expenditure projections over time



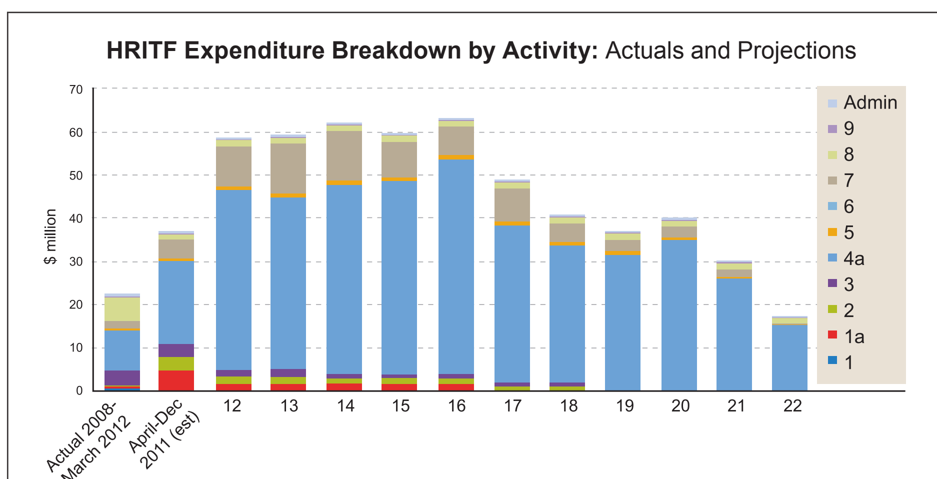
Source: HRITF team

The chart shows how the projected level of overall disbursements has changed over time. The April 2011 Annual Report was the first to present projections for expenditure of the total HRITF funds (earlier reports had only made partial projections[13]). The updated April 2012 projections shows that spending for the rest of 2012, 2013 and 2014 are likely to be lower than earlier anticipated. Providing such a longer term perspective is helpful but only becomes useful if expenditure planning as a whole is credible which has yet to be proven.

Although the projections have clearly changed it remains to be seen whether they have improved. As this is a key concern of donors they should assess progress in this area using data from the secure donor connection at the end of 2012 (comparing actual expenditure from April to December with the expected $39.3m).

Overall, implementation of the RBF pilots is expected to account for 73.6% of total Trust Fund spending with evaluation accounting for a further 12.6%.

Figure 25: Expected HRITF Expenditure



Source: HRITF team. For list of activities see table 14

13 The November 2010 donor report projected spending only part ($215m) of the total Trust Fund resources

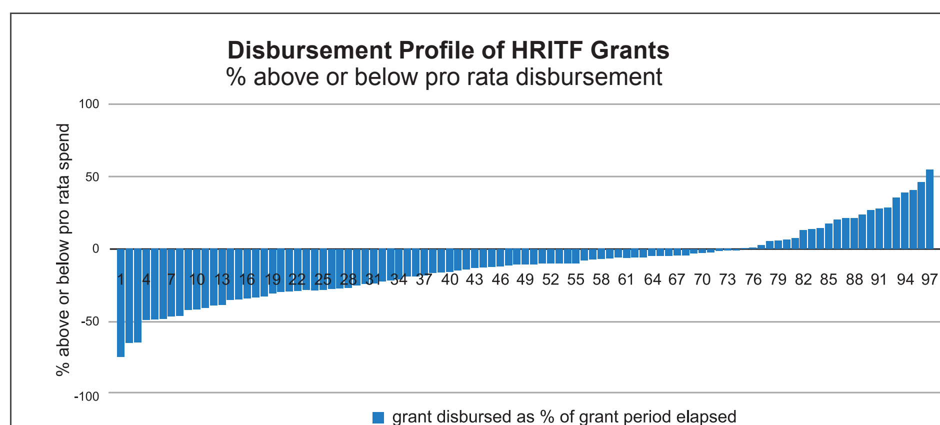
Disbursement Performance of HRITF Grants

The chart below shows how rapidly individual grants are disbursing by showing spending in relation to the length of the effective grant period which has elapsed[14]. Basically this approach assumes that a grant is disbursing slowly if it has, for example, spent less than half of the grant amount halfway through the effective grant period. We clearly recognise this is a crude measure of disbursement progress but the best available in the absence of actual projections of grant expenditure.

Those grants on the left hand end of the spectrum in the chart are spending most slowly in relation to period the grant has been effective - those on the right hand side the most rapidly. It shows that most grants have disbursed a lower share of total available funds than the share of the grant that has expired. Of the 97 grants for which data was available 74 were spending "slowly" – with 34 more than 20% behind what they would have spend if spending were equally spread throughout the grant period[15]. In practice, as the HRITF team point out, grants are generally expected to spend little in the first year with much more in later years. As a result, the method we use tends to over estimate the degree of under spending - though it remains useful in terms of ranking disbursement spending performance by grant.

To allow better analysis of grant disbursement performance it would be helpful if the original grant disbursement projections by calendar year are included with the grant by grant data presented on the secure donor website. This would allow for a more systematic assessment of progress in expenditure.

Figure 26: Disbursement Profile of HRITF grant



Source: Secure Donor Website: Individual Grant information

The chart below presents aggregate figures taken from individual grant data which distinguishes between Bank and recipient executed programmes and by grant size.[16] With the single exception of grants in the $1m to $5m range all

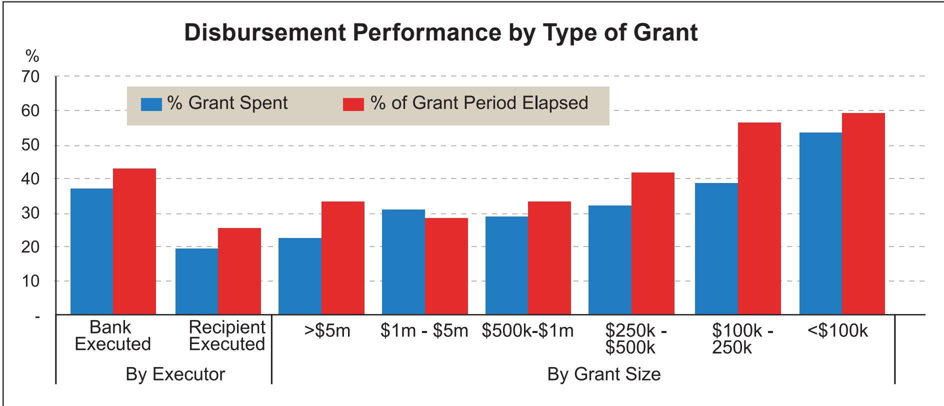
14 i.e. it assumes a grant is disbursing slowly if it has spent less than half of the grant amount halfway through the grant period which we clearly recognise as a crude measure of disbursement but the best available in the absence of actual projections

15 Source: Grant information from secure donor connection accessed May 2nd 2012

16 It was not possible with available data to do a similar analysis by activity.

grants were spending more slowly than if they were spending in line with the grant duration.[17]

Figure 27: Disbursement performance by type of grant

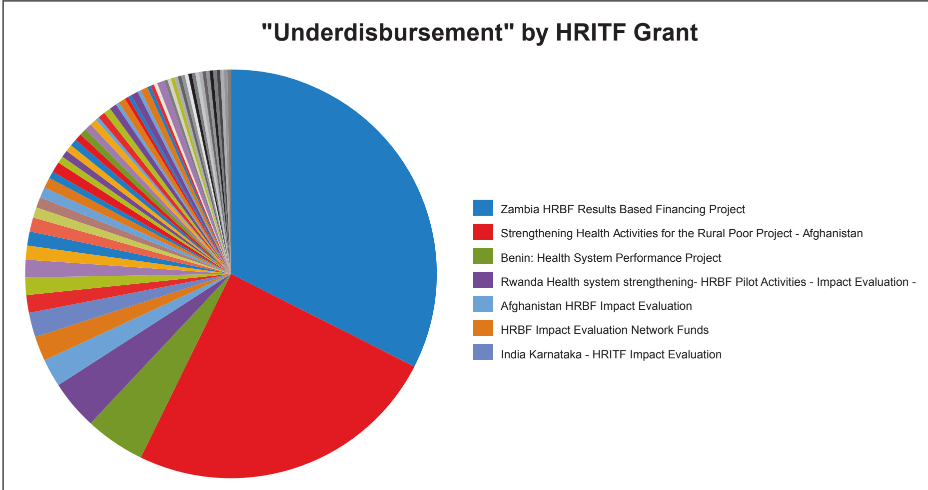


Source: Secure Donor Website: Individual Grant information

A large share of the grant under-disbursement is accounted for, using this approach, by a small number of grants. A single grant – Zambia - accounts for almost a third of the total under spend the Zambia and Afghanistan pilots account for over a half and ten grants account for just under 76%.

The Annual Donor Consultation is expected to discuss issues of budget execution. Our understanding is that this issue has not been discussed in detailed to date. Our analysis suggests that identification of slow-disbursing grants may not be too difficult and that any discussion/feedback could be usefully focused on a manageable number of grants.

Figure 28: "Under-disbursement" by HRITF grant



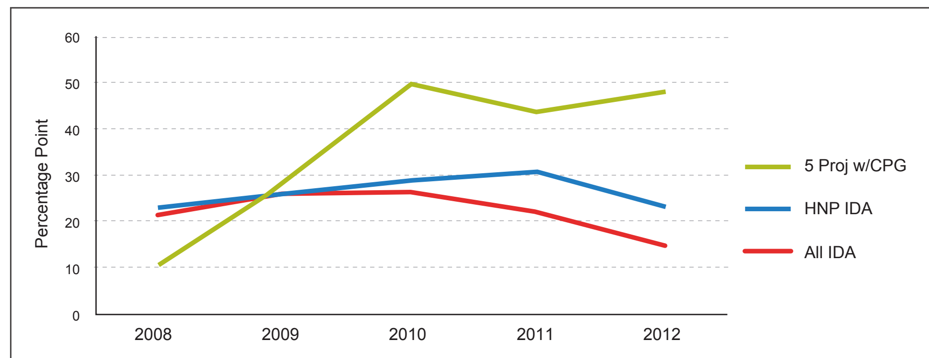
Source: Secure Donor Website: Individual Grant information

17 As the individual grant data presented on the secure donor website does not indicate the activity support we could not investigate why this was the case. Certain activities e.g. the impact evaluation of likely to be heavily represented in the $1-$5m category and rapid expenditure here might account for these findings.

Comparison of HRITF Grants with overall World Bank lending

The HRITF team were invited to present data illustrating the fact that the performance of HRITF grants is no worse than that of World Bank operations as a whole. The Bank provided information on five Country Pilot Grants (these were all the country pilot grants that were active at the time, but just five out of more than 40 grants), the data from which suggests that whilst initial disbursement might have been low later disbursement performance improved and exceeded that of other Bank operations.

Figure 29: Comparison of disbursement ratios for a sample of HRITF grants with wider Bank operations



Source: HRITF team HNP = Health Population and Nutrition, IDA = International Development Association

The results are dependant on the length of the grant (shorter grants would be expected to have higher disbursement ratios though HRITF grants are typically of comparable length to those of Bank lending as a whole). Overall, we would conclude that this provides useful but, at best, partial evidence that HRITF grants disburse no more slowly than other Bank operations. Given donor concerns this is an important issue – the HRITF team should consider whether it is possible with reasonable effort to provide stronger evidence.

Key Findings

- HRITF expenditure has been lower than expected although it has accelerated rapidly after the end of the evaluation period (after the end of March 2011).
- Crude measures of disbursement performance suggest than many grants are disbursing more slowly than might be expected. Overall, under disbursement is concentrated in a small number of (larger) grants. However, there is partial evidence which suggests that disbursement performance is comparable to Bank spending in the health sector as well as for the Bank as a whole.
- The allocation of resources – heavily focused on Africa with substantial allocations to South Asia and global activities - seems broadly appropriate.
- The Trust Fund received funding in advance of need due to a combination of the Bank requesting funds at an early stage, donors willingness to release funds and slower than expected disbursement on HRITF activities. Cash balances held by HRITF remained high in March 2011 but have declined markedly since – as expenditure has accelerated - and are now at more reasonable levels for operational purposes. The HRITF team should justify the current policy of holding 12 months of expected expenditure as a cash balance.
- Expenditure forecasting has been poor. Efforts have been made in this area in recent months and projections of spending have been reduced. It remains to be seen whether the new projections are more realistic. This should be assessed by donors using the secure donor website at the end of 2012.
- Donors need to consider whether or not to allow the HRITF team to over commit funds on the grounds that countries might not secure the rewards available under the pilots. Specific decision on how much to commit should wait until more is known about the performance of the pilots.
- The sector Donor Website should be advertised more actively among the donors agencies and made more easily available for external evaluations like this. If donors are interested in might be useful to run a short session on its use.

4.3 Accounting and Financial Management

According to the Grant Agreement (December 4th 2009), the Bank is expected to keep separate records and ledger accounts related to Trust Fund activities. It is expected to provide current financial information on receipts, disbursement and fund balances through the World Bank's Trust Fund Donor Centre Secure website. It should provide within 6 months of the end of the Bank's fiscal year (June 30th) an annual single audit report. The Bank is also required to provide indicative forecasts for expenditure by category over the following 12 months.

4.3.1 Slow HRITF spending by the Bank?

To set the scene we would state the following (see also some statements gathered from interviews in the box below):

- The Bank accepts that it is not necessarily a rapid implementer but adopts a methodical approach. It would argue that it is good at its core business – developing and implementing projects and that being slow is not necessarily a bad thing. In terms of safeguards such as fiduciary "the Bank is very tough" - "donors say they want to take risks but they don't"

- The Bank has extremely powerful (arguably too powerful) incentives to disburse through internal agreements between Vice Presidents/country directors etc

- The donors would rather the money be spent but are more concerned that it is spent well. If disbursement is slow then they would like to understand the reasons for this but they would also like to have more certainty on future levels of disbursements so they can manage their overall resources effectively

A slow start is not surprising but it should pick up
"heavy architecture to get started"
"RBF adds an extra layer – it was very labour intensive"
"maybe the design process does take longer – we don't mind a slow spend – as long as we can plan for it"
"the Bank is intrinsically slower than other mechanisms. If you want things fast don't ask the Bank – it takes a minimum 2 years preparation. We don't do quick and dirty, we do transformational work"
"HRITF is very labour intensive – especially on the side of Government – this is less an issue for the Bank as the Trust Fund pays for staff and some supervision costs"
"it takes time to set up but should be easier and quicker to implement. With investment projects we revisit the results framework at mid term. They are often not watertight … but here you only get one chance"
"it took longer than expected – we needed to make sure they understand what it entails"

Sources: statements gathered during interviews

4.3.2 Is disbursement unnecessarily slow?

The aim here was not to assess Bank procurement or financial management systems as a whole – rather to assess whether there were specific issues related to the operation of the Trust Fund.

The donors raised the question of whether the slow disbursement reflected shortcomings on the design and implementation of the Trust Fund or whether it reflected factors inherent to RBF – in particular its novelty and complexity.

Causes of Slow Disbursement
External factors were responsible in some settings – the mini revolution in Kyrgyzstan in 2011 meant that SWAp audit could not be completed - a condition for signing the Grant Agreement for the CPG. In Zambia the 2009 corruption scandal resulted in all donor funds being stopped and the Bank operations needing restructuring, so the 6 month pre-pilot ended up lasting for 3 years.

Other factors included:
Resource constraints at the outset – which meant implementation had to be phased. The 2008 Annual Reports that implementation had to be staggered as the Bank needed to have the money in hand to finance key activities and "as the

Norwegian contributions to the Trust Fund are received over a 4 year period, the Bank can only commit RBF grants to countries as Norwegian funds are received in the trust fund. As such, the three selected pilots will need to have the following implementation schedule:

1 RBF pilot linked to one project with Board approval date CY 2009
1 RBF pilot linked to one project with Board approval date CY 2010
1 RBF pilot linked to one project with Board approval date CY 2011"

The lack of decision making authority: The HRITF team are required to go back to donors to get approval on individual items of spending. We understand that this is not normal practice for a Trust Fund. The TF has typically had to go to donors to seek a no objection – a formal part of the process which can take a long time. With the growth of the Trust Fund and the rolling approval process this issue has intensified. This issue needs to be reviewed with a view to moving towards a retrospective approval process, establishment of a negative list or a simple action plan.

Managing expectations is important at the beginning – it is very difficult to get started especially if there is little support from other donors.

Small HRITF Team unable to process incoming demands. In 2008, the first annual report referred to "a large work program for a small team" and to "unexpectedly high demand for technical and financial support for RBF from countries", in spite of which another round was called the following year while the size of the HRITF team remained roughly the same.

Bank fiduciary, legal and procurement rules are sometimes challenging for RBF: Although teams find creative ways to prepare and implement projects that include RBF mechanisms, the Bank's rules complicate efforts to link financing to results. This is particularly true for investment lending. In an effort to ensure that innovative financing methods can be compatible with Bank systems, country teams have been documenting and discussing the issues with Bank management. One example under discussion is the requirements that health services be treated as "outputs" with unit pricing.

In country presence: RBF requires a multitude of decisions (see box below illustrating this point in the Kyrgyz Republic). Though implementation is possible remotely it is much more effective when there is an active TTL in country -or at least in the region- and where there are strong local staff. Norway reports that their RBF project in Tanzania began slowly but proceeded more rapidly when a consortium approach was adopted.

Complex and took time … but it could be worse. In the Kyrgyz Republic interviews stressed the complexity of the approach and the multiple decision points which required significant inputs and this despite the fact that the SWAp there is relatively well developed and much time has already been spent on funds flow/fiduciary issues. The Ministry of Finance, whilst frustrated at the slow

progress, did compare the process favourably with that of the education sector arguing that at least the RBF project was clear about the activities to be funded in contrast to the education sector where a lack of clarity on this made it very difficult to agree on a fund flow mechanism

Complexity of RBF - Lack of Knowledge –Unrealistic Expectations: At the outset there were very few global experts in this area so it was not known quite how long it would take to prepare projects and activities. It is quite apparent that timeframes were routinely underestimated (often significantly so) and continue to be to a degree. As noted earlier disbursement projections were poor, with heavily but understandable reliance on TTLs. The TF has a much better sense of what is involved now and disbursement planning has become more systematic. Applying the approach in the health sector is also seen as extremely demanding as the links between inputs, outputs and outcomes are particularly complex. For example, health centres and hospitals produce multiple outputs raising questions about which results to targets and how to track unrewarded outputs. Dimensions of performance such as quality are also difficult to measure (the Basic Scorecard to be used for rayon hospitals in Kyrgyzstan was some 360 indicators). As the Kyrgyz experience showed even from a strong starting point the process was long and time consuming, but still apparently smoother than in other sectors.

Allocation of funds in advance of need: Having received a large upfront contribution of $93m the Trust Fund has not had to request further funding from donors since (in 2010 and 2011). The issue may be less one of low spend but more one that resources were transferred before they were needed.

4.3.2 Procurement

Goods and services are procured in accordance with the Bank's guidelines on "Procurement under IBRD Loans and IDA Credits" and "Selection and Employment of Consultants by World Bank Borrowers" (for recipient executed programmes) and in line with internal Bank procedures for Bank executed programmes.

4.4 Capacity of the HRITF team

In several parts of this report we have advocated for a more proactive approach to certain management functions and tasks by the HRITF team. This section briefly explains what evaluators mean by this. In essence, the size and composition of the HRITF team have remained roughly the same yet the size and complexity of the HRITF supported programme have grown exponentially since its launch in 2007. For example:

- There are 19 CPGs and linked IEs to oversee, each one of them is unique and requires a differentiated approach in terms of implementation and oversight by the HRITF team.
- While the TTLs and country teams will continue to have the primary responsibility for implementation it is up to the HRITF team to ensure that, for

example, documentation and learning are taking place as they should, evidence is being generated and contributes to the HRITF knowledge programme, country stakeholders are being systematically targeted, sustainability considerations are taken on board, etc.

- It is crucial that information on CPG implementation flows bottom up from the countries and that the right (first and second generation) questions are being addressed as part of "looking into the black box" of RBF.

- There are also the changes (advocated elsewhere in this report) in the focus of reporting (on objectives and results not activities; with improved financial forecasting and reporting, and with more strategic, forward looking engagement with HRITF donors; etc) that are the remit of the HRITF team.

- In sum, this consolidation and expansion phase of the HRITF requires a stronger, more sophisticated approach to certain management functions undertaken by the HRITF team, and perhaps for some additional tasks to be adopted.

Evaluators believe that a capacity assessment of the HRITF team in the context of the functions it should perform and of its links with other parts of the Bank is necessary and urgent and should be undertaken by the Bank itself. It should lead to a stronger and fairer division of labour to address the challenges ahead. We are not advocating for a parallel, top heavy management structure but for a functional reorganisation of certain key functions within the HRITF team or, perhaps, within other parts of the Health, Nutrition and Population (HNP) hub.

5. Conclusions and recommendations

This section includes the main conclusions and recommendations from the evaluation. It uses, for guidance, the specific questions and areas where recommendations were requested in the terms of reference of this evaluation. (see Annex 5).

5.1 Conclusions

The following conclusions can be drawn in response to the questions that were raised in the ToR. Instead of repeating here each of the questions as they were phrased in the ToR –some of which are long or include several sub-questions- we have created short headings in order to make this part of the report more readable.

a. **Contents of RBF operations.** By mid 2011 the HRITF was supporting RBF pilots (and their linked impact evaluations) in about 19 countries (table 6) through so called Country Pilot Grants (CPG). CPGs are at different stages of implementation: 10 CPGs are under design or pending Bank board approval; 4 CPGs are pre-piloting (feasibility); 5 CPGs are in full implementation (i.e. pilot stage). The first Initial results from Impact Evaluations are expected in 2013 in Rwanda, and maybe in DRC and Zambia too (2013 or 2014). All the RBF pilots clearly focus on reproductive, maternal, neonatal and child health (RMNCH) outputs and outcomes, and thus should contribute –if successful- to achieving the Millennium Development Goals, particularly MDG 4 (child health), MDG 5 (maternal health) and, to a lesser extent[18], MDG 1c (nutrition) and MDG 6 (HIV, Tuberculosis and malaria).

b. **Poverty, equity and gender focus.** The case studies and desk reviews have shown that most CPGs studied had a clear equity, poverty and gender focus, often implicit in the fact that CPGs target women and children and sometimes explicit by focusing on poorer geographical areas or social

18 To a lesser extent because there are much fewer nutrition programmes in place that the HRITF might target, and because most HIV, tuberculosis and malaria national programmes are usually for all population groups and not just for women and children, so they would not meet HRITF eligibility criteria. Some HRITF operations are covering these areas, as in Zambia.

groups. However, our rather small sample of countries covered in this evaluation may have missed additional efforts on poverty, gender or equity that would require a detailed reading of the pilot design. For example, we are aware that some pilots used a stronger equity focus like the use of remoteness bonuses for rural facilities (e.g., Zambia, Zimbabwe), higher incentives to treat poor patients (e.g., Nigeria), equity-based resource allocation formula for RBF fund flow to provinces (e.g., Burundi, Benin), etc. Gender, equity and poverty, among other variables, are better built in programmes when these are based on a thorough social assessment, and evaluators have found that the quality of the social analysis and of the linked social inclusion strategy were weak in a few countries. This is why we have recommended that the social assessment toolkit that is being developed by the Bank should be used systematically and rigorously in the CPGs or impact evaluation designs, current and future.

c. **Focus of RBF pilots.** The range of RBF mechanisms the Trust Fund is supporting is quite narrow and it is not clear whether this is intentional or what donors or the Bank had in mind. For example, most CPGs (14) support supply-side incentives, while fewer support demand and supply side incentives combined (5). There is one example of a community RBF and there are no examples where only demand side incentives have been provided. Our rapid assessment of the pilots suggests that the focus has largely been on contracting out and contracting in methods with some focus on limited demand side initiatives. There has been no focus on Cash on Delivery (COD) or Output Based Aid (OBA), and in-kind incentives were excluded from the HRITF in 2010 (they are being piloted in Rwanda because its application preceded that date). What is needed is a clear mapping of the current portfolio (evaluators have been told that such mapping has been recently commissioned) and a debate among HRITF partners on how any perceived gaps might be covered. For example, should the Trust Fund invest in a wider range of mechanisms (how, since the models are largely country chosen?) or should donors pursue these through their bilateral programme?

d. **Are RBF operations context specific?** While design of most RBF pilots has been thorough some of the earlier proposals in Rounds 1 and 2 suffered from limited feasibility analysis For example, evaluators could not find a single example of an RBF application being turned down following poor feasibility assessment on the ground. The Bank recognised some of these issues and mitigated some risks by linking the CPGs to IDA grants (which undergo rigorous feasibility and risk assessments) and by implementing more lengthy pre-pilots to better test systems and tools. While the IDA link results in a more robust feasibility assessment than was the case in Rounds 1 and 2 attention is drawn to the fact that RBF presents distinct features when compared to standard IDA operations, such as the fact that under HRITF there is an intention to learn from the pilot and, should it be successful, to ensure the lessons and perhaps the RBF intervention as such are eventually adopted/scaled up by the country. For this and other reasons a proactive approach by the HRITF team should ensure that essential

aspects linked to the objectives of the Fund which are not necessarily a core component of IDA credits (like documentation of pre-pilots and pilots, or ensuring that a wide range of stakeholders are actively approached for implementation and sustainability purposes) receive the attention they deserve.

e. **Alignment and harmonisation.** All pilots studied were found to be firmly rooted in national policy. The degrees of country ownership and consultation with other donors and with government were generally good, although important variations were observed from country to country. Main variations observed depended on the presence and quality of the World Bank's Task Team Leader and country team and their willingness and ability to engage with ministries of health, development partners, academia, technical agencies, NGOs and civil society, among the main ones. Involvement of stakeholders was found to be crucial for the successful design and implementation of the RBF pilots as well as for their eventual sustainability (should these prove successful). On harmonisation, the Bank was found to use country systems as often as possible, although in many cases parallel systems had to be developed to cover for fiduciary and other risks. Our impression is that initial expectations of the integration of activities with national systems were over optimistic, and that a generally pragmatic approach has been adopted.

f. **Governance and accountability mechanisms.** Funding partners get information on how the TF is performing from Annual Reports, Mid-Year reviews and informally as required. There is an annual donor consultation meeting. Use of annual work plans is not yet standardised as part of HRITF operations by the HRITF Team – only one has been produced to date and has not yet been reported about (it should happen in next annual report April 2011-March 2012). Most reporting focuses on activities not results/ objectives/ indicators as required by the Grant Agreement. This makes it hard to see the bigger picture. Current reporting framework (two reports every year) imposes unnecessarily high burden on relatively small HRITF Team, which negatively affects its operations given its large mandate and limited staffing resources. Apart from these points about the reporting framework, the governance structure appears fit-for-purpose.

g. **Are expectations from the HRITF donors being met?** Expectations are not clearly set out for either donors or implementing agency as there is no explicit theory of change underpinning the HRITF. There have been efforts in the past for a more clear results framework, including the DFID log frame that is being used internally by DFID, but its focus remains on the 9 administration activities and not the 4 HRITF objectives. Our assessment is that that initial expectations (on both sides) on what the Fund would achieve were not clearly laid out and transformed into measurable indicators for results. This situation can lead to different perceptions among Fund partners as to whether the scope of interventions (RBF focus) or the timeframe are right. Some initial expectations may have been unrealistic and failed to

appreciate, for instance, the tradeoffs between country ownership, testing a range of RBF mechanisms and having scientifically rigorous impact evaluations applied to highly dynamic and changing health systems.

h. **Economies of scale and leverage**. The initial phase of the TF has been to build up the infrastructure to support the pilots – it would be unrealistic to expect economies of scale to date. This is likely as the TF moves to its full scale of operations 2012-2016. The TF has leveraged significant inputs from HQ and there has been significant demand from countries. According to senior World Bank managers interviewed HRITF activities have played a role in the development of the Pay for Results (P4R) instrument within the Bank. P4R offers implementers an additional choice of instrument – and potentially a means of ensuring a greater results focus in the Bank's work – though its scope is set to be relatively limited in the short term.

i. **Interaction with country stakeholders and civil society.** As mentioned earlier (e) while interaction between Bank teams and national stakeholders were generally good important variations were observed from country to country in terms of the quality of the engagement. Thus, there have been interactions and good examples with donors at both country and IWG level but also a number of missed opportunities and lack of a consistent approach to engaging country stakeholders in HRITF work. In general, there has been limited interaction with civil society (other than as implementers, beneficiaries and through the Inter-Agency Working Group –IWG- and membership of Independent Review Panel).

j. **Relationship between planned and actual disbursements.** It is not possible to fully assess the relationship between planned and actual disbursements on the basis of available information. Only a very partial picture can be gleaned from analysis of the annual reports. This suggests that expenditure planning has weak at the beginning of the programme but also that steps have been taken to strengthen this, particularly since 2010. Financial data have not been presented in a consistent manner in annual reports, nor in a way which allows disbursement performance to be assessed in a meaningful way.

k. **Effectiveness of procurement processes.** Goods and services are procured in accordance with the Bank's guidelines on "Procurement under IBRD Loans and IDA Credits" and "Selection and Employment of Consultants by World Bank Borrowers" (for recipient executed programmes) and in line with internal Bank procedures for Bank executed programmes.

l. **Is the skill-mix of the staff of the Bank, the recipients and the donors responsible for the TF appropriate for implementation of the current / planned RBF project portfolio?** At the outset there was little corporate capacity in RBF and IE within the Bank and limited understanding about it -with a few noteworthy exceptions- among Bank staff, HRITF donors and country stakeholders. One of the key aims of the HRITF has been to build

this up, and evaluators feel there has been considerable success in this respect through the use of knowledge products, awareness and dissemination events, staff training and a well managed website. While overall understanding and capacity/skills for RBF have grown the size and composition of the HRITF team in the Bank have remained roughly the same, yet the size and complexity of the HRITF supported programme have grown exponentially since its launch in 2007. For these reasons evaluators draw the Bank's attention to the need to reassess the capacity of the HRITF team in the context of the functions it should perform and of its links with other parts of the Bank (see 5.2, recommendation 2 for more details).

m. **Planned versus actual M&E of RBF pilots.** RBF is a complex approach and the time required to design RBF approaches was initially underestimated. It has not always been possible to design IEs in the way the Bank team would have liked but all studies involve some form of randomisation and will yield useful if not optimal results. There is a risk that some confounding variables and unpredictable events that might influence the outcome of both pilots and impact evaluations are not being captured due to limited documentation of RBF implementation in some of the countries covered in this evaluation.

n. **Sustainability of RBF.** It is too early to tell if the schemes are likely to be sustained or if they are worth sustaining. There are some positive early indications in terms of strong country commitment, efforts to identify future funding sources, identify savings to create fiscal space etc but the poor economic outlook in some countries will make this difficult. The Bank generally has strong relations with Finance Ministries but has missed opportunities of engaging with some donors who might become potential financiers in aid dependant settings. The IDA link offers the potential to improve the effectiveness and wider impact of HRITF programmes – especially through the links enjoyed with Finance Ministries.

5.2 Areas where recommendations where requested

The ToR (Chapter 3 - main tasks) required evaluators to provide recommendations on the following specific questions.

1. **Are any changes to the programme agreement or forward plans required for the TF to achieve its four objectives?** Changes to the programme agreement are not necessary. What is essential for the donors and the implementing agency is to define and, to the extent possible, quantify what is expected from the HRITF in terms of results, and to do so at both programme level as well as at annual planning level This implies the **need to define clearly and explicitly the results that the HRITF expects to achieve over time for each of its four objectives, and to include indicators to measure such progress.** Such a results framework is not yet in place and, we feel, it should be developed as a matter of urgency (please refer to section 3.2.3 for more details). A clear results framework would

contribute to providing direction to the HRITF at a crucial time of rapid growth. It would also improve annual reporting and help define the focus of annual work plans (see 2.12 below).

2. **Are any changes to the organisational structure of the TF needed?** We do not think that changes to the organizational structure are needed since the existing one provides an optimum integration of the HRITF with Bank operations in a mutually reinforcing manner. However, while structure serves the purpose evaluators recommend increased attention to capacity issues at the level of the HRITF Team at a time of rapid growth. Now is the time to step back, assess the programme as a whole from a knowledge generation perspective and ask whether country demands are likely to meet the overall Trust Fund goals (and results, as discussed in the previous point). If this programme were simply about implementing a proven intervention the current approach would be fine. It isn't - it's also about investing in a global public good: knowledge.

   For the programme to respond to the challenges of the next four years and ensure that the pilots and evaluations deliver knowledge and that this is effectively analysed and disseminated **the HRITF team will need to become more proactive and it will need to receive additional and regular analytic support.** More proactive engagement does not mean changing the ways in which the Bank implements its operations, but to make sure that such implementation fully serves the purposes of the RBF programme and that learning really drives the HRITF. For example:

   2.1 There is a need to map out in more detail the current RBF portfolio as a means of identifying gaps. For details please refer to thoroughness of RBF designs – feasibility studies in 3.3.2 and what types of pilots are being implemented? in 3.4.2.1 and 3.4.2.2.

   2.2 The link between improved mapping of RBF pilots by the HRITF team with improved documentation of pilots at country level (see 3.3.3 and 3.4.4) should be made in order to make sure that emerging issues and lessons -even if preliminary- are swiftly captured and discussed at programme level. Every HRITF pilot should be effectively documented for both design and implementation, and a clear knowledge programme should be built focusing on many of the issues above and reflected in explicit questions that should lead to analytical pieces for the Bank and the international community to learn from.

   2.3 The focus on training TTLs and Bank staff on RBF should continue, and it should be combined with the provision of more spaces and opportunities for them to discuss practical progress with RBF pilots and knowledge products, and to tap into regional communities of practice.

   2.4 There should be more regular (once or twice a year) and systematic (a set of key points to cover) de-briefings and updates between the TTLs and the HRITF Team on the countries that are receiving CPG support.

2.5 Steps should be taken for the HRITF Team to explore funding and sustainability issues linked to the RBF pilots well before these come to an end. The full cost implications of the RBF pilots should be better assessed and reflected in existing reports, as should a brief discussion of efforts being made at country level towards sustainable financing (see 3.6.5 for a discussion on sustainability).

2.6 Countries where pilots are taking place should be guaranteed a continued presence by Bank teams (see ownership, alignment and harmonisation at design in 3.3.2), to the extent that if Bank effective country presence (involvement in sector reviews and policy dialogue included) cannot be guaranteed the case for letting the country apply for pilot funding should be revisited Alternatively other approaches could be considered e.g. a bilateral donor or multilateral donor taking forward the programme – either independently using the Trust Fund tools and technical support or even using Trust Fund resources (to be discussed among the TF partners).

2.7 Key health donors and decision makers in each country need to be systematically targeted with the right information and capacity building interventions, rather than leaving this to chance (see 3.6.3 leveraging funds from other sources and ownership, alignment and harmonisation at design in 3.3.2).

2.8 There should be a stronger and clearer link between the learning activities at country level and the regional and global HRITF learning programme, with the learning programme being far more visible than it is to date. Most TTLs were found to be uninformed about the priorities of the HRITF learning programme or the existence of such a programme, yet they are the primary sources from where information should flow.

2.9 All the above information should continue to be placed on the RBF website with a stronger focus on emerging evidence on RBF - the option for an RBF website committee that used to be in place may need to be revisited but with a stronger involvement of countries and regions rather just a group or “global experts”. For a discussion on website related issues please refer to 3.4.5.4.

2.10 The learning programme will need to reach out to the general RBF/PBF “communities of practice” that exist in Africa and Asia to explore possible avenues for collaboration and possible HRITF support to interesting opportunities for mutual learning.

2.11 For many of the activities above the Bank may need to strengthen the human resource base of the HRITF Team that appears way too narrow to respond to the challenges ahead. Either the team should grow or time from RBF experts should be freed up and purchased by HRITF

for them to provide additional analytical support to the HRITF team and its programme manager. In addition, this phase of the HRITF characterised by growth requires a stronger, more sophisticated approach to certain management functions undertaken by the HRITF team, and perhaps for some additional tasks to be adopted. We recommend a re-assessment of capacity of the HRITF team in the context of the functions it should perform and of its links with other parts of the Bank. Specifically, the support for the impact evaluation components within the HRITF Team appears under resourced given the key role that this component plays and the considerable complexity involved in designing, documenting and overseeing impact evaluation studies applied to RBF mechanisms.

2.12 Annual reporting should be improved and annual donor consultations adapted towards a more strategic engagement. Specifically, annual reports should focus on the four objectives and on the (yet to be defined) results, with activity reporting being brought to the annex section. Financial reporting should be substantially strengthened to better capture expenditure versus forecast (by regions, by HRITF products, by poverty indices, etc) and reasons for deviations; and with all the above being placed in the context of the annual work plans, with donor consultations focusing on reviewing performance against the previous work plan and on the focus of the next work plan.

3. **Are there any risks that the TF needs to monitor or manage?** Or if there is a risk analysis, does it need updating? Evaluators could not find any risk assessment other than the one included in the log frame developed by DFID in 2009. In our opinion the main risks for the programme at this point relate to the absence of a results framework and the limited capacity of the HRITF Team to oversee what has become a very large program – both points have been discussed earlier. The HRITF team relies on standard Bank implementation arrangements to ensure that HRITF objectives will be effectively met, and while this may work it should not be taken for granted. This is why we have recommended that the HRITF Team and its Project Manager should become more proactive in overseeing country operations, particularly where pilots have been approved.

4. **Does the work plan for the next 1-2 years need to be revised?** As mentioned earlier annual work plans have not yet become standard operating procedures in HRITF operations. Only one annual work plan was prepared for the period July 2010-June 2011 which should be presumably reported in the 2012 Annual Report[19]. Evaluators have already emphasised (see question 1 above) that without annual work plans specifically focussed on HRITF operations and linked to the (yet to be developed) results framework it is virtually impossible to monitor progress within such a large

19 The 2012 HITF Annual Report was produced in May 2012 as evaluators were finalising their report. The annual report confirms that the Bank is not using annual workplans as there is no reporting against the July 2010-June 2011 Annual Workplan that it prepared.

programme, not to mention that annual work plans are explicitly mandated in the HRITF Administration Agreement. Moving from an activity driven reporting system to a strategic one requires sharper and explicit focus from the HRITF team on what will be attempted year on year for HRITF to achieve expected results. This is not being done systematically enough and while evaluators are aware that work plans are being prepared in the Bank at sector or hub levels we do not consider these to be equivalent to HRITF-specific annual work plans developed by the HRITF team for the purpose of ensuring transparency, accountability and programme focus. A more detailed discussion of progress reporting can be found in *reporting requirements: have they been met?* in 4.2.1.

5. **Does the budget need adjustment, e.g. with regards to balance of spending at country level vs. HQ level, distribution of spending among various budget lines, etc.?** There is always a risk in a large programme that resources may be spread too thinly. For example, given the dilemma it would be better to do fewer studies well than do a lot badly (we are not saying that any are being done badly right now). Clearly they should demonstrate value for the money invested but we would propose a more flexible approach allowing additional funding to be provided – especially for impact evaluations - where a strong case can be made for doing this. Linked to these issues the Bank through the HRITF should have a stronger work programme to assess financial, operational and transaction costs linked to RBF implementation, and should use this information for learning purposes and to improve its own financial management and forecasting of financial needs linked to the HRITF programme.

6. **Does there need to be improved social analysis in the operations of the TF? How could the social inclusion and gender equity dimensions of the TF be improved?** Yes, social analysis should be improved as a step prior to exploring social inclusion issues that are closely linked to gender, equity and poverty. The Bank has developed a social assessment toolkit that is expected to be used in all new CPG grants and linked IEs. We recommend the Bank (through the HRITF team) to ensure that the said toolkit is being used systematically and rigorously.

7. **Are the TF's monitoring and evaluation procedures fit for purpose? Are they generating the information needed, is the information the M&E system generates useful, and are all parts of TF using the M&E tools consistently?** Several related issues have been already discussed. In general, procedures are fit for purpose but they would require some adaptation, for example:

    7.1. As mentioned earlier the theory of change and related results framework with specific indicators for HRITF should be developed. Since some interviewees questioned the feasibility of a results framework for HRITF it might be appropriate for the Bank to contract some external, independent support to work with the HRITF team.

7.2. The Annual Report should focus on progress against the four HRITF objectives, and focus on expected results as soon as the theory of change and related indicators are defined.

7.3. The need for 2 reports annually is excessive and bears important opportunity costs for the small HRITF team: the mid-year report should be dropped.

7.4. Annual work plans should become standardised, and relate explicitly to the four objectives and the results framework. Performance against work plans should be reported annually in the annual report. In this manner the work plan and linked annual report would become the main basis for the annual donor consultations, which should become more forward looking and strategic.

7.5. Information on activities by country should be included in the main Annual Report as an Annex. Country pages and key country documents might be included on the Trust Fund website and key documents placed there.

7.6. More clear and explicit reference should be made in annual reports and work plans about staffing and capacity issues at the HRITF Team level given the substantial programme growth. While staffing, capacity and workload issues came up repeatedly during our meetings in Washington there is hardly any mention of these in the annual reports. Is the HRITF team fit for purpose? Can short term consultants compensate for staffing ceilings? Are there efforts needed elsewhere in the Bank –not just at the HRITF team level – for the programme to meet its targets?

7.7. Donors should make more use of the secure donor website – the Bank should provide support to enable them to do so effectively if felt necessary.

7.8. Efforts to improve expenditure planning and reporting should continue and progress monitored. There should be a revised financial reporting format which sets out much more clearly:

  7.8.1. the cash flow situation of the Trust Fund – clearly outlining revenues (investment income and donor contributions) and expenditures (by activity and by country);

  7.8.2 forecasts to be provided by activity and country by calendar year with a comparison of the previous year's expenditure with the actual one. Major discrepancies should be identified and a brief explanation noted. It is also recommended that donors should assess the accuracy of current expenditure projections in early 2013 using April to December 2012 expenditure figures when these become available.

7.9. For the HRITF evaluation planned for 2015 evaluators should have full access to data from the secure donor connection from the outset.

8. **Finance: Is there any efficiency savings which the TF should endeavour to make? Are there any aspects of the budget that are under-funded?** Due to the lack of disaggregated data it was not possible to analyse this issue in detail.

5.3 Conclusions and recommendations linked to HRITF objectives

In addition to the broad recommendations made above there are a number of quite specific, detailed conclusions and recommendations linked to the review of the four HRITF objectives. These have been grouped here for visibility and ease of follow up purposes. To the extent possible we have avoided repetition with 5.2 but some repetition is unavoidable.

Table 30: Conclusions and recommendations linked to RBF objectives

Conclusions	Recommendations
Objective One - Support design, implementation, monitoring and evaluation of RBF mechanisms	
In terms of the approval process the establishment of funding streams has provided greater clarity but there are still some mixed messages, and poor communications following the application process. There are also questions about geographical focus – little emphasis in India despite its huge needs. We found no examples of negative feasibility assessments – despite the strict eligibility criteria . The initial focus has been on building demand – there is little overview/strategic analysis of what the TF has currently committed to. The support provided by the Bank for RBF design was relevant and has been well delivered especially given that it has had to develop its systems from scratch and learn by doing. Pre-piloting is extremely challenging, time consuming, expensive, for many reasons: limited initial guidance in rounds 1 and 2; the novelty of the approach; initial teething problems; and unrealistic timeframes have undermined performance. Qualities of the task team leaders (TTL) and their being or not based at country level, in which case the quality of staff at the country office to follow up on decisions made in Missions and to participate in sector policy dialogue becomes crucial. A lack of continuity with consecutive Bank missions often involving different people caused gaps in communications and made policy dialogue more complicated. It is too early to say much in relation to pilot implementation though similar issues are likely to apply.	There is a need for more thorough feasibility assessments, and for clarity about what aspects will be supported in the pilot when compared to the contents of the original application. The TF needs to develop a more strategic approach in the choice of pilots. It needs to – map more precisely what is currently being funded – identify the gaps – discuss with donors/other partners – consider ways if necessary to incentivise TTLs. A more flexible approach is needed to allow for individual country circumstances. E.g. countries are allowed to apply only once for a stream for each IDA grant – there may be circumstances where additional funding might be appropriate for needs unforeseen or under-budgeted at design. The Bank should proactively explore interest for HRITF support in selected countries rather than using the “demand driven” approach (Cambodia, India) when interesting PBFs are in place or might be developed due to large poverty and need for RMNCH services. A more formal process is needed for reviewing and informing countries of decisions made following applications. More thorough guidelines for pilot design and for pre-piloting based on a more realistic assessment of costs should be developed. The Bank should provide stronger support to TTLs as is needed for them to work more closely with health partners at country level. In addition to country criteria The Bank should only support RBF pilots where it has the capacity to take them forward effectively e.g. TTL with practical experience on RBF, based in country/country has a strong country team, close follow up from HRITF team in Washington and/or in the region, adequate time budgeted for donor/MoH interactions e.g. attending SWAp reviews. Project preparation can be easier if this learning is documented with the Bank’s Legal department so future projects can benefit from the flexibilities within the Bank’s legal framework.

Conclusions	Recommendations
Objective Two - Develop and disseminate the evidence base for implementing successful RBF mechanisms	
The IE component is being taken forward in a systematic manner. Every CPG will have an IE linked to it. Although it has been a struggle the need for IE now seems to be broadly accepted in most pilot countries . The IEs have tested a limited range of RBF mechanisms. It is not clear to evaluators whether this was the intention or not. The IE toolkit has been developed, which should provide broad direction but in a few places tradeoffs do exist between the scientific rigour of IE, country ownership and the feasibility of undertaking IE in fast changing health systems. A number of interviewees questioned the reliance on IE – however, this does seem to have been what the donors wanted. There has been and there still is insufficient focus on (external) monitoring[1] and documentation of the design and implementation of pilots, confirmed in Rwanda, Nigeria and partly in Zambia but which may be affecting more pilots. Please see 3.3.3. and 3.4.4. Documentation should be the main source for HRITF learning about pilot design and implementation until the end-line surveys are conducted – yet no internal or external analytic pieces have been found by these evaluators. The TF has established a website which has largely achieved its aim of acting as a “global knowledge centre and network” for RBF. The level of usage has been very respectable for a (relatively new - at the time) technical topic such as RBF. It provides a rich source of information up to date and has generally been kept up to date followed the standard **good practice processes** for developing and maintaining the website - strategic communications plan - explicit (written) QA process for all products. It contains positive and negative content though there are some contradictions and even examples opposed to TF objectives. It now provides more - but still too little – content on HRITF. The site does not list the countries with RBF pilots. The IWG has been reasonably useful – but is largely done because it is a requirement in the Grant Agreement. Tensions remain as to whether it should be agency based or have a broader focus and whether it should focus on information exchange or actually “do” more.	There needs to be a stronger focus on documenting designs and pilot implementation. Every country where a pilot is being designed or implemented should have a documentation requirement built in the design that collects, analyses and disseminates information on design, pre-pilot and pilot with an agreed periodicity and in a systematic manner. This task should be contracted out to enhance objectivity and accountability. The Bank needs to reach a balance at country level between the emphasis on IE (which many see as the main or only interest of the Bank) and an equal effort on documentation that is not yet visible enough at either country or global levels. Where documentation was underestimated or under-resourced at design, countries should be allowed and encouraged to apply for documentation funds from the HRITF. There needs to be clear strategy to delivering results from ongoing baselines to a set of key stakeholders, and then to target those stakeholders on a more regular basis. IE concepts notes need to be more explicit about tradeoffs and justify final approach. There needs to be greater clarity on what constitutes the minimum standard for a useful IE. The IE capacity at the level of the HRITF Team should be enhanced - staff/consultants numbers are too small vis a vis more than 20 IE at design or implementation stage: risks to IE quality and full use of results. A mapping of the current pilots is needed to set out the current situation – discussion on range . The website should make greater distinction between types of content. It should prioritise those related to impact. This might be done by facilitating access to documents through additional entry points (e.g. by technical area, country, and through a search function), and to have a clearer separation between ‘newsy’ items and features, and the more technical documents including lessons and analyses. Need for a health warning/disclaimer for those using the website (as some content is contradictory/is plain wrong) . There should be more HRITF content on the website – including country pages with key operational documents.

Conclusions	Recommendations
Objective Three - Build country institutional capacity to scale-up and sustain the RBF mechanisms, within the national health strategy and system	
Several points linked to capacity made in earlier objectives. In general capacity efforts could be seen at country level (mainly linked to the training effort to launch pilots) with workshops and other activities being used. In this sense the approach to capacity building was generic and ad hoc rather than part of a broader or systematic capacity building plan. Bank engagement at country level is key for the learning, capacity building and attracting additional financing objectives. Relying on "remote control" from Washington or a weak country team compromise progress on all three objectives. Points on the use of country systems covered elsewhere. The Bank has made visible attempts to use country institutions as part of pilot design and implementation. However the complexities of RBF and IE design should not be underestimated and often country institutions are not familiar with these concepts and require a lot of technical assistance. Many of these issues cannot be detected or fully appraised during application and RBF contract negotiations.	Need for the HRITF team to adopt a more proactive approach to ensuring that countries have institutional development and capacity building plans: what capacity needs to be built where? Who will be targeted? How will this be reviewed? Earlier recommendations about the Bank ensuring the presence of a competent and pro-active TTL where pilots are being implemented is emphasised again here. Since the technical assistance inputs for bringing country institutions up to speed with RBF and IE design and implementation matters can be very substantial (cost and effort) it is recommended that capacity building plans become part of any pilot being implemented and that they are based on better capacity assessments during feasibility studies and pre-piloting, since the real capacity gaps cannot be fully assessed during the application process. This may require TTLs being allowed to apply for additional capacity building support funds, which in turn require the HRITF Team to be responsive and flexible in the way internal HRITF expenditure norms are applied. The involvement of stakeholders at country level should become more systematically pursued (what should TTLs do and how often) and closely monitored given that information sharing at early stages and a regular dialogue might increase the chances for other donors to help with the scale up of pilots if these are successful. At global level the platform for keeping donors informed on Bank supported RBF initiatives and for exploring funding options remains narrow. While much will depend on results there should be more proactive information strategy with key health donors in each region: what is being piloted and researched? What preliminary results? How can donors help in an eventual scale up effort?

Conclusions	Recommendations
Objective Four - Attract additional financing to the health sector.	
There is no great clarity in available documents or in the interviews held on what the intention was in relation to this objective, and no targets. The link between IDA credits and access to TF grants has been formalised. There is some evidence that HRITF grants have brought in additional IDA funds but causality runs both ways. We were unable to verify some claims of pure additionality (made in the 2008 report). The TF has data on the association between TF grants and the IDA credits but no systematic assessment of additionality has been made since the 2008 Annual Report. There is some evidence the TF support has contributed to greater aid effectiveness and also leveraging funds from other Trust Funds (but not from other donors. There is a general perception that as important (if not more so) as the attracting additional financing objective are the broader implications of the link between TF grants and IDA credits. Not possible to assess impact but experiences from other Bank initiatives which did not establish such link suggest that it was the right thing to do. We found evidence of cases where substantial support was being provided by other parts of the Bank in support of RBF and that working arrangements were being formalised.	There should be more systematic reporting of additionality – assumptions/judgements need to be clearly set out. The approach should continue to build on strong links with Finance Ministries but also build relations with bilateral agencies, especially in aid dependant countries . Sustainability: the HRITF Team and donors should consider how best to deal with uncertainty relating to any failure of the countries to secure the rewards set out in their pilots. If necessary an options paper should be prepared. Greater emphasis should be placed on the issue of transaction and incremental costs as part of the impact evaluation to help clearly set out the institutional and financial sustainability challenges. Evaluations to help fully assess the costs of sustaining RBF approaches if appropriate. Costing of future requirements would be useful beginning from midpoint of the pilots.

Annexes

Annex 1 – List of People Met and Approached

We present the key informant form the overall study first followed by those approach for case studies and desk reviews. All in alphabetical order within the respective organisation or country.

M = Met in person; P = by Phone; S = by Skype; E = by email;	
Norway	
Balbir Singh (M,P,E)	Senior Adviser, Norad Evaluation Department
Ingjerd Haugen (P)	Senior Adviser, Ministry of Foreign Affairs
Ingrid Hordvei Dana (M,P,E)	Senior Adviser, Ministry of Foreign Affairs
Ingvar Theo Olsen (M,P,E)	Senior Adviser, Global Health and AIDS Department, Norad
Marie M Gaarder (M)	Director, Norad Evaluation Department
Siv J Lillestøl (M,P,E)	Senior Adviser, Norad Evaluation Department
Tore Godal (P)	Special Adviser, Ministry of Foreign Affairs
World Bank in Washington or contacted from Washington	
Abdo Yazbeck (M)	Lead Economist, Health, HDNHE
Benjamin Loevinsohn (P)	Lead Public health Specialist, AFTHE.
Christel Vermeersch (M, P, E)	Senior Economist, HDNHE. HRITF Team.
Christian Baeza (M)	Sector Director, HDNHE
Daniel Cotlear (M)	Lead Economist, HDNHE, Former HRITF Project Manager
Darren Dorkin (E, P)	Senior Operations Officer, EASHH. Former HRITF Project Manager
Elena Nesterova: (M)	Resource Management Officer, HDNOP
Fadia Saadah (P)	Manager OPCIL
Gayle Martin (M,E,P)	Senior Health Economist, AFTHE, HRITF Rwanda TTL
Kathryn Boateng (M)	Consultant, HRITF
Kees Kostermans (M)	Lead Public Health Specialist, SACHN
Kimberley Bumgartner (M,E,P)	Knowledge Management Officer, HDNHE – HRITF Team
Nicole Klingen (M, E)	Sector Manager, HDNHE
Petra Vergeer (M)	Consultant, HRITF

M = Met in person; P = by Phone; S = by Skype; E = by email;	
Rachel Light (P)	Operations Analyst, HDNHE
Rama Lakshminarayan (M, P, E)	Senior Health Specialist, Interim Project Manager, HRITF
Tony Measham (P)	Consultant, HRITF
DFID London	
Ellie Cockburn (M)	International Trade and Development, DFID
Julia Watson (M,E)	Senior Economic Adviser, DFID
Rachel Turner (M)	Director, International Finance Division, DFID
Sally Waples (M,E,P)	Global Funds Department, DFID
Other key informants	
Abebe Alebachew (P)	Ethiopia Independent Consultant
Aboubacar Kampo (P)	UNICEF
Alix Beith (M)	Independent consultant – writer on RBF
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Klara Osconbaeva	Ex-Chief accountant, MHIF
Marat Kaliev	Deputy Minister of ealth – ex MHIF
Melitta Jakab	WHO
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Annex 3 – Summary reports from desk reviews and case studies

This annex contains the executive summaries of :

Rwanda Case Study

Kyrgyz Republic case Study

Benin Desk review

DRC Desk review

India Desk review

Nigeria Desk Review

Zambia Desk Review

Notes on Tajikistan Pilot

Notes on Senegal

Rwanda Case Study

Main findings and conclusions

Background to the health sector in Rwanda

While the focus of this case study is to look specifically at the support provided through the HRITF it has been extremely challenging to dissect such support from other development initiatives which should be seen as complementary and mutually reinforcing. For example:

- The Rwanda health facility level PBF (facility PBF) began in 2005 and has been increasing in both coverage of health facilities and scope of services included under the PBF package over the years. The experience developed in the implementation of the facility PBF has therefore been crucial in designing and implementing the community PBF (CPBF) program, which is what is being supported by the HRITF Country Pilot Grant (CPG).

- The Community PBF concept predated Rwanda´s application for HRITF CPG funding in 2008 and was already captured in the Health Sector Strategic Plan II (2009-2012) and fitted nicely with the Vision 2020 Umurenge programme (VUP) led by the GoR aiming to ensure that economic growth is pro-poor and that the majority of the population could benefit from the improvements in living standards that the country as a whole has been experiencing. The Community PBF is also fully consistent with and complements a key policy reform brought about by the VUP known as the Ubudehe process of village-level community decision making. These reforms have complemented other policy initiatives such as decentralisation by which basic health and education services are now the primary responsibility of local governments.

- Separate from the HRITF the Bank has been supporting all the processes above since 2005 through different types of grants, credits and loans, all of which have had a strong capacity building component. Examples include: technical support to the evaluation of the facility PBF initiatives (resulting in the highly publicised impact evaluation study by Basinga et al (2011): general budget support to the GoR with a strong focus on community outcomes (notably health) through 3 consecutive Community Living Standards Grants (CLSG) (two grants in 2009 & 2010 and a credit in 2011), each worth approximately US$6m; other interventions, such as the Decentralization and Community Development Project, a Sector Investment Loan (SIL) worth US$20 million that was completed in 2011; just to mention some key interventions that are directly related to the community PBF. The HRITF grants where delivered in sync with the three CLSG grants, so the World Bank health missions conducted since 2008 reviewed both the CLSG and HRITF grants as part of a unique support programme.

- The World Bank has been supporting health through on-budget interventions and has been working with other donors providing on- and off- budget support to community and facility based interventions in parallel to the support being provided by the Bank. World Bank. Specifically, the Global Fund is a key contributor to the incentives being provided to CHW cooperatives, the supply-side element of the PBF. USAID has been for several years the largest bilateral funder to the Rwandan health sector. Its funding has directly supported health facilities and the community level interventions while, indirectly, its funding through Management Sciences for Health (MSH) has been a key input to the conceptual development of the CPBF model and the training of CHWs, CHW Cooperatives, sector Steering Committees and health facility managers , among others, all of whom are key stakeholders in the CPBF model. UNICEF has also played an important role in strengthening community development and community training activities. Other donors like DFID, Germany and Belgium have been contributing sector budget support to the MoH (and Germany and the UK general budget support too), a key financing input for the MoH to finance facility and community level PBF interventions. Finally, it is worth reminding that Belgian and German technical cooperation played a critical role to develop the initial PBF pilots in post-genocide Rwanda that triggered the community health insurance model (mutuelles) and the national PBF approach. The European Commission (EC), the African Development Bank (AfDB) and the World Health Organisation (WHO) should also be seen as key partners of the GoR in strengthening the national health system.

In sum, the HRITF CPG and linked IE covered in this case study should be seen as just one element within a much broader development strategy fully owned and driven by the GoR and closely supported by all the above development partners. This is why dissecting the CPG from that context has been so challenging, if only, in this case, for all those highly positive reasons.

What is the HRITF supporting in Rwanda

The Rwanda pilot supported by the HRITF is the Community Performance Based Financing (CPBF) scheme by which performance incentives are delivered at community level. Specifically, supply-side cash incentives are targeted at community health worker (CHW) cooperatives for delivering a selection of RMNCH services while demand-side in-kind incentives are paid directly to village women when they use selected RMNCH services. The pilot addresses a well recognised gap –the failure of the ongoing facility PBF (operating in all Rwandan health centres) to generate sufficient demand for maternal and child health services and to increase the delivery of these services to the required levels for Rwanda to meet its MDGs 4 and 5. The pilot builds on and attempts to improve a pre-existing CPBF scheme that the government launched in 2006 that did not include demand-side incentives and did not pay as per performance – CHW cooperatives where paid cash incentives regardless of numbers of services delivered- as the latter could not be easily measured by the information systems available at that time. To distinguish the HRITF supported pilot from the

national pre-existing scheme we refer to the pilot throughout this report as the CPBF+, even though this is not a term used in Rwanda.

Design of the RBF project

Application. The application process for HRITF funding was **well managed by the Bank.** The resulting proposal was **well aligned** with the Health Strategic Plans (HSSP) I and II(2009-2012) and was developed in a collaborative mode with health institutions and with regular consultation with other health donors and multilateral agencies. The proposal had a **clear focus on Reproductive, Maternal, Neonatal and Child Health (RMNCH) services** and, specifically, on improving Rwanda´s performance on **MDGs 4 and 5 (less so MDG 1c – the CPBF has no nutrition-related indicators)**. The original proposal did have **a clear poverty focus** by targeting the **pre-piloting** of the model on the 30 poorest sectors- It also had an **implicit gender focus** by targeting incentives on CHWs (who are mostly women), on CHW cooperatives (organisations led mainly by women) and on women of reproductive age. The proposal included a draft Impact evaluation design that incorporated all the elements above including gender disaggregated data.

Design – engagement by the World Bank with country stakeholders during the design process . The range and scope of activities that took place as part of the design of the CPBF are very impressive in terms of the performance of the MoH and the Bank (see milestones in Annex 1). During this period the World Bank relied on missions to provide technical support and to oversee the grant and HRITF implementation, with missions taking place approximately twice in a year. Several donors and MoH staff interviewed were of the opinion that lack of presence of a TTL in Kigali and constant changes in the composition of World Bank staff who participated in the missions made the policy dialogue between the World Bank, the MoH and the donors less fluent than it should have been and reduced the visibility of the CPBF effort to external stakeholders including important health donors. This is perhaps why most representatives from the main health donors in Rwanda interviewed by the author were unaware that the World Bank had been supporting the CPBF effort or that an impact evaluation would be undertaken. This represents missing opportunities to involve other donors in a scheme with learning, sharing and dissemination at the core. It is also inconsistent with the fact that should the pilot be successful and the CPBF scaled up, as planned, the support from other donors might prove important for sustainability purposes, so the earlier donors are briefed about the scheme the better.

Country Case Study findings

Implementation: external monitoring and documentation of the ongoing process. After all the effort invested during design the World Bank ceased to provide regular technical support by September 2011, or to finance support for external monitoring and documentation of the pilot by mid-2010 when the existing contract with the School of Public Health of the National University of Rwanda expired. Since the HRITF is primarily a learning programme that is testing RBF models lack of technical support and absence of documentation at

the crucial time of implementation might jeopardise the learning side of the scheme and might also reduce the validity of the IE results (see why in next paragraph). In general, the absence of a learning work programme linked to questions and issues that are emerging from the pilot is of concern to the evaluators.

Impact evaluation. The Impact Evaluation has been thoroughly designed and implemented according to international standards. It should provide a necessary and essential ex-ante and post-intervention snapshot that will enable a link between the interventions and expected changes at service output and outcome levels within specific population groups, with particular emphasis on children, village women and CHW. From a policy perspective it is desirable to complement the IE results with improved information and documentation of the ongoing process that, as has been explained, is not being documented. Proper documentation would enable to establish, for example, the level of effort (human, not just financial) that has been required under each of the models being tested, particularly if the differences in impact found for two different CPBF models are too small while the associated costs (mainly staff time) might be substantially different. External documentation of the implementation process is also critical so as to avoid or deal with potential contamination within the 4 intervention arms of the IE. Improved monitoring and documentation should be resumed (if possible)- the bank and the MoH should determine the best ways to achieve this aim.

Lesson learning and dissemination. We do not think that there is an explicit and systematic knowledge gathering and dissemination strategy linked to the Rwanda pilot. This is largely linked to the afore-mentioned lack of effective documentation of the CPBF+ and to the absence of a set of questions and issues that will be looked at as these emerge rather than just at the time of the end-line survey. With the exception of workshops the costs devoted to documentation, knowledge generation and dissemination linked to the CPBF+ that have been supported by the HRITF (or by anyone else) have been very modest and, in our opinion, insufficient. There is no shortage of interesting questions linked to CPBF implementation – the problem is that nobody is financially or technically supporting a programme to address those questions. It should be also possible to strengthen formal links between the work that the WB has supported in Rwanda and the African Community of Practice on RBF and, perhaps, to explore north-south and south-south research collaborations and publications on RBF in the region.

It is important to emphasise the learning programme at regional and global levels cannot take place in the absence of a strong knowledge programme at country level.

How aligned and harmonised has been the HRITF support? The Bank's support to the Rwanda CPBF+ has been highly strategic –PBF is a central feature of Rwanda´s HSSP- and opportunistic –there was a good chance to strengthen an existing national initiative to improve MNCH services and

outcomes for poor women through a combination of community-based supply and demand interventions. The Bank provided its financial support through the budget, which means it was fully aligned and harmonised with country systems.

Capacity building linked to HRITF support in Rwanda. A capacity building strategy as such has not been a visible part of the HRITF/CLSG support, neither has it been explicitly defined, systematically pursued or targeted at the right decision and opinion makers. This is not to say that capacity building has not taken place: of course it has in the form of workshops and formal and informal exchanges during the design of the CPBF+, but in a programme with learning and capacity building at its core the capacity building side could have been much more prominent. The Bank was fortunate to operate in an environment that was considerably open to and knowledgeable about the PBF concept and its application. We see the lack of an explicit capacity building strategy rooted in causes similar to those reported earlier in relation to the lack of effective external monitoring and documentation of the CPBF+.

Lastly, in the absence of effective documentation we do not think that the costs of implementing PBF to Government and other health partners are being assessed - to our knowledge there has not been an attempt to costing the CPBF+ activities other that some rough costs estimated during the baseline surveys. It is noteworthy to report that the CPBF+ costs to date and those linked to its eventual future scale up were not part of the preparatory work for the resource envelope for the next Health Sector Strategic Plan (to begin in 2013) that were taking place during the author´s visit to Rwanda. The Bank has not been part of those discussions to date because, as said earlier, its country office is not involved in health matters.

Objective four - attract additional financing to the health sector. There was not much clarity among stakeholders met about the practical implications of this objective. It is clear that the HRITF investment has been additional but now that it has been disbursed there is no evidence of the MoH or any donor having been approached to assess the financing scenario should a decision to scale up the CPBF+ be taken. The costs of CPBF+ implementation are not yet known (or systematically documented, as mentioned earlier) but these are likely to be high. After all the CPBF is a programme with many internal “verification loops” and where the logistics for ensuring availability of the in-kind demand-side incentives to be paid to women should not be underestimated. The government of Rwanda has born the bill to date but the current economic recession, the increasingly lesser number of health donors and lower health aid budgets by key donors all suggest that sustaining CPBF expenditure may prove challenging.

In conclusion, there is a need to work closely with health sector partners BEFORE the results of the IE are available to estimate the CPBF projected resource envelop. This would have been much easier if the World Bank had participated in established health donor meetings or if it had continued supporting the monitoring and documentation of the CPBF that it helped design.

Can HRITF continue to support CPBF in Rwanda? The HRITF support provided by the World Bank to the CPBF seems to have come to an end, with the exception of the end-line survey impact evaluation planned form 2013. There does not seem to be any Bank health operation in the pipeline. Does this mean that the technical support from the HRITF and the support for external documentation of the pilot have also ended? In that case, and under current HRITF rules, can Rwanda apply for additional technical support and for documentation support for its facility and community based PBF? These are questions that the MoH and some donors asked this consultant which are conveyed to the Bank, with a view to encourage the Bank to engage with the GoR on these matters. Can the HRITF team in Washington strengthen its communications with Rwanda and clarify if a PBF learning programme implemented by Rwandan institutions might still be funded from the HRITF? The bottom line seems to be that while the lifetime of the HRITF may have come to an end the Rwanda PBF pilots continue to need attention from the HRITF and the international community.

Kyrgyz republic Case Study

Main findings and conclusions

Background to the health sector in Kyrgyzstan

The RBF project in Kyrgyzstan has been developed over the lifetime of two health strategies: the **Manas Taalimi reform programme (2006–2010)**, and the new sector strategy, **Den Sooluk (2012-2016)**. The main goal of *Manas Taalimi* was to improve the health status of the population through the creation of a responsive, efficient, comprehensive and integrated health system and through increased responsibility of the population, society and state authorities for population health. The Den Sooluk aims to build on the foundations of Manas Taalimi.

During this period, a **Health SWAp** has also been developed - started by the World Bank, WHO and USAID/ZdraPlus project in 1995 - but now incorporating other partners including DFID, KfW, SDC and SIDA, with pooled financing channelled through the government systems. The remaining external funds for the country's health system take the form of parallel financing for implementation of various projects and come from a variety of international organizations.

The framework for the SWAp is the Manas Taalimi, alongside a five-year Programme of Work, sector expenditure programme, Medium Term Budget Framework and a common Performance Monitoring Instrument which sets out a range of outcome, output, input (and fiduciary) indicators. Government prepare an Annual Programme of Work setting out key actions, activities, responsible agencies, sources of financing and timing in 8 programme areas, which includes parallel funded activities.

The Kyrgyz Government remains committed to observing the SWAp principles for the design and implementation of Den Sooluk: MOH leadership and partnership with donors; one national sector program; implementation led by the MOH; donor funds aligned with program priorities including both budget support and other funding modalities; and formal sector monitoring and coordination mechanisms through joint annual reviews.

What is the HRITF supporting in Kyrgyzstan?

The US$12 million Kyrgyz Republic Health Results Based Financing (RBF) Project includes US$11 million for RBF payment mechanisms and US$1 million for an Impact Evaluation. The approach involves the **introduction of a quality-related dimension into *existing payment systems* for primary health care (capitation) and hospital care (case-based payment)**. The two main interventions are:

a. enhanced supervision only
b. performance-based payments (which naturally include enhanced supervision)

HRITF approved the Country Pilot Grant for the Kyrgyz Republic Health RBF Project in December 2008. Preparation has been ongoing since. Only the Trust Fund Preparation and Impact Evaluation Grants have been awarded to date. The Implementation Grant is expected to be signed shortly.

The project will be pre-piloted for six months in one Rayon Hospital to allow for at least two full cycles of incentive payments, and then be piloted in rayon hospitals throughout the country over a three year period. Twenty rayon hospitals will be in each of the pilot intervention and control arms. 18 months after the start of the Pilot, it will be introduced at the PHC level in the pre-pilot rayon.

Design of the RBF project
The following **key principles** drove the design process;

- integration of the approach with existing provider payment mechanisms/ contracting system
- payments to organizations not individuals
- use of quality - clinical, health output, administrative/management and fiduciary - indicators
- verification of results by an independent third party with payment subject to verification
- promotion of management autonomy, ensuring transparency and achieving impact
- mandatory participation according to an agreed schedule (to avoid self-selection bias)
- size of payments linked to their potential contributions to MDG 4 and MDG 5

Management and oversight will be carried out by:

- An RBF governance body - the **National Steering Committee (NSC)**; to be comprised of MOH, MHIF, Ministry of Finance (MOF), and the World Bank. Responsible for the full oversight of the project, including regulating the size of the performance-based payments.
- An RBF operational team - the **RBF Secretariat**; responsible for: day-to-day implementation and management; peer verification; validitation of reported data. Housed in the Mandatory Health Insurance Fund (MHIF) but report to the National Steering Committee in the MOH.
- The **purchaser (MHIF),** responsible for fund flow, accounting, and disbursement. It will receive a flat administrative fee of 2 percent of RBF payments to cover operating costs.
- An **Impact Evaluation (IE)** Team.

In terms of the **level of payments and use of funds**, the following rules will apply:

- The payments will constitute an additional 15 percent of total treated case payments using DRGs - assuming the highest level of performance - and similar amounts for PHC facilities, paid on a quarterly basis.
- Facilities can use a maximum of 40% of performance based payments for civil works purposes. No guidelines are set for the proportion of salary and non-salary expenditures from performance based payments.

Country case study findings

The Kyrgyz health system is relatively sophisticated. Unlike most countries in the region, the Kyrgyz Republic was successful in maintaining universal coverage during the post soviet era. Health sector reforms have been going on for a considerable time with significant external support, and substantial local capacity has been built. A results based funding approach is *already* in place, at both secondary (rayon hospital) and primary care levels, and the pilot is building on this.

The pilot addresses a priority health need. The pilot addresses a well recognised shortcoming - the failure to improve maternal outcomes – and the key role played by poor quality services in hospitals in this. The pilot design is focused on the rayon hospital level with a small PHC component. It is widely accepted that **quality of services is more of a constraint that quantity and access issues.**

The mid-term review of the Manas Taalimi Health Sector Strategy 2005-2010 identified that while substantial gains have been obtained in financial risk protection, equity, access, and efficiency, quality and health outcomes have not improved and threaten achievement of the MCH MDG targets. The SWAp mid-term review also reported on the challenges regarding the quality of care.

The maternal mortality ratio more than doubled between 2003 and 2008 going up from 49 cases to 104 per 100,000 live births. Infant and under-five mortality rates, although slightly improved, remained high over the period. Infant mortality reduced from 43 per 1,000 live births in 2000 to only 27.1 in 2008, while under-five mortality was reduced during the same period from 50 to 31.5 per 1,000 live births. Further, the share of perinatal deaths in child mortality was as high as 70%.

There is great pressure domestically to demonstrate results. The health SWAp has used a lot of resources, there has been a large increase in the share of the national budget going to the social sectors, and there is pressure on the Government to show results. Whilst many of the indicators are moving in the right direction it has been difficult to demonstrate results in terms of outcomes. As a result there has been strong government leadership in the design of the Kyrgyz RBF Project, and considerable discussion and debate has taken place about the design of the RBF pilot project.

Issues that have created debate:

- The use of funds – how much flexibility to award providers
- Focus on results not just process indicators - a set of quality indicators has been adopted
- Expansion of the pilot to higher level hospitals - this was rejected
- Piloting a community based approach – this has also been rejected
- Impact of large salary increases that have been made to public servants
- Transitioning of key staff (on Government and donor side) during the process
- Perverse incentives (i.e. focusing on secondary rather than primary care)

The design process has taken a lot of time and effort. The process of discussion is important, and a lot of ownership has been developed through the back and forth, but it has taken a long time. The preparation phase will actually be longer than the implementation – which has led to frustration on all sides and concerns about loss of momentum. Lack of money to prefund a pilot is seen as an issue, as is the Government having made funds available to renovate offices to house the RBF Secretariat when the project has not even started. Key national staff being part time was reported to have slowed progress, and there were suggestions that the Secretariat could have been set up earlier.

The design of the Impact Evaluation has also been subject to a large amount of discussion between Government, partners and the World Bank, with the World Bank ultimately agreeing to a reduction in the scope of the Impact Evaluation, as requested by the Government. As a result the Impact Evaluation will address the following primary research questions:

- Does the RBF package (including enhanced supervision) at the rayon hospital level improve quality of care?
- Does enhanced supervision *alone* improve quality of care at the rayon hospital level?
- What is the relative cost-effectiveness of the RBF package (including enhanced supervision) vis-à-vis enhanced supervision alone vis-à-vis business-as-usual in terms of quantifiable quality of care indicators?

The "impact evaluation/scale up if successful" model is not the norm in the Kyrgyz Republic. Government initially struggled with the concept of impact evaluation – the usual approach is to pilot in each oblast and roll out if successful. Some concern was expressed that IE was driving the whole project and concerns about how valid it could be – for example, "can you control for all factors which affect outcomes?" The approach has now generally been accepted. There is clear recognition in government that this pilot might succeed or fail. The MoF suggested that they would like to see an independent review of progress (highlighting concerns about the independence of the process).

The project will make considerable - but not exclusive - use of national systems. The project is a stand-alone operation, but linked to the SWAp. Initial expectations were to use SWAp mechanisms, however the requirements of the

RBF project and the impact evaluation it requires have dictated a rather different – but generally reasonable approach.

The RBF Secretariat will be a quasi PIU using government systems for finance and procurement but bring in contracted staff. Donor partners raised some concerns about the use of parallel structures but were generally supportive of the approach. UNICEF provided some technical assistance to help building national capacity to appraise the case for RBF *before* Trust Fund activities began.

There was a long process of dialogue on financing arrangements. Under the original proposal ***six key principles were agreed to guide the design of the funds flows for the RBF:***

- flexibility required for RBF implementation and achieving program impact
- included in the KR budget approved by the parliament
- accounted for or tracked separately from budget and SWAp funds
- allow immediate and easy payment to VHCs (NGOs rather than government institutions)
- not be subject to taxation
- allow carry-over of funds from year-to-year

There was a clear preference to use existing financing arrangements to the degree possible. A Special Means account was finally chosen as the preferred option for managing the funds.

Sustainability cannot be guaranteed but it is being considered. There are clear ideas on institutional sustainability – the current provider payment system will be amended if the pilot proves successful. It is less clear where the funds for expansion and roll out will come from. The poor economic environment and outlook raise inevitable concerns.IDA resources are scarce – around $60m per annum for the next 2 years, with little prospect for follow up funds to support RBF in the medium term. But the MoF is closely engaged in the process. They are interested in the approach and report strong links with the World Bank in terms of dialogue about financing and fiscal space issues.

Although not linked to the SWAp, the World Bank saw support for the RBF pilot as being conditional on elements of the SWAp agreement, notably the **government commitment to increase the share of the budget going to health.** The Government track record in this respect is extremely positive.

> "The increase in public financing observed since the launch of the SWAp has contributed to many of its achievements. It has allowed salary increases to medical personnel, increased financing for medicines and supplies, which in turn have reduced patient out-of-pocket payments."
> Source: SWAP MTR

Benin Desk Review

Summary conclusions and recommendations

Findings - overview

> “The dynamic is quite positive in Benin – because the government is clearly engaged in HF reforms, implementing new instruments, RBF, but also health insurance etc. There is a positive dynamic to increasing health finances and there is the alignment of partners”.
> *Source: WB interviewee*

- **Progress**: Despite a slow start, interviewees felt that Benin was making good progress.
- **Government engagement and buy-in**: Government interest is again strong, but political engagement has varied over the course of the RBF planning, perhaps due to changes at ministerial level.
- **Harmonisation**: The harmonised approach that has been achieved for the RBF across Benin with agreed indicators and project manual in place for the World Bank, GAVI and the Global Fund was seen by all interviewees as a success of the RBF initiative to date.
- **Procurement**: Procurement was very slow and resulted in lengthy delays in the baseline. This was seen as having been as a result of trying to avoid transaction costs by having one large provider.
- **Gender:** While there is a focus on gender and equity as part of the IE, interviewees were not clear as to the systematic approach to gender and equity issues, such as engagement of women and other vulnerable people in planning and monitoring of services.
- **Balance**: Several interviewees felt that the balance between the RBF pilot and the IE was about right and that very important lessons will be learned about what works that will enable effective use of RBF, as well as making Benin a regional model. Others thought that even in Benin, where there is capacity to do this work, there is too much emphasis on – and resources devoted to - IE. One interviewee felt that there was a strong link between the implementation and the IE side, as well as a clear understanding of each other’s needs and objectives. This was seen as important for the effectiveness of the intervention overall.
- **Payment risk**: One interviewee identified a risk in terms of payments – after a two year commitment there will be a full assessment based on performance. If there is underperformance, there is a risk of reduced payment, which could cause a mismatch between different areas.
- **Wider health systems transforming**: RBF was not seen as the only approach to improving healthcare provision – wider health systems reform is needed alongside RBF. In Benin, the broader IDA programme provided some of this, in terms of improved access and a pro-poor approach.

Recommendations

Objective 1
Procurement: It is worth weighing up the balance between transaction costs for multiple smaller contracts with the time that may be required for a large, low-transaction-cost contract, which may delay implementation. (interviewee)

Gender: Some additional focus on gender equity issues to ensure a systematic approach (e.g. a gender and pro-poor checklist for human resources and service delivery) may be helpful for further increasing the effectiveness of the intervention.

Objective 2
IE: Integrating the IE with the project is very complicated. It is critically important to design the IE either before or at the same time as the planning for the project itself, otherwise there is a risk that there will be IE components that are left without funding, which can then result in difficult changes being required in the project itself. (interviewee)

Objective 3
Ongoing alignment of the capacity building component with the RBF work to ensure the capacity needs of RBF are addressed across sectors will be important

Objective 4
Building capacity – particularly of local and community based organisations to carry out verification – and maintaining the engagement and interest of government at a high level were seen as important for the sustainability of RBF in Benin.

To avoid a mismatch in payments (in the case where one area underpeforms) it will be important to monitor regularly to give the proejct every chance of success, as well as communicating effectively to ensure clear understanding of emerging issues.

DRC Desk Review

Summary conclusions and recommendations

Conclusion

- **Design**: The original design was complex for a fragile state with little capacity. Simplifying this and reducing the funding from the originally requested $15 million to the current $420,000 was a good decision.
- **IDA**: Linking the pilot to the IDA caused a number of additional problems (such as funding interruptions, arrangements with NGOs, problematic contracts) but has potential benefits as well.
- **Government buy-in:** There is strong government buy-in to the RBF pilot as well as the IE to provide evidence for rollout in health and other sectors. Education was one area mentioned by the government interviewee where RBF could have a significant impact on gender equality in increasing girls' and women's access to education, particularly in rural areas. Some further efforts could strengthen the partnership, such as provision of the baseline in French.
- **Programme time:** Preparation for the programme took a long time – 2 years. Now DRC is in the second year of implementation; all interviewees felt that it is important that the programme is completed. Interviewees appreciated the length of the overall RBF programme, which allows for development, lesson learning and sustainability.
- **Baseline revision:** It was difficult to control for emerging variables linked to staffing, etc, resulting in a necessary revision of the baseline.
- **Access to site:** Katanga is an inaccessible area, and particularly difficult for WB staff who cannot use commercial airlines, although worsened access emerged after the choice had been made. Interviewees noted, however, that much of DRC is inaccessible. Difficult access contributes to high supervision costs. This has been addressed in part by strong TA staff in the field to deal with quality issues.
- **Capacity building:** A hundred local staff have been trained in RBF and regular lesson learning sessions are in place on an ongoing basis. A more systematic approach to capacity building nationally and regionally may help sustainablity.
- **Turnover/continuity**: There has been high turnover in the project, with changes in the NGO coordinator, the TTL, project coordinator, PI and team and implementing agency, resulting in lack of continuity. The design was changed in 2010.
- **Gender/equity approach**: There is an implicit gender approach in the programme (e.g. indicators focused on MCH); although some felt that t a stronger 'gender equity' focus (for example, collection of sex disaggregated data) would be premature in such a fragile state, government felt that RBF – if assessed as being effective – can be a strong tool for gender equality.
- **Programme balance:** The balance between implementation and IE was considered problematic by a number of interviewees: IE is a complex intervention with high opportunity that requires considerable management time to resolve problems, which can reduce the time available for policy dialogue or other relevant activities; the emphasis in lesson learning (for example in the Bangkok event) was largely on IE, with little time devoted to RBF itself.
- **Application criteria:** Criteria for application – at least in the early rounds – have been changed and have been considered by interviewees to be rigid.

Recommendations

Objective 1

- It is important to clearly document all agreements and arrangements to ensure consistency across changes of staff, whether in-country or in Washington.
- A number of interviewees noted how difficult changes to HRITF criteria had been in DRC and recommended that such changes not be made in relation to projects in place. Changes to criteria (for example, in relation the percentage of IDA funding allocated to RBF or changes to funding codes) were felt by interviewees to make funding arrangements difficult. More flexibility may be needed to ensure effective implementation that takes into account local conditions, particularly in fragile, under-resourced, post-conflict countries such as DRC.
- Flexibility may also be needed as this is a new concept in many countries and the design may need to be adjusted along the way, particularly in a post-conflict country such as DRC.
- Two interviewees suggested increasing the weighting on gender/pro-poor sensitive indicators to enhance programme impact on gender inequality and poverty.

Objective 2

- It is very important to have strong TA in the field in an under resourced, fragile area such as DRC, for quality assurance of approaches and data.
- There is a need to build capacity and expertise to support francophone countries in relation to RBF.

Objective 3

- Regional and national plans for capacity building for the RBF could contribute to a sustainable, consistent, evidence based approach to RBF rollout.

Objective 4

- A critical issue is to work with government to ensure the approach is sustainable. (interviewee)
- It is important to ensure service provision is backed up by an effective procurement system so that the system is not just paying service providers to do consultations with no drugs to back them up.

India Desk Review

Summary findings

Focus on the Poor and MDGs
Regarding the proposals which were funded:

TB Evaluation study. This study was straight forward and funded with no obstacles; it is however noted that the RBF does not address MDG 1, 4 or 5 – it does address MDG 6.

Karnataka Study 1. While the RBF targets the provision of tertiary care for Non Communicable Diseases -NCDs and therefore is not exactly in line with the objectives of the RBF, it does target the poor.

For the proposals which were not funded:

UP and Nutrition. Both these projects were at preparation stage when they submitted proposals for HRITF funding. Both clearly are within the HRITF priority i.e. addressing MDGs 1, 4 and 5 for the poor. Both Task Managers report that they were informed about the decision not to fund through a phone call and received no written communication. There was no offer to provide technical assistance to design a RBF element within the project under preparation. This contrasts to the successful outcome from providing very substantial TA to the Nigeria project.

On the effectiveness of HRITF application, review processes and criteria for grant approval
Unclear, over burdensome and excessively long review and approval process: The approval process has problematic and unclear from the onset. For example, it is not clear what value is added by having the Bank undertake two technical reviews with two sets of external reviewers of the same proposal only five months apart, particularly in view of the fact that the HRITF participated in the first review and the task team was not consulted during the second review (and not able, therefore, to respond to questions or to explain misunderstandings. It is of concern that the two reviews came to different conclusions and recommendations - especially since the HRITF team received detailed comments on their observations from the first review.

It is also worrying that more than a year after having received clearance for funding of the original request the team were informed that they may not receive funding. This is after they had worked extensively on it for more than one year– and received no funding for this work.

The review process needs to be made clear at the beginning so the country team can determine if there is a reputational risk involved in applying and risking having the funding cut off half way through the process. If the HRITF wish to

fund evaluations of existing RBF projects they will need to be flexible in accepting designs within the existing constraints – and they will need to provide seed funding to cover the significant preparation costs. The HRITF finally needs to decide if they wish to have evidence produced for the international scientific community or for the clients i.e. country governments to make informed decisions.

One size fits all approach not relevant to a very large country with significant demand. These two cases represent a **very substantial missed opportunity** for the HRITF. India is the country in the world with the highest number of poor people, a very large share of whom live in the state of UP; it has the largest number of malnourished children; it is the one country which contributes the largest number of child deaths and that state of UP contributes 25% of India's child mortality. Considering the objectives of the HRITF one might have expected these two projects to have been key priorities for the HRITF and offered the potential for close collaboration with the Bank team – and possibly the Norad and DFID teams in country - to set up major operations.

The India team had also requested substantial learning grants and had a clearly articulated plan for expanding the knowledge base in Indian states regarding RBF. These grants were not funded – on the grounds that each country could only receive $US 50.000 – which they did receive. This raises the question of whether the fixed limit is relevant to all countries – especially countries the size of India and whether exceptions might be made where there are strong reasons to think that there is major demand.

Strong case for the Bank implementing The DFID advisor commented that the Bank is better placed for RBF than some bilateral donors as if results are not achieved in one year and payments therefore are not made, the Bank can 'roll over' funding while DFID and some other bilateral donors cannot.

Nigeria Desk Review

Summary findings

Leveraging of Bank resources
There was significant leverage of Bank resources: This operation has received very substantial inputs and attention from the Country Director and the Sector Management i.e. 'it seems the Africa HD region 'own' RBF' as well as both very substantial additional preparation funding and 'free' technical assistance with a lot of experience in setting up RBF at facility level. This has clearly supported the planning of the combined IDA and HRITF operation.

Application process
There were long delays – there is a need to learn lessons on how to procure under RBF: In spite of the support outlined above **the preparation process has been unnecessarily lengthy** due to the following:

Procurement: A RBF project which pays a lump sum to a facility upon documented achievement of results raises interesting challenges for the Bank's normal project preparation processes as these are largely based on input driven operations. As procurement in a RBF context deals with purchase of goods, works and services from reward money and as these are small and distributed among a large number of facilities – regular approaches of doing procurement plans and bidding/ processes would not work. After much discussion it was agreed to use strengthened country systems along with a set of guidelines for how facilities can use this reward money, including restrictions on what and from where drugs can be purchased, has been developed. **A World Bank standard set of guidelines on how procurement would operate in a RBF context would make it easier to prepare similar operations in the future.**

RBF in the Bank financing context has been implemented as a Sector Investment Loan (SIL) using OPCS (Banks Operational Policy Department) rules for output based disbursement. There is also experience of doing DLIs as SIL. **Project preparation can be easier if this learning is documented with the Bank's Legal department so future projects can benefit from the flexibilities within the Bank's legal framework.** The new Pay for Results (P4R) lending instrument could be an opportunity for doing future PBF projects and early work on the operational policy implications with the use of this new instrument would be beneficial.

Both of the above would have made the internal Bank approval processes much easier. It has been suggested that since the Bank has a recently approved P4R (Pay for Results) lending instrument for their own leading, the Operational Policies regarding this type of lending should have an overhaul so the preparation process can be clarified and time is not wasted on procurement, disbursement and legal discussions.

Government ownership

Government pre-financing shows commitment and has enabled many issues to be addressed at an early stage. The timely and effective TA provided for preparation has enabled the states to initiate a pilot activity in each state using the 'retroactive financing facility of the Bank. This has served two purposes: (i) detailed operation manuals can be prepared prior to the project becoming effective and the project can "hit the ground running" and (ii) the states have been able to take the initiative thereby facilitating state commitment.

Institutionalisation and communications with country donors

The scope of the project is narrow and opportunities to link with other similar approaches in different states should be explored There is a plan for building institutional capacity at all levels during implementation but only in the three states. While it is not clear how effective this will be several other states have approached the Bank asking to be included in future operation. DFID for example is supporting a small scale pilot at facility and LGA level in a few Northern states which includes both demand and supply side RBF approaches. It is a missed opportunity that the Bank and DFID (and possibly other donors) have not joined hands in preparation so more states could be covered, evaluation frameworks aligned and experiences shared between states.

Zambia Desk Review

Summary conclusions

HRITF application and design
The original application for RBF funding was quite vague and did not yet include any elements of design. These were to be developed after the funds were approved.

The design took place during 2008 and then was tested in a pre-pilot in the district of Katete from January 2009. The Katete pre-pilot was initially expected to last for six months, but due to circumstances beyond the control of the Bank (a corruption scandal that affected the MoH in 2009) it was not possible to proceed to pilot implementation until three years later, in April 2012.

In early 2011 the Bank produced and disseminated the findings of an independent review of the Katete pre-pilot. Findings were encouraging and pointed to a number of issues that required further attention and that the RBF design team then incorporated into the pilot design and its impact evaluation. For example, it was found necessary to define minimum eligibility criteria for health facilities to become part of the pilot, to avoid the risk of targeting incentives, commodities or equipment to completely under-staffed facilities.

The Katete pre-pilot had a clear MNCH, pro-poor, equity and gender focus. These aspects are now incorporated into the pilot design and the impact evaluation.

Focus of the HRITF CPG pilot
The RBF intervention is Zambia focuses exclusively on supply-side incentives for government health facilities. The main justification for this approach (and for excluding demand side incentives) is provided in the IE concept note as the fact that in Zambia "health facilities face severe shortages of essential drugs, medical equipment, and staffs are frequently absent, making supply-side interventions necessary to ensure service delivery at acceptable standards". It is also mentioned that health facilities may decide to use the additional income for demand-side incentives. The proximate goal of the Zambia RBF pilot is "to increase service utilisation at sufficiently staffed and equipped facilities, as higher rates of health service utilization are associated with better MCH outcomes" (World Bank, 2010). The model to be implemented in Zambia is a "fee for service" performance based financing through the public health sector paid on a quarterly basis based on quarterly verification. The pilot aims to test a scalable RBF model in Zambia.

Alignment
The RBF pilot is aligned with the health policies of the Government of Zambia (GRZ) and has adopted harmonised approaches and national systems to channel resources. Two external firms are being hired, one to support implementation and internal data validating and a second firm to do the external verification. There is a Project Implementation Unit to provide focus during pilot implementation: this is part of the MoH and reports to MoH departments.

HRITF Implementation – issues and lessons
The corruption scandal cause most health activities implemented by donors to halt and caused a restructuring of the IDA and HRITF operations. In addition to these issues another key factor for delays in RBF design was the considerable time taken by the Bank in Washington to process what was in many ways a very different operation from the ones that it used to implement (from input to results driven): legal and procurement issues were constantly raised that it took time to resolve.

The very long, three-year pre-pilot may have been a blessing in disguise as it helped the Bank to produce a well thought of RBF design linked to a strong impact evaluation design. In the process the Bank attracted considerable interest in the new RBF model and buy in from the government and from health development partners.

The Bank has made good use of the independent evaluation of the Katete pre-pilot for knowledge generation and dissemination purposes in Zambia, in the Africa region and internationally (such as at the November 2011 meeting of the Inter-Agency Working Group for RBF. In general there seems to be a good focus on lesson learning and dissemination among the World Bank and MoH design team. The team could produce evidence of several learning products that have been or are being commissioned analysis the RBF experience to date. Members of the team did not see a clear link having been established between the research agenda of the country team and how this might feed to the global RBF agenda managed by the HRITF team in Washington. They considered that there should be more learning and information exchange opportunities among TTLs and country teams, although they recognised the practical difficulties of increasing the meetings workload.

There seems to be good recognition of the importance of closely documenting the implementation of the pilot in the 10 intervention districts from day one. Part of this will be done through provincial contact persons who will oversee implementation. The World Bank team also expects to hire local, national institutions (the University of Zambia was mentioned) to document issues on a case by case basis, although one month from beginning pilot implementation no such contract for documentation has been planned.

The long pre-pilot has enabled a long term focus on capacity building to bring the essential RBF concepts to the levels of government and to the donors to ensure interest and buy in. While these efforts have been quite systematically

targeted and pursued no specific capacity building plan has been considered necessary or developed to date.

The impact evaluation design

The impact evaluation of the RBF is a thorough, quite sophisticated design that will address three main policy questions. The design should enable attribution to specific interventions and comparison with other service delivery approaches being used in Zambia but not necessarily with other RBF approaches used in Zambia for which little information on performance and impact is likely to be available. The Baseline surveys   were completed between December 2011 and January 2012.

Attracting additional funding

Since the pilot has not even begun it is too early to say much about approaches to attract additional funding for RBF. It should be mentioned though that the Zambia RBF programme team seem to be maintaining regular contacts with key health donors (EC, JICA, SIDA and DFID, and CDC among the technical agencies) and that one of them (CDC, through the CIDERZ project) is already using the pre-pilot in Katete to target incentives for HIV services based on 2 HIV indicators.

Tajikistan RBF Pilot

Detailed Design Characteristics

Key Design Dimensions	Tajikistan Approach
Basic Design	Fee for Service: Payment to PHC team/Quality and Quantity of MCH services
Who funds? (the principal)	HRITF Grant/IDA credit
Who delivers the results? (the agent)	PHC teams (demand side possibilities being explored)
What: Which results are targeted?	MCH related – specifics to be agreed. Quantity and quality
How: Which levers are used?: Funds, Targets, Grant Agreement, (some) Competition	Funds, Grant Agreement, Performance Targets
Detailed Design Dimensions	
Choice of "results" extremely narrow terms to very broad ex post or ex ante terms	Ex ante
Who sets the results	MoH
All or nothing v proportionate	To be agreed
The degree to which the approach is aligned with national systems.	Operated through existing PIU – proposes to make greater use of national systems that existing programmes
The degree to which the reward is *financial* or not.	Scope of in kind demand side incentives being considered
Equity	Equity will be criteria for choice of rayons to be included in programme
Basis for setting reward	To be determined locally
Conditions on use of funds	The majority of the incentive payment would be for salary top-ups with a smaller percentage going towards the purchase of basic supplies, drugs etc for the PHC facilities
Dependence of the recipient on results based funds	Not known
Provision of up front support to build capacity and help agents benefit from performance based payments.	No but the overall programme has a PHC strengthening component
Reliance on competition and the focus on choice	No
Verification of results	Counter verification potentially by the District Treasury administration. Periodic semi-annual independent third-party verification mechanism envisaged

Notes on Senegal

Application for CPG funding
Senegal submitted a proposal in 2008. The following comments on Senegal's proposal appear in the report of the RBF Selection Panel (2008):[1]

> On the basis of the aggregate scores of all panellists alone, four proposals were judged to be good (Benin, Burundi, Ghana, and **Senegal**)... **Senegal**, Madagascar and Burundi were recommended for funding if additional funds were to become available and Vietnam was supported for funding if some clarifications were made in the proposal.
>
> **Senegal**: Very well written proposal that reflected a clear understanding of health systems and the potential value of RBF. The proposal included a combination of demand and supply side elements. There was some question of whether facilities would have sufficient autonomy to act on the increased RBF motivation. Africa management noted that Senegal does not have the same leadership role that it once had for francophone countries. The Panel suggested this proposal be funded if additional funds become available in future.

The current TTL for Senegal (who was not the author of the proposal) was not aware of the need to follow up the proposal. The writer of the original proposal (not the current TTL) had received a verbal rejection of the bid referring to a perceived lack of support from the Ministry of Health and was not aware of any need to follow up the proposal.

The TTL for Senegal is currently in the early stages a knowledge and learning programme to prepare a strategy and procedures for RBF.

Recommendation: Central follow-up of proposals can help ensure continuity and consistency of approach and ensure that the high cost of bid preparation is not lost.

1 Report of the Results-based Financing Selection Panel: Round 2. World Bank, 16 December 2008

Annex 4 – Evaluation hypotheses and questions

ToR Question	Hypotheses	Questions /Comments	Who What How
Objective 1: Support design, implementation, monitoring and evaluation of RBF mechanisms			
1. What is the **content** of supported activities at global and country level	The World Bank supports a wide range of RBF approaches which should give a broad overview of its effectiveness (rather than focusing on a narrow range of RBF approaches). The approach should be more interventionist and less country led or need to become more so (i.e. so far it has responded to country needs rather than trying to maximise the knowledge gain) Selection criteria for countries are sound, clear and have been consistently applied	What are the types of RBF approaches supported through the RBF pilots? Present a typology of pilots supported to date. Is there any discussion of what they add compared to other pilots Is the Bank undertaking RBF pilots exclusively in IDA countries? (similar to Q27 in Table 3.1) In that case: • What are the pros and cons of this approach, including countries that may not be interested in IDA borrowing yet are keen on developing RBF? (For example Cambodia, Vietnam and may be others?) • Are there missed opportunities i.e. countries with interesting RBF experience that are excluded from HRITF support for developing a pilot? (either because of lack of interest or poor relationship with the Bank) • If RBF initiatives are in place in a country not receiving IDA support is the WB attempt to support that country through another HRITF window such as IE, documenting experience, etc.? How were countries selected? What are the criteria for feasibility studies? Were they applied? How about countries that don't fit this? E.g. Zimbabwe did not submit a proposal yet a pilot was put in place Has there been to date any analysis of areas covered/ mechanisms e.g. CCT/research questions (do a checklist) Why has the IE toolkit just come out? Q17 – Who led the design? To what extent was it WB push or country pull?	Case Studies and desk reviews **All team members** will report on these issues, including whether these were explicitly addressed in documents reviewed

ToR Question	Hypotheses	Questions /Comments	Who What How
2. To what extent is the current design and implementation anchored in **context** analysis of the recipient countries? Included herein is an assessment of a sample of feasibility studies underlying the current activity portfolio of the HRITF activities	The current pilots will deliver credible evaluation results (i.e. evaluation designs are sound) Pilots complement other efforts at sector level and fit well with health sector strategic plans. Reporting arrangements (on pilots) at sector level have been discussed and adhered to The process of developing pilots and implementing these has involved key donors and key institutions (MoH, academia, etc.) in country The evaluations delivered will address key research questions and allow us to decide whether scaling up is now justified (i.e. there are no gaps – all bases are covered)	Q8 - Do RBF schemes have clear goals and targets? Q9 – Is it too early to assess if goals and targets have been achieved? When will information become available to assess results, and is such information likely to be robust enough? Q10 – Will attribution of results be possible / feasible given design and information availability? Q11 – Will the planned M&E provide information about the effectiveness of the RBF scheme for achieving results in comparison to other mechanisms? Q18 – To what extent are supported activities aligned with health policy objectives of recipients and what is the extent of recipient ownership of the supported activities? Q19 - Will implementation and monitoring arrangements use existing sector channels? Was this explored at design and is there any justification for using parallel arrangements? Q26 – Who were approached at country level in relation to HRITF? Describe the approaches that were used by the WB: how inclusive and effective were these?	Case Studies and (to the extent possible) desk studies undertaken by the team. **All team members** will be expected to report on these issues to the extent possible and highlight any gaps identified in design and implementation reports.

ToR Question	Hypotheses	Questions /Comments	Who What How
3. At country level, does project design make it clear which social groups are intended to benefit from the activities of the HRITF? (Q6) Are marginalised or vulnerable people actively included in RBF activities? (Q6) What (if any) is the social inclusion strategy of the HRITF? (Q6)	Pilot designs have adequately considered equity, pro-poor and gender issues. Design and implementation has been guided by a clear social inclusion strategy	**Indicators** Indicators: national HRITF operations include indicators at project/programme levels with a specific focus on gender, on reducing inequalities and on targeting the poor, marginalised or those groups for whom access to essential health care is an issue. Data Collection: Sex disaggregated/other equity related data (e.g. income quintiles, defined vulnerable groups) are systematically collected and analysed Capacity: Staff have skills to collect, analyse and use sex disaggregated/other equity related data to increase programme focus on equity Use: Data/information (including evidence of effectiveness) relating to gender/equity are used in planning, delivery and monitoring of services Champions: There are champions for a gender/wider equity approach at programme and country project levels Partnership: Delegates of organisations representing the interests of women/other vulnerable groups are meaningfully involved in planning, delivery, monitoring and governance of programmes and services Engagement: The views of women/other vulnerable groups meaningfully inform planning and monitoring of services Resources: Tools/resources are available and used to ensure problem solving, lesson learning, and sharing of successes in relation to gender equity Staffing: Project staff are skilled and capable of providing effective gender equitable services. Internal communication: There are effective mechanisms for sharing information and lessons learned about effective approaches to reducing inequality (e.g. programme website, coordination groups) across the programme and within country projects External communication: Communication about the programme with partners, the media and the public positively covers gender and wider equity issues Design: Service design is based on guidance of effective practice and focuses on improving the access to service of women, poor people and other vulnerable groups. Delivery: Services focus directly on women and poor people (e.g. through CCTs or vouchers) or where indirectly, there is a clear causal pathway (i.e. focus is on services used primarily by women/ poor people/on regions where poorest people live) Infrastructure: appropriate infrastructure is in place to ensure delivery of gender equitable programmes (e.g. M/F toilets; M/F hospital beds) M&E: There is a credible plan for monitoring whether women, poor people and other vulnerable groups benefit from the programme Agendas : Gender / wider equity issues are a standing item on the agenda of programme coordination meetings Levers: Adequate mechanisms are in place to ensure gender/equalities are addressed in the programme Q5 – Are the mechanisms designed to help poor and vulnerable groups? Q7 – Does there need to be improved social analysis in the operations of the HRITF? How might the social inclusion and gender equity dimensions be strengthened?	Case Studies and (to the extent possible) desk studies. **All team members** will be expected to report on these issues and gaps identified. **Barbara James** will, on the basis of the above, do a cross cutting analysis of major issues, gaps and possible remedial action.

ToR Question	Hypotheses	Questions /Comments	Who What How
4. At country level does project design make it clear how will HRITF target RMNCH services and outcomes? Does design complement other ongoing efforts in such direction?	Pilots complement efforts made by others as part of the RMNCH national strategies. The WB support adapts to ongoing efforts at sector level to achieve maximum H&A of pilot design, implementation, reporting and monitoring.	The WB participates in the existing coordination structures at country level and reports on the pilots at that level There are robust evaluation (or IE) arrangements in place to measure the impact of pilots on RMNCH services or outcomes. RMNCH indicators are part of the sector monitoring framework and `progress is routinely reported at annual sector reviews or similar How visible is the RBF pilot within national efforts for focus on results? Are these reported at all in sector reviews or similar coordination mechanisms? Q1 - Are the aims of the RBF relevant to achieving MDG s 1C, 4 & 5? Q3 - Do the results being financed reflect cost-effective basic services?	Case Studies and (to the extent possible) desk studies. **All team members** will be expected to report on these issues and gaps identified. **Birte Holm Sørensen** will, on the basis of the above, do a cross cutting analysis of major issues, gaps and possible remedial action
5. To what extent does the HRITF governance structure offer the donors a sufficiently clear picture of how the HRITF is delivering on Included herein is an assessment of the reporting formats and the accountability relationships.	HRITF objectives are clear and shared between all key stakeholders Donors are kept well informed on progress with the HRITF. The balance between analysis and description is about right The skills mix is broadly correct	What is the quality of annual reports in terms of analysing progress, issues and lessons versus, say, just reporting on activities undertaken? What is the governance structure for HRITF? How is it supposed to work? How does the HRITF unit interact with various parts of the WB? Are HRITF activities well intertwined with WB implementation, review and oversight processes at both HQ and country levels? Q 23 – At country and global levels is the right skills mix available to support HRITF implementation? What are the major gaps found, if any? Q24 – What are the main risks linked to HRITF support? Was a risk analysis done at programme level and how effective are the mitigation measures undertaken, if at all? Q25 – Is there a broad work plan for the next 2 years or so, and if so does it need to be reviewed?	These aspects will be assessed from available documentation and through interviews to be held at the WB in Washington (w/c 6F) and with funding partners. Assessment to be led by **Javier Martinez.** Important links with ToR Question 6.

ToR Question	Hypotheses	Questions /Comments	Who What How
6. Does the HRITF implementation so far reflect the initial expectations of the HRITF donors and recipient countries?	It was clear at the outset what the HRITF was expected to deliver: expectations have been met. Stakeholders at both global and country levels have been fully consulted in changes in approaches & / strategies – the HRITF has responded effectively to emerging experience	Is the HRITF rooted on a clear, explicit and shared theory of change depicting which results would HRITF partners expect to achieve over time? If not, is such theory of change necessary and how might it be developed? Is the HRITF log frame used for monitoring purposes, and is this reflected in the annual reports submitted by the WB? Does the log frame need reviewing and which areas might need reviewing? How will the questions above condition the feasibility of future HRITF evaluations? How will VfM be assessed, if at all? Are pilot designs explicit on how will performance of the HRITF be measured given the chance, for instance, that the pilot may not deliver the expected results in terms of improving services yet it may still deliver important lessons on RBF practice that should be documented? At HRITF programme level have annual work plans been prepared, approved and then reported about? Do work plans address specific analysis and synthesis work to be undertaken in order to document experience to date?. Have there been over expectations? Q4 – What is the relationship between the planned and actual monitoring And evaluation activities, at both programme and pilot level, and what would explain any differences found? Q20 – If the RBF pilots are implemented through parallel structures what is the likelihood of future integration into the government systems? Q22 – What is the evidence so far to show that RBF pilots are likely to continue in the absence of HRITF funding? Do recipients have the capacity & financing to implement either similar RBF pilots or the scaling up of these?	These aspects will be assessed from available documentation and through interviews to be held at the WB in Washington (w/c 6F) and with funding partners. Assessment to be led by **Mark Pearson.** Important links with ToR Question 5..

ToR Question	Hypotheses	Questions /Comments	Who What How
7. What are the achievements of the HRITF at global and country level with respect to Objective 1	Pilots are proceeding as planned and time from design to implementation is reasonable	Summary of where the pilots are Range of designs covered/type of mechanisms tested Quality of implementation/monitoring Quality of evaluation framework	Case studies and desk reviews and information from annual reports **Javier Martinez** to lead this
8. How effective has the HRITF been in realising the economies of scale and scope in the implementation of HRITF activities?	The World Bank has made an effective use of its programmes, presence in countries and national & regional networks to maximise the opportunities linked to HRITF funding.	Included herein should be an analysis of the HRITF cooperation and coordination with: a. The World Bank Group at large both at the HQ and the country level b. The recipient's central and provincial administration c. Civil Society d. Global multilateral and bilateral donors engaged in Health sector in recipient countries Particular attention will be paid to the way HRITF has been used by the World Bank´s regional offices, particularly in Africa (as the team cannot cover the whole world due to time & resources) to maximise the achievement of the HRITF objectives. (Similar to Q 14 in Table 3.1)	**Javier Martinez** to lead. Important links with Questions 5 and 6
9. What is the relationship between planned and actual disbursements so far? What explains deviations if any?	Disbursements have been largely as planned. Deviations have been explained and are largely justified. The allocation of resources has been sound.	Included herein is: a. A mapping of the HRITF expenditures at the headquarters, regional and country level. The mapping shall focus on activity level break-up covering staff costs (salaries, benefits, indirect costs), extended term consultants, consultant fees, contractual services, travel expenses, media, workshops/ conferences and meetings, associated overheads, temporary staff costs. b. A mapping of the status with respect to recipient revenues and expenditures. The mapping shall focus on activity level break-up on services, goods, works, incremental costs covered, and budget financing. Q12 – Costs of the WB support: are there any benchmarks in terms of other WB support or comparable activities in the case study countries? Q13 – Costs to the recipient: are there comparable costs e.g. historically from other parts of the country? Q16 – Are there any efficiency savings which the HRITF should endeavour to make? Are there any components in the budget that appear underfunded?	**Mark Pearson** to lead

ToR Question	Hypotheses	Questions /Comments	Who What How
10. How efficient are the internal and external procurement processes with respect to staff, goods and services in the current implementation of HRITF activities?	The Bank provides value for money in delivering services in support of the programme	What is the approach? Describe the approach used by the World Bank for procuring staff, goods and services. Are the right people overseeing the HRITF operations? Are they adequately supported on technical areas and their progress overseen by WB in HQ? What is the role played by the HRITF Unit in WB Washington? Is the HRITF unit in Washington fit for purpose in terms of capacity for effective and efficient oversight? Country studies – any evidence of delays due to procurement issues	Meetings in Washington Interviews with WB staff Information from case studies and desk reviews. **Javier Martinez** to lead the analysis with support from **Birte Holm Sørensen**

ToR Question	Hypotheses	Questions /Comments	Who What How
Objective 2 - Develop and disseminate the evidence base for implementing successful RBF mechanisms			
11. What are the achievements of the HRITF at global and country level with respect to Objective 2?	There is a clear, explicit strategy on how the evidence will be developed and it will then be shared and disseminated. Such approach is being followed and regularly reported about by the World Bank,	Existence of an approach to knowledge building and dissemination: Where and how is the analysis of evidence undertaken? How robust is the analysis? Quality of evaluation frameworks developed Quality of data on website/materials used for dissemination Q 28 – Is the evidence about successful RBF mechanisms relevant to MDGs 1c, 4 and 5? Q29 – Do dissemination messages accurately reflect the available evidence? Q30 – In countries that are not receiving HRITF for pilots but which nevertheless have ongoing RBF initiatives (funded from other sources) have efforts been made by the WB to tap on those initiatives for assessment and dissemination purposes? Examples may include Cambodia, Vietnam, India, Mozambique, among others.	For country level dimension sources will be the case studies and desk reviews – **All team members** For assessing wider dissemination efforts the services of specialised HLSP will be contracted using the consulting pool (**Claudia Sambo**, Head of knowledge and dissemination, HLSP Institute, with support from **Corrina Mills**
12. Is the skill-mix of the staff of the Bank, the recipients and the donors responsible for the HRITF appropriate for implementation of the current /planned RBF project portfolio?	The resources invested and approaches used to develop and disseminate the evidence are sufficient and appropriate	Who is leading in the country programmes Q31 - Has the evidence base been developed or (given that this may be an early stage) are the milestones in place to develop the evidence base? Q 32 – Ho has the dissemination been targeted? Has it targeted appropriate audiences, particularly in LICs? Q34 – Do the costs seem appropriate? What comparable costs are there within and beyond the WB? Q35 – Are there institutions which collect and collate evidence about RBF? How are these funded?	**Javier Martinez** to lead
13. What is the relationship between the planned and actual monitoring and evaluation activities undertaken so far and their contribution to the evidence building and dissemination objective?	There are structured approaches within the WB for linking information gained from pilots, workshops and IE activities with the efforts to build the evidence base.	What processes at central WB level and in the countries are in place to support the hypothesis? Describe such structures and processes. Q36 – What quality assurance mechanisms are there for the knowledge products about RBF?	Case studies at country level. **All team members** **Javier Martinez** for HRITF itself?

ToR Question	Hypotheses	Questions /Comments	Who What How
Objective 3 - Build country institutional capacity to scale-up and sustain the RBF mechanisms, within the national health strategy and system;			
14. To what extent are supported activities aligned with health policy objectives of recipients and what is the extent of recipient ownership in the supported activities? If the HRITF is implemented through parallel structures what is the likelihood of future integration into the government systems?	Given the choice countries might invest the HRITF earmarked resources in very different ways. RBF is very context sensitive, and therefore issues identified under objective one linked to design and implementation will influence the achievement of this objective,	Country case studies: Is RBF mentioned as a specific objective? Are the targets aligned with those of the national plan? Does the approach use parallel structures? What steps are being taken to integrate – has there been a discussion? Is there a plan? Q39 - Did capacity building efforts attempt to contextualise the country context with the experience about use of RPF from other countries and settings Q42 - Did the approaches used for capacity building target the right decision and opinion makers in the country, and was there adequate follow up following those events? Q45 - Is the capacity fully institutionalised? What will happen when key individuals change job? (Interviews DR & CS countries)	Case studies and desk reviews
15. What is the strategy for alignment of interventions with bilateral development assistance and in particular health sector assistance in the Recipient countries? This should include an overview of HRITF strategy to mainstream cross-cutting issues such as gender and good governance.	Institutional capacity building is an identifiable and explicit objective within the HRITF implementation arrangements at country level, and therefore there are specific objectives and strategies in place to achieve it	Q37 - Are the capacity-building activities relevant to the countries' overall efforts to achieve MDGs 1c, 4 and 5? Q38 . To what extent are supported activities (for institutional capacity building) aligned with health policy objectives of recipients? Q40 - Is there an explicit strategy and steps in place to develop institutional capacity, in the countries, in the WB, among development partners? Q41 - Is the skills-mix of the staff at the Bank, the recipients and the donors responsible for the HRTF appropriate for the implementation of the current/planned RBF portfolio? Q43 - What is the cost break-down for capacity-building and what can this be compared with? Q44 - How clear are the costs of implementing PBF to Government and other health partners? Has there been an attempt to cost existing initiatives in a systematic manner? Q46 - Has turnover of WB staff responsible for country operations affected implementation arrangements? Is HRITF too "person" dependent? (Interviews DR & CS countries) Q47 - Are there realistic budgets for capacity building? (I WBC, WBH, AR), FR)	Case studies. All Team members. Birte Holm Sørensen and Barbara James to assess the second part of ToR Question 15

ToR Question	Hypotheses	Questions /Comments	Who What How
16. What are the achievements of the HRITF at global and country level?		What is the added value of country workshops and IWG meetings in terms of building capacity? What examples can be provided about initiatives undertaken to date, and their relative success/merit? Are nationals being used and targeted for capacity building?	

ToR Question	Hypotheses	Questions /Comments	Who What How
Objective 4 - Attract additional financing to the health sector			
17. What are the achievements of the HRITF at global and country level? Are current Bank instruments appropriate i.e. a good way of supporting results based approaches?	Countries have been more willing to take on Bank sector loans as a result of HRITF support Investing a larger share of Bank resources in health is a good thing Other donors and actors in country have been influenced by the WB pilots and become more interested in and focused on results The HRITF will have broader impact within the Bank in terms of a shift towards results based approaches	How does the WB measure additionality (early references were made to this – have they been updated? Is it part of the country pilots and how is this reflected in the pilots? Q59 - What is the strategy for achieving this objective? Q48 - What have been the main strategies used for attracting additional financing for PDF by the WB? How have other donors been approached in this respect in the country pilots or where HRITF activity took place? Q49 - Are the efforts to attract financing – and any actual additional financing – relevant to the countries' efforts to achieve MDGs 1c, 4 and 5? Q50 - To what extent are supported activities aligned with health policy and health financing objectives of recipients? Q51 - Has additional funding become available? (It may be too early to say, and hence the appropriate question is the funding likely to be forthcoming? Q52 - How much is being spent on this objective and is it likely to provide good returns in terms of additional financing? Q54 - At global (HRITF Program) level, does the budget need adjustment, e.g. with regards to balance of spending at country level vs. HQ level, distribution of spending among various budget lines, etc.? To what extent has HRITF contributed to the establishment of the Bank's new Payment 4 Results instrument?	**Mark Pearson** to lead
18. What is the evidence so far to show that HRITF supported projects are likely to continue in the absence of HRITF funding? Do the recipients have the necessary capacity and discretionary financing to implement (scale up) the RBF projects?	Managing and monitoring RBF initiatives requires institutional capacity and skills that are not necessarily available in some contexts or which may be needed for other uses. Unless RBF is fully institutionalised it may generate small "silos of excellence" that may be hard to scale up.	Probably too early to tell But has there been any discussion yet? Do the grant applications shed any light on this? Q55 - Is any additional financing likely to be short-term or long-term? Is there a risk that RBF will be a "fashion" which attracts unsustainable levels of short-term funding? Q56 - Look for links for sustainability questions under Objective 1 (table 3.1) Q57 - Does the HRITF implementation so far reflect the initial expectations of the HRITF donors and recipient countries? Q60 - What is the strategy for alignment of interventions with bilateral development assistance and in particular health sector assistance in the recipient countries? This should include an overview of HRITF strategy to mainstream cross-cutting issues such as gender and good governance	Case studies and desk reviews. Interviews with WB staff and with key informants in countries. **Mark Pearson** to lead.

Annex 5 – Terms of Reference

Terms of Reference for Evaluation of the World Bank Multi-Donor Trust Fund for Health Result Innovation (HRITF)

Background
The Multi-Donor Trust Fund for Health Result Innovation (hereafter referred to as the TF) is initiated by Norway to support result-based financing (RBF) approaches in the health sector. The TF is administered by the Health Nutrition and Population Unit of the World Bank. The TF was established in response to an initial commitment of US$104 million by the Government of Norway in December 2007. In December 2009 Norway made an additional commitment of US$264 million. Following recommendations of the High Level Taskforce for International Innovative Financing for Health, the United Kingdom joined the TF with a commitment of US$190 million in 2010. The total commitments of US$575 million (US$ 388 million from Norway and US$ 187 million from UK [2] shall be paid by the donors over a period covering 2007-2022.

The goal of the TF is to support result based financing (RBF) mechanisms in the health sector, for achievement of the health-related Millennium Development Goals (MDG), particularly MDGs 1c, 4 and 5: to reduce the prevalence of underweight children, child mortality and improve maternal health.

The TF has *four specific objectives*:

- support design, implementation, monitoring and evaluation of RBF mechanisms;
- develop and disseminate the evidence base for implementing successful RBF mechanisms;
- build country institutional capacity to scale-up and sustain the RBF mechanisms, within the national health strategy and system; and
- attract additional financing to the health sector.

The objectives of the TF are operationalised through nine activities, of which six will be implemented by the Bank, two by the recipients, and one jointly by the Bank and the recipient. Table 1 shows status of actual disbursement by activity as per March 2011[3].

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2 Figures are approximate, as commitments are made in Norwegian kroner and British pounds respectively
3 Source: Health Results Innovation Trust Fund, Annual Report to Donors April 2010-March 2011.

Table 1 (all figures in million US $)

	Activities	Responsibility	Disbursements
1	Preparation and review of proposals	Recipient and Bank	0.69
	RBF Seed Grants	Recipient and Bank	0.41
2	Design of RBF Projects /components	Recipient	0.24
3	Preparation and Appraisal of RBF projects / components	Bank	3.56
4	Implementation of Bank RBF projects	Recipient	9.2
	Implementation of Recipient RBF projects	Recipient	
5	Supervision of Bank and recipient projects	Bank	0.09
6	Monitoring and Documentation of projects	Bank	
7	Evaluation of Bank projects	Bank	2.15
8	Dissemination and knowledge sharing	Bank	5.33
9	Trust Fund Management and Administration	Bank	0.17
	Administration Fee*	Bank	0.77
	Total		22.61

Source: Health Results Innovation Trust Fund, Annual Report to Donors April 2010-March 2011

As shown in Table 1 the TF so far is in its starting phase. Of the total disbursements of US$ 22.6 million 11.7 million have been made for Bank-executed activities while recipients-executed activities account for 9.44 millions. In addition, a small amount is allocated to joint implementation activities.

As regards the country level, the TF currently operates in 40 countries of which 24 countries have received grants for preparation of proposals/seed money (activity 1) ranging from US$ 7000 to US$ 188,000. Eleven countries have received project preparation and appraisal supports (activity 3) of which three are in the implementation stages (activity 4). The project in Eritrea stands cancelled due to the withdrawal of the Bank from the country. The activity break-up of these eleven countries is given in Table 2. For further details of disbursements see Health Results Innovation Trust Fund, Annual Report to Donors April 2010-March 2011, Annex 1.

Table 2 (All figures in thousand US $)

Activity	1a	1b	2	3	4a	4b	5	6	7	8	9	Total
Afghanistan	16			199	1,026				10			1251
Benin	85			379					21			485
Burkina Faso	34			48								82
Burundi				47								47
DRC	48			139	175				607			969
Eritrea	49		132	249					26			456
Kyrgyz Republic	50			336								386
Rwanda	49			387	8,000		88		579			9103
Sri Lanka				4								4
Zambia	47		100	373					74			594
Zimbabwe				74					38			112
Total	378		232	2235	8185		1114		1345			13489

Source: Health Results Innovation Trust Fund, Annual Report to Donors April 2010-March 2011

The TF funding will be used to finance the activities undertaken by the Bank and recipient countries. The activities to be implemented by the Bank are to be compensated by TF on full-cost recovery principle. Eligible expenditures for Bank activities include staff costs (salaries, benefits, indirect), extended term consultants, consultant fees, contractual services, travel expenses, media, workshops/conferences and meetings, associated overheads, temporary staff costs; and for RBF mechanisms, performance-based payments, capitation payments and other forms of cash transfers to beneficiaries.[4] The activities to be implemented by the recipient countries shall be compensated at a pre-determined rate to be agreed by the Bank.

The Agreement establishing the TF mandates periodic, donor initiated independent external evaluations to be undertaken in 2011, 2016, and final evaluation in 2022. The three evaluations are to be seen in connection with each other. This Terms of Reference refers to the first evaluation scheduled for 2011.

Objective

The *main objective* of this evaluation is to assess the performance of the TF with regard to its above mentioned objectives, and to provide recommendations that can improve current operations and future programming and governance of the initiative. The study shall cover the time period 2007 – March 2011.

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4 Amended and Restated Trust Fund Administration Agreement between the Ministry of Foreign Affairs of the Kingdom of Norway and the International Bank for Reconstruction and Development and the International Development Association concerning the Multi-Donor Trust Fund for Health Results Innovation" December 4 2009 , Annex 1 , section 2: Programme Description, and section 4: Categories of funding.

Main Tasks
The evaluation will be based on **four evaluation criteria** - relevance, effectiveness, efficiency and sustainability.

The evaluation questions to be addressed include but are not necessarily limited to the questions below. Please also note that no prioritisations are implied in the ordering of the questions:

1. What is the content of supported activities at global and country level and to what extent is the current implementation anchored in context analysis of the recipient countries? Included herein is an assessment of a sample of feasibility studies underlying the current activity portfolio of the HRITF activities.
2. To what extent are supported activities aligned with health policy objectives of recipients and what is the extent of recipient ownership in the supported activities? If the TF is implemented through parallel structures what is the likelihood of future integration into the government systems?
3. At country level, does project design make it clear which social groups are intended to benefit from the activities of the TF? Are marginalised or vulnerable people actively included in RBF activities? What (if any) is the social inclusion strategy of the TF?
4. What is the strategy for alignment of interventions with bilateral development assistance and in particular health sector assistance in the Recipient countries? This should include an overview of HRITF strategy to mainstream cross-cutting issues such as gender and good governance.
5. To what extent does the TF governance structure offer the donors a sufficiently clear picture of how the TF is delivering on the four objectives? Included herein is an assessment of the reporting formats and the accountability relationships.
6. Does the TF implementation so far reflect the initial expectations of the TF donors and recipient countries?
7. What are the achievements of the TF at global and country level with respect to the four specific objectives specified for the TF?
8. How effective has the TF been in realising the economies of scale and scope in the implementation of TF activities? Included herein should be an analysis of the TF cooperation and coordination with:
    a. The World Bank Group at large both at the HQ and the country level
    b. The recipient's central and provincial administration
    c. Civil Society
    d. Global multilateral and bilateral donors engaged in Health sector in recipient countries
9. What is the relationship between planned and actual disbursements so far? What explains deviations if any? Included herein is:
    a. A mapping of the TF expenditures at the headquarters, regional and country level. The mapping shall focus on activity level break-up covering staff costs (salaries, benefits, indirect costs), extended term consultants, consultant fees, contractual services, travel expenses, media, workshops/ conferences and meetings, associated overheads, temporary staff costs.

b. A mapping of the status with respect to recipient revenues and expenditures. The mapping shall focus on activity level break-up on services, goods, works, incremental costs covered, and budget financing.

10. How efficient are the internal and external procurement processes with respect to staff, goods and services in the current implementation of TF activities?
11. Is the skill-mix of the staff of the Bank, the recipients and the donors responsible for the TF appropriate for implementation of the current /planned RBF project portfolio?
12. What is the relationship between the planned and actual monitoring and evaluation activities undertaken so far? For example what explains deviations if any? Included herein is an analysis of data availability for M&E.
13. What is the evidence so far to show that TF supported projects are likely to continue in the absence of TF funding? Do the recipients have the necessary capacity and discretionary financing to implement the RBF projects?

As part of the evaluation the TF and its donors need recommendations on the following:

- Are any changes to the programme agreement or forward plans required for the TF to achieve its four objectives?
- Are any changes to the organisational structure of the TF needed?
- Are there any risks that the TF needs to monitor or manage? (Or if there is a risk analysis, does it need updating?)
- Does the work plan for the next 1-2 years need to be revised?
- Does the budget need adjustment, e.g. with regards to balance of spending at country level vs. HQ level, distribution of spending among various budget lines, etc.?
- Does there need to be improved social analysis in the operations of the TF? How could the social inclusion and gender equity dimensions of the TF be improved?
- Are the TF's monitoring and evaluation procedures fit for purpose? Are they generating the information needed, is the information the M&E system generates useful, and are all parts of TF using the M&E tools consistently?
- Finance: Is there any efficiency savings which the TF should endeavour to make? Are there any aspects of the budget that are under-funded?

Methodology

It will be part of the assignment to develop a methodological and conceptual framework to ensure an objective, transparent and impartial assessment of the issues to be analysed in this evaluation. For details see *Part 3, annex 1* of this document.

The consultants will mainly make use of publicly available documentation, including the regular financial reporting from the Bank. Information received through interviews with the Bank and donors at the headquarter levels and the country level shall supplement the publicly available information. Although the

study is not expected to examine internal accounts of the Bank, documentation from the Trust Fund Administration at headquarters and at the country level shall be used to the extent possible.

The consultants shall in consultation with the Bank, DFID, the Norwegian Ministry of Foreign Affairs/Norad propose two country case studies for analysing the recipient country level issues in this study. The proposed cases should be selected using the criteria actual disbursement, length of support, geographic coverage (one country from Africa and another country from outside Africa), and type of activities, at least one of the case studies should be linked to implementation of RBF projects. The proposals should be presented in the inception report.

Data collection
The evaluation team is responsible for data-collection and validation. Access to archives will be facilitated by the Bank, DFID and Norad/MFA.

Consultant team
The team shall cover the following competencies:

Team leader	Team Members
Academic: Higher relevant degree Knowledge and experience with: Evaluation principles, methods and standards in general Leading multi disciplinary evaluations Development Cooperation	Academic: Minimum Bachelor's level Included herein is an assessment of the team composition in meeting the following requirements: Discipline: Social sciences, economics, health Sector: Public finance, social analysis Development Cooperation: Health sector operation, capacity building, results based financing Country/region/organisations: World Bank Group

The proposed team must cover following language skills:
- Team leader: English – Written, reading and spoken
- At least one member of the team: Norwegian/Swedish/Danish – Reading

Organisation
The evaluation will be managed by the Evaluation Department in Norad (EVAL). An independent team of researchers or consultants will be assigned the evaluation according to the standard procurement procedures of Norad.

The team leader shall report to EVAL. All decisions concerning these terms of reference, the inception report, draft report and final report are subject to approval by EVAL.

The evaluation team shall take note of comments received from stakeholders. Where there are significantly diverging views between the evaluation team and stakeholders, this should be reflected in the report.

Budget
The tender shall quote a total price for the assignment excluding travel and subsistence costs related to case project/programme visits. The evaluation is budgeted with a maximum of 30 consultant person weeks.

The team is expected to visit the case countries as well as head quarter offices of the Bank, DFID and Norad/MFA. Additionally, the team leader is expected to participate in the following four meetings in Oslo: A contract-signing meeting, a meeting to present the inception report, a meeting to present the draft report and a meeting to present the final report to relevant stakeholders. Direct travel costs related to the possible dissemination in the Bank (Washington) or DFID will be covered separately and are not to be included in the budget.

The budget and work plan should allow sufficient time for presentations of preliminary findings and conclusions, including preliminary findings to relevant stakeholders in the countries visited and for receiving comments to the draft report.

Deliverables
The **deliverables** in the consultancy consist of the following outputs:

- **Inception report** not exceeding 15 pages shall be prepared and discussed with the reference group before final approval by EVAL.
- One work-in-progress reporting **seminar.**
- **Draft final report** for preliminary approval by EVAL for circulation to the stakeholders. The stakeholders shall provide feedback that will include comments on structure, facts, content, and conclusions.
- **Final evaluation report**.
- **Précis of the final report** (two pages).
- **Stand-alone reports: one on each case study country** (as annexes to the main report), (4 pages).
- **Presentation** of the final report at a seminar in Oslo[5].

All presentations and reports (to be prepared in accordance with EVAL's guidelines given in *Part 3: Annexes* of this document) are to be submitted in electronic form in accordance with the deadlines set in the time-schedule specified in *Part 1 Tender specification, Section 2 Administrative Conditions* of this document. The data collected during the study shall be submitted in EXCEL format. EVAL retains the sole rights with respect to all **distribution, dissemination and publication** of the deliverables.

The evaluation team is expected to adhere to the DAC Evaluation Quality Standards[6] as well as the Norad Evaluation Guidelines.[7]

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5 Additional presentations at the Bank/Washington and DFID/London may be requested on need basis. Costs related to such presentations will be financed separately and should not be included in the budget for this assignment.
6 http://www.oecd.org/dataoecd/43/54/35336188.pdf
7 See http://www.Norad.no/en/Tools+and+publications/Publications/Publication+Page?key=109574

Annexes:

- Amended and Restated Trust Fund Administration Agreement between the Ministry of Foreign Affairs of the Kingdom of Norway and the International Bank for Reconstruction and Development and the International Development Association concerning the Multi-Donor Trust Fund for Health Results Innovation, December 4, 2009.
- DFID Log-Frame
- Health Results Innovation Trust Fund, December 2010 Mid Year Update
- Health Results Innovation Trust Fund, Annual Report to Donors April 2010-March 2011

Annex 6 – Tables supporting the study methodology

Table 31: Data collection, analysis and roles of team members

Main data needs	Main sources of data & tools	Roles evaluation team & progress to date
General information on HRITF pre-inception report	Original WB proposal; administrative agreements; annual reports; documents on selection processes and criteria linked to rounds 1, 2 and then to the various HRITF 'streams'; funding recommendations made by selection panels and linked decisions; approaches to knowledge management and dissemination; managerial processes for programme oversight within the WB; among the main ones. Data collection: • Email requests for information • Phone and personal interviews with: DFID in London (Dec. 2011); Norad/MFA (Nov.2011 and March 2012) in Oslo; interviews in Washington with a range of World Bank staff (TTLs, sector leaders, country leaders, HRITF program staff) and with key informants, some of whom involved in IWG on RBF or previously involved in HRITF (see list of key informants) Data analysis: information from documents and interviews is being downloaded into draft reports following a structure similar to that of Annex 1	TL and DTL browse through main docs received in flash drive and share these with evaluation team (done) TL and DTL use main docs and meetings to develop more hypotheses and questions (done) Annex 1 is shared with team to guide data collection within desk reviews (done) Inception report prepared (done) Notes prepared on main issues emerging from meetings in Washington, London and Oslo shared with the team. These influence the list of questions and the focus of country work. (in progress)

Main data needs	Main sources of data & tools	Roles evaluation team & progress to date
Detailed information on: design and implementation of HRITF pilots; design and implementation of impact evaluations;	Guidelines (including the HRITF Requests for Proposals) produced at WB HQ level outlining design and implementation issues In prospective desk review countries (average of 0.25 days for each country being considered): • List of prospective countries developed based on information from annual reports and anecdotal views of key informants & contacts by evaluation team in countries • Phone & email interviews with TTLs to gather HRITF country information and explore opportunities & interesting issues to cover in desk reviews; • submit a preliminary assessment to team members with recommendations for proposed desk reviews; • On the basis of these TL/DTL to finalise a list of desk review countries – these to be shared with Norad evaluation department, for information. In desk review countries (average of 3 person days per each desk review): • Thorough review of available documents (quarterly reports used only at country level; reports submitted to WB HQ; analytic pieces produced by training staff and by visiting consultants supporting the programmes • Interviews with TTLs, DFID country staff (where available), key informants (from the networks of team members) and, if possible, a sample of important health donors and government officers • Data collection and analysis will use same structure as in Annex 1, although given the level of effort (time of researchers, at a distance, using phone & email) not all hypotheses and questions may be answerable. Focus should be on interesting features and lessons emerging from docs and from people approached. • Deliverable would be a short (5-7pages) annex to the evaluation report. In case study countries (average of 7 person days including preparatory work and in country work): • same as in desk review countries, except that the depth of analysis should be greater and a wider range of stakeholders would be interviewed, most of them in person. • Field visits to pilot sites to be undertaken. • Preliminary results to be discussed with key informants in country. Deliverable in the form of a report (10-15 pages) responding to main hypotheses and questions (Annex 1)	All team members share key documents that indicate the modus operandi, to then compare this with reality of design and implementation (done) BS and BJ undertake 2 desk reviews each (in progress: during February 2012. JM and MP undertake 1 desk review and 1 case study each (in progress: expected first week of March) Where IE have been designed evaluators share information with **MP who will look across IE designs** (2nd week March) All team members cover as many aspects from Annex 1 as possible, including RMNCH and gender – equity - pro-poor focus. In addition: • BS looks across desk and case studies for RMNCH focus. • BJ does the same for gender focus, equity and pro-poor orientation
Design and implementation of knowledge management and dissemination activities.	Interviews by TL and DTL in Washington with key WB staff and collaborators responsible for this area. Internal notes prepared by TL/DTL point to issues to further explore. Samples of knowledge products requested/received ToR prepared for knowledge management and dissemination (KM&D) adviser to support the evaluation team Assessment of products (website, bulletin, workshops, training materials etc) and follow up interviews by KM&D adviser Deliverable is a short report to go as annex in evaluation report, and executive summary to go in main report discussing findings as part of assessment of objective 2.	All team members assess the extent of KM&D in the desk review and case study countries (are WB and pilot implementation staff prepared, is RBF understood, etc) They feed information to KM&D adviser KM&D adviser looks across evidence from her work and from countries

Main data needs	Main sources of data & tools	Roles evaluation team & progress to date
Putting the various parts of the evaluation together	TL and DTL exchange initial drafts and ensure that every broad question, hypothesis and related questions are addressed in draft evaluation report QA processes include both editorial as well as technical QA	TL and DTL exchange initial drafts and incorporate annexes – Draft zero is produced for internal review (2nd and 3rd weeks March) Evaluation team members comment on the report (3rd week March) ED and CW QA initial draft (3rd week March) Draft report sent to Norad (4th week March)

Table 32: Stages of the evaluation study and roles of team members

Name	Main Role	Inception Phase	Stage 1	Stage 2	Stage 3
Javier Martinez	Team Leader Health Systems Aid Effectiveness Organisation and management	Initial contacts with HRITF partners Document review and share with team Develop evaluation approach (Annex 4) Inception report	Document review Develop approach to desk reviews Interviews in Washington Notes on meetings in Washington and with HRITF donors for team Begin to talk to key informants Feedback progress to Norad ED	Conduct & write 1 desk review Conduct Rwanda case study Assists CS with assessment of KM&D Downloads key issues to ongoing draft Interviews key informants in Oslo Feedback progress to Norad ED	QA 3 desk reviews (1 MP, 1 BS, 1 BJ) Cross cutting: programme management, skills and governance Cross cutting procurement (with BS) Cross cutting KM&D (with CS) Produces draft report
Mark Pearson	Deputy Team Leader Health Economics PBF/PBA Financing and budgeting	Initial contacts with HRITF partners Document review and share with team Develop evaluation approach (Annex 4) Inception report Meet WB staff	Document review Develop approach to desk reviews Interviews in Washington Notes on meetings in Washington and with HRITF donors for team Begin to talk to key informants	Conduct & write 1 desk review Conduct Kyrgyz case study Downloads key issues to ongoing draft	QA 3 desk reviews (1 MP, 1 BS, 1 BJ) Cross cutting: Impact Evaluation studies Cross cutting: HRITF planning, forecasting, budgeting, resource allocation and expenditure tracking & reporting Produces draft report
Birte Holm Sørensen	Public Health / MNCH	Document review Support design Browse docs for RMNCH focus	Reading of key documents Assess four countries out of which two desk reviews to be selected	Conduct & write two desk reviews	Cross cutting: RMNCH focus and points for main report Cross cutting: helps JM with procurement assessment
Barbara James	Social development gender & equity	Document review Support design Browse docs for gender, equity & poverty focus	Reading of key documents Assess four countries out of which two desk reviews to be selected	Conduct & write two desk reviews	Cross cutting: gender, equity & poverty focus and points for main report
Claudia Sambo	Knowledge management and dissemination		Terms of reference for CS to be prepared during the visit to Washington by the TL and DTL	Conducts assessment of KM&D activities: website, bulletin, workshops, articles, training and learning products, etc.	Cross cutting: KM&D (with JM support)

Name	Main Role	Inception Phase	Stage 1	Stage 2	Stage 3
Catriona Waddington	Quality Assurance	Reviews inception report			QA first draft QA final report
Emma Denton	Technical Coordinator	Supports team Reviews inception report		Invited to part of analysis meeting	Review first draft and final report – compliance TOR
Eva Hannah	Project Officer	Supports team Logistics Oslo Formatting	Supports team Contracts with national consultants	Supports team Logistics country visits	Formatting of reports Logistics Oslo

Annex 7 – Example of key design features table - Tajikistan

Key Design Dimensions	Tajikistan
Basic Design	Fee for Service: Payment to PHC team/Quality and Quantity of MCH services
Who funds? (the principal)	HRITF Grant/IDA credit
Who delivers the results? (the agent)	PHC teams (demand side possibilities being explored)
What: Which results are targeted?:	MCH related – specifics to be agreed. Quantity and quality
How: Which levers are used?: Funds, Targets, Grant Agreement, (some) Competition	Funds, Grant Agreement, Performance Targets
Detailed Design Dimensions	
Choice of "results" extremely narrow terms to very broad ex post or ex ante terms	Ex ante
Who sets the results	MoH
All or nothing v proportionate	To be agreed
The degree to which the approach is aligned with national systems.	Operated through existing PIU – proposes to make greater use of national systems that existing programmes
The degree to which the reward is financial or not.	Scope of in kind demand side incentives being considered
Equity	Equity will be criteria for choice of rayons to be included in programme
Basis for setting reward	To be determined locally
Conditions on use of funds	The majority of the incentive payment would be for salary top-ups with a smaller percentage going towards the purchase of basic supplies, drugs etc for the PHC facilities
Dependence of the recipient on results based funds	Not known
Provision of up front support to build capacity and help agents benefit from performance based payments.	No but the overall programme has a PHC strengthening component
Reliance on competition and the focus on choice	No
Verification of results	Counter verification potentially by the District Treasury administration. Periodic semi-annual independent third-party verification mechanism envisaged

Annex 8 – World Bank Response to the Evaluation Report

We deeply appreciate Norway's commissioning this first assessment of HRITF, which is an invaluable contribution to the performance of the HRITF. We are also very grateful to HLSP for the in-depth review and a rich set of recommendations. We believe that many of them are very useful and will contribute to enriching the program and moving it effectively from its initial launch in Phases 1 and 2 and its scale up, from Phase 3 onwards (underway since September 2010).

The HLSP team has done an enormous amount of work in a relatively short term including numerous consultations with HQ and country staff and other key informants, as well as the review of a large number of documents and we found the report to be comprehensive and well written.

The following are our comments on the final report, based on consultations with country teams and Bank management. We have divided our responses into two main parts. First, we have provided an overall response to the key messages and synthesis of findings which we found very useful. We recognize that some of these require further discussion with key stakeholders to ensure similar understanding. Second, we have suggested ways in which the recommendations could be made more useful from an operational perspective.

We also believe that the assessment does not fully recognize the substantial progress that has been made in the area of knowledge sharing and learning and that the report does not adequately reflect the current status in this area. On our part, we will continue to work on making this substantial body of work more readily accessible, if that was the reason for not reflecting it in the final assessment.

A. Comments on overall recommendations and findings

1. **Need for a Results Framework:** As indicated in the this assessment, the program originally defined four objectives for HRITF, which are the basis for an evaluation at this time, and which we believe the launching of HRITF has fulfilled substantially since its creation. These are: (1) to support design, implementation, monitoring and evaluation of RBF mechanisms; (2) to develop and disseminate the evidence base for implementing successful RBF mechanisms; (3) to build country institutional capacity to scale-up and sustain the RBF mechanisms, within the national health strategy and system; and (4) to attract additional financing to the health sector. However, we welcome and agree with the recommendation that moving forward, after

initial launching and scale-up based on these four original objectives, a more granular results framework may be useful. Indeed, the Bank and donors have been discussing the need for such a Results framework beyond the current log frame that we have for the program. We are making this a topic for discussion at the next Annual Donor Consultation, including how to capture in the results framework, the original objectives to pilot test RBF mechanisms, as well as the need for country ownership and alignment.

2. **Need to preserve a demand driven approach but to ensure that HRITF support is strategically positioned:** We fully agree with this objective and welcome a conversation with the donors on whether the current balance is the right one. A key challenge in ODA in health is the balance between country alignment and funder advice /priorities /views.

3. **Rigorous Feasibility Assessment prior to final approval of an RBF proposal:** The evaluation team recommends that "CPGs should be conditionally approved and subject to more rigorous feasibility analysis – RBF will not be feasible in all settings". We agree. Indeed, we believe this is how HRITF CPGs are managed today, particularly after the link to IDA preparation and quality review was strengthened in phase 3 and beyond. All initial approvals are preliminary and subject to completion of IDA program preparation with in-depth analysis, not only of the RBF component of the operation but of the overall program. So the thorough feasibility assessment that the report recommends is already built into the approval process of an IDA operation and is applied to the RBF mechanisms that are mainstreamed within that operation. The importance of more closely linking HRITF funding with IDA (i.e., with a much broader country program review) is one of the key lessons learned from phases 1 and 2 not only because of the additional funding it has provided but, also because it fully plugs in the RBF sector discussion into the sector program and Ministry of Finance dialogue. This has proven of such relevance that we believe it would be extremely difficult, expensive (would otherwise need to somehow duplicate the technical, country, fiscal and fiduciary analysis done by IDA), and risky not to have such link.

4. **Lack of formal communication on specific HRITF decisions:** The concern about a more transparent process raised by the evaluation team seems to be determined by an apparent lack of formal communications with the country on specific HRITF decisions. In practice, since 2010, specific dialogue on HRITF funding agreements is an integral part of the IDA credit process. Countries themselves do not apply to RBF grants directly. They apply for IDA credits that include RBF and, will also then include HRITF grant support. Countries and Bank teams have in-depth dialogue on the country program, the IDA project and the RBF components in it. The deep and transparent dialogue and assessment is embedded in a number of Bank documents such as the Concept Note, Aide-Memoires, Project Appraisal Documents, Concept Note Review, fiduciary assessments and Decision Meeting Minutes, etc. Moreover, the TF Agreement becomes

active only when the IDA operation is approved. However, we welcome and take seriously the evaluation team's suggestions on how to further improve communications in the context of IDA credit processing.

5. **Strategically oriented and more hands-on HRITF Team.** We very much appreciate this feedback. It is extremely useful and we are grateful for the granular discussion of actions and recommendations which will greatly contribute to the effectiveness of the program.

6. **The full implications of the RBF pilots should be better assessed and reflected in existing reports.** This is very useful feedback. We agree with the spirit of the recommendation. It is, however, a very complex objective to achieve, until well into the pilot, when the overall direction and implications of the pilot are clearer, as happens with all pilots and reforms in developed and developing countries.

7. **Work harder to ensure that successful RBF pilots can be scaled up and sustained.** We fully agree with the importance of ensuring that successful RBF pilots are scaled up and sustainable. Although we will work as hard as possible to facilitate scale up and sustainability through the HRITF, the current scope, mandate, and resources of the TF, although very effective in supporting pilots and experimentation, pose significant limitations to achieve this expanded objective. We have advanced, to the extent possible, this additional objective, particularly since phase three, by linking and leveraging HRITF with IDA for RBF. This has provided a larger financial envelope (about $363 million additional to the $209 million committed by the HRITF). However, we recognize that any substantial scale up is likely to require far more resources than those currently committed for HRITF. In this regard, we are engaging with donors at country level, to align and harmonize results-based aid using RBF.

8. **Financial information:** The Annual reports contain substantial financial information in the format agreed upon with the donors. This meets the standards set for financial monitoring for all Bank Trust Funds. However, we acknowledge that incorporating some of the recommendations in the report, such as comparing trends in actual versus projected disbursements and explaining any deviations, would be useful for future reporting.

B. Additional general comments

1. **Monitoring and documentation of progress on a continuing basis:** We agree that monitoring and documentation of progress at the country level should be an integral part of our work. Given that a lot of effort was put into preparing projects and getting them ready for implementation, it is now an opportune time to capture the lessons from implementation. As we see it, the focus of the monitoring would include qualitative information generated during design, pre-pilot, and pilot phases regarding issues such as demand

for services, health worker motivation, incentive levels, and unintended effects. It would also include the more design/ process oriented issues like the political economy of RBF design, stakeholder analysis, legal issues affecting the design (facility autonomy for example), etc. In addition, it would capture any strengthening of health systems that occurs due to the pilots such as improved HMIS, or timely fund flows. This has been specified in our work program for the coming years and we will be able to share the lessons from implementation as we gather and analyze the information. As before, we will continue to work on making the annual reports more responsive to donor needs including further financial analysis on areas such as deviations of actual expenditures from the forecast.

2. **Capacity at the Bank to deliver the HRITF program:** The evaluation makes an important point on the need for considerable technical resources to deliver on the large country pilot and IE programs that have been developed. During preparation, the Bank used a mix of staff and consultant support to build awareness about RBF at the country level and assist countries with the preparation of pre-pilots and pilots, once countries were committed to moving forward with a pilot. As a result of these efforts, the work program has expanded considerably. In our opinion, technical support during this initial period was adequately met by the arrangements that were in place. However, we also recognize the increasing demand due to the expanding program and the critical need to support country teams during implementation. Within the matrix structure of the Bank, quality assurance and accountability are shared responsibilities between the regions and the HNP Hub. We plan on sharing our business model with the donors during our next Annual Donor consultation.

3. **Leveraging additional funds:** The report rightly points out that the aim on attracting additional funding is poorly defined. In order to achieve this aim, the Bank has used the HRITF to help leverage IDA for RBF. We agree that, in the absence of the counter-factual, it is very difficult to measure the "additional resources" that are leveraged. We think it would be useful to have a discussion on measuring this objective in the context of developing the Results Framework.

4. **Usefulness of the website:** We are pleased to note the report's assessment of the website as a rich source of information that serves the broader RBF community's needs. We agree with the recommendation to use the website as a platform for sharing the latest evidence from the impact evaluation work as well as other activities supported by the HRITF, including relevant documents that pertain to country pilots.

C. Operationalizing the recommendations for the next phase

1. **Costing out recommendations:** The report provides a list of recommendations without estimating the budgetary implications for implementing them. We fully understand that all recommendations need to be first examined in terms of their value-added, but it would have been very useful if the recommendations had been prioritized and a cost estimate for implementing these recommendations provided, given administrative and financial constraints.

2. **Social Inclusion:** The section on social inclusion, including gender, would have benefitted from further elaboration. The pilots are strongly focused on MCH, so the results that are being paid for have a strong gender bias. Moreover, there is a Social Assessment Toolkit that is being prepared, which will further provide necessary instruments to teams to mainstream social analysis within the operations. It would therefore have been helpful to know how the assessment team would ensure greater social inclusion, so it can be compared with current Bank practices on project-related social safeguards and analytic instruments (all applicable to IDA operations), and changes made, if necessary.

EVALUATION REPORTS

1.00 Review of Norwegian Health-related Development Cooperation1988–1997
2.00 Norwegian Support to the Education Sector. Overview of Policies and Trends 1988–1998
3.00 The Project "Training for Peace in Southern Africa"
4.00 En kartlegging av erfaringer med norsk bistand gjennomfrivillige organisasjoner 1987–1999
5.00 Evaluation of the NUFU programme
6.00 Making Government Smaller and More Efficient.The Botswana Case
7.00 Evaluation of the Norwegian Plan of Action for Nuclear Safety Priorities, Organisation, Implementation
8.00 Evaluation of the Norwegian Mixed Credits Programme
9.00 "Norwegians? Who needs Norwegians?" Explaining the Oslo Back Channel: Norway's Political Past in the Middle East
10.00 Taken for Granted? An Evaluation of Norway's Special Grant for the Environment

1.01 Evaluation of the Norwegian Human Rights Fund
2.01 Economic Impacts on the Least Developed Countries of the Elimination of Import Tariffs on their Products
3.01 Evaluation of the Public Support to the Norwegian NGOs Working in Nicaragua 1994–1999
3A.01 Evaluación del Apoyo Público a las ONGs Noruegas que Trabajan en Nicaragua 1994–1999
4.01 The International Monetary Fund and the World Bank Cooperation on Poverty Reduction
5.01 Evaluation of Development Co-operation between Bangladesh and Norway, 1995–2000
6.01 Can democratisation prevent conflicts? Lessons from sub-Saharan Africa
7.01 Reconciliation Among Young People in the Balkans An Evaluation of the Post Pessimist Network

1.02 Evaluation of the Norwegian Resource Bank for Democracyand Human Rights (NORDEM)
2.02 Evaluation of the International Humanitarian Assistance of theNorwegian Red Cross
3.02 Evaluation of ACOPAMAn ILO program for "Cooperative and Organizational Support to Grassroots Initiatives" in Western Africa 1978 – 1999
3A.02 Évaluation du programme ACOPAMUn programme du BIT sur l'« Appui associatif et coopératif auxInitiatives de Développement à la Base » en Afrique del'Ouest de 1978 à 1999
4.02 Legal Aid Against the Odds Evaluation of the Civil Rights Project (CRP) of the Norwegian Refugee Council in former Yugoslavia

1.03 Evaluation of the Norwegian Investment Fund for Developing Countries (Norfund)
2.03 Evaluation of the Norwegian Education Trust Fund for Africain the World Bank
3.03 Evaluering av Bistandstorgets Evalueringsnettverk

1.04 Towards Strategic Framework for Peace-building: Getting Their Act Togheter.Overview Report of the Joint Utstein Study of the Peace-building.
2.04 Norwegian Peace-building policies: Lessons Learnt and Challenges Ahead
3.04 Evaluation of CESAR´s activities in the Middle East Funded by Norway
4.04 Evaluering av ordningen med støtte gjennom paraplyorganiasa-joner.Eksemplifisert ved støtte til Norsk Misjons Bistandsnemda og Atlas-alliansen
5.04 Study of the impact of the work of FORUT in Sri Lanka: Building CivilSociety
6.04 Study of the impact of the work of Save the Children Norway in Ethiopia: Building Civil Society

1.05 –Study: Study of the impact of the work of FORUT in Sri Lanka and Save the Children Norway in Ethiopia: Building Civil Society
1.05 –Evaluation: Evaluation of the Norad Fellowship Programme
2.05 –Evaluation: Women Can Do It – an evaluation of the WCDI programme in the Western Balkans
3.05 Gender and Development – a review of evaluation report 1997–2004
4.05 Evaluation of the Framework Agreement between the Government of Norway and the United Nations Environment Programme (UNEP)
5.05 Evaluation of the "Strategy for Women and Gender Equality in Development Cooperation (1997–2005)"

1.06 Inter-Ministerial Cooperation. An Effective Model for Capacity Development?
2.06 Evaluation of Fredskorpset
1.06 – Synthesis Report: Lessons from Evaluations of Women and Gender Equality in Development Cooperation

1.07 Evaluation of the Norwegian Petroleum-Related Assistance
1.07 – Synteserapport: Humanitær innsats ved naturkatastrofer:En syntese av evalueringsfunn
1.07 – Study: The Norwegian International Effort against Female Genital Mutilation
2.07 Evaluation of Norwegian Power-related Assistance
2.07 – Study Development Cooperation through Norwegian NGOs in South America
3.07 Evaluation of the Effects of the using M-621 Cargo Trucks in Humanitarian Transport Operations
4.07 Evaluation of Norwegian Development Support to Zambia (1991 - 2005)
5.07 Evaluation of the Development Cooperation to Norwegion NGOs in Guatemala

1.08 Evaluation: Evaluation of the Norwegian Emergency Preparedness System (NOREPS)
1.08 Study: The challenge of Assessing Aid Impact: A review of Norwegian Evaluation Practise
1.08 Synthesis Study: On Best Practise and Innovative Approaches to Capasity Development in Low Income African Countries
2.08 Evaluation: Joint Evaluation of the Trust Fund for Enviromentally and Socially Sustainable Development (TFESSD)
2.08 Synthesis Study: Cash Transfers Contributing to Social Protection: A Synthesis of Evaluation Findings
2.08 Study: Anti- Corruption Approaches. A Literature Review
3.08 Evaluation: Mid-term Evaluation the EEA Grants
4.08 Evaluation: Evaluation of Norwegian HIV/AIDS Responses
5.08 Evaluation: Evaluation of the Norwegian Reasearch and Develop-ment Activities in Conflict Prevention and Peace-building
6.08 Evaluation: Evaluation of Norwegian Development Cooperation in the Fisheries Sector

1.09 Evaluation: Joint Evaluation of Nepal´s Education for All 2004-2009 Sector Programme
1.09 Study Report: Global Aid Architecture and the Health Millenium Development Goals
2.09 Evaluation: Mid-Term Evaluation of the Joint Donor Team in Juba, Sudan
2.09 Study Report: A synthesis of Evaluations of Environment Assistance by Multilateral Organisations
3.09 Evaluation: Evaluation of Norwegian Development Coopertation through Norwegian Non-Governmental Organisations in Northern Uganda (2003-2007)
3.09 Study Report: Evaluation of Norwegian Business-related Assistance Sri Lanka Case Study
4.09 Evaluation: Evaluation of Norwegian Support to the Protection of Cultural Heritage
4.09 Study Report: Norwegian Environmental Action Plan
5.09 Evaluation: Evaluation of Norwegian Support to Peacebuilding in Haiti 1998–2008
6.09 Evaluation: Evaluation of the Humanitarian Mine Action Activities of Norwegian People's Aid
7.09 Evaluation: Evaluation of the Norwegian Programme for Develop-ment, Research and Education (NUFU) and of Norad's Programme for Master Studies (NOMA)

1.10 Evaluation: Evaluation of the Norwegian Centre for Democracy Sup-port 2002–2009
2.10 Synthesis Study: Support to Legislatures
3.10 Synthesis Main Report: Evaluation of Norwegian Business-related Assistance
4.10 Study: Evaluation of Norwegian Business-related Assistance South Africa Case Study
5.10 Study: Evaluation of Norwegian Business-related Assistance Bangladesh Case Study
6.10 Study: Evaluation of Norwegian Business-related Assistance Uganda Case Study
7.10 Evaluation: Evaluation of Norwegian Development Cooperation with the Western Balkans
8.10 Evaluation: Evaluation of Transparency International
9.10 Study: Evaluability Study of Partnership Initiatives
10.10 Evaluation: Democracy Support through the United Nations
11.10 Evaluation: Evaluation of the International Organization for Migration and its Efforts to Combat Human Trafficking
12.10 Evaluation: Real-Time Evaluation of Norway's International Climate and Forest Initiative (NICFI)
13.10 Evaluation: Real-Time Evaluation of Norway's International Climate and Forest Initiative. Country Report: Brasil
14.10 Evaluation: Real-Time Evaluation of Norway's International Climate and Forest Initiative. Country Report: Democratic Republic of Congo
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