

# HRITF LEARNING STRATEGY



RBF**HEALTH**

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## Executive Summary

From its inception in 2007, evaluation and learning have been at the center of the Health Results Innovation Trust Fund (HRITF). The trust fund was financed by Norway and the United Kingdom and administered by the World Bank to test whether results-based financing (RBF) can be effective in improving Reproductive, Maternal, Neonatal and Child Health and explores how to improve that effectiveness. As a testament to its commitment to learning whether RBF can be a vehicle towards those ends, the HRITF has worked with 28 countries to implement RBF and has established a sound evaluation in each—among which are 24 rigorous experimental or quasi-experimental impact evaluations (IEs) and a series of qualitative evaluations.

The early phases of the HRITF Learning Strategy were concerned with initiating evaluations (including producing tools that would aid in developing evaluations) and learning from the early experiences of implementing RBF programs across its vast portfolio. To support that effort, the HRITF has developed multiple toolkits which have been used by thousands. A rich array of learning has been generated from implementation, particularly through in-country studies and cross-country analyses and topical learning.

From the outset, HRITF teams have undertaken extensive consultations at the country level to secure buy-in and ensure that the design of each impact evaluation considers the country context, policy-maker needs, stakeholder interests and evidence gaps. The HRITF has now initiated all RBF interventions and evaluations.

The present iteration of the HRITF Learning Strategy sets out the blueprint for taking advantage of the maturing evaluation and RBF portfolio. Going forward, the HRITF will continue to support country learning and country evaluations. Furthermore, it will endeavor to leverage opportunities to aggregate knowledge across its uniquely large portfolio to gain rare generalizable insights. Concurrently, it will continue to disseminate lessons from country evaluations, topical learning, and broader evaluations.

As outlined in this learning strategy, the HRITF will focus on leveraging existing and upcoming data collection to generate further learning within countries, while emphasizing further learning across the portfolio. It will continue to monitor RBF results, and it will leverage that monitoring by learning from implementation. The learning strategy also seeks to take advantage of the complementarity of the mixed methods evaluations found in many of the RBF evaluations: The quantitative impact evaluations indicate what effects RBF had in a country, while the descriptive and qualitative process evaluations explain how implementation actually happened; together these two approaches indicate why RBF had the effects that it did and often what can be done to make improvements.

The depth and scale of the HRITF learning portfolio have been significant. The portfolio's highly rigorous evaluations lend it internal validity, while the relatively narrow, well-defined intervention set across a large number and variety of different contexts lend it considerable external validity.

Recognizing that its evaluation resources have largely been committed, the HRITF secretariat engaged in a lengthy consultation process with implementers, policy makers, researchers, and donors to identify a range of learning topics which were then prioritized into three categories.

The first tranche of learning opportunities includes those evaluation questions that demonstrate high demand, relatively low cost, and have readily available data from the HRITF portfolio. There was a strong sense that continued learning from implementation should include two topics: (i) verification and (ii) how RBF interacts with and strengthens health systems. There were five topics prioritized for aggregated learning across the impact evaluations: the effectiveness of RBF, equity implications of RBF, strength of incentives and their effects, the effect of RBF on unincented outcomes, and the effect of RBF on quality of care.

The second tranche in the prioritization exercise identified highly relevant learning opportunities that, if not for cost considerations, would have been selected for study by the HRITF. These lines of inquiry would leverage the existing HRITF portfolio and would provide tremendous insights into the broader themes of health system strengthening and value for money by conducting (i) a rigorous analysis of the contextual and design factors that influence RBF effectiveness to understand the conditions that are likely to lead to success, (ii) a system dynamics model coupled with agent-based modelling to understand how RBF interacts with the health sector as a system, (iii) a study of the long term effects and sustainability of RBF by extending the utility of 1-3 impact evaluations with an additional round of surveys and analysis, (iv) a series of case studies on how RBF influences the individual components of health systems—particularly governance, data and health information systems, purchasing mechanisms, and financial flows, (v) expanding the number of IEs that also do cost effectiveness analysis and synthesizing those results across contexts to better understand value for money of RBF, and (vi) a set of case studies that explore RBF and the private sector.

The third set—evaluation topics not selected for other reasons—are found in an annex in the learning strategy. Recognizing the tremendous contributions of the PBF Community of Practice and other outside researchers and trainers, and to facilitate further learning by these external actors, the HRITF is committed to publishing evaluation data and reports of its RBF activities to the extent possible. In addition to sharing these (non-exhaustive) lists of potential evaluation topics, this learning strategy also includes several aids that may be useful for crowdsourcing knowledge generation, including a heatmap of expected IE results in the intervention-outcome space and a list of the specific research questions for each impact evaluation.

As learning activities are completed, the HRITF team will continue to disseminate RBF-related knowledge within and across countries to inform evidence-based practice and decision-making among practitioners, researchers, policymakers, donors and other stakeholders. A variety of dissemination methods will be used as appropriate for different audiences, both within and across countries, enumerated in the results frame.

One ready recipient of that knowledge dissemination is the Global Financing Facility (GFF). Because the GFF shares the same secretariat, the learning from the HRITF has been and will continue to be integrated into the programming of the GFF. The GFF approach has taken advantage of lessons learned by the HRITF on delivering a package of services, using results-focused financing, using data for decision making, integrating and aligning governments and partners, identifying and strengthening the broader needs of a health system, and sustainable health financing. The considerable body of knowledge that will be created by the HRITF will continue to be used and disseminated through GFF workshops, Investment Case preparation, and peer-to-peer knowledge transfer through multi-country GFF webinars and knowledge events.

## Introduction

The learning portfolio of the Health Results Innovation Trust Fund (HRITF) has contributed considerably to a rigorous evidence base of knowledge focused on the function and effect of Results Based Financing (RBF) schemes. It is thereby responding to one of the HRITF's main objectives, namely developing and disseminating evidence on RBF. Implemented by the World Bank since 2007, the HRITF is the trust fund dedicated to RBF in health. It was funded by the governments of Norway and the United Kingdom to improve access to and the quality of health services for women and children in developing countries while seeking to understand whether RBF could be a viable vehicle towards those goals. More specifically, the HRITF seeks to (1) support the design, implementation, monitoring and evaluation of RBF mechanisms; (2) develop and disseminate an evidence base for the implementation of successful RBF mechanisms; (3) build country institutional capacities to scale up and sustain RBF mechanisms in line with the national health strategy and systems; and (4) attract additional financing for the health sector.

Even as the knowledge about *what works* and *what doesn't* and *why* is still growing, RBF and its focus on outcomes rather than inputs has shifted the debate to service delivery issues and health system challenges. RBF offers the potential to accelerate progress toward the universal coverage of key preventive services. Early evidence suggests that it can contribute to enhanced service utilization, increased focus on the quality of care, strengthened governance and accountability including improved data use, and enhanced donor alignment, amongst other benefits.

To date, the HRITF has developed multiple toolkits, which have been used by thousands, and disseminated the results of eight evaluations. It is also on track to produce a total of 24 impact evaluations (IEs). In addition, a rich array of learning has been generated from implementation, particularly through country studies and cross-country analyses and topical learning. Going forward, the HRITF will continue to support country learning and country evaluations. Furthermore, it will endeavor to leverage opportunities to aggregate knowledge across its uniquely large portfolio to gain rare generalizable insights. Concurrently, it will continue to disseminate lessons from country evaluations, topical learning, and broader evaluations.

This iteration of the Learning Strategy (LS), therefore, aims to build on the wealth of information generated over a decade of RBF implementation and explore learning opportunities within the HRITF portfolio, disseminating information tailored to its specific audiences to inform decision making and improve RBF design and implementation. It is recognized though that the HRITF learning portfolio will not be able to fill every gap in the evidence and learning on RBF, nor will it seek to do so. Rather, the goal is to create a solid and well-founded base of studies on the impact of RBF in health while making learning and data more widely available for others to contribute to this learning.

## The RBF Model

Results-based financing (RBF) is an approach that links financing to results, which can be applied at multiple levels in the health system. Payment is made after predefined results have been attained and verified. For example, financing to (sub) national governments can be linked to results, such as in the case of financial

transfers to provincial governments in Argentina or the use of Disbursement Linked Indicators in World Bank projects. Another example is the use of conditional cash transfer programs, whereby consumers are paid conditionally based on measurable actions undertaken – for example, by children to attend preventive health services check-ups. In most of the countries of the HRITF portfolio, Performance Based Financing (PBF) is used to channel financing to frontline providers based on the quantity and quality of services provided. While input-based financing mechanisms used in many Low and Middle-Income Countries (LMICs) do not readily allow financial flows to the primary healthcare level in part because funding for primary care is often crowded out by secondary and tertiary care as well as by expenses related to infrastructure and human resources expenses, PBF can serve as a kick-starter for a paradigm shift by changing financial flows, delivering larger resources to primary care facilities, and linking financing to results.

Several elements underpin RBF programs (Figure 1), with three of them playing the most important role:

Figure 1: Linking payments for results

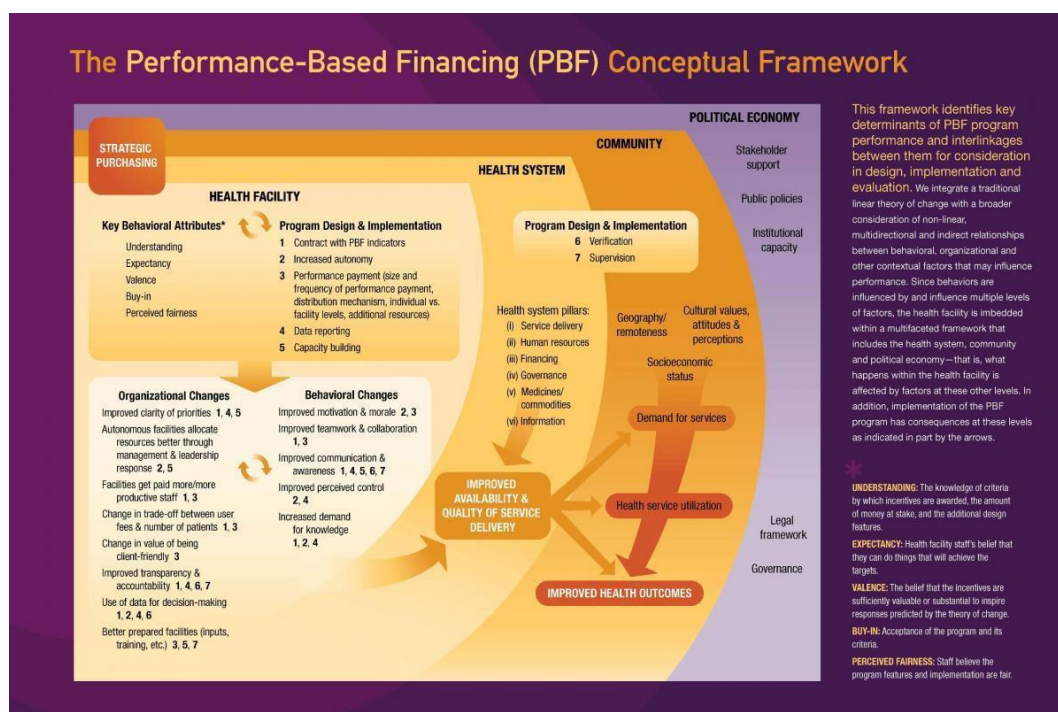


1. Linking payment to results: A common feature across all RBF projects is that finances are disbursed upon the delivery of results, as determined by the achievement of measurable and verifiable indicators, rather than inputs. Financial incentives are one of the largest elements of the RBF approach, and the results can vary by level of engagement. For example, at the facility level, results can be reflected by the number of quality-assured deliveries; at the sub-national level, by the number of supervision visits made; at the national level, by the funds allocated for recurrent budgets.
2. Providing autonomy to ensure providers can achieve these results. Some degree of autonomy is required to ensure that facilities, districts and/or governments can define the means and pathways required to get results. For health workers, having the tools to carry out their work is in itself an incentive, and the provision of health facility autonomy along with some financial autonomy is a key aspect of many facility-based RBF projects. This enables service providers to procure drugs, organize a health facility, clean their surroundings; and make necessary changes and innovations to produce better results.

3. Putting a premium on the monitoring and verification of results to ensure accuracy. RBF projects support performance improvements through better monitoring, record keeping, and the continuous tracking of results. Supervisors make periodic visits, review implementation, fill out checklists, and work with staff to understand and respond to performance-related bottlenecks. A positive spin-off is the greater contact time between healthcare providers and their supervisors. To mitigate the risk of over-reporting, results need to be independently (counter-) verified, which has cost implications. Many projects are, therefore, exploring risk-based verification as a means to target and reduce the need for large-scale verification mechanisms. Due to the strong emphasis placed on data and continuous monitoring and verification of performance measures, RBF programs also contribute to strengthening health information systems. In many countries, a cloud dashboard system has been introduced, thus enhancing the accuracy and efficiency of data entry and the timeliness and usefulness of data analyses and management decision-making.

A conceptual framework (see Figure 2) systematically guides learning within the HRITF portfolio. This conceptual framework illustrates the causal pathways through which RBF can generate positive results on healthcare delivery, quality of care, healthcare utilization and ultimately, health outcomes. It is sufficiently detailed to facilitate learning related to performance-based financing (PBF) as well as to inform other types of RBF designs, taking key behavioral and organizational changes into account. The conceptual framework maps how RBF functions within the larger contexts (i.e. health system, community factors and political economy). It also serves as a basis to illustrate knowledge gaps (see heatmap in Annex 4). Within, the portfolio, the conceptual framework both guides learning from implementation and learning from the evaluations.

Figure 2: PBF conceptual framework



## The RBF Portfolio of the HRITF

The World Bank’s HRITF RBF portfolio comprises 36 projects that span over 28 countries in the Africa, East Asia and Pacific, Europe and Central Asia, Latin America and Caribbean, Middle East and North Africa and South East Asia regions. The HRITF is evaluating RBF in 30 countries—the 28 in which it is financing projects plus Argentina and China where it is evaluating “standalone” RBF efforts (See Map 1), with most in Africa.

Map 1: Countries with RBF projects supported by HRITF



RBF designs are influenced by country context and adjusted over the years based on lessons learned during implementation and based on evolving sector priorities. A large majority of the projects seek to generate supply-side improvements using RBF at the health facility level. Over time, several of these designs have evolved to address identified bottlenecks; most RBF programs now include administrative indicators or disbursement-linked indicators. For instance, programmatic designs now frequently enhance timely verification and supervision or focus on health system strengthening such as increasing the availability of medicines and commodities. Results from the initial impact evaluations indicate that demand- and supply-side incentives work on different margins, suggesting they may be even more effective when combined. To this end, some countries have integrated supply-side incentives with community level RBF interventions or voucher programs to enhance demand. For sustainability purposes, some countries also use social health insurance systems as part of their RBF designs and implementation. To date, six countries are now implementing nation-wide RBF programs (i.e. Afghanistan, Armenia, Benin, Burundi, Sierra Leone, and Zimbabwe).

In line with the objective of the HRITF to build the evidence and learn from RBF implementation, most of the RBF programs are accompanied by an impact evaluation. In some Middle-Income Countries (MICs), such as [Argentina](#), impact evaluations have been supported through the HRITF to further the learning about



RBF in such contexts and to share relevant lessons with Low-Income Countries (LICs). Where an impact evaluation was not possible—either because of the lack of availability of a counterfactual because RBF was already rolled out nationwide or for some other reason—the HRITF has implemented program assessments and enhanced program assessments. Additional learning activities in the portfolio include (i) “Learning from RBF implementation” (LFRI) case studies which focus on learning from and during program implementation, including the analysis of administrative data, and (ii) analytical products which aim to learn on specific aspects of RBF through knowledge products on topics such as [Family Planning and Incentives in RBF](#), [Verification in RBF](#), [RBF and Human Resources for Health](#) (HRH), and [Cost-effectiveness](#) and [Qualitative Tools to Evaluate RBF](#).

All impact evaluations were designed and approved contemporaneous to project design, financing, and implementation. The HRITF portfolio currently includes 24 impact evaluations, 5 program assessments and 3 enhanced program assessments. Many of these evaluations employ mixed methods designs with both a quantitative IE and qualitative/descriptive elements. This approach allows for learning on the critical question of *whether* a design/context variant of RBF has been effective as well as on *how* the RBF worked; together these dual tracks provide insight on *why* the RBF was effective or not.

A synopsis of the results generated thus far from the first seven completed impact evaluations and complementary qualitative work is readily available: [Completed Impact Evaluations and Emerging Lessons from the Health Results Innovation Trust Fund Learning Portfolio](#). Annex 1 gives an overview of evaluation results for each of these first countries: Afghanistan, Argentina, Cameroon, Democratic Republic of Congo (Haute Katanga province), Rwanda, Zambia, and Zimbabwe. Perhaps unsurprisingly in a portfolio so large and covering a range of contexts and variation in project design and implementation fidelity, the evidence is often somewhat uneven. Although not every country saw improvements in every indicator, in general these early results indicate that RBF approaches can be effective at increasing utilization, coverage, and quality of care.

Despite the substantial investment in RBF-based reforms of health systems, the rigorous evidence base of the HRITF impact evaluation portfolio is still nascent and will mature alongside those investments. As such, the balance of the IEs and the descriptive work expected to be completed in the coming years offer a unique opportunity to add to that knowledge base.

## Objectives of the Learning Strategy

The overall objective of the learning strategy for RBF in the health sector is to develop and disseminate an evidence base for the implementation of successful RBF mechanisms, mirroring the evaluation-specific objective set out for the HRITF. This learning strategy describes how the HRITF will leverage its existing knowledge and use its planned evaluations to further generate new knowledge at the country level and at a generalized level across countries—and how it will disseminate that knowledge to promote further learning.

The specific objectives of the learning strategy are to

- Facilitate access to relevant knowledge about design and implementation of RBF to enable its application to improve existing and future RBF programs
- Produce a robust evidence base on RBF and contribute to understanding of the effectiveness of RBF approaches for improving Reproductive, Maternal, Neonatal and Child Health to help make informed decisions about efficient spending of domestic and donor resources, and
- Effectively communicate and disseminate RBF Knowledge and Learning to inform future research with an emphasis on learning from rigorous impact evaluations.

These objectives will benefit four distinct audiences. First, RBF and health development practitioners will be able to use the knowledge and evidence generated to help inform design and implementation of RBF programs. Government policy makers in Ministries of Health and Finance as well as the donor community will be able to use the evidence and learning to make informed decisions about RBF, including whether to scale it up and/or sustain it in a country. Finally, through sharing the evidence and learning with the academic and research community in global health, this learning strategy can inform current and future research on RBF.

## Learning opportunities within the portfolio

The breadth and scale of the HRITF learning portfolio has been substantial. The recently completed Mid-Term Review (MTR) emphasized the added value and effectiveness of HIRTF impact evaluations. Going forward, the HIRTF will leverage existing data and upcoming data collection to generate further learning within countries, while extending additional learning across the portfolio. To pace the progress of the development of these learning activities, the HRITF instituted a learning strategy results framework (Annex 2). To facilitate flexibility and responsiveness in the learning strategy, the HRITF will highlight those learning activities expected to be undertaken in the coming year at the annual donors' review meeting.

Building upon its existing knowledge base, the remainder of the HRITF learning resources will concentrate on three different classes of learning opportunities:

### 1. Monitoring RBF results

Monitoring data from RBF indicators – often called operational data – is critical to measure progress on results – i.e. improved availability and quality of services (at the center of the Conceptual Framework featured in Figure 2). While the levels of development and capacity of countries' operational data systems differ within the HRITF portfolio (e.g. in terms of how data are collected, reported, managed, analyzed, utilized, and disseminated), the use of RBF data is promoted and supported in all countries to enable evidence-based decision making.

Monitoring is critical to track progress and ensure the attainment of intended results, including through

corrective action, when needed. This may require changing an aspect of RBF design (e.g. the level of incentive linked to a specific indicator) or focusing on specific areas of the health system (e.g. the supply chain to ensure availability of medicines). Such RBF data is also used at portfolio level by the HRITF to monitor seven core RBF indicators aggregated across countries and report to HRITF donors in the annual results framework. In addition, the HRITF will continue to make information available from country [performance dashboards](#) on the dedicated RBF [website](#) to further enhance accountability and transparency.

## 2. Learning from implementation

The performance dashboards used for monitoring can also help improve the delivery of RBF services. This “Learning from Implementation” is critical to inform the design and operationalization of RBF, focusing on specific elements of RBF design and implementation, as well as on their effects. The PBF Conceptual Framework (see Figure 2) guides this learning as it clearly describes the seven design features relevant to this learning from implementation, namely: (i) contract with indicators; (ii) autonomy; (iii) performance payment; (iv) data reporting; (v) capacity building; (vi) verification; and (vii) supervision. When implemented well, these design features stimulate (intended) organizational and behavioral changes –at facility level and beyond. In addition, effects of – and on – the health system, the community and the political economy should be considered.

The proposed learning will build on previous work, including individual country studies, such as “[Pathways to high and low performance: factors differentiating primary care facilities under Performance-Based Financing in Nigeria](#),” which explores the effects and changes generated at health facility level as well as determinants for success. Such learning from implementation typically uses RBF quantitative payment data to identify patterns, bottlenecks and issues, while using qualitative or mixed methods to understand its underlying causes and devise strategies to address these issues. In addition, cross-country analyses have been developed and guidance provided to support countries in addressing specific RBF design issues. An example of this is “[Economics and Ethics of Results-Based Financing for Family Planning: Evidence and Policy Implications](#),” which provides a framework to make decisions on the incentivization of family planning to address demand- and supply-side barriers while considering RBF-related ethical concerns.

Specific attention will be given to two areas identified as critical to inform the future of RBF implementation that are of interest to RBF practitioners and to those interested in supporting RBF: verification and the effect of RBF on the health system.

### *a. Verification*

Further learning is needed on verification, building on existing comparative learning. A comparative analysis entitled “[Verification in Results-Based Financing for Health](#)” explores the similarities and differences that exist in verification methods across six cases and provides key findings and recommendations to improve verification design and implementation. It underlines the need to further determine how best to minimize verification costs, while still ensuring accurate reporting. Pushing the opportunities for learning further,

some countries are considering risk-based verification. This includes some countries' exploratory work on using machine-based learning to better identify providers who would potentially be at higher risk of over-reporting. In the same vein, other countries are using (mobile) technology to enhance reporting or verification processes. Supporting such learning and identifying what can be learnt about efficient verification mechanisms across the portfolio will be a critical contribution to the sustainability of RBF, both to rationalize costs and to maintain trust in payments based on verified results.

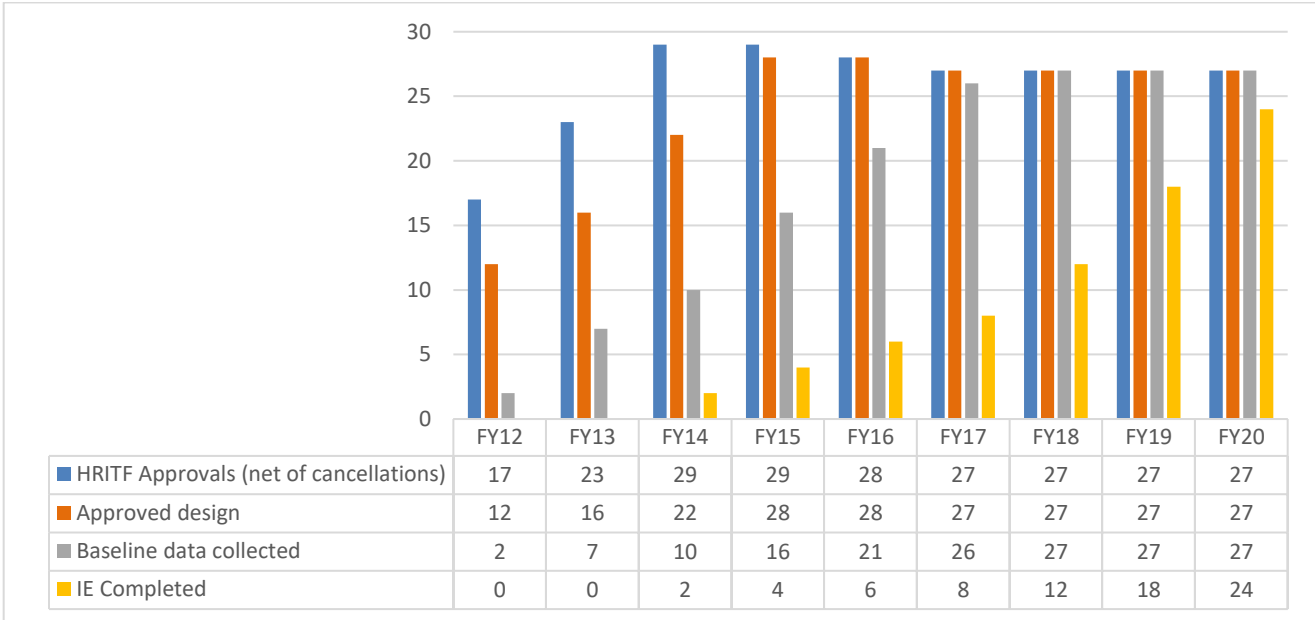
#### *b. Effect of RBF on the health system*

Examining trends in operational data from different countries can help understand how RBF may have influenced the health system over time. Further exploring data from RBF quality scorecards may reveal effects on the quality of service delivery (e.g. improvements in privacy measures and Infection Prevention and Control services at facilities) as well as supply chain improvements (e.g. improved availability of equipment and medicines). If possible, the influence of RBF on governance and patient satisfaction will also be investigated. Learning about the effect of RBF – and its limitations – on health systems is critical not only at individual country level, but also across the portfolio to inform better design and implementation for RBF programs, now and in the future.

### 3. Impact Evaluation portfolio

This is a pivotal time for the HRITF evaluation portfolio: there are several evaluations and learning activities to complete in the short to medium term that will bring a critical mass of results on RBF. Figure 3, below, demonstrates that the number of completed impact evaluations is expected to increase dramatically—nearly tripling from eight to 24 over the latter half of the trust fund (three of the 27 IEs that had baseline data collected have had to be stopped due to national security, statistical power, or national interest). Each IE holds a double promise of learning: each evaluation is especially instructive for the country context it evaluates, and each adds an additional point of reference for broader analysis across the portfolio to understand the nature and variation of RBF effectiveness. Both learning opportunities with the IE portfolio will be reflected on in this section.

Figure 3: HRITF IE portfolio timeline



*a. Learning from individual impact evaluations*

In line with the richness of the RBF programmatic portfolio, the evaluation portfolio of RBF is characterized by a diverse range of outcomes of interest and evaluated interventions – as described in Table 1 and Table 2. Annex 3 details the research questions used by each IE along with their current status and highlights the depth and diversity of these studies. In addition, many of these IEs use a combination of quantitative and qualitative tools to both help understand the mechanisms behind any observed impact and unpack the “black box” of complex RBF projects.

The design of each impact evaluation was influenced by the country context and by the gaps in the evidence base of the impact of RBF. The design process of each IE started with a series of consultations between the World Bank country team, the government and key stakeholders to ensure relevance and buy-in.

In addition to generating rigorous evidence on the effect of RBF on maternal and neonatal health outcomes, select impact evaluations should also yield estimates on the impact on (1) health care utilization and equity; (2) the quality of care provided; and (3) health systems and human resources. Further, several of these impact evaluations will be able to assess the cost-effectiveness of PBF, particularly in comparison to other health interventions, as can be seen below in Table 1.

Table 1: Interventions evaluated in HRITF IEs

Intervention evaluated	Countries
Supply-side RBF payments	Afghanistan, Argentina, Armenia, Benin, Burkina Faso, Burundi, Brazil, Cameroon, China, Democratic Republic of Congo (1 and 2), Republic of Congo, Gambia, Ghana, Haiti, India, Kenya, Kyrgyz Republic, Liberia, Mexico, Nigeria, Rwanda, Senegal, Tajikistan, Tanzania, Zambia, Zimbabwe
Demand-side RBF payments	Gambia, Nigeria, Rwanda, Senegal, Zimbabwe
Community-Based RBF	Gambia, Senegal, Rwanda, Democratic Republic of Congo 2, Republic of Congo
RBF for quality of care	Afghanistan, Armenia, Argentina, Benin, Brazil, Cameroon, China, Democratic Republic of Congo 2, Haiti, Kyrgyz Republic, Nigeria, Senegal, Tajikistan, Tanzania, Zambia, Zimbabwe
RBF in hospitals	Afghanistan, Argentina, Burundi, China, Democratic Republic of Congo 2, India, Kyrgyz Republic, Liberia, Nigeria, Senegal
Health insurance and RBF	Burkina Faso, China, Ghana, Kenya
Additional financing	Benin, Democratic Republic of Congo 2, Nigeria, Zambia, Zimbabwe
Differential incentive levels	China
Enhanced monitoring & supervision	Cameroon, Kyrgyz Republic
RBF and training of providers	Zimbabwe
RBF at higher administrative levels	Argentina, Republic of Congo
Unintended consequences	Afghanistan
Targeting/Subsidies/Equity	Burkina Faso, Benin, Republic of Congo

The evaluation Heat Map in Annex 4 indicates the expected directions of future learning from country evaluations. Countries in red are those impact evaluations that have been completed. Where there is a country case there is the potential to answer a question at that intersection of design element and outcomes. So, for example, the IE from the RBF in the Kyrgyz Republic should be able to reveal the effect of enhanced monitoring and supervision on the quality of maternal and child health care. However, The HRITF secretariat may not be able to evaluate all those questions due to resource constraints and the fact that even if there are country cases available, the information needed to answer a particular question may not be available.

Table 2: Outcomes of interest in HRITF IEs

Outcomes of interest	Countries
Maternal Care (Quality/Utilization)	Afghanistan, Argentina, Armenia, Benin, Burkina Faso, Burundi, Cameroon, Democratic Republic of Congo (1 and 2), Republic of Congo, Gambia, Ghana, Haiti, India, Kenya, Kyrgyz Republic, Liberia, Nigeria, Rwanda, Senegal, Tajikistan, Tanzania, Yemen, Zambia, Zimbabwe
Family Planning	Afghanistan, Armenia, Cameroon, Democratic Republic of Congo (1 and 2), Republic of Congo, Lesotho, Rwanda, Zambia, Zimbabwe
Child Health Care (Quality/Utilization)	Afghanistan, Argentina, Benin, Burkina Faso, Burundi, Cameroon, Democratic Republic of Congo (1 and 2), Republic of Congo, Gambia, Ghana, Haiti, India, Kenya, Kyrgyz Republic, Lesotho, Liberia, Nigeria, Rwanda, Senegal, Tajikistan, Tanzania, Zambia, Zimbabwe
Child mortality	Argentina
Children and adolescent outcomes	Burundi, Democratic Republic of Congo 2,
Nutrition	Burundi, Gambia, Democratic Republic of Congo 2, Republic of Congo, Senegal
Quality of Care	Afghanistan, Armenia, Benin, Burundi, Cameroon, Democratic Republic of Congo (1 and 2), Republic of Congo, India, Kyrgyz Republic, Liberia, Nigeria, Senegal, Tajikistan, Zimbabwe
Out-of-pocket Payments	Afghanistan, Benin, Burkina Faso, Cameroon, Democratic Republic of Congo (1 and 2), Republic of Congo, India, Tajikistan, Zimbabwe
Tuberculosis, Malaria, HIV/AIDS	Afghanistan, Benin, Liberia, Nigeria, Rwanda, Zambia, Zimbabwe
Staff Motivation	Benin, Democratic Republic of Congo (1 and 2), Zambia, Zimbabwe
Non-communicable diseases	Armenia (cervical cancer), China, India (tertiary care), Tajikistan (hypertension)
Cost-effectiveness	Afghanistan, Argentina, Cameroon, Democratic Republic of Congo 2, Burundi, Tajikistan

*b. Synthesizing learning generated from impact evaluations*

Moving forward, the individual evaluations across the HRITF portfolio offer an unparalleled opportunity to aggregate lessons from across a range of country contexts. To elicit the range of these learning opportunities, the HRITF secretariat engaged in a broad consultative process with project leaders, researchers, donors, representatives from the wider RBF community, and other stakeholders. From that

list, topic selection was a function of three factors: perceived demand for answers to a particular question, the ability to answer the question within the RBF designs in place, and the resources required to answer the question adequately.

A series of evaluation questions that meets all of these criteria is listed below. These questions are answerable using data generated by existing evaluation efforts or that will be generated by future impact and descriptive evaluations, recognizing, as does the HRITF mid-term review, that the HRITF “is now beginning to address process issues and other identified gaps in the evidence but has limited funds for additional research.” Given the importance of responding to opportunities and constraints in available data, at this stage, the following opportunities have been identified.

- *Effectiveness*: A systematic review and meta-analysis is in progress to further explore the broad question of the effectiveness of supply-side and demand-side RBF schemes. This systematic review will rigorously assemble all evidence that meets inclusion criteria and pass an evidence quality check and summarize trends from that evidence. The meta-analysis will aggregate the effects of supply-side versus demand-side interventions on improving maternal and neonatal health outcomes. Preliminary results from this study were recently presented at the International Health Economics Association (IHEA) world congress, and it will be updated periodically until information from all additional impact evaluations becomes available to finalize the product.
- *Equity*: Most HRITF impact evaluations estimate the effects of RBF on coverage. Comparing effectiveness across the portfolio and examining the effect of RBF on the bottom two quintiles versus the two top quintiles will help understand beneficiary incidence from the perspective of absolute and relative equity.
- *Incentive effect*: Organizing the type and quantity of services incentivized across the portfolio, may generate some understanding of the variation in incentive design in relation to outcomes.
- *Unintended consequences*: Examining whether the delivery of non-incentivized services will decline with the introduction of RBF – a common concern about RBF from the outset – through a review of survey data from various IEs may indicate whether that concern is warranted or whether spillovers are negative, null or even positive.
- *Quality of care*: The evaluation portfolio can be used to examine constraints to the provision of higher quality clinical care, which is critical to address maternal mortality across the portfolio. Poor clinical quality may be caused by at least three factors: (i) a lack of infrastructure to perform critical actions (the can-do gap); (ii) inadequate training and knowledge (the know-do gap); and (iii) a lack of motivation or cooperation even if knowledge and infrastructure are in place (the effort gap). The quality of care modules in select impact evaluations can also be used to examine the degree to which infrastructure, knowledge and effort limit improvements in birth outcomes. These classes of quality of care gaps can then be correlated with characteristics of facilities, providers, and patients.



Additional topics that are high on all selection criteria as knowledge products may include the relative effectiveness of direct financing versus RBF and comparing the results of cost-effectiveness studies.

In addition to the evaluation topics above, there are several that are particularly salient to the issues of health system strengthening and value for money. This second class of evaluation questions, below, has a high level of potential influence and would take advantage of the historically unique depth of the RBF evaluation portfolio, but the questions cannot be explored at this point due to resource constraints. Even so, these topics are worth explicitly enumerating here.

- An analysis of the contextual and design factors that influence RBF effectiveness. This would not redefine the theory of change or conceptual framework of Results-Based Financing, which has demonstrated remarkable robustness, but it would provide insights into why RBF is effective in some instances but not others. Although the planned meta-analysis will be able to partially answer the question of “does RBF work”, it will not be able to answer when or why. Understanding the conditions that are likely to lead to RBF working or not would require further data collection and evaluative work, as through a rigorous cross-country Qualitative Comparative Analysis.
- To better understand the effect of RBF on health systems as a *system*, develop a system dynamics model combined with agent-based modelling of how RBF interacts with the health system, leveraging qualitative and quantitative data from RBF countries in the HRITF portfolio.
- A set of follow-on surveys to understand the temporal trajectories, sustainability, and longer-term effects of RBF to extend IE results to the period after the initial project closes. Ideally this would be done for a selection of countries choosing different transition strategies, e.g. discontinue RBF, continue with similar financial arrangements, and continue under a high level of domestic financing.
- A series of structured country case studies to build the evidence base on understudied aspects of RBF within health systems: Governance, Information systems and data verification, RBF interactions within the mechanisms of the health system, and purchasing, financial flows and autonomy.
- Extending knowledge on value for money by leveraging the IE work on effectiveness to also do analysis of cost effectiveness, then incorporating all cost-effectiveness work into a synthesizing piece.
- A series of country case studies on the interaction effect of RBF and private sector clinics—e.g., where private clinics are eligible for RBF and where they are not. Similarly, the link between RBF and private sector elements of the supply chain could be explored.

Finally, a sample of the questions not selected at this point—because they were perceived to have lower demand or the HRITF programming is not conducive to answer them or because they are especially cost prohibitive—is found in Annex 6. That list is presented in an effort to spur further thinking and research, rather than as a prescriptive, definitive list of research topics; it is not intended to be a suggested research agenda to the wider RBF community. The HRITF recognizes the considerable contributions made by others towards filling these and other important gaps. To facilitate further third-party evaluation to better understand the range of effects of RBF and its dynamic processes, the HRITF will continue to make its evaluation data—not just its reports—publicly available to the extent possible.

## Link with the Global Financing Facility

Learning from the HRITF portfolio has substantially informed the development of the Global Financing Facility (GFF), particularly in relation to the following lessons learned and design elements:

- *Delivering a quality package of services:* The thinking on the delivery of a package of quality services at primary level through RBF, particularly focusing on high impact interventions, has been instrumental. Evidence that financing delivered to the frontline can enhance the delivery of services has come squarely from the HRITF portfolio. As a result, GFF countries (such as Cameroon) have elected to prioritize the sustainability and/or expansion of existing RBF programs in their Investment Cases.
- *Using results-focused financing:* Linking payment to results, a critical aspect of RBF, has expanded from facility-level to other levels of the health system in some GFF countries (e.g. at county level in Kenya, and between donors and the government in Mozambique).
- *Using data for decision making:* All results-focused financing approaches highlight the importance of results monitoring, data quality, and data use to inform decision-making. This includes learning from experiences with verification and results monitoring within the HRITF. Emphasizing the importance of improving the use and quality of data at all levels, the GFF has placed data for decision making as a core function of the country platform in GFF countries. In addition to results monitoring, the use of implementation research to inform corrective action is also promoted in the GFF.
- *Integration and alignment:* As described in [How Governments and Development Partners Can Jointly Support Results-Based Financing to Improve Health Outcomes and Strengthen Health Systems - Long Version](#), different financiers have supported a comprehensive package through RBF, rather than incentivizing specific services, which led to improved alignment. Such alignment and integration are core pillars of the GFF as a means to improve efficiency and reduce transaction costs, as in the DRC.
- *Broader health system strengthening needs:* One of the lessons from the HRITF portfolio has been that it may not be feasible to improve RBF results when parts of the health systems are not functioning properly. For example, immunization coverage may not increase if vaccines are not available and quality of care may not improve in the absence of qualified staff. Hence, the GFF goes beyond focusing on RMNCAH-N to ensure critical investments in essential health system strengthening.
- *Sustainable health financing:* Experiences across the HRITF portfolio paved the way for GFF work, particularly on strategic purchasing and domestic resource mobilization. The importance of domestic financing to sustain RBF and other successful approaches to attain RMNCAH-N outcomes, is a clear priority in the GFF. Further work is needed to ensure approaches such as RBF and other strategic purchasing approaches are included in country budgets, as in Cameroon. Similarly, although PBF experiences have built capacity in provider payment mechanisms, thereby providing the corner stone for strategic purchasing in many countries, there remains a need to understand how to best integrate RBF into governments' Public Financial Management processes.

Clearly, learning from the HRITF portfolio is—and continues to be—highly relevant to the GFF. The HRITF and the GFF are closely linked and managed by the same secretariat, allowing for ample opportunities to leverage the HRITF’s considerable learning on RBF to inform interested GFF countries. Several HRITF countries have gone on to be GFF countries, enhancing the applicability of knowledge generated from their RBF experience. The considerable body of knowledge that continues to be created by the HRITF will be used and disseminated through the GFF as the secretariat shares RBF learning during early stage workshops, in preparation of the Investment Cases, and through continued peer-to-peer knowledge transfer during GFF webinars and knowledge events that bring together multiple countries.

## Dissemination

The HRITF has developed a diverse array of means to try to put knowledge gained through its activities into the hands of those who would use that knowledge. A selection of disseminated learning examples is found in Annex 5. The HRITF will continue to disseminate RBF-related learning within and across countries to inform evidence-based practice and decision-making among practitioners, researchers, policymakers, donors and other stakeholders. A variety of methods will be used as appropriate for different audiences, both within and across countries.

### 1. In-country learning

The HRITF will continue to promote and support in-country learning to apply lessons from implementation and facilitate learning exchanges and informed decision-making at country level, tailored to different audiences.

Policymakers in government – especially health and finance – will be particularly interested in the results of RBF. Operational data and impact evaluation findings can inform decisions to continue, scale up and/or sustain RBF. Such use of RBF data and IE findings is promoted and supported for all countries to enable evidence-based decision making.

Impact evaluation results are disseminated at in-country workshops attended by policymakers, RBF practitioners, financiers and other interested stakeholders. This ensures that IE findings are shared and validated in-country before they are published elsewhere. From the outset of evaluation activities, there have been extensive consultations at country level to secure buy-in and ensure that the design of each impact evaluation considers the country context, policy-maker needs, stakeholder interests and the evidence gaps. Building on this culture of evaluation and creating local ownership of the IE is critical to ensure buy-in and disseminate results. In parallel to sharing IE findings in-country during face-to-face events such as workshops, specific attention will be paid to disseminating IE results in short notes and policy briefs tailored to policymakers.

RBF operational data is obtained and used at country level to monitor results and to undertake corrective action when needed. It is also used in several countries to inform further analysis and exploration of country-specific RBF elements (e.g. prices, indicators) to improve RBF design and implementation at country level. For example, such learning from implementation is documented in process evaluations and case studies as an important component of learning within a country and across countries. Pending approval from governments, such in-country learning will be made available on the RBF website.

## 2. Cross-country learning

The HRITF will continue to support cross-country learning, either through face-to-face or virtual events, emphasizing peer-to-peer learning to further enhance learning and share of experiences.

Building on the experience of the September 2016 Results and Impact Evaluation Workshop organized in Zimbabwe, a workshop will be held to share new evaluation findings and learning from implementation generated by the RBF and IE portfolio of the HRITF. Such a workshop will bring together practitioners, researchers, policymakers, donors and other stakeholders to discuss experiences and challenges, and share lessons learned. Relevant countries in the RBF portfolio will be targeted for this workshop: beyond the learning shared, it will also provide networking opportunities between RBF implementers to continue sharing the learning. It is also important for such cross-country learning to continue to engage with the broader RBF community of practice and gain from their perspective during knowledge creation.

Brown Bag Lunches (BBLs) and seminars/webinars will be held on a quarterly basis to share IE results and/or discuss learning from implementation on topics of interest related to the how and the why of RBF mechanisms. These panels will be organized online and/or face-to-face. Based on experience, this knowledge sharing format is typically attended by a wide range of audiences including RBF practitioners, Bank staff and researchers.

## 3. Beyond the portfolio

As highlighted throughout this learning strategy, in the coming years, the HRITF team will focus specifically on summarizing and synthesizing key lessons learned across countries and disseminating them in ways that maximize their utility and visibility.

As more and more country IEs will become available, the results will be published in peer-reviewed journals. It is recognized though that the peer review process can take months, if not years. Therefore, in addition to in-country dissemination workshops, several intermediate steps will be carried out to ensure that IE findings are shared with the RBF communities of practice and research, well before the peer review process is completed. These intermediate steps include presenting findings from the IEs at an internal (to the WB) seminar, then through in-country workshops, and finally, during conferences and seminars attended by policymakers and academic counterparts.

Lessons from IEs and operational learning from RBF implementation will be presented at policy-focused conferences, such as the biannual Health Systems Research symposium. In addition, with an eye to incorporating lessons from RBF pilots into the dialog for universal health coverage, the HRITF team will organize panels on key topics at the annual Forum on Universal Health Coverage, such as the session on RBF and equity organized in April 2018.

In addition, findings from evaluations will also be presented at research conferences, such as the International Health Economics Association's biannual world congresses. Findings will thus be disseminated in a targeted manner to meet the knowledge and learning needs of researchers, particularly to inform future research.

The HRITF impact evaluations constitute a rich set of experience, learning, and data that can be further leveraged to shed light on potential broad trends of RBF effectiveness. The preeminent purpose of the evaluations has been to inform decisions on scale-up and appropriateness of RBF for a given country. In addition, the HRITF has assembled learning across specific themes based on the experiences of countries

in its portfolio and will continue to do so. By increasingly making the number of data sets available to the broader evaluation and research community through the World Bank’s microdata library and on other platforms, new evidence can be generated, either through examining topics not anticipated by the original investigators or from cross-country analysis. As seen in the Heat Map of HRITF Impact Evaluations (Annex 4), there are many areas that could lend themselves to further investigation in cross-country studies. On the other hand, where there is little or no evidence, the portfolio will not be able to address that question. For example, the portfolio is not built to be able to answer questions on the political economy of decisions taken around RBF.

Nevertheless, multi-country learning can be challenging in the face of issues of external validity, heterogeneity in the portfolio, and methodological and measurement inconsistency. If there is variation in results—as there often is in a portfolio the size of the HRITF’s, particularly a portfolio that set out to study how variations of an approach affect outcomes—then it becomes difficult to understand whether that heterogeneity is due to variation in design or variation in implementation and contextual factors. Similarly, variation in approaches to measuring the complex changes in health service delivery, health outcomes, the health system, and behavioral and organizational changes at different levels of the health system can inhibit cross-country comparison. Even so, the HRITF portfolio has made significant contributions in norming the measurement of some of these areas, as seen in its work on quality of care measurement through video vignettes, lab-in-the-field experiments, and a birthing simulator.

As the evaluation and learning portfolio is maturing and generating a broader set of results, further synthesis of the RBF experiences and results will be summarized in relevant knowledge products. These cross-country knowledge products—one to two per year—will be disseminated through BBLs/seminars, at the country workshop and relevant conferences, as well as through the website.

The [RBF Health website](#) and its accompanying RBF Bulletin, are an important communication platform for the HRITF to disseminate its findings and learnings among wider audiences in RBF countries as well as at the global level. Through its RBF website and pending approval of country counterparts, the HRITF will support the dissemination of country knowledge products such as analyses, case studies, blogs and videos of specific country experiences. The HRITF will also endeavor to format existing learning to respond to the needs of specific audiences and continue to disseminate learnings through blogs, policy briefs and experiences papers.

Lastly, the HRITF will continue promoting the use of relevant toolkits and e-courses developed to better target researchers and RBF practitioners. These will be updated as needed:

- The [Impact Evaluation Toolkit](#) and the companion [toolkit to conduct cost-effectiveness analysis of RBF programs](#) were developed to further facilitate learning and ease comparability between studies. The toolkit explicitly incorporates novel modules on quality of care and other system strengthening efforts. The guidelines and tools for the IE toolkit will be updated and state-of-the-art techniques (e.g. “lab experiments”, discrete choice experiments, using administrative data in impact evaluation, etc.) are being explored to further foster learning through a diversity of creative measuring tools.
- The facilitated [RBF E-learning Course](#) which, together with the RBF game “[unlocking health](#),” was developed targeting RBF practitioners and novices about the principles of RBF as well as the learnings so far gathered from the HRITF portfolio. The course has recently been modified from a facilitated format to a [self-paced RBF E-Learning Course](#) to enable a larger audience to access its content and will be updated if deemed necessary based on new learnings becoming available.

*Annex 1: Impacts of Results-Based Financing, first 7 countries*

<b>Country</b>	<b>Impact on utilization and coverage</b>	<b>Impact on quality</b>	<b>Impact on health workers</b>
<b>Argentina 1</b>	IE 1: increase in number of antenatal visits; 24.7% increase in tetanus vaccination coverage.	Reduction in in-hospital neonatal mortality	None identified.
<b>Afghanistan 1</b> <b>Afghanistan 2</b>	There were no significant changes in any of the targeted indicators.	The intervention health facilities had a statistically significant higher performance on engagement of community in decision-making, staff received training, equipment functionality, health facility management functionality, pharmaceuticals and vaccines availability; more time was spent with clients	Positive impact on health worker satisfaction.
<b>Cameroon</b>	There was an increase in child immunization and in maternal immunization against tetanus and improvements in coverage of family planning, but not for others, such as antenatal care visits and facility-based deliveries. The difference between the RBF and additional financing group were not significant.	A significant impact on the availability of essential inputs and equipment, qualified health workers, and increased satisfaction among patients and providers	Greater staff satisfaction.
<b>DRC Haut Katanga</b>	There was no measurable impact on increase in utilization.	No impact on patients' perceived quality of care. Reduced levels of equipment and supplies in the treatment facilities.	Staff in RBF facilities showed lower attendance levels than the control following the intervention and had lower satisfaction rates. 34% more workers in the RBF group attached importance to remuneration.
<b>Rwanda 1</b>	A 23% increase in institutional deliveries and a 56% increase in preventive care for young children. No increase in women completing 4 PNC visits, or in full child immunization.	Increased quality of prenatal care	Evidence that the use of incentivized quality indicators led to improved quality of care.
<b>Zambia 1</b>	Institutional deliveries increased by 13 percentage points and skilled birth attendance increased by 10 percentage points; however, the enhanced financing arm (with no RBF) showed higher rates of increase for each at 17.5 percentage points and 14.2 percentage points respectively.	Improvement in equipment and supplies, and some aspects of care quality; comparison groups showed greater improvements than treatment groups for other care quality indicators.	No impact on health worker satisfaction and motivation.
<b>Zimbabwe</b>	There was a general increase in RBF and control facilities in health service utilization. Key indicators such as skilled provider deliveries, institutional deliveries and deliveries by caesarean sections improved at a faster rate in RBF facilities.	Mixed results for quality indicators; no significant increase in quality of equipment and supplies; no increase relative to control for client satisfaction.	Mixed effects on health worker motivation.

Annex 2: HRITF Learning Strategy Results Framework

Building on the existing HRITF results framework, all activities will be tracked in a results framework for the HRITF learning strategy (for donor purposes only).

Indicator	FY19 Targets	FY20 Targets	End Target (FY22)	Notes
Country Learning				
1. Number of completed impact evaluations that include rigorous experimental or quasi-experimental methodology *	3	4	23 total	The target of 23 reflects the HRITF experience that unforeseen circumstances may lead to premature closure of at least one of the 24 IEs currently under implementation.
2. Cumulative number of articles in peer reviewed literature on impact evaluation results from HRITF-financed evaluations *	2 (+/-2)	2 (+/-2)	13	Includes articles from principal investigators (WB or external), but not all publications that use HRITF data.  There will be natural year-to-year variation due to time consuming steps of the publication process being outside of authors' control
3. Number of presentations of results to decision-makers with a development constituency ^	5	5	15	Number of presentations, not the number of attendees
Aggregated Learning				
4. Number of knowledge products developed on RBF topics *	1	2	6	Derivative products that aggregate and synthesize across evaluations
5. Meta-analysis of RBF data completed ^ *	Continue work	Continue work	Complete	

Disseminated Learning				
6. Number of evaluation reports disseminated in forms other than peer review articles, per year *	BBLs – 4 Blogs – 3 Conferences – 2 Videos – 1 Other – TBD	BBLs – 4 Blogs – 3 Conferences – 2 Videos – 1 Other – TBD	Cumulative Total: BBLs – 20 Blogs – 18 Conferences – 15 Videos – 8 Other – 20	Modified to include dissemination of all products, including IEs and aggregating products that are derivative from across evaluations. “Other” can include short briefs, infographics, and similar “easily digestible” formats
7. Number of readers of technical documents **	Blog visits – 1,000 Toolkit Downloads – 20 Newsletter Readers – 250	Blog visits – 1,000 Toolkit Downloads – 20 Newsletter Readers – 250	Blog visits – 4,000 Toolkit Downloads – 80 Newsletter Readers – 1000	An individual with multiple visits to a given document counts as a single reader; visits to multiple documents counts as multiple readers. Opening a newsletter counts as a reader.
8. Cumulative number of unique visitors to website *	50,000	50,000	150,000	Maintains previous target
9. Cumulative number of academic papers and policy reports citing HRITF studies ^	15	15	50	



10. Number of data sets made openly and freely available to external researchers ^	4	4	16	
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Notes:

^ Denotes indicators that are new starting from FY19

\* Denotes indicators that appear in the HRITF Results Framework

\*\* Denotes an indicator from the HRITF RF, revised from FY19

\*\*\* Denotes indicator from the HRITF RF with revised targets from FY19

Annex 3: Research Questions of Impact Evaluations in the HRITF Portfolio

Country	RBF Project Name	Research questions	Milestone on last update
Argentina	AR Provincial Maternal-Child Health Investment APL2 (Plan Nacer) / Provincial Public Health Insurance Development Project	Impact of incentives on: <ul style="list-style-type: none"> <li>• Utilization of services associated with the performance incentives.</li> <li>• Utilization of services not associated with the performance incentives.</li> <li>• Health outcomes of children measured by low and very low birth weight, infant mortality, and health for age and weight for height.</li> </ul> The cost-effectiveness of Plan Nacer will also be assessed.	Endline report shared
DRC	Health Sector Rehabilitation and Support Project	<ul style="list-style-type: none"> <li>• Effect on the production of health services (quantity and quality)                             <ul style="list-style-type: none"> <li>- Does the financing mechanism lead to an increase in the quantity of targeted services provided?</li> <li>- What is the effect of targeting one set of services on the provision of other services?</li> <li>- Does the financing mechanism lead to a change in the quality of care?</li> </ul> </li> <li>• Effect on the prices of health services: does the financing mechanism lead to a reduction of user fees for targeted services / increase of user fees for non-targeted services?</li> <li>• Effect on the behavior of health staff:                             <ul style="list-style-type: none"> <li>- Does the financing mechanism influence the motivation of health personnel?</li> <li>- Does the financing mechanism influence the satisfaction of health personnel?</li> </ul> </li> <li>• Effect on the behavior of households:                             <ul style="list-style-type: none"> <li>- How does the increased performance in the intervention group influence the health-seeking behavior of the population?</li> <li>- What is the influence of the financing mechanism on patient satisfaction?</li> <li>- What is the influence of the financing mechanism on the morbidity and the mortality of the population?</li> </ul> </li> </ul>	Endline report shared

Country	RBF Project Name	Research questions	Milestone on last update
Rwanda	Community Living Standards Grant Credits, I, II and III Project	<p>Do Demand and supply side incentives:</p> <ul style="list-style-type: none"> <li>• Increase the % of total prenatal care visits in the first 4 months?</li> <li>• Increase the % of total of prenatal care visits?</li> <li>• Increase the % of in-facility deliveries?</li> <li>• Increase % of total women-child pairs seen for postnatal care follow-up?</li> </ul> <p>Is there a multiplicative effect on outcomes when demand and supply side incentives are combined?</p> <p>Do Supply side incentives only:</p> <ul style="list-style-type: none"> <li>• Improve the motivation and behaviors of the CHWs?</li> <li>• Improve nutritional status in under-fives?</li> <li>• Increase the use of modern contraceptives?</li> <li>• Increase the time between births?</li> </ul>	Endline report shared
India-Karnataka	Karnataka Health Systems Project	<ul style="list-style-type: none"> <li>• Aim 1: Evaluation of the impact of VAS on tertiary care utilization, health outcomes, household out-of-pocket health expenditures and quality of care;</li> <li>• Aim 2: Evaluation of the impact of results-based incentives for village health workers (ASHAs) on take-up of benefits by BPL patients requiring tertiary care; and</li> <li>• Aim 3: Evaluation of the impact of results-based incentives for primary health care centers (PHCs) and ASHAs on follow-up care for VAS beneficiaries.</li> </ul>	Endline report shared
Afghanistan	Strengthening Health Activities for the Rural Poor (SHARP) Project	<ul style="list-style-type: none"> <li>• What is the impact of the intervention on utilization and quality of priority maternal and child health services (family planning, antenatal care, institutional deliveries and immunization)?</li> <li>• What are the un-intended effects, if any, of the RBF intervention?</li> <li>• What are the lessons that can be learned from project implementation? How can these lessons be applied to scaling up the intervention in a sustainable manner both financially and institutionally?</li> <li>• What is the cost-effectiveness of the RBF intervention?</li> </ul>	Endline report shared
Benin	Health System Performance Project	<ul style="list-style-type: none"> <li>• Measuring the impact of RBF on health outcomes and equity</li> <li>• Understanding the factors driving this impact: RBF versus lump sum, increased management autonomy</li> <li>• Does management autonomy strengthen the impact of RBF?</li> <li>• What is the relation between RBF and health workers' motivation?</li> <li>• What is the relation between RBF and health workers' corruption?</li> <li>• Does RBF have an impact on health care seeking behaviors?</li> </ul>	Endline report expected to be shared by end of FY18

Country	RBF Project Name	Research questions	Milestone on last update
Burkina Faso	Reproductive Health Project	<ul style="list-style-type: none"> <li>• Does performance-based financing increase utilization and quality of maternal and child health services delivered in Burkina Faso?</li> <li>• Does PBF improve financial access to and utilization of quality health services for vulnerable populations without systematic targeting of the poor?</li> <li>• Does PBF improve financial access to and utilization of quality health services for vulnerable populations through systematic targeting of the poor for improved health service coverage among vulnerable populations?</li> <li>• Does the combination of PBF and community-based health insurance generate added value to improve access to and quality of health services for all populations, including the most vulnerable?</li> <li>• Which combination of interventions provides the most value for money?</li> </ul>	Baseline data shared
Cameroon	Cameroon Health Sector Support Investment (SWAP)	<ul style="list-style-type: none"> <li>• Does the PBF program increase the coverage of MCH services?</li> <li>• Does the PBF program increase the quality of MCH services delivered?</li> <li>• Is it the enhanced monitoring &amp; evaluation and supervision or the link between payments and results that leads to improvements observed in quality or coverage?</li> <li>• What is the contribution of enhanced supervision and monitoring to improving MCH service coverage and quality in the absence of increased autonomy or additional financial resources?</li> <li>• Does the PBF program lower informal charges for health services?</li> <li>• Does the PBF program lower formal user charges?</li> <li>• Does the PBF program increase funds available at the operational (i.e., facility) level?</li> <li>• Does the PBF program improve physical and social accessibility of health services? Accessibility of health services will be examined in terms of the convenience of facility opening hours, availability of services through outreach, client perceptions of convenience of accessing health services and client perceptions of health providers' attitudes towards clients?</li> <li>• Does the PBF program lower staff absenteeism?</li> <li>• Does the PBF program increase demand generation activities by health facilities?</li> <li>• What is the effect of the PBF program on access and utilization of MCH services across different socio-economic groups?</li> </ul>	Endline report shared
Zambia	Malaria Booster Project	<ul style="list-style-type: none"> <li>• What is the causal effect of the Zambian HRBF on the population health indicators of interest?</li> <li>• Do higher incentive payments in rural/remote areas result in increased health outcomes and greater retention of staff?</li> <li>• How does the likelihood of audit/external verification of results affect the accuracy of reported data?</li> </ul>	Endline report shared

Country	RBF Project Name	Research questions	Milestone on last update
Zimbabwe	Health Results Based Financing Project	<ul style="list-style-type: none"> <li>• What is the causal effect of the simultaneous introduction of results-based financing with suspension of user fees on priority population health utilization and outcome measures in RBF districts?</li> <li>• What is the effect of skill upgrading and capacity building of primary care nurses on priority health outcomes, utilization of services, and quality of care among the populations served, as well as the effect on health worker motivation in rural health facilities?</li> <li>• What is the combined effect of capacity building of primary care nurses, RBF, and suspension of user fees on health outcomes in rural health facilities?</li> </ul>	Endline report shared
Burundi II	Health Sector Development Support Project	<p>The research will be organized in eight work packages (WPs), each package answering to a list of research questions:</p> <ul style="list-style-type: none"> <li>• WP 1: Impact evaluation of the intervention on the nutritional status of children at population level. WP 1 will examine barriers and determinants on the demand side.</li> <li>• WP2: Impact evaluation of the intervention on health facilities performance in nutrition activities. WP 2 will look at bottlenecks and determinants on the supply side.</li> <li>• WP3: Evaluation of the intervention with secondary data. WP 3 will look at bottlenecks and determinants on the supply side and explore spillover effects at the level of the health facility.</li> <li>• WP4 will assess how and why the intervention works (or not).</li> <li>• WP5 will assess the efficiency or cost-effectiveness of the intervention, especially compared to an unconditional equivalent payment.</li> <li>• WP 6 will assess systemic effects of the 'nutrition-PBF' and of the impact evaluation, including spillovers at national level.</li> <li>• WP7 will assess whether PBF can generate a demand for professional trainings by the health facilities (optional).</li> <li>• WP8 will assess the PBF system as a whole in Burundi (optional).</li> </ul>	Endline report expected to be shared by end of FY18

Country	RBF Project Name	Research questions	Milestone on last update
China *	Analysis of Provider Payment Reforms on Advancing China's Health (APPROACH)	<ul style="list-style-type: none"> <li>• What are the impacts of alternative provider payment incentives on efficiency and quality and thus health outcome improvements?</li> <li>• How do they impact on cost and therefore affordability and financial burden faced by patients?</li> <li>• What are the unintended consequences of alternative PPMs as a result of providers' gaming behavior?</li> <li>• Within a broad type of PPM, how do variations in design affect the outcomes of interest differently?</li> <li>• What are the institutional conditions necessary for effective design and implementation of different PPMs?</li> </ul>	Technical review cleared
Congo, Rep. of (ROC)	Congo Health Sector Strengthening Project II	<p>The overall research question of this impact evaluation is, does performance-based financing improve outcomes related to the utilization and quality of maternal and child health services in Republic of Congo? The primary research questions for the impact evaluation will be grouped into two thematic groups:</p> <p>Improved financial access through integrating PBF and social safety nets</p> <ul style="list-style-type: none"> <li>• Does PBF improve financial access to and utilization of quality health services for vulnerable populations without demand-side interventions that aim to improve financial access for the poor?</li> <li>• Does the combination of PBF and pro-poor targeting mechanisms improve financial access to and utilization of quality health services for vulnerable populations more than PBF alone?</li> </ul> <p>Behavior change through community-based PBF services</p> <ul style="list-style-type: none"> <li>• Does the introduction of the PBF indicator "household visit according to protocol" lead to improved preventative health behavior within targeted households, such as improved water, sanitation and hygiene, and use of bed nets?</li> <li>• Does the introduction of the PBF indicator "household visit according to protocol" lead to improved maternal and child health seeking-behavior, such as use of family planning, reproductive health education for adolescent girls; antenatal and delivery services, vaccination status for pregnant women and babies?</li> <li>• Does the introduction of the PBF indicator "household visit according to protocol" lead to improved population knowledge related to maternal and child health, hygiene and sanitation?</li> </ul> <p>Finally, what is the combined effect of strengthening the supply-side through PBF, improving financial access through targeting the poor, and improving health behaviors through counseling and coaching during household visits by health care professionals?</p>	Baseline data shared

Country	RBF Project Name	Research questions	Milestone on last update
DRC 2		<p>Question 1: What are the effects of the PDSS PBF approach with and without home visits on utilization and quality of primary health services, in comparison to equivalent amount of input-based financing?</p> <p>Question 2: What are the effects of different components of the quality checklist on quality of care?</p> <ul style="list-style-type: none"> <li>• What are the effects of measuring and paying for quality using the Vignettes Quality Checklist in comparison to using the quality checklists that do not incorporate vignettes (Process and Content of Care Checklist and Structural Quality Checklist)? (Q2a)</li> <li>• What are the effects of measuring and paying for quality using the Process and Content of Care Checklist in comparison to using the Structural Quality Checklist? (Q2b)</li> </ul> <p>Question 3: What are the effects of community engagement approaches complementing PBF program on nutrition, community behavior and service utilization?</p> <ul style="list-style-type: none"> <li>• What are the effects of a PBF approach with household visits in comparison to a PBF approach without any community-level component? (Q3a)</li> <li>• What are the effects of a PBF approach with Community behavioral change rewards intervention in comparison to a PBF approach without a community-level component? (Q3b)</li> <li>• What are the effects of a PBF approach with Community behavioral change rewards intervention in comparison to a PBF approach with household visits? (Q3c)</li> </ul>	Baseline data shared
Haiti	Improving Maternal and Child Health Through Integrated Social Services	<ul style="list-style-type: none"> <li>• Does the RBF program improve the coverage and quality of priority health services related to MCH, particularly for vulnerable populations?</li> <li>• Does a reinforced equity fund alone improve the coverage and quality of priority health services related to MCH, particularly for vulnerable populations?</li> <li>• Does a reinforced equity fund in combination with the RBF program improve the coverage and quality of priority health services related to MCH, particularly for vulnerable populations?</li> <li>• What is the relative cost-effectiveness of the RBF program vis-à-vis a reinforced equity fund alone vis-à-vis status quo in terms of the coverage and quality of priority health services related to MCH, particularly for vulnerable populations?</li> </ul>	Baseline data shared

Country	RBF Project Name	Research questions	Milestone on last update
Kenya	Kenya Health Sector Support Project (KHSSP)	<ul style="list-style-type: none"> <li>• Does providing a health insurance subsidy for the poor significantly improve health care utilization among the poor?</li> <li>• Does providing a health insurance subsidy for the poor significantly improve financial risk protection among the poor?</li> <li>• Does providing a health insurance subsidy for the poor significantly improve health status of the poor?</li> <li>• What is the implementation experience of the purchasers (NHIF), providers (facility), beneficiaries (the poor), patients (the poor who actually seek care) and other relevant stakeholders?</li> </ul>	Baseline data shared
Kyrgyz Republic	Kyrgyz Health Results Based Financing	<ul style="list-style-type: none"> <li>• Does the PBF package (including enhanced supervision) at the rayon hospital level improve quality of care?</li> <li>• Does enhanced supervision alone improve quality of care at the rayon hospital level?</li> <li>• What is the relative cost-effectiveness of the PBF package (including enhanced supervision) vis-à-vis enhanced supervision alone vis-à-vis business-as-usual in terms of quantifiable quality of care indicators?</li> </ul>	Endline report expected by end of FY18
Liberia	Liberia Health Systems Strengthening	<p>Under reassessment given Ebola crisis. Previous research questions included</p> <ul style="list-style-type: none"> <li>• Did the HSSP achieve its goal of improving the quality of service delivery in target hospitals?</li> <li>• How did facilities improve performance and meet the objective of improved quality? In particular, did levels of competence, capacity or performance change as a result of the HSSP? And which of the intervention levers (management, information, structural improvements, incentives or training) made an important contribution to the success of the HSS project?</li> <li>• What role did existing human resources in the health sector play in the success/failure of the program? Did existing levels of skills and experience or motivation hinder or facilitate the interventions?</li> </ul>	Technical review cleared for previous research questions.



Country	RBF Project Name	Research questions	Milestone on last update
Nigeria	States Health Program Investment Project	<ul style="list-style-type: none"> <li>• Impact of the program on the availability, utilization and quality of healthcare</li> <li>• How cost-effective are the PBF and Decentralized Facility Financing (DFF, i.e. average payments to RBF payments but not based on performance) packages?</li> <li>• Do the PBF and DFF packages affect the various segments of the population differentially (i.e. effect disaggregated by socioeconomic status and gender)?</li> <li>• In the PBF package, only one facility per ward will receive PBF incentives while the other facilities in that ward will not receive any PBF incentives. Is P1 associated with improvements in the availability, utilization and quality of priority MCH services in health facilities located in project states that do not receive PBF funds?</li> </ul>	Endline report expected by end of FY18
Senegal	Health & Social Financing	<ul style="list-style-type: none"> <li>• Do supply-side PBF incentives improve the motivation and behaviors of clinic staff? Are there improvements in absenteeism, motivation, drug stocks, retention of qualified staff, and quality of care provided by clinic staff?</li> <li>• Do maternal vouchers to pregnant women, conditional on compliance with maternal health guidelines, lead to increased utilization and improved health?</li> <li>• What's the additional impact when both supply and demand incentives are combined?</li> <li>• What is the impact of supply and demand side incentives on: <ul style="list-style-type: none"> <li>o Increasing the total number of prenatal care visits to up to 4?</li> <li>o Increasing institutional deliveries?</li> </ul> </li> <li>• Do program effects vary by different socio-economic groups (e.g. income groups and rural/urban locations, to be achieved by stratification and interaction of income level by other outcome variables)?</li> </ul>	Technical review cleared
Tajikistan	Tajikistan Health Services Improvement Project (HSIP)	<ul style="list-style-type: none"> <li>• Does the PBF program increase the coverage of MCH and Cardio Vascular Disease (CVD) services?</li> <li>• Does the PBF program increase the quality of MCH and CVD services delivered?</li> <li>• Does information on service delivery performance and community involvement increase the coverage of MCH and CVD services?</li> <li>• Does information on service delivery performance and community involvement increase the quality of MCH and CVD services?</li> </ul>	Baseline report shared

Country	RBF Project Name	Research questions	Milestone on last update
The Gambia		<ul style="list-style-type: none"> <li>• Effect on nutrition and health outcomes:</li> <li>• Do supply- and/or demand-side interventions improve: <ul style="list-style-type: none"> <li>○ Maternal and child health and nutrition outcomes (e.g. child mortality, stunting, breastfeeding, low birth weight)</li> </ul> </li> <li>• Effect on services and adoption of behaviors: <ul style="list-style-type: none"> <li>○ Quantity of service utilization (e.g. skilled birth attendance, ANC, PNC, referrals from community to facilities, VAS, deworming, SAM treatment, OPD visits, uptake of contraception)?</li> </ul> </li> <li>• Adoption of healthy behaviors (e.g. hygiene and sanitation practices, knowledge of IYCF)?</li> <li>• Quality of service provision</li> <li>• Effect on intermediate outcomes along pathways of impact <ul style="list-style-type: none"> <li>○ Do supply- and/or demand-side interventions have an effect on: <ul style="list-style-type: none"> <li>▪ Perceptions of seeking care?</li> <li>▪ Staff motivation and satisfaction? VSGs and communities?</li> <li>▪ Out of pocket payments for MCH services?</li> <li>▪ Baby Friendly Community Initiative (BFCl) implementation?</li> <li>▪ Health facility infrastructure and village development?</li> <li>▪ Linkage between communities &amp; health facilities?</li> <li>▪ Supervision of facilities &amp; communities by RHTs?</li> <li>▪ Health facility staff availability?</li> <li>▪ Three delays for delivery care?</li> <li>▪ Awareness/knowledge at community level?</li> <li>▪ Data reporting and management?</li> </ul> </li> </ul> </li> </ul>	Baseline report shared
Argentina - Plan Sumar 2 and 3		<ul style="list-style-type: none"> <li>• Effect of PBF-tied checklist for clinicians on service delivery</li> <li>• Effect of mobile outreach application for community health workers for at-risk catchment areas on integration of care and health outcomes in 3 arms <ul style="list-style-type: none"> <li>- App tied to PBF incentives</li> <li>- App alone</li> <li>- Business as usual</li> </ul> </li> </ul>	Technical review cleared

Annex 4: Heat Map of HRITF Impact Evaluations

Outcomes Interventions	Maternal Care - Quality - Utilization	Family Planning	Child Health Care - Quality - Utilization	Child mortality	Children & adolescent outcomes	Nutrition	Quality of Care	Out-of- pocket Payments	TB, Malaria, HIV/AIDS	Staff Motivation	NCDs (Non- Communicable Diseases)	Cost Effectiveness
Supply-side RBF payments	AFG, ARG, ARM, BEN, BFA, BDI, CMR, DRC12, GMB, GHA, HTI, IND, KEN, KGZ, LSO, LBR, MEX, NGA, ROC, RWA, SEN, TJK, TZA, YEM, ZMB, ZWE	AFG, ARM, CMR, DRC12, LSO, ROC, RWA, ZMB, ZWE	AFG, ARG, BEN, BFA, BDI, CMR, DRC12, GMB, GHA, HTI, IND, KEN, KGZ, LSO, LBR, NGA, ROC, RWA, SEN, TJK, TZA, ZMB, ZWE	ARG	BDI, DRC2, LSO	BDI, DRC2, ROC, GMB, SEN	AFG, ARM, BEN, BDI, CMR, DRC12, IND, KGZ, LSO, LBR, NGA, ROC, SEN, TJK, ZWE	AFG, BEN, BFA, CMR, DRC12, IND, ROC, TJK, ZWE	AFG, BEN, LBR, NGA, RWA, ZMB, ZWE	BEN, DRC12, ZMB, ZWE	ARM, CHN, IND, TJK	AFG, ARG, BDI, CMR, DRC2, LSO, TJK
Demand-side RBF payments	GMB, NGA, RWA, SEN, YEM, ZWE	RWA, ZWE	RWA, SEN, ZWE			SEN	NGA, SEN, ZWE	ZWE	NGA, RWA, ZWE	ZWE		
Community-Based RBF	GMB, SEN, RWA, DRC2, ROC	GMB, SEN, DRC2, ROC	GMB, SEN, RWA, DRC2, ROC		DRC2	GMB, SEN, RWA, DRC2, ROC	SEN, DRC2, ROC	DRC2, ROC		DRC12		DRC12
RBF for Quality of care	AFG, ARG, ARM, BEN, CMR, DRC2, HTI, KGZ, NGA, SEN, TJK, TZA, ZMB, ZWE	AFG, ARM, CMR, DRC2, ZMB, ZWE	AFG, ARG, BEN, CMR, DRC2, HTI, KGZ, NGA, SEN, TJK, TZA, ZMB, ZWE	ARG	DRC2	DRC2, SEN	AFG, ARM, BEN, CMR, DRC2, KGZ, NGA, SEN, TJK, ZWE	AFG, BEN, CMR, DRC2, TJK, ZWE	AFG, BEN, NGA, ZMB, ZWE	BEN, DRC2, ZMB, ZWE	ARM, CHN, TJK	AFG, ARG, CMR, DRC2, TJK
RBF in Hospitals	AFG, ARG, BDI, DRC2, IND, KGZ, LBR, NGA, SEN	AFG, ARM, DRC2,	AFG, ARG, BDI, DRC2, IND, KGZ, LBR, NGA, SEN	ARG	BDI, DRC2	BDI, DRC2, SEN	AFG, BDI, DRC2, IND, KGZ, LBR, NGA, SEN	AFG, DRC2, IND	AFG, LBR, NGA	DRC2	ARM, CHN, IND	AFG, BDI, DRC2
Health Insurance and RBF	BFA, GHA, KEN		BFA, GHA, KEN					BFA			CHN	
Additional Financing	BEN, DRC2, NGA, ZMB, ZWE	DRC2, ZMB, ZWE	BEN, DRC2, NGA, ZWE		DRC2	DRC2	BEN, DRC2, NGA, ZWE	BEN, DRC2, ZWE	BEN, NGA, ZMB, ZWE	BEN, DRC2, ZMB, ZWE		DRC2
Differential Incentive Levels											CHN	
Enhanced Monitoring & Supervision	CMR, KGZ	CMR	CMR, KGZ				CMR, KGZ	CMR				CMR
RBF and Training of Providers	ZWE	ZWE	ZWE				ZWE	ZWE	ZWE	ZWE		
RBF at higher Administrative Levels	ARG, ROC	ROC	ARG, ROC	ARG		ROC	ROC	ROC				ARG
Unintended Consequences	AFG	AFG	AFG					AFG	AFG			AFG
Targeting/Subsidies/ Equity	BFA, BEN, ROC	ROC	BFA, BEN, ROC			ROC	BEN, ROC	BFA, BEN, ROC	BEN	BEN		

*Annex 5: Some examples of disseminated learning*

Online learning tools

[RBF E-learning Course](#)

[RBF Game](#)

Workshops and Conferences

[Community results-based financing in health practice: reflections on implementation from experiences in six countries](#)

[Annual Results and Impact Evaluation Workshop for Results-Based Financing](#)

[Setting a path for Improved Health Outcomes](#)

Seminars

[Lessons from Impact Evaluation: The Unintended Impact of the Baseline Survey of Ghana](#)

[Can Incentives for Frontline Health Workers Impact Health Outcomes? Case studies from India](#)

[Cost-Effectiveness of the Results-Based Financing Programs in Zimbabwe and Zambia](#)

Publications

[Re-Imagining Results-Based Financing: Gearing up for the Future](#)

[Measuring quality of health care using video vignettes](#)

[Scaling up and integrating your Results-Based Financing scheme: a progression in four phases](#)

[Scaling up your Results-Based Financing scheme: a progression on five dimensions](#)

[Pricing and The Use of Data in RBF: Towards a Higher Return on Investment](#)

[Results-Based Financing Writeshop: Improving implementers' documentation and dissemination of experiences and lessons learnt](#)

[What do we know about the linkage between RBF and health worker performance and motivation?](#)

[Reflections from a recent 3-country study](#)

[Verification in Results-Based Financing for Health: Summary of Findings and Recommendations from a Cross-Case Analysis](#)

The following list are questions that were not selected into the current HRITF learning strategy, largely because of their cost, lower perceived demand, and a mismatch with the ability of HRITF programming to be able to provide answers. This list is not intended to be exhaustive, neither is it intended to be a proposed research agenda for the broader RBF community. Rather, it is shared in the hope that it may spark further ideas for research. Data collected during HRITF impact evaluations can contribute to partially answering many of these questions; that data will be made publicly available through the World Bank's microdata website.

1. What are the effects of RBF on health and coverage outcomes?
  - a. What can we learn about equity patterns across countries?
  - b. Can we detect an effect on maternal and child health and mortality for RBF programs (for example, matching geo-codes with DHS data)?
  - c. What can we learn about direct effects of RBF on providers?
  - d. What HR profiles of clinics are providing more services?
2. How has RBF affected each of the six pillars of health systems?
  - a. Service Delivery: Which services are incentivized across the RMNCAH continuum of care? Which services are consistent in being delivered (or are not) and which are context dependent? Do incentivized services crowd out non-incentivized services?
  - b. Human Resources: What is the range of experience of RBF programs with staffing issues, e.g. retention, motivation, performance evaluation, or qualification?
  - c. Financing: How has RBF affected financing; for instance, have user fees been reduced? Have RBF schemes been integrated with the national health financing strategy?
  - d. Governance: Has facility governance changed through RBF? For example, do facilities have more autonomy to hire (and fire), to procure supplies, and to manage assets? What can we learn by comparing greater autonomy (CMR) to direct incentives for improving care (BEN)?
  - e. Medicines/Commodities: What kinds of procurement changes can RBF facilitate? What design features are related to reducing stockouts (or improving order fill rate)?
  - f. Information: What information indicators have been incentivized? How have quality and use of information systems evolved with RBF data requirements or processes?
3. Is RBF good value for money?
  - a. Efficiency How efficient is RBF versus direct financing and other financing schemes?
  - b. Effectiveness: What do we learn about cost effectiveness by comparing VFM results of the 3 principle project objectives/outcomes of the RBF across countries?
4. What can we learn from the HRITF portfolio to help us improve RBF?
  - a. What is the relationship between the level of RBF financing (e.g. \$1 per capita, \$4 per capita) and improvements in service delivery & quality?

- b. What sort of institutional, programmatic or contextual factors are linked to improved health, service delivery, or quality?
  - c. How can RBF programs reduce verification costs while maintaining data accuracy?
  - d. There are a range of indicators used in RBF (e.g. on quality of care, quality of data, incentivized outcomes); which indicators perform best
5. How can the HRITF experience be leveraged to inform the frontiers in RBF?
- a. What can we learn about the potential complementarity of supply-side and demand-side (e.g. CCTs and vouchers) PBF from a systematic review of the literature?
  - b. What are the long-term effects of RBF?
  - c. What is the role of RBF and strategic purchasing in preparation for UHC?
  - d. What has been the effect of an RBF scheme on the private sector? How can the private sector be integrated into RBF?