

# **African participation and partnership in performance-based financing: A case study in global health policy**

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## Executive summary

Participation is a key policy concept in global health, and relates to the ability of stakeholders to engage with and shape health policy at four intersecting levels: local, national, regional and global. Such engagement remains the key normative aim behind debates about furthering more equitable health diplomacy and has, as a result, been increasingly integrated into the agenda of global agencies, including the Global Fund to Fight AIDS, TB and Malaria and the World Bank.

This report forms part of a research programme led by the Regional Network for Equity in Health in East and Southern Africa (EQUINET) through Training and Research Support Centre (TARSC) and University of Carleton focusing on the participation of African actors in global health diplomacy. This specific case study focuses on the participation of African actors in global health governance. In an attempt to better understand the spaces and places within which participation can occur, and particularly the ways in which global actors such as the Global Fund and the World Bank provide such opportunities, the research sought to explore the following questions:

- How do the Global Fund and World Bank provide spaces for participation in global health governance processes?
- To what extent can African actors nationally and regionally extend their agency within these participatory spaces?
- What role does the World Health Organisation (WHO) and its own governance play in the interface between African actors and the Global Fund and World Bank?

Because participation is a broad concept in health diplomacy, we have focused on one particular thematic case study within global health: performance-based funding (PBF). More specifically, we have investigated how global health actors (local, national, regional and global) in South Africa, Tanzania and Zambia participate in decision-making processes related to the PBF mechanisms associated with the Global Fund and World Bank. By using PBF as a lens to examine how actors participate in global health policy and by focusing on specific country contexts, it is possible to better isolate the role of African actors within global health decision-making processes. PBF was selected as a thematic case study because it has emerged as an increasingly important policy phenomenon in the governance of health and global development. As such, the following sub-questions were developed to answer the above research questions:

- How did the idea of PBF emerge as a key idea in the reform of global health governance and development?
- How do different actors understand and know about PBF and how do these understandings shape participation in the design, implementation and delivery of PBF?
- How have actors at country and regional levels participated in PBF processes in the World Bank and Global Fund? And to what extent can east and southern African actors nationally and regionally extend their agency within these participatory spaces?
- What barriers and facilitators exist to participation?
- Are there participatory opportunities that remain underdeveloped and underutilised?

The research used a qualitative methodology to answer these questions. We implemented a policy and literature review, national level, semi-structured key informant interviews in Zambia, Tanzania and South Africa, non-participant

observation of policy meetings and PBF project site visits, and global level key informant interviews with actors from global health institutions in Washington, D.C., and Geneva, including the World Bank, Global Fund, and WHO.

Through these processes, issues pertaining to PBF in particular, and participation more generally, were illuminated. The emergence of PBF as a key idea in the reform of global health governance and development is inextricably tied to the concept of 'participation'. It has risen to prominence on the back of a participation and ownership agenda, and has been promoted as a manifestation of increased participation and a global South-driven initiative. PBF is thus framed in the language of South-South learning. Yet, at the same time, it is subject to capture by external funders, and this can inhibit rather than enhance regional African agency. Further, where more country-specific forms of PBF are being developed, there is a drive by external funders to ensure that the 'right kind' of PBF is being implemented, often with reference to the Rwandan experience with PBF.

In terms of participation at the global level, there are few formal structures for participation of African actors at the Global Fund, the World Bank or at the WHO in relation to PBF. Informal spaces give more meaningful opportunities for participation, however, such spaces are skewed in the interests of elite African agents. A hierarchy of participation exists, with participation dependent on factors such as position within government, relationships to external funders and awareness of informal opportunities for participation.

A source of African agency lies in the strength of a country's health system, which determines the ability of African actors to say no to external funders and set their own policy preferences. Clear differences were visible among the case study countries. South Africa especially was able to push back against external funders. By contrast, with a less developed health system in Zambia it was easier for external funders to create a PBF programme and associated institutional structures that risk fragmenting the health sector.

There is a clear commitment to PBF at national and global levels, and a positive view of its effectiveness as a funding modality for health systems, despite limited existing evidence to support this. The buzz around PBF comes from the political capital it gives those working to promote it. This positive view towards PBF shapes the way supporting evidence is generated and interpreted, and the way PBF is implemented. As such, at all levels of health governance, there appears to be a lack of critical engagement with the concept, both normatively and practically, and with possible alternatives to it.

Despite PBF being largely driven and led by external funders, there is considerable space for greater African agency in driving the PBF agenda. PBF is also applied to the operations of external funders, and to the brokerage role played by UN agencies and international consultants. African agents – governments, civil servants, and civil society organisations – can thus hold development partners to account for their own activities. Countries that have said no to external funders have enhanced rather than reduced their agency.

This report, therefore, offers some recommendations on how African actors can claim spaces for participation with regards to PBF. These recommendations relate to the importance of: understanding PBF and how it relates to the specific goals for reform of a given health system; understanding the evidence base in favour of PBF and the limitations of PBF; knowing how to gain leverage for health system reform goals through partnership and engagement across sectors, both formally and informally; knowing the capacity, context, and funding of domestic health systems and how this may be used as leverage in discussions over PBF;

knowing that PBF does not always work and how to assess its effectiveness; simply knowing how to say no to pressures to implement PBF.

## **1. Introduction**

### **1.1 The idea of participation in global health**

Participation is a key policy concept in global health, and has a long and varied genealogy in global development thinking and practice (Hickey and Mohan, 2004). In its most basic understanding, participation in global health relates to the ability of stakeholders to engage with and shape health policy at four intersecting levels: local, national, regional and global. Such engagement continues to remain the main normative aim behind debates about furthering more equitable health diplomacy and, as a result, has been increasingly integrated into the agenda of global agencies. Participation has been integrated as a guiding concept and concern in recent WHO campaigns, such as securing universal access to health. It is a guiding principle of the Global Fund to Fight AIDS, TB and Malaria (hereafter the Global Fund), which rose to prominence on the back of the advocacy campaigns about universal access to anti-retrovirals to treat HIV/AIDS, and also an operational principle of the World Bank. Participation is also the master concept underwriting the Millennium Development Goals (specifically Goal 8: “To develop a partnership for development”), as well as other recent development statements about the nature of aid relationships, including the national ownership principle embedded within the Paris Declaration.

Within policy statements and discussions, participation is often seen as having a normative value (something we ought to strengthen for moral reasons) as well as having practical relevance (a governance mechanism that will produce more equitable and effective outcomes). Yet, the role of participation in establishing more robust global health partnerships remains undertheorised and underexamined (Barnes and Brown, 2011), particularly in relation to how local and governmental actors can/should participate as effective participants in 1) the formulation of global health policy; 2) the conception and design of health system interventions; and 3) their subsequent implementation. Indeed, despite a clear global policy focus on participation, there is little understanding of how African actors engage and exert their agency in these different aspects of global health policy, and with what effect on social justice outcomes (cf. Gaventa, 2004) such as universal access to health. Here we use Brown and Harman’s (2013:2-3) definition of African agency as an intellectual intent to “get beyond the tired tropes of an Africa that is victimised, chaotic, violent and poor” by asking “how much influence or power is being exerted and how much freedom of action African political actors have available to them” and what kind of agency is enacted

Recent scholarship has emphasised the importance of understanding not only the temporal dimensions to participation, including the various stages at which African actors can access and engage in the governance of global health policy: from design (agenda setting) through to implementation and delivery; but also the importance of understanding the spaces and places within which participation can occur, and particularly the ways in which different global actors, such as the WHO, World Bank and Global Fund provide such opportunities (Harman, 2010). This involves consideration, for example, of the political characteristics of these spaces and places, including whether they are closed, invited, claimed or created spaces (Gaventa, 2004). To respond to this lacuna, this research has sought to explore the following questions:

- How do the Global Fund and World Bank provide spaces for participation in global health governance processes?

- To what extent can African actors nationally and regionally extend their agency within these participatory spaces?
- What role does WHO and its own governance play in the interface between African actors and the Global Fund and World Bank?

The work reported here is part of a wider research programme led by the Regional Network for Equity in Health in East and Southern Africa (EQUINET) through Training and Research Support Centre (TARSC) and University of Carleton, focusing on the participation of African actors in global health diplomacy. This specific case study focuses on the participation of African actors in global health governance.

Because participation is a broad concept in health diplomacy, which encompasses numerous interlinked mechanisms for participation at different levels and scales, we have focused on one particular thematic case study within global health: performance-based funding (PBF). More specifically, we have investigated how global health actors (local, national, regional and global) in South Africa, Tanzania and Zambia participate in decision-making processes related to the PBF mechanisms associated with the Global Fund and World Bank. By using PBF as a lens to examine how actors participate in global health policy and by focusing on specific country contexts, it is possible to better isolate the role of African actors within global health decision-making processes. PBF was selected as a thematic case study because it has emerged as an increasingly important policy phenomenon in the governance of health and global development. Further information about PBF is provided below, before moving on to set out the project's aims, to justify our case studies and explain the research methods.

## 1.2 Participation and PBF

PBF refers to the idea of transferring resources (money, material goods) on condition that particular actions are taken or specific, predefined performance targets are achieved (Eldridge and Palmer, 2009). This mode of financing is coming to dominate the development lexicon and is popular with all key external funders. PBF is increasingly promoted by leading global actors as a way to efficiently and effectively reform the way that health systems are planned, financed, co-ordinated and steered, particularly in low- and middle-income countries. Key external funding agencies such as the Global Fund and World Bank argue that PBF will promote reform in a way that is locally owned and accountable (Witter et al., 2012), given that performance targets and indicators will be developed or negotiated through active participation of local actors from the bottom up, rather than being set by global agencies from the top down.

While the term PBF is used within the context of this research, it is important to highlight that external funders employ a range of different terms to signify this type of funding modality. These include:

- performance-based funding
- performance-based financing
- performance-based contracting
- pay for performance
- results-based funding
- results-based financing
- output-based aid
- value for money
- buy-downs.

At the same time, there are variations in the way that PBF schemes are conceived, designed, and implemented. Common to all PBF schemes, however, is the idea that positive health system reforms can be brought about by tying the transfer of resources to predefined performance targets. Often, the resources that are transferred are financial in nature (though in-kind transfers are also used). The performance targets, however, can be aimed at different aspects or levels of the health system to bring about reform. For example, targets can be to change the behaviour of individual health professionals, to increase or change the coverage of services that district health facilities or clinics provide, or to reshape or reorient the broad focus of action of the health system as a whole. Despite these differences, PBF schemes tend to be of two broad types, as outlined in *Table 1*.

**Table 1: Typical features of the two broad types of PBF**

Type	Types of performance target	Level of action within health system	Examples of targets	Notes/Issues
I	Narrow targets based on payment for service/ outputs	Often district or facility based and/or may be targeted at individual health professionals	Number of pregnant women counselled and tested for HIV; Number of HIV pregnant women given Niverapine or AZT; Number of fully vaccinated children under one year of age; Number of institutional deliveries; ANC prenatal and follow-up visits	Easier to set targets/track performance
II	Targets based on broader health system indicators/outputs/ outcomes	Often national/health system based and targeted at whole Ministry of Health or similar health related department	Health workers by 1,000 population (HMIS); Total health expenditure per capita (HMIS); Proportion of births attended by skilled personnel (MDG); Prevalence of underweight children under five years of age (MDG)	Local pressure to integrate PBF into system strengthening; Reliable targets hard to set due to M & E shortcomings/ difficult to track performance

These performance targets are often characterised as focusing on ‘supply-side’ aspects of a health system, in the sense that they are designed to improve the supply of health care services. They are often coupled with interventions that are theoretically aimed at increasing the ‘demand’ for health services through the transfer of resources to local communities: for example, conditional cash transfers to encourage local people to attend facilities or in-kind mama kits for expectant/new mothers.

### 1.3 PBF debate

While global proponents argue the case for PBF strategies in global health governance, different issues (real or suspected) are associated with their use (see *Table 1*). These issues have emerged in global health and development literature and have been relatively contentious. They touch upon various aspects of the implementation of PBF schemes.

Some studies have shown the success of PBF in improving process outcomes, for example in increased access to, and utilisation of, priority health programmes

and improvements in quality of care (Basinga et al., 2011; Brenzel et al., 2009; Soeters et al., 2006; Mamdani et al., 2012); increased cost-effectiveness of health care at community and subnational levels (Fryatt et al., 2010). Such results lead some reports to draw favourable conclusions on the effectiveness of PBF (Low-Beer et al., 2007; Meessen et al., 2011).

However, other reports have questioned the effectiveness of PBF as a financing scheme for health care for various reasons. Multiple studies have contested the nature of the evidence base supporting PBF, branding it as inconclusive, flawed, or low in quality (Emmert et al., 2012; Eijkenaar et al., 2013; Eldridge and Palmer, 2009; Ireland et al., 2011; Magrath and Nicther, 2012; Montagu and Yamey, 2011; Scheffler, 2010; Witter et al., 2012). Even where evidence has indicated improvements in Type I outputs, a lack of isolation of the effects of PBF and of controls means that these effects cannot be solely attributed to PBF (Eijkenaar et al., 2013; Eldridge and Palmer, 2009; Mæstad, 2007; Witter et al., 2012).

There has been little appreciation for the context-specific nature of PBF schemes. For example, a study by Basinga et al. (2011) – widely cited and one of the more convincing empirical studies of the impact of PBF in low- and middle-income countries – showed Type I benefits of PBF schemes in Rwanda, but not why those benefits came about. Thus, others have lamented that generalised conclusions were drawn from case studies that use too varied methods of PBF and were undertaken in too disparate settings to draw such conclusions (Witter et al., 2012), and failures to appreciate the causes of effects of PBF, rather than their magnitude (Ssengooba et al., 2012).

As Montagu and Yamey (2011) highlight, even where PBF has led to increases in quantity and quality of care, this does not necessarily translate into increased population health, a view echoed by Eldridge and Palmer (2009). Meeting a target under a PBF strategy does not *ipso facto* equate to an improvement in the overall health system. Essentially, PBF has been shown by some studies (see above) to have an effect on Type I processes, without evidence showing a causal link between PBF and Type II system strengthening.

Studies on PBF have predicted or observed initial indications of unintended consequences of PBF strategies, with potential short- and long-term detrimental effects on health service provision. Among the concerns raised, it appears that PBF can: distort the priorities of national health systems due to targeting of services (Ireland et al., 2011; Scheffler, 2010); lead to ‘gaming’, false reporting of results and ‘cherry-picking of patients (Ireland et al., 2011; Kalk, 2011); give rise to ‘perverse incentives’ (Fryatt et al., 2010); lead to a focus on quantity over quality of service (Ireland et al., 2011; Langenbrunner and Liu, 2005); perpetuate in-country inequities by targeting areas where targets are more easily met (Ireland et al., 2011); and carry debilitating hidden costs for establishing and monitoring PBF systems (Kalk, 2011). Specifically in relation to Global Fund PBF schemes, based on data from 508 Global Fund grants Fan et al. (2013) argue that by virtue of calculating grants using a multitude of indicators and discretionary factors, “the incentives transmitted from the Global Fund to its recipients are weak at best” (Fan et al., 2013:e166). If recipients do not see how performance is tied to future disbursement of grants, or they view the Fund’s calculating mechanism as inaccurate, they are unlikely to be incentivised to achieve set goals (*Ibid.*).

Ireland et al. (2011) perceive a favourable bias towards PBF amongst policy makers and scholars, which has led to the overlooking of negative consequences and the sweeping attribution of positive outcomes to PBF schemes without consideration for other factors. As will become evident below, our study found



this favourable bias for PBF is significant to the framing and delivery of our case studies.

Despite the apparent emphasis on PBF and participation, there is no systematic research on the relationship between PBF and participation, and how African actors have participated in the design, implementation and delivery of PBF initiatives. In addition, there is limited empirical research to determine whether negotiations and deliberations have been equitable, and what implications this has in terms of reshaping local forms of governance, participation and authority (see Brown et al., 2013). As will be presented in the case studies below, due to the nature of World Bank and Global Fund PBF mechanisms, most participation takes place unilaterally between the funder and the national government/principle recipients. This often does not involve regional actors and tends to exclude and/or undervalue many local stakeholders (although this varies from case to case and is primarily determined by how well stakeholders are incorporated into decision-making processes by national bodies during wider prioritisation/target-setting processes, or specific grant/loan writing stages).

African actors within national governments generally **participate** in the design, implementation and evaluation of PBF schemes, even if the **quality** of that participation, including their ability to negotiate PBF schemes, may vary. This raises questions about how much influence or power is being exerted and how much freedom of action African political actors have available to them within global health governance and thus the level of partnership that exists. As we will demonstrate, different types of African actors are marginalised at various stages and levels of the PBF process. Research indicating which actors are afforded points of access to decision making and with what real input is lacking.

Finally, it is unclear and under-theorised how regional bodies are involved in decision making at the global level in relation to PBF. As later sections of this report will show, regional bodies are seemingly marginalised (although there has been recent movement on regional PBF schemes, see below).

The general lack of clarity in existing literature as to which actors have a real input in PBF schemes represents an intellectual gap that is clearly at odds with the normative value placed on participation as a key policy concept for global health governance. The role and points of access that African actors are afforded in organisations like the Global Fund and the World Bank need further examination to highlight: a) who is driving the PBF process and b) whether commitments to country ownership and partnership are fulfilled. This study represents an initial step forward in understanding these issues.

In summary, existing literature has raised concerns over the development and implementation of PBF strategies for a number of reasons:

- Flawed, inconclusive or low-quality evidence in support of PBF success, including a lack of isolated evidence for the effect of PBF independently of other schemes.
- Lack of appreciation of context-specific nature of PBF schemes and causes of PBF success (or failure).
- Non-generalisable results, e.g. positive outcomes seen in Rwanda.
- Lack of evidence supporting causal relationship between PBF and Type II system strengthening.
- Unintended consequences such as: distortion of national health priorities; 'gaming' and 'cherry-picking'; creation of 'perverse incentives'; focus on quantity over quality; perpetuation of in-country inequity; debilitating hidden costs.

- Complex and non-transparent grant mechanisms that provide weak incentives for achieving goals.
- Favourable bias towards PBF amongst policy makers and scholars, i.e. an ideational belief that PBF works or will work.
- A lack of understanding and systematic research of African actors' access to decision-making processes around PBF, and how access, or lack thereof, impacts upon equity, governance and participation.

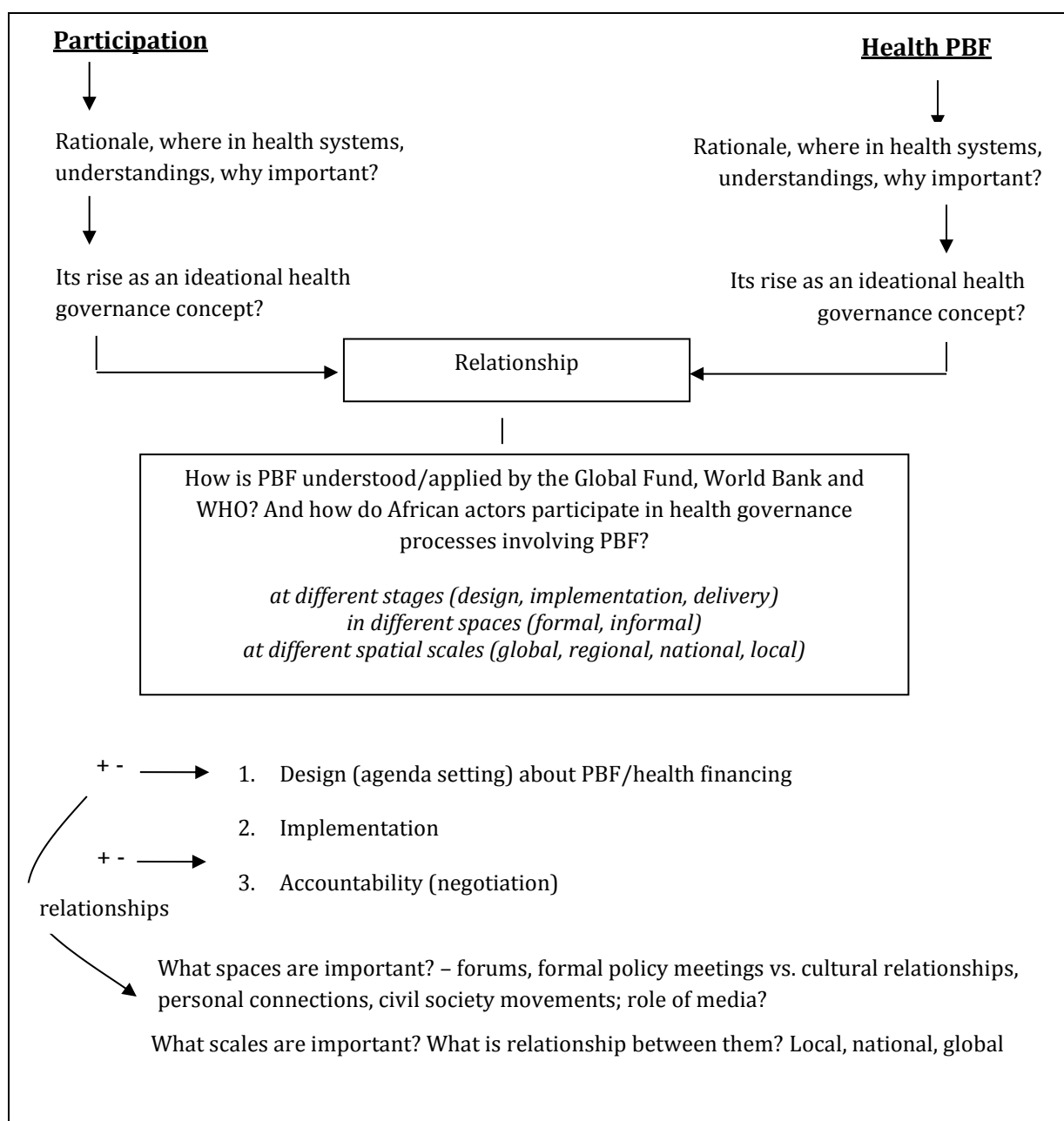
## 1.4 Objectives

The objectives of this research are to explore and bridge the research gaps highlighted above, analysing global health policy participation through the specific lens of health-related PBF. The way in which we have conceptualised the links between participation and performance-based funding is illustrated in *Figure 1*. As indicated in *Figure 1*, the aim of the research has been to investigate how and why PBF has come to prominence as an ideational policy concept, tracing the history of the idea as a mode of governance reform and mechanism for participation in health, and also the theory and rationale behind its application by the Global Fund and World Bank. From this, we sought to investigate empirically the ways in which African actors understand PBF in practice and how understandings of PBF shape participation in policy processes relating to it, including in the conception, design, implementation and delivery of PBF schemes. The research therefore has a theoretical and historical, yet also strongly empirical, focus. The aim of the empirical work was to identify the current diplomacy spaces relating to PBF mechanisms and implementation in the World Bank and Global Fund, analysing how different actors currently experience, negotiate, influence, are involved, or are excluded, in PBF processes.

To answer our overall research questions, we focused on the following sub-questions (SQ):

- SQ1. How has the idea of PBF emerged as a key idea in the reform of global health governance and development?
- SQ2. How do different actors understand and know about PBF and how do these understandings shape participation in the design, implementation and delivery of PBF?
- SQ3. How have actors at country and regional levels participated in PBF processes in the World Bank and Global Fund? And to what extent can east and southern African actors nationally and regionally extend their agency within these participatory spaces?
- SQ4. What barriers and facilitators exist to participation?
- SQ5. Are there participatory opportunities that remain underdeveloped and underutilised?

**Figure 1: The conceptual linkages between participation and PBF**



Source: Author construction. Figure 1 seeks to visualise the relationship between participation and performance-based funding - where they intersect and at what levels. For example, increasing national participation in global health policy is a dominant normative aim in the development lexicon as is PBF. Yet, at the global, regional and local levels, it is unclear how these concepts interact and the degree to which they are complimentary. This study examines how African actors can participate in three levels of PBF policy (design, implementation and accountability), at what levels (global, regional and national) and with what affect in terms of quality of participation.

## 1.5 Case studies

The research focused on two global actors as case studies – the Global Fund and the World Bank. These were selected because of: 1) their high-profile roles in global health governance and 2) their stated operational commitment to apply PBF approaches within health systems and to work in a participatory way. While both the Global Fund and World Bank operate PBF mechanisms, they employ different approaches (see *Table 2* for a detailed comparison).

**Table 2: Key characteristics of the Global Fund and World Bank's approaches to performance-based funding**

	<b>Types of performance target</b>	<b>Country-based partners</b>
Global Fund	Type I and Type II targets based on disease-specific indicators/outputs/outcomes - HIV/AIDS, malaria and TB (with health systems strengthening dimensions)	Country Co-ordinating Mechanisms (CCM) – multisectoral actors
World Bank	Narrow Type I targets based on payment for service/outcome - increasingly the focus is maternal health (when project/programme – based) Also contributes to Type II targets as part of wider health reform programmes and MDGs (but this is case specific)	Managed through state/MoH project teams District or facility based and/or may be targeted at individual health professionals Often combined with resources transfers to communities

Given these different approaches, focusing on both the Global Fund and World Bank provided an opportunity to compare and contrast the types of institutional spaces available for African actors to participate within PBF initiatives, and thus offer useful comparative insights in regards to the way in which PBF schemes are designed, implemented and evaluated. In addition, we also examined the WHO as a potentially key interfacing actor because of the global role that the WHO maintains regarding health policy uniformity at both the global and national levels. Given this, it was necessary to consider whether the WHO had any kind of 'shaping' role in how participation and PBF operate in relation to both the Global Fund and World Bank. Thus, we included it as an additional focus to better understand the 'regime complex' (Raustiala and Victor, 2010) in which health participation and PBF operate.

To ensure that the project was manageable on a practical level, case study countries also had to be identified to provide: 1) a clear focus for exploring the participation of different African actors; and 2) comparative insight into the potentially different ways in which participation can take place and how this is shaped by wider contextual factors. Zambia, South Africa and Tanzania were selected as our countries of focus. This decision was made for both pragmatic and intellectual reasons. Zambia was chosen because project team members have expertise relating to the health system and external funding arrangements. Zambia is also currently piloting a World Bank-funded PBF scheme and has Global Fund projects running.

Tanzania and South Africa were also highly suitable case studies since: 1) both countries have plans to move ahead with PBF programmes; 2) our research team has connections with local partners who could be drawn upon during the research; and 3) contextual differences between the countries and the types of PBF scheme currently in operation provided an opportunity for comparison.

The contextual differences and similarities that support the suitability of these case studies for comparison are as follows. Similar to Zambia, in both Tanzania and South Africa, Global Fund projects are being implemented using PBF. In terms of the World Bank, however, introduction of PBF schemes has stalled in South Africa and to some extent in Tanzania, which suggests differences in the way in which actors within our case study countries engage and negotiate with the Bank. In Tanzania, a pilot supported by the Clinton Health Access Initiative is up and running instead (discussions with the World Bank continue about the national rollout of the pilot, which is based on a PBF model). Including the three-country case studies was intended to shed comparative light on similarities in the

use of PBF models and to highlight differences in participation and engagement, which provide a means to identify social, political and economic circumstances and contexts that shape African participation in global health policy processes.

In this regard, the variables that were deemed relevant in the selection of the case studies for comparison included: 1) all country case studies had recent or ongoing PBF projects associated with the World Bank and Global Fund; 2) all case studies were in negotiations with the World Bank and Global Fund in relation to future pilot rollouts or on scaling up, or adding to ongoing PBF grants; 3) all countries had diplomatic missions in Geneva engaged with the WHO on global health policy and were members of regional bodies with health policy remits.

In terms of differences deemed useful for cross-country comparison: 1) the percentage of overall health budget for each case study was significantly different in national reliance on external funding, thus allowing comparison in terms of how greater economic independence allowed for better or worse participation in relation to the design, implementation and evaluation of PBF; 2) each case study had stated different forms of 'success' in ongoing partnership with the World Bank. For example, Tanzania and Zambia were engaged in active discussions about continued funding with the World Bank, whereas South Africa had once decided to discontinue relations with the World Bank by terminating its loan negotiations, only recently reopening discussions with the World Bank in relation to a different type of support for rolling out the South African National Strategic Plan (NSP). In all cases, the self-definition of success in terms of African agency had different meanings and substantive quality, which could provide insights on African agency in terms of PBF. 3) Each case study exhibited different mechanisms for governing PBF programmes and thus provided interesting comparative insights in how national programmes are devised, implemented and evaluated. This is particularly relevant for comparison, given the existence of similar grant/loan conditions that are placed upon each case country by the World Bank and Global Fund.

## **2. Research methods**

The research employed a qualitative methodology to ensure understanding, from the perspective of African actors themselves, the types of spaces that exist for participation in global health governance relating to PBF. Within this, a range of research methods were used to ensure that the theoretical, historical and empirical aspects of the research were fully met. Secondary sources drew on existing academic literature on PBF and participation in global health and international development (see Section 2.1). Primary research was based on policy analysis, semi-structured interviews, participant observation and stakeholder analysis.

Interviews were either recorded and transcribed or captured through extensive note taking during the interview, with additional details added to the transcripts immediately after the interview. The interviews followed predesigned guidance questions related to PBF and various participation mechanisms available. The questions were divided into six parts. These were: 1) interviewee's professional association with PBF and background; 2) understanding of participation and partnership in global health; 3) understanding of PBF; 4) knowledge of decision-making processes; 5) influence on process; 6) contextual aspects of strategic planning, input and outcomes of PBF.

As stated above, this study engaged with qualitative methodology to gain depth in analysis that cannot be reached in quantitative research using predefined questions and answers, which are then coded for statistical analysis. Alternatively, respondents were encouraged to explore the questions more freely,

with the aim of capturing subjective experiences related to participating in the design, implementation and evaluation of PBF.

During the analysis phase, main concepts and themes were identified through familiarisation with the interview material collected (Ritchie et al. 2003, p. 221). Familiarisation took place during interviews and from thoroughly reading through the interview transcripts (Neuman, 2011, p. 510). Thus, there was no clear-cut border between the interview phase and the analysis phase. As a result, the floating character of this qualitative research allowed the project to better understand the subject of inquiry and the complex political relationships that existed between various actors involved with PBF. The main aim of interviews was to identify key categories of PBF as it related to participation and the quality of that participation in practice. Accordingly, the presentation of the findings in the following sections are categorised in relation to these emerging themes.

Like any qualitative study based on a smaller number of informant interviews, questions of generalisability will arise. For example, the sample of 102 interviews is small in comparison to large-N quant studies that seek to sample a large cross section of a given population. As a result, a qualitative method will always entail some trade-offs between using open-ended questions that can elicit unpredicted responses that would be unobserved in a quantitative study versus having well-defined variables and values that lend themselves to processes of statistical regression analysis and high statistical reliability. Nevertheless, in this study, the sample size was deemed suitable for a number of reasons: 1) the stakeholder analysis took care in locating the main actors at the outset and ongoing stakeholder analysis was allowed as processes of snowballing revealed new stakeholders during interviews; 2) there was a good variation in the elite stakeholders interviewed, with a majority of sectors represented; 3) during the final stages of the interview process, the interview results started to resemble earlier ones, indicating that the data had become saturated. In all cases, interviews were pursued until a reasonable sense of data saturation and natural triangulation was present; 4) importantly, the purpose of qualitative research is not mass sampling, but to understand variations in personal experiences. In this project, qualitative interviewing and analysis are most suitable, since the aim is to capture subjective/intersubjective understandings of PBF and participation by African actors as well as by global institutions engaged with global health PBF. This is because large-N data sets have difficulty capturing subjective concepts like 'participation', and a primary aim of this study is to discover how African actors see themselves as meaningful participants within a broader development frameworks associated with PBF and health.

## **2.1 Policy and literature review**

To develop a detailed understanding of the historical development of PBF in the arena of global health, a detailed policy and literature review was carried out. This involved systematic analysis of existing research into PBF globally (e.g. in Rwanda, Cambodia etc.) and the role and participation of African actors within global governance, with specific reference to Zambia, Tanzania and South Africa. It involved content analysis of health strategies in Zambia, Tanzania and South Africa, PBF directives and strategy documents of global and regional institutions such as WHO, World Bank and the Global Fund, speeches and communications on PBF from the Zambian, Tanzanian and South African ministries of health, ministries of finance, and HIV/AIDS agencies, regional bodies, and reports and discussion documents on the role of PBF by southern African advocacy groups, civil society organisations, and the private sector. The purpose of this policy and literature review was to: 1) identify events and institutions within the history of PBF development; 2) map the African actors (and any interconnections between them) involved in policy deliberations, negotiations and implementation of PBF; and 3) begin to appraise the rationale and preference of external funders

implementing PBF, along with the role of southern African governments and civil society in conception, design and implementation. The full literature review and the published and documented material consulted can be found in EQUINET Discussion paper 98 at: <http://tinyurl.com/nxb49u5> (Brown et al., 2013).

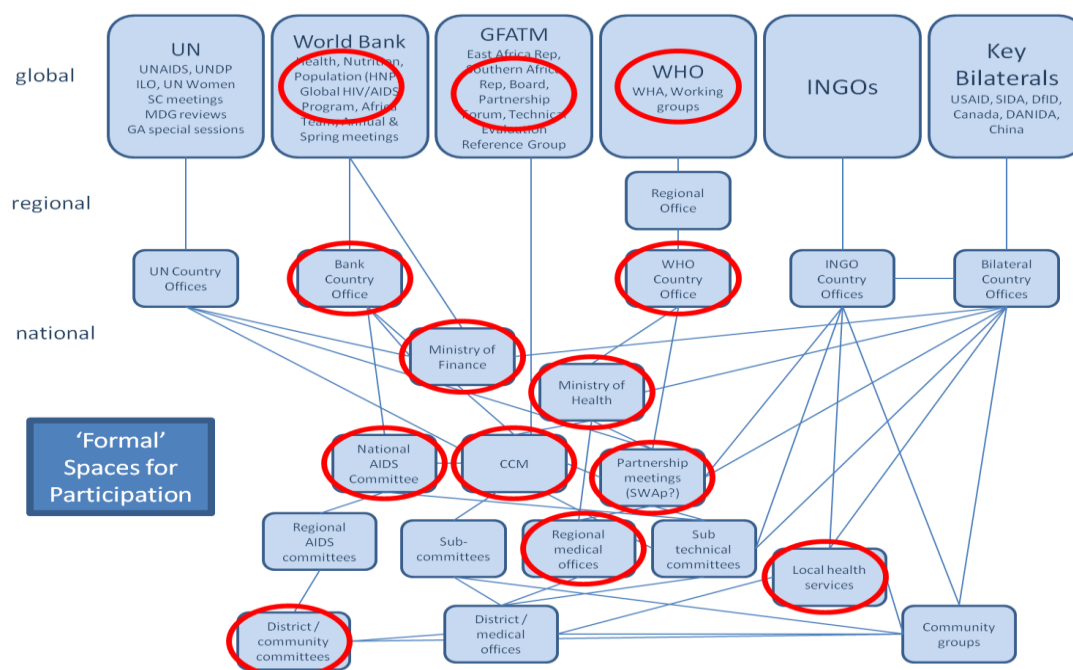
## **2.2 Fieldwork**

Fieldwork was undertaken at both national and global levels to develop a detailed picture of how participation within PBF partnership initiatives plays out in different diplomacy contexts, and to trace the rationales/understandings, policy processes, and practical application of PBF. At national level, semi-structured interviews were carried out with informants in Zambia, Tanzania and South Africa. Non-participant observation of related policy meetings was also conducted, along with visits to relevant PBF project sites within each country (where this was possible). At the global level, informant interviews and group-informant interviews were carried out with actors involved in regional meetings of the East, Central and Southern African Health Community (ECSA HC), the Southern African Development Community (SADC), in Washington, D.C., and in Geneva.

To support this process, the first activity was a mapping exercise of diplomatic spaces and formal opportunities for participation within global health policy processes associated with the Global Fund and World Bank. A schematic map was produced and circulated within the research team for discussion. A finalised version is included in *Figure 2*. This schematic map was a starting point for a stakeholder analysis of PBF documents, to identify research informants in Zambia, Tanzania and South Africa (including, for example, officials within central and regional government levels, Ministry of Finance, national HIV/AIDS agencies, health NGOs and advocacy groups, private sector partners, and external funders). In the case of the Global Fund and World Bank, relevant PBF documents were freely accessible on-line *via* both institutional websites. These listed participating parties and delineated their specific functions, often providing and contact details. To triangulate our interviews and to construct a more reliable and balanced understanding of participation in PBF, our team located groups outside the formal institutional process (i.e. outside health NGOs, regional political entities, civil groups, academics, the media, practitioners and others affected or potentially affected by PBF initiatives). A database of potential stakeholders was created to track the availability for participatory spaces, existing communication networks, policy relationships and policy practice.

More information follows about the field research in each of the case study countries and in Washington, D.C., and Geneva, along with a discussion of the limitations of the field research process in each location.

**Figure 2: Schematic diagramme illustrating key diplomatic spaces for participating in global health policy processes**



Source: Authors.

Fieldwork in **Washington, D.C.**, was completed in September 2012. The aim of the research was to investigate how global health institutions (particularly the World Bank) understand, rationalise and seek to apply PBF, and to explore how this relates to national contexts of practice (South Africa, Tanzania and Zambia). The aim was also to explore more generally, from the perspective of global actors, what spaces exist for African actors to engage in global health policy processes. Twelve representatives of the World Bank, USAID and Inter-American Development Bank conducted a mix of individual and group interviews.

Individuals interviewed included staff members involved in the Bank's flagship Health Results Innovation Trust Fund (HRITF). However, there were certain shortcomings. Most pertinent, the World Bank's external affairs department co-ordinated access to officials due to apparent sensitivity around the topic. It was unclear why this sensitivity in discussing PBF existed given that the aim of the research was to develop a balanced understanding of the way in which African actors participate in governance processes related to PBF. This sensitivity is also striking in that the World Bank is championing evidence-based policy making and tailoring funding mechanisms based on results, a relationship to which this study could provide interesting insights and analysis. The result of this sensitivity was the organisation of group interviews and filibustering during the interview process, a tactic that was also witnessed to a lesser degree during interviews with the Global Fund (see below).

Fieldwork in **Geneva** was conducted in September–October 2013. The focus of these interviews was on informants within the headquarters of the Global Fund, the WHO, individuals who work for regional bodies related to African health in Geneva, and personnel from health missions for South Africa, Zambia and Tanzania to the United Nations. The purpose of the fieldwork was to investigate how actors within our three case study countries are and/or have been involved in the conception, negotiation, design, and implementation of PBF initiatives in global health institutions, to understand how African stakeholders participate in



PBF activities and/or discussions of PBF within the Global Fund, World Bank and WHO. Engagement with other external funder organisations (i.e. PEPFAR, UNAIDS) was also explored where this intersected with the work of the Global Fund, World Bank or local African stakeholders.

To prepare for the field research, a stakeholder analysis of key actors in Geneva was conducted. This was accompanied by an analysis of national-level stakeholders who have UN missions in Geneva or who represent African regional bodies working on issues of global health policy. In total, 10 semi-structured interviews were conducted in Geneva. The interviewees represented a broad range of actors involved in PBF policy, including project managers at the Global Fund, WHO administrators, personnel from UNAIDS, regional bodies representing African health, and national and UN representatives of South Africa, Tanzania and Zambia.

The **South African** fieldwork was completed in February-March 2013. In line with the aim of the fieldwork as mentioned above, the purpose of this was to investigate how South African actors are and/or have been involved in the conception, negotiation, design, and implementation of PBF initiatives of global health institutions. The primary focus of the research was to understand how South African actors participate in the PBF activities of the Global Fund and World Bank. Other external funder organisations were also engaged (i.e. President's Emergency Plan for AIDS Relief [PEPFAR] and Department for International Development [DfID]) and explored where they intersected with the work of the Fund and Bank. In preparation for the field research, a situation analysis of past and existing PBF initiatives in South Africa was conducted. This was accompanied by an analysis of national-level stakeholders. In total, 24 semi-structured interviews were conducted in and around Pretoria, Cape Town and Johannesburg. The interviewees represented a broad range of actors involved in the South African health system, including provincial and district health officials, the South African National AIDS Council (SANAC), CCM members, local consultants, principal recipients of Global Fund grants, UN agencies, and businesses involved in the health system. Securing access to these stakeholders was greatly assisted by the use of a local consultant who provided organisational and logistical support.

The field research in **Tanzania** was carried out during October-November 2012. As with the research in South Africa, the aim was to understand how Tanzanian actors understand and participate in the planning, development and subsequent implementation of the PBF initiatives of the Global Fund and World Bank. A situation analysis was conducted to identify national-level stakeholders. This initial review was updated when in-country by snowballing through participant referrals and attending key meetings. In total, more than 30 semi-structured interviews were conducted with a broad range of actors involved in the Tanzanian health system. Interviewees included representatives of the Ministry of Health and Social Welfare, Ministry of Finance, UN agencies, World Bank, other external funder organisations, non-governmental organisations, and programme managers and principal recipients of Global Fund grants. In addition to interviews, non-participant observation at three key policy meetings was carried out to broaden and strengthen the methods for gathering research data:

- Annual Health Sector Review, Bluepearl Hotel, Dar es Salaam (16 October 2012);
- Fifth P4P Advisory Committee, Ministry of Health and Social Welfare, Dar es Salaam (31 October 2012); and
- Joint Annual HIV/AIDS Technical Review, Bluepearl Hotel, Dar es Salaam (1 November 2012).

Field research was conducted in **Zambia** in two stages. An initial research visit in November-December 2012 was intended as a mechanism to secure local ethics and government approvals and to conduct some initial interviews centrally in Lusaka. A second trip in June 2013 allowed for more detailed exploration of PBF activities in-country and of opportunities for Zambian actors to participate in global health institutions. As with work in South Africa and Tanzania, a situation analysis of past and existing PBF initiatives in Zambia was carried out and accompanied by an analysis of national-level stakeholders. Over 28 interviews were conducted during the research process. These included representatives of external funding agencies, UN agencies, the Zambian CCM, principal recipients of the Global Fund, civil society organisations, the National HIV/AIDS Council, and past World Bank/Ministry of Health staff. Eight interviews were conducted in Eastern Province at facility level with health workers. These were all tape-recorded (where consent for this was given) and transcribed.

While the interview process generated important data for the project, the research did not progress as planned in Zambia for a number of reasons. First, it proved extremely difficult to secure interviews with stakeholders in government ministries, the World Bank and in local implementation sites. Second, and despite prior discussions with research partners in Zambia, securing a letter to proceed with the research from the permanent secretary for health proved time-consuming, with a delay in receiving an appropriately worded letter to proceed. Third, despite having a letter from the permanent secretary and initial agreement to take part in the study, personnel associated with the implementation of the World Bank pilot in Zambia continually attempted to change the requirements for taking part in the research; for example, asking for differently worded letters or other additional research documentation. Fourth, access to relevant staff within the World Bank proved difficult given sensitivity about requiring explicit approval from senior staff within the Washington headquarters. As with the research in Washington, D.C., there was an apparent level of sensitivity in discussing the topic –the reasons for this were not explicitly discussed or explained. Despite these difficulties, a number of pertinent themes and issues were discerned from the research data, thus providing a useful comparison with the country studies in Tanzania and South Africa.

Interviews with **regional bodies** were carried out in Geneva, Tanzania and South Africa between July 2013 and October 2013 with case study members of East Central and Southern Africa Health Community (ECSA HC) and Southern African Development Community (SADC). The focus of these interviews was on informants who work for regional bodies related to African health and who represent the three case- study countries. The purpose of the fieldwork was to investigate how actors within our three case study countries are and/or have been involved in the conception, negotiation, design, and implementation of PBF initiatives via their regional bodies. The primary focus of the research was to understand how African stakeholders participate in the PBF activities and/or discussions of PBF within the Global Fund, World Bank and WHO through their regional bodies and/or how PBF is discussed between members of ECSA and SADC.

To prepare for the field research, a stakeholder analysis of key actors in Geneva, ECSA and SADC was conducted. In total, five semi-structured interviews were conducted with members of these organisations. The interviewees represented regional representatives from South Africa, Tanzania and Zambia.

## **2.3 Ethical approval**

Ethics approval was secured from the University of Sheffield Research Ethics Committee (REC), the University of Zambia REC, the Ministry of Health Zambia, Tanzania Commission for Science and Technology (COSTECH) and the Human Sciences Research Council South Africa.

## **2.4 Analysis**

Analysis of the research data progressed by drawing on previous experience and existing literature to triangulate, challenge, and reflect on the theoretical and practical implications of the findings. Interviews were analysed in an iterative way using thematic analysis (i.e. sorting/labelling/summarising data using predefined concepts, such as understandings, assumptions, rationales, leadership) while also identifying new, emergent ones, detecting patterns and developing explanations to answer the research questions. An initial case study report was prepared and circulated within our research team for comment, and with the EQUINET project team. A report was drafted and preliminary findings presented at the ECSA meeting in August 2013 and at a stakeholder workshop in Cape Town in November 2013. Feedback from these meetings was integrated into this final report.

## **3. Research findings**

This section of the report details the main findings from the research. The characteristics of PBF schemes within Zambia, South Africa and Tanzania are set out first, before moving on to discuss and respond to the main sub-questions of the research, namely:

- SQ1. How has the idea of PBF emerged as a key idea in the reform of global health governance and development?
- SQ2. How do different actors understand and know about PBF and how do these understandings shape participation in the design, implementation and delivery of PBF?
- SQ3. How have actors at country and regional levels participated in PBF processes in the World Bank and Global Fund? To what extent can east and southern African actors nationally and regionally extend their agency within these participatory spaces?
- SQ4. What barriers and facilitators exist to participation?
- SQ5. Are there participatory opportunities that remain underdeveloped and underutilised?

We indicate in the discussion below which sub-questions are being specifically addressed in that subsection.

### **3.1 Characterising PBF in Zambia, Tanzania and South Africa**

This refers to SQ1, SQ2 and SQ3.

As indicated in the introduction to this report, PBF is a label that can be applied to a range of projects and health system interventions. The research, however, has identified two types of PBF programmes, which are in development or being implemented in Zambia, South Africa and Tanzania. The first type – which we have called Type I – is a straightforward results-based system (as called in Zambia and South Africa) or pay for performance (P4P) programme (as called in Tanzania) in which health professionals (doctors, laboratory technicians, ambulance drivers) get paid when they (or the health facility in which they work) meet certain outputs or outcomes related to service delivery. This is usually in the form of a bonus payment and performance tends to be identified by a set of indicators drawn from national Health Management Information Systems (HMIS)

data. This type of project is at the preliminary pilot stage in Tanzania (supported by Clinton Health Access Initiative or CHAI), and the advanced pilot stage in Zambia (supported by the World Bank through the Health Results Innovation Trust Fund or HRITF). Both pilots focus on indicators based on outputs or outcomes for maternal and child health. More details about these pilots are provided in *Table 3* about Type I – Fee for Service PBF Programmes. In South Africa, there are preliminary discussions and initial work, particularly within the national treasury, around introducing Type I PBF frameworks for hospitals and health professionals, but these are currently at an early stage of development (this is why South Africa does not feature in *Table 3*).

**Table 3: Key features of the ‘Type I – Fee for Service’ PBF programmes in Tanzania and Zambia.**

Features	Tanzania	Zambia
Overview	Provision of fee-for-service incentive payments based on individual and institutional performance	Provision of fee-for-service incentive payments based on individual and institutional performance
Aim/focus	Maternal and child health - To accelerate the attainment of Millennium Development Goals (MDGs) 4 and 5	Maternal and child health - To increase coverage of maternal/child services (and improve outcomes) in rural areas by changing behaviour/system strengthening
External support	Clinton Health Access Initiative (CHAI) with the Norwegian Ministry of Foreign Affairs	World Bank (through Health Results Innovation Trust Fund or HRITF) with particular support from Norwegian Ministry of Foreign Affairs - HRITF US\$16.79 million (initial grant was US\$12 million)
Geo-graphic focus	Pwani region – 7 districts	Initially implemented in Katete District. Larger pilot now involves 10 districts across provinces (Mumbwa, Lufwanyama, Lundazi, Mwense, Mporokoso, Isoka, Mufumbwe, Siavonga, Senanga)
Stakeholders	All facilities (hospitals, health centres, dispensaries) within the 7 districts are eligible to participate if they provide reproductive and child health services, have full HMIS data and have bank accounts. Supervising authorities at district and regional levels are eligible for bonuses (district Council Health Management Teams and Regional Health Management Team)	Health facilities with 1 trained health worker are eligible. Neighbourhood health committees intended to support community participation in decision-making process. District- and provincial-level structures have supervisory/governance roles: performance assessment (either of facilities or districts), audit, technical support and co-ordination of activities. Stakeholders at national level are the MoH HQ (incl. Project Implementation Unit) and National RBF Steering Committee
Targets and indicators	6 monthly bonus payments based on maternal and child health service indicators, HMIS strengthening, facility management, and overall performance. Examples of facility indicators: proportion of antenatal clients on malaria prophylaxis; proportion of newly delivered mothers who attended postnatal clinic within 7 days. Other indicators linked to bonuses at facilities: % of HIV+ clients on	Pre-agreed core package of 9 facility-based indicators associated with extra payments: curative consultations, institutional deliveries by skilled birth attendant, ANC prenatal and follow-up visits, postnatal visit, full immunisation of children under 1 year of age, pregnant women receiving 3 doses of malaria IPT, FP users of modern methods at the end of the month, pregnant women counselled and tested for HIV, no. of HIV pregnant women given Niverapine+ and AZT

	ARVs for prevention of mother-to-child transmission; proportion of facility-based deliveries. Correct/correctly used partographs a hospital indicator	
Judgement of performance	Performance reports submitted. Overall performance score calculations made. Planned and random checks by various verifiers.(NB. Implementation been accompanied by introduction of new Health Management Information System (HMIS) designed to strengthen collection/ use of HMIS data)	Indicator index and associated fee schedule. Verifications through monthly quantity audits and quarterly quality audits. Performance calculated by multiplying a quality score with the total quantity of services delivered (based 9 indicators)
Payments	Every 6 months. Facility bonus paid for disbursement to staff and for facility operations (maximum \$723 in dispensaries and \$7,875 in hospitals) Staff top ups can be 10% of monthly salary for maternal/child health workers	Quarterly. Health facilities divide payments based on staff performance bonuses (based on a staff index) and can use payments for reinvestment (min. 25% of total): e.g. to buy drugs, recruit temporary nurses and midwives
Other information		To trigger demand for services, incentives (in-kind or cash) are provided to Traditional Birth Attendants, pregnant mothers, undernourished children

Sources: Borghi et al., 2013; HRITF, 2013; MoH (Zambia), 2011.

The second PBF approach (Type II) aligns more closely with older models of aid conditionality: whereby broader and sometimes system-wide objectives, indicators and targets are set by recipients of aid (with external funder input in many cases), and as long as targets are met (or nearly met), the money keeps coming (South Africa). However, the slight, but vital, shift is that recipients of aid have to demonstrate results with their own funds before receiving money and/or consistently do not receive any further funds if the agreed targets are not met. This type of PBF programme is being widely introduced to HIV/AIDS funding and other areas of health financing by agencies such as the Global Fund and the President's Emergency Plan for AIDS Relief (PEPFAR). Global Fund projects are in operation in all three of the case study countries and tend to contain both Type I and Type II performance targets. As with all Global Fund projects, grant applications are made by a principle recipient in conjunction with a locally organised multisectoral body - Country Co-ordination Mechanism (CCM). The aim of local co-ordination is to create nationally owned targets and projects that best fit the specialised needs of a particular state, province or group. In this sense, the choice of performance targets is left to the CCM grant writing body to decide, although as discussed below, the Global Fund does favour certain types of target areas and it was seen by interviewees as heavily steering CCMs to adopt certain kinds of targets.

### 3.2 Different understandings about PBF

This refers to SQ2.

When asked, most civil society organisations and government officials interviewed in Tanzania and Zambia were reticent to say what they thought PBF was, who is doing it and how it is applied, as they were not particularly familiar with the particular term. For example, one respondent in Zambia suggested:

*We do not have performance-based financing. I mean well maybe yes and no. Let me say yes and no. I think the US component is the fact that all these projects you get funding only after you submit your reports and satisfactory report*

*and the next trunk of money comes, even the project we have with CHAI, they only give us the funding after certain deliverables....*

*So that is performance based funding?...*

*(Laughing) Yeah.*  
(Interview ZAM1)

Some interviewees appeared to be more conversant with other terms used to signify this type of funding modality. Indeed, terminology was a major determinant of understanding; for example, a doctor working in a health centre that was part of the P4P pilot in Tanzania was familiar with the term P4P but had not heard of PBF. This supports a recent study by IFAKARA (2013) which suggested that “After two years of the pilot, most stakeholders did not know what P4P was” (Interview TNZ2).

Despite differences in terminology, during interview discussions most government and civil society organisations in Zambia, Tanzania and South Africa understood the broad idea of PBF with regard to the financing models promoted by global health institutions, such as the Global Fund, PEPFAR, USAID and DfID. PBF was also deemed to be broadly about showing and checking results, and about accountability (to external funders): you propose to do something and hit certain targets, and then you get the money when you show performance. This is illustrated in the following excerpts from interviews in Tanzania and Zambia.

*With PBF you have to, for example if you want to give me money, you want me to use whatever I have and then I show you I have managed. This is my plan. I plan to provide services to this number of people, and this is my budget. Let's say \$1,000, I need \$1,000 to provide for 100 people. Now I depend on you to give me money, but you don't want to give me money straight, but you want to show, to look for some resources, if I get like \$500 or \$600, up to \$1,000 I need. I do some work with \$600 and then I report to you that I have managed to secure \$600 out of my targets but this is not enough and then what you do - correct me if I am wrong – what you do is if you see that I have made some efforts and I have given the milestones, I have done this, you say okay if that is what you have done I give you the dollars. And then another quarter or another year then you support me.*  
(Interview TNZ8)

*Okay broadly that whatever financing you're going to give me, I'll only merit more finances as I give feedback. And feedback based on what we have agreed will be the measure and we call it performance.*  
(Interview TNZ9)

*...results-based financing is really funding programmes according to how they perform, or according to a set target or according to, so you can either say if you reach this target I will give you this amount or for every to provide, I will give you this amount.*  
(Interview ZAM8)

In Zambia and Tanzania, those with the clearest understanding or familiarity with the term were either the principal recipients of Global Fund grants, external funders themselves, or those working in government who were piloting P4P or result-based financing programmes. In South Africa, however, all interviewees seemed familiar with the idea of PBF and appeared content to use the term in discussing the South African health system.

In terms of external funders interviewed during the research, all Global Fund, World Bank and USAID interviewees saw PBF as a positive initiative for health systems. However, people believed there were different purposes for this type of funding intervention. On the one hand, it was about health service performance and ensuring the best use of resources in service delivery, given the explicit linkage of inputs to performance and outputs. On the other hand, it is about the wider reform of health systems and changing prevailing modes of health governance. As one interviewee commented:

*What I like about PBF, is it is a systematic approach to strengthening health systems... It strengthens the health system because it strengthens all the WHO building blocks, it really attacks, addresses each one of them and tries to improve them and I think this is a powerful, potentially powerful intervention to do that. It's a lot more than pay for performance.*

(Interview WAS2)

In other words, PBF is about changing existing institutional structures and behaviours, which are perceived to be deleterious to achieving health results. To this end, contracting was seen as important by at least one interviewee closely associated with the World Bank, who indicated that “contracts are a powerful behaviour change tool” (Interview WAS2). In terms of changing behaviour, respondents at the Global Fund shared a similar belief to those at the World Bank, claiming that PBF helped to alter the way actors perform. As several Global Fund grant managers suggested, the role of the Global Fund is “to make sure they get assistance, but also a level of monitoring to keep things moving in the right direction” and to make sure that “governments follow through on their commitments” (Interview GEN2).

A number of other interviewees who were involved in implementing PBF programmes supported this view of PBF as being about changing prevailing (i.e. negative) forms of behaviour within the health system. For example, one interviewee in Tanzania commented that: “It will make people be responsible; that is the thing I see” (Interview TNZ8) and an interviewee in South Africa indicated that PBF tends to act on the “assumption that fraud and corruption must exist” (Interview SA6) (an assumption that this particular interviewee was not particularly happy about). A health worker in Zambia questioned whether PBF was to “find out if really money motivates people to put in more effort in their level best or its really just a culture of maybe Zambians they are not hard working” (Interview ZAM9). Several interviewees with country representatives in Geneva also reflected this sense of paternal conditioning, with one interviewee stating that the Global Fund “expects applicant[s] to do as they are told” (Interview GEN4).

Interviews with the Global Fund, WHO and African stakeholders in Geneva generated similar results in terms of how PBF was understood. In particular, respondents generally believed that PBF serves four overall policy functions. First, there was an overall belief that PBF was a mechanism to better monitor health interventions so that more reliable evidentiary judgements could be made about what policies work and what policies struggle to generate results. As one Global Fund interviewee claimed, PBF “ensures that funding decisions are based on transparent assessment of results” (Interview GEN1). In this regard, despite a lack of correlative evidence to suggest that PBF produces significantly better health outcomes (see below), most respondents made a firm link between PBF mechanisms and global initiatives to increase evidence-based policy. That said, a respondent from Zambia suggested that the World Bank favoured pilot studies because there is a lack of evidence about the effectiveness of PBF and that more well-designed pilots would support the World Bank’s PBF policy (yet, the respondent did suggest that the Zambia pilot could actually provide evidence that

undermined the presumption that PBF 'works' and was waiting with interest to see the results in Zambia pan out). This respondent also claimed the World Bank's need for more evidence of PBF success as a key driver behind their push for the pilot study in Zambia.

Second, there was a unanimous belief that PBF either limited corruption or was a mechanism designed by external funders to help curb corruption by increasing the level of accountability by recipients. As one country health attaché to the UN suggested, "they want to make sure their [funders] money isn't buying new BMWs for the minister" (Interview GEN6). Respondents at the Global Fund also mirrored the perceived effectiveness of PBF on corruption, arguing that it helped to "satisfy external funder demands for accountability and the reduction of waste and corruption" (Interview GEN1).

Third, and related, PBF was seen as a mechanism to increase value for money and limit waste. As one country delegate to the WHO suggested, "The logic behind these funding models is to get more from the money spent and to make sure the money is going to the right places" (Interview GEN3). PBF Several regional organisations working in health mirrored this understanding of PBF, maintaining that "PBF is used by funders to control how money is used and to make sure they are getting more out of it" (Interview GEN5). At the Global Fund, interviewees suggested that result-based funding had positive effects in terms of external funder perceptions about getting the most value from their donations and that this helped generate more funding, claiming that "it is a self-perpetuating cycle... the more the GF can show that it is having an impact, the more external funders will want to give" (Interview GEN1) and that the aim of the Global Fund was to "try to keep all grants on track as well as possible and to make sure the money is having its greatest affect" (Interview GEN2).

Fourth, members of the Global Fund stressed their belief that PBF is about being accountable to those most in need by only funding projects that "impacted on peoples well-being in measurable and meaningful ways" (Interview GEN2). However, this view was not always shared by country representatives in Geneva, who often suggested that accountability was hierarchical at the Global Fund with priority given to the demands of the funders. As one national health mission to the UN argued, PBF is a external funder-led initiative to 'conditionalise' funding and "it might not be in the best interests of African states" because these conditions are "something all applications must conform to regardless of whether it is right for that particular applicant" (Interview GEN4). This understanding of accountability hierarchy was also prevalent with many of the interviewees in the three case study countries, where there existed strong sentiment that the Global Fund catered to the needs of funders over the needs of recipients.

As implied above, one interesting finding of this research involves the level of ideational acceptance of PBF and the overwhelming assumption that PBF is representative of effective aid delivery and best practice. This ideational acceptance of PBF was most prevalent within the Global Fund and World Bank, although it was also the favoured mechanism in all of the other aid organisations interviewed (see below). In addition, the ideational acceptance of PBF as best practice was predominant within the official governmental structures of the Tanzanian and Zambian case studies, with many public officials often suggesting that PBF was the best method for delivering health (PBF was held with more explicit suspicion by public officials in South Africa). This corresponds with Ireland et al (2011) who highlighted a perceived favourable bias towards PBF.

The rationale for PBF holding a favoured position in global health policy was not always clear. In particular, respondents from the WHO stressed that there was a general lack of debate about PBF and that it was often assumed that it was the



most effective mechanism. This belief that PBF works was widely held despite an inability by many respondents to cite concrete evidence. At best, respondents were able to point to a small number of particular cases where PBF had been seen to be effective (usually Rwanda and Burundi), but the direct evidence for such claims was often admitted to be based more on “everyday conversations and not from any report or evidence” (Interview GEN5). As shown in Section 1.3, much literature on PBF has questioned the lack of evidence on the effectiveness of PBF considering the widespread support it has in policy circles, an issue that has become more apparent through this study. As one African WHO country representative remarked:

*These sorts of [PBF] programmes are very popular and their effectiveness is often assumed. I don't think there is a great deal of argument taking place about the risks of these types of funding mechanisms... on the whole donors and consultants are in favour of target-driven financing and they have successfully entrenched this as the primary mode of operation* (Interview GEN3).

### **3.3 The origins of PBF: A site of African agency?**

This refers to SQ1, SQ2, SQ3.

What is interesting about how different people understand PBF or are familiar with the term is the origins of the idea and what this tells us about African participation in ‘setting the PBF agenda’. A significant number of external funders interviewed suggested that the idea for PBF came from Africa and that African countries had been clearly demanding such an intervention within health systems for a long time. This was particularly the line taken by several World Bank staff members, who were keen to assert that it is African countries asking for the money and technical support, and that states such as Rwanda and Burundi were flagship countries or innovators in such reform. As one World Bank staff member indicated, “The demand is overwhelming, we have a very hard time meeting the demands [for PBF]” (Interview WAS3). Rwanda in particular was often cited as a model example, particularly with regard to the leadership taken from President Paul Kagame and throughout the Ministry of Health:

*We as an institution, we have learned a lot from, and we continue to learn a lot from the collective experience in Rwanda... this shift from an input based approach to an outcome-based approach. And Rwanda pioneered many things in that regard* (Interview WAS1).

In other words, PBF was presented (by the World Bank in particular) as a site of African agency and, in some senses, a distinctly claimed space for the participation of African actors in global health policy processes.

Interestingly, key to this process was the participation of African actors in mutual forms of knowledge exchange and learning activities and, more specifically, involvement in workshops and study tours to Rwanda to learn more about PBF. As one World Bank interviewee explained:

*They usually organise by themselves study tours or we finance it, to see it, to visit a neighbouring country to visit it, and see how a design works and then they sort of embark on a process where they adapt the general idea to a local context* (Interview WAS3).

In this sense, the idea of PBF was presented here as an example of South-South participation or African-African learning, and therefore that its application and use emanated from Africa. Several people working in the World Bank and bilateral agencies such as USAID, the Clinton Foundation and PEPFAR supported this assertion. Nevertheless, this understanding of PBF as a South-South initiative

was not prevalent within the WHO and other health-related UN bodies. In contrast, the majority of WHO and UN interviewees understood PBF as an external funder- driven initiative. In particular, it was widely believed that most large bilateral agencies were strongly pushing the adoption of more PBF financing models and that this was further pursued by health consultants working for these agencies. For example, one African member of UNAIDS suggested:

*Organisations like Gates, Clinton and USAID are suggesting PBF as an effective health reform tool... there are a great deal of consultants and experts brought in to discuss things and I think they are keen on the idea of PBF (Interview GEN7).*

Another WHO delegate remarked:

*On the whole, donors and consultants are in favour of target driven financing and they have successfully entrenched this as the primary mode of operation (Interview GEN3).*

When asked about alternative funding models being discussed within the WHO, several respondents claimed that sector-wide approaches (SWAps) and direct budgetary funding are talked about, but suggested “key donors prefer PBF models” (Interview GEN6). As a regional representative for Africa furthered stated:

*Funders are the main proponents of PBF and this is often made very clear in WHO policy conversations... [so] there is not much scope for discussing funding modalities in the WHO... I mean it does come up, but more in terms of the system needing targeted aid, and more of it. We largely discuss policy in terms of priorities, strategy and practice, not on the details of aid delivery (Interview GEN5).*

Furthermore, the idea of PBF being driven by South-South learning was not a dominant notion within the Global Fund. Alternatively, Global Fund interviewees saw PBF as a particular US management device. According to Global Fund interviewees:

*Performance-based funding emerged in the 1970s in the tertiary education sector in the United States; it was developed to improve the quality of education by funding results attained rather than funding according to the size of an institution or standard budgeting procedures (Interview GEN1 – WHO paraphrased the above and referred interviewer to the Global Fund website).*

In this regard, unlike the World Bank, the Global Fund recognised a different origin of PBF and reiterated the reach of this funding modality’s global influence by stating:

*Today, the performance-based funding model is used by a number of development organisations and initiatives (including the GAVI Alliance, the Millennium Challenge Account and the European Commission) as a way to ensure the accountability, efficiency and effectiveness of programmes being funded” (Interview GEN1 – WHO paraphrased the above with reference to Global Fund website).*

### **3.4 Questioning the origins of PBF**

This refers to SQ1, SQ3, SQ4.

Government officials in Zambia, South Africa and Tanzania were more sceptical of PBF being a South–South participatory initiative. As a result of this and the Geneva-based understandings of PBF, the notion of PBF as a clear site of African agency is less straightforward on closer inspection.

## **South Africa**

Interviewees in South Africa suggested that PBF had been around for an extended period of time, predating the Rwanda pilots and the interventions of the Global Fund in 2002. They indicated that, although it was not referred to by PBF in the past, the general model of setting targets to secure funds has a history in African development. In the South African case, it was pointed out that a tense relationship between the Global Fund, World Bank and the South African government has historically existed, with the South African government having its only World Bank PBF project cancelled due to an inability to reach mutually acceptable terms and a general belief by the then-Minister of Health that the World Bank loan would undermine national self-reliance. This lack of engagement with global external funders like the World Bank and Global Fund was exacerbated by the HIV/AIDS denialism of the Mbeki administration, which many respondents believed to have greatly undermined national health initiatives in South Africa before 2009.

In the case of the Global Fund in South Africa, there is a history of the national government being unable to secure grants due to the ineffectiveness of its CCM (SANAC). Consequently, it was a widely held view that the South African government was traditionally an ineffective partner with global institutions, local NGOs and provinces. This was seen as limiting the agency of South Africa in key global policy debates and as hampering the use of international funds as a 'bridging mechanism' for health system strengthening. As one respondent claimed:

*Things are changing under the new leadership. Since 2009 there is a better sense of co-operation between the local and the global - within SANAC, the DoH and from the new Minister of Health. Prior to that many global funders were shut out from working with the South African government because the minister disliked the West, particularly the US (Interview SA13).*

As a result, in the past most Global Fund money was awarded to provincial governments and NGOs (Western Cape and KwaZulu-Natal) effectively sidestepping the national government and undermining the formation of a more unified national health system. As mentioned earlier, provincial governments and local NGOs as well as external global institutions did not see the idea of South African agency or equitable participation in international negotiations as being effective or relevant prior to 2009. As one NGO remarked:

*SANAC has traditionally been very difficult to deal with. It was nepotistic and ineffective. In the past it had favourite NGOs that have not always been the most efficient or successful. Some NGOs were pushed out because they were not in-line with the government's political views. This is changing now and there is a general sense that the government means to reset the button on global health relations. Given the chaotic development quagmire created up until 2008, things look on the road to a more genuine health partnership (Interview SA14).*

All respondents in South Africa understood the current practices of PBF modelling within the Global Fund and other funders such as PEPFAR as a representation of an externally driven form of finance management. In line with understandings of PBF from the Geneva interviews, nearly all respondents in South Africa held that PBF was a funder-based initiative founded on a two-level rationale. One, that PBF was a way for funders to limit corruption by increasing the level of accountability by recipients. Two, that PBF was a mechanism for funders to "get their money's worth," or as one respondent suggested, "to get more bang for their buck" (Interview SA12). This underwriting rationale was largely accepted by most respondents interviewed and was seen as a reasonable set of general conditions for aid delivery. However, many respondents also

expressed that in-practice PBF is not unproblematic and that there were several problems with how PBF targets are set, monitored and evaluated which undermined the foundational aims behind using PBF (see below).

### **Tanzania**

In relation to Tanzania, interviewees reported that the idea of PBF had something of a confused history. Initially the government had wanted a country-wide PBF intervention rolled out in the area of maternal and child health as the government did not favour pilots (Interview TNZ11). Respondents attributed this to pilot fatigue and a commitment to universalism across the country by the government of Tanzania. However, external funders wanted to pilot the project first. It was also reported that negotiations between the government, the World Bank, CHAI, and Norway meant that this ended up being channelled into a parallel programme, as one interviewee explained:

*The original model of P4P was meant to be built on a joint basket with money from Norway. However, the World Bank demanded that P4P funds could not be from a joint basket and thus forced a parallel funding mechanism to be designed (Interview TNZ2).*

After on-off discussions and something of a stalemate, CHAI brokered a partnership with the government for a pilot to take place in Pwani region, which it is now overseeing. This pilot was only meant to be short term before a country-wide scale up; however, there were delays in this happening. There is frustration with some consultants to the MoHSW that this is not really being taken seriously (Interview TNZ1). This is perhaps an unfair classification of those directly involved in the project who show commitment to making it a success. However, in practice they are running in parallel to existing operations in the MoHSW; with the only people really aware of their activities being those working on mother and child health at the national level. The pilot was not flagged at the Annual Health Sector Review in any real depth, and some respondents implied that this was just another external funder fad. Clearly, this explanation contradicts the supposition that PBF is an example of South-South participation and learning; the design and conception of PBF is actually far more politically complex. This history has led to many different interpretations of where PBF originated. For example, people working in the health sector in Tanzania noted:

*I'm not sure but definitely it did not originate in this country, but literature tells us it has been piloted in many countries. I've not searched very much the literature but I think we saw here about 4/5 years ago and then we started researching and reading literature and we saw that it is actually working in different places and there are different experiences. (Interview TNZ5)*

*The same group of partnership with the technical working groups in SWAp, brainstorming, before that we need to see that something must be happening, some are not performing well, others are excellent, we have to initiate a mechanism to make sure that these people are coming up so that is why let us try this and this is in relation to target and purpose...I'm aware Rwanda are doing the same but there is no harm if we can learn from others. I cannot say if we took it from Rwanda but I remember from the scratch I was involved in it and I feel something, if it gives good results we may have to roll it out (Interview TNZ7)*

*Actually the idea of PBF comes from partners and the MOH (Interview TNZ10).*

The South-South reading of PBF 'take-up' is further questioned when placed in the context of the current national rollout of P4P in Tanzania. In particular, there is concern that the Tanzanian government is pursuing this rollout without properly

debating and examining the evidence behind the claims of P4P success. As one member of the P4P evaluation team argued:

*We found evidence of non-PBF success, yet the Ministry did not want to hear this because it would affect future funding from the World Bank for national rollout. In the government report on P4P, World Bank methodology was used and never questioned. Even though there is evidence to suggest problems with P4P, the government is acting counter to this evidence (Interview TNZ2).*

As a result, one argument is that the Norwegians, the World Bank and USAID are overly enthusiastic for a P4P national rollout and that the government is too keen to get this additional funding. The concern is that pressures to accept funding may seriously run contrary to the sustainability needs of the national health system and as a consequence points to the influencing role of funding institutions in shaping PBF policy. In particular, Tanzania's health budget already relies on external funding for nearly 50% of its overall health budget. The sustainability concern is exacerbated by the fact that this loan will underwrite an unproven programme that has not been properly debated.

Furthermore, the influence of external funders is witnessed in the current discussions on the terms of the P4P national rollout loan. This is because, at the moment, the negotiations for this rollout are taking place only between the Ministry of Health, the P4P Task Team, the World Bank and USAID (who might add some funds). It is not clear where that money will be going or how the rollout will be effectively phased in nationally for that amount. As a contributor to an independent P4P report argued:

*The Tanzanians are using weak negotiators that were picked by the Ministry, but that are not the right people. They know little about the facts of P4P and have little experience dealing with the likes of USAID, World Bank and others. I am trying to present my findings to this body, but I have only been able to discuss this as a possibility with the Ministry (Interview TNZ2).*

### **Zambia**

There appears to be a similarly complex history to PBF in Zambia. During interviews, there was some suggestion that PBF had been developed in Zambia in the mid-1990s as part of a health system reform. This health system reform was generated by a change in government in 1991 and led to the establishment of now defunct health boards. According to one Zambian expert on health system financing, health boards piloted PBF and thus it was believed that Zambia was in fact one of the first countries in Africa to trial it (Interview ZAM3).

While there is evidence of local government officials (and also mission facilities) piloting incentive systems in relation to maternal health services in the eastern province district of Katete (see MoH 2011), the system in place had a considerable focus on local 'demand'; involving, for example, the provision of mama kits to new mothers at delivery centres (napkins, pins, soap, Vaseline), gifts to traditional birth attendants for each set of five pregnant women delivering at the health facility and food for antenatal clients. There was also, however, a 'supply' side payment of US\$285 for the best performing health centre (MoH 2011). There is little information about the history of this initial initiative. The subsequent development of the World Bank-funded pilot appears to have been influenced by the new availability of external funding. When asked in more detail, a senior government official involved in the World Bank-financed Zambia pilot admitted that such projects come about when someone in Washington has an idea and offers the country money to implement it – countries want the financial resources and so they choose to do the project:

*You know, you know how the World Bank is. Someone comes up with a concept paper, pushes it on the country. They push. They ask if you want the money, you want the money, so you do the project (Interview ZAM2).*

This view was supported by another government official who had an association with the Zambian pilot:

*I think it was, you know when they propose that there is this project, so then we applied for that project as a government. So there was, we were informed by the World Bank there is the project, would you be interested? So we said yes we would and we applied for it and we started from there (Interview ZAM8).*

The overall picture from Zambia is that while the idea of implementing health sector reform based on results and performance is not new, the method currently being developed for this is new. The origins of this new method are being driven by the World Bank and the Global Fund with regard to both Type 1 and Type 2 PBF. Government officials associated with the World Bank project are keen to assert the Zambian ownership of the project; however, they were also resistant to any general questions about how the programme was designed and how indicators were identified. Only those officials no longer working with the Bank or the Ministry of Health were open to sharing information; they clearly indicated that the project was led and designed by the World Bank and that the enthusiasm for the project was on account of the money being made available to the ministry. PBF may have previously existed in Zambia but not in its current incarnation.

### **3.5 Positive perceptions about PBF: Influencing evidence and agenda setting?**

This refers to SQ2.

There is a governance bias towards the reproduction of a popular perception of PBF. The World Bank and Global Fund have a key role in driving (or attempting to drive) forward PBF interventions within African health systems. External funders have invested significant volumes of money in generating knowledge about health sector-oriented PBF. A key example of this (and one that was frequently referred to across interviewees) is the HRITF; a multi-donor fund created by the World Bank in 2007, with funding from Norway and the UK, to support the development of health-related PBF (see HRITF, 2013). The HRITF not only provides country pilot grants to support the design, implementation and evaluation of PBF programmes (such as the project underway in Zambia), but also provides financing for knowledge and learning. Reflecting a positive stance towards PBF, a key purpose of the Fund is to build the evidence base on health sector PBF initiatives, or rather (as will be demonstrated below) to build the evidence base for scaling up PBF. As one interviewee remarked:

*... part of what the Bank is trying to do as part of the trust fund, [is] to build the evidence for this... I think this multi-donor Trust Fund is a really important institutional mechanism, a really important learning opportunity for the world (Interview WAS2).*

As part of this institutional structure, the World Bank regularly publishes and circulates around the world a series of RBF bulletins that reassert the promotion of PBF.

The South-South learning mentioned above was actually facilitated to a considerable extent by HRITF by paying for the study workshops and study tours. This was not only evident from discussions with the World Bank, but also from the country-level interviews that noted:

*Yeah we went and we reached the office and later in the field to see how it happens, to several districts, so we went to several hospitals and health facilities, health centres, to see what is happening there, so we saw what is happening and they told us the management of health facilities that things are working well, and we have seen from the data, there is agreement on PBF there (Interview TNZ10).*

*Yeah I think there were some studies, some tours, some study tours undertaken to Zimbabwe. Zimbabwe is already doing something in that line, they undertook a study tour to Uganda and they also went elsewhere and they said 'eh you have seen these models working in other countries so let's see how to communicate' (Interview ZAM5).*

In other words then, it is external funders who are facilitating cross-country participation in relation to PBF and thus, in some respects, the 'selling' of the idea of PBF to African states through knowledge exchanges and the offer of health-sector financing. The idea about generating evidence and support **for** PBF in African states was reflected in an underlying discourse around PBF, particularly across USAID and the World Bank, on the market for PBF; the implication being that PBF is presented (through technical assistance, informal discussion and study tours) as a useful product to recipient countries, and something that would deliver a return to those who invest in taking it forward (i.e. external funders and governments).

All this seemed to manifest in interviews in an implicit, yet overarching, **positive** stance towards PBF. While external funders who were interviewed were certainly keen to indicate that more evidence was needed about PBF – a view generally shared by literature on the area as indicated in Section 1.3 – the collection of more evidence seemed to be presented as a simple precursor to the future scaling up and further rolling out of this approach, rather than part of a process through which PBF will be critically reflected upon and a possible decision made not to proceed with the approach. This positive stance is reflected in the underlined sections of the following quotes:

*I think everybody has been very careful to say we think it is a positive model, it brings results, so maybe it's right, but let's collect even more evidence before we scale up to other countries. I think that's going to be a very rich result from impact evaluation (Interview WAS4).*

*I don't think we are yet at the stage where we should go with ideas to our partner in Tanzania and say oh government of Tanzania this should be your policy (the implication being that this would happen in the future) (Interview WAS4).*

Of concern, this positive stance towards PBF, which seems to be institutionally embedded within the World Bank and within the operational framework of the Global Fund, risks closing down opportunities to develop other (and potentially more innovative) mechanisms for delivering funding or reforming health system governance - such as other potentially innovative ways to supervise or motivate health workers (like diagonal funding approaches or co-operative ownership schemes). In short, funding to pilot or developing other interventions or the intellectual space to conceive of them is closed down because of this positive stance towards PBF. As one WHO representative stated:

*These sorts of [PBF] programmes are very popular and their effectiveness is often assumed. I don't think there is a great deal of argument taking place about the risks of these types of funding mechanisms... on the whole donors and consultants are in favour of target-driven financing and they have successfully entrenched this as the primary mode of operation (Interview GEN3).*

In general, most of the country-level respondents in Zambia, Tanzania and South Africa also shared a positive view about PBF – or at least about the **theory** of PBF and in principle the work of the World Bank and Global Fund. For example, some respondents thought it was an important and much-needed health system intervention to reform how government works in Zambia, South Africa and Tanzania (this was echoed by external funders, NGOs and most government officials in these countries) and that PBF projects had begun to show results. In Tanzania and Zambia, maternal health had long been a neglected area of health care and thus it was great that there was a potential for outcomes to be met through the pilot projects of CHAI and the World Bank. It was believed that ‘in theory’ PBF would help monitor where money goes, improve monitoring and evaluation systems, and thus limit the misappropriation of funds. Government officials working in HIV/AIDS councils were also positive, but were worried about funds being deflected away from the disease as a result.

According to one CEO of a large multinational NGO operating in South Africa:  
*Performance- based funding forces NGOs and other bodies to keep better records and to create better monitoring and evaluation systems. As a result, this increases transparency and accountability on the part of recipients. Performance-based funding, and PEPFAR in particular, has tightened up the system by cutting poor performers and rechanneling money to NGOs or governmental bodies that provide better results* (Interview SA14).

Another NGO suggested:  
*Funders have targets too and must spend money wisely. PBF provides a useful tool to determine funding and creates a good mechanism to match funds with output* (Interview SA12).

A positive view of PBF came from a senior official in the South African Treasury who stated that he had a strong commitment to PBF and that he has been actively designing frameworks for inserting PBF models into the health and development system nationally. He was keen to see more PBF modelling because it increases accountability, monitoring and efficiencies. He further stated that he is eager to use PBF in hospitals and was currently working with individuals from the Oxford Policy Institute and various health consultants to design a Type I PBF model for health professionals. As he suggested, “South Africa needs to come into line with the rest of the world and utilise PBF modelling” (Interview SA3).

In addition, as a senior advisor to the South African Ministry of Health argued, there is a strong push to add PBF into the National Health Insurance programme and to use PBF modelling to strengthen the system and to better manage target realisation. As he suggested, things “are moving in the right direction and for once the government is taking health reform and PBF seriously” (Interview SA8).

Tanzanian respondents were keen to emphasise the transparency in PBF:  
*Yeah it shines a light and everybody is responsible, you just remember there is responsibility in the health system. There are a lot of health system problems, a lot of them. I don't know because when we were starting this thing we were thinking maybe we have to strengthen our health systems and we have to see how all the facilities have basic equipment and everything but they said no, this is not our duty, our duty is just the health systems. So that is that issue, but for Zimbabwe they did request, they did something for the health system. Yeah.* (Interview TNZ6).

*I think it is a very good thing. It will make people to be responsible, that is the thing I see.* (Interview TNZ8).



In Zambia, the autonomy and motivation associated with PBF were positive attributes:

*If they get the performance they have the autonomy to decide who to pay, what is working, what is not working, no-one from outside the institution, those themselves can check themselves out, they will check each other out to ensure it is fairly distributed (Interview ZAM6).*

These positive attributes should not be downplayed. In many respects PBF is sold as a panacea for problems of tracing where the money goes, stimulating progress, and rooting out incidents of government bottlenecks and corrupt practices. This is a powerful sell as these issues cause common frustrations among civil society organisations and external funders. It also allows sectors of health ministries to present themselves as dynamic in invoking alternative forms of project implementation: the problem being that such alternatives lead to parallel systems and silos of money and influence within a government structure.

### **3.6 Politics of participation in practice**

This refers to SQ3, SQ4, SQ5.

Evidence from national case studies and global level interviews illustrates that there are many formal and informal mechanisms for participation between government, external funders, international agencies, private agencies and civil society organisations at different levels of health system governance and in relation to PBF more specifically. As will become clear, however, the issue here is not whether participation occurs, but **how** it proceeds, **who** is involved, and thus the overall **quality** of participation involving African actors and the extent to which participation can be considered as a **partnership**. This section explores the politics of participation by first outlining the formal and informal spaces for participation at global and national levels, before exploring issues of how participation and partnership are used as tick-box activities, policy procrastination and as a means of supplementing public sector incomes.

#### ***Global formal and informal spaces for participation***

At the global level, informal interaction with and between leading development agencies was 'the' key mechanism to participate in, influence and shift the global health policy agenda, including the development of new strategic policy ideas such as the use of PBF. Formal networks were less evident in the World Bank in Washington, D.C., or the Global Fund in Geneva. These institutions preferred to engage formally with in-country partners at the national level through mechanisms associated with a particular project and delegations from headquarters going on field visits. Despite a lack of formal channels of communication at headquarter level, those working in the World Bank were keen to stress their openness to informal means of communication: the general notion was in-country partners, i.e. government partners, could contact project managers and co-ordinators at any point via email or telephone if necessary (Interview WAS3).

Some global level interviewees suggested that informal networking is particularly important in relation to PBF given the few formal channels for discussions on PBF to take place (Interview GEN3). This is because external funding modalities and performance targets tend to be negotiated at national level and on a bilateral basis - between those receiving and those providing the funding. This bilateral process does not allow for much diplomacy in discussions in formal global health policy spaces or for much regional involvement. Opportunities do exist for African delegates to the UN or African WHO representatives to discuss informally such issues, for example. Generally, however, the formal spaces that exist to discuss global health policy centre on broader health policy areas, themes or issues (e.g. maternal health, child health, undernutrition) rather than specific funding

modalities (Interview GEN6; Interview GEN5). Nevertheless, one interviewee did indicate the usefulness of informal conversations for altering perceptions regarding the types of interventions that should be pursued via PBF. As one interviewee commented:

*Geneva is a small place and we all know each other. We often chat about what's working and what's not, what needs more attention and what's getting too much. These chats filter into WHO policy and these policies affect the operations of the Global Fund and World Bank. (Interview GEN3).*

Another senior African representative at the WHO suggested:

*There is not much scope for discussing funding modalities ... I mean it does come up, but more in terms of the system needing targeted aid, and more of it. We largely discuss policy in terms of priorities, strategy and practice, not on the details of aid delivery. (Interview GEN5).*

This situation was not necessarily seen to be desirable at the global level, particularly since aid funding provided through PBF tends to shape the wider process for governing funding and budgets within African health systems. As a result, a number of interviewees expressed some level of frustration that PBF was not being, what they called, “properly” or “fully debated” within the WHO (Interview GEN5; Interview GEN6).

Of course, an issue here is how a more informal and/or more generally participatory process could be fostered. Improved staffing, a broader mandate and more power (less need for formal permissions to communicate) were suggested to improve the functioning of the African Commissions. This might help move towards equitable partnership in discussions, not only about PBF, but also wider health policy issues (Interview GEN3; Interview GEN5). At present, it was felt that there was not much co-ordination in pursuing an African agenda at the WHO in terms of agenda setting and policy direction. As one interviewee indicated, African diplomats “come to the table too late” and have to operate within “an agenda that is already set”. The key “is for us to better set the agenda so as to get our needs better addressed” (Interview GEN3). Regional platforms were seen as a potential space for participation. However, these were underused in global decision-making forums such as WHO (Interview GEN5). At the same time, it was generally felt that the WHO lacks ‘punch’ and is not effective in taking a lead in global policy. As one interviewee stated, “the G8 can set policy faster and more effectively than the WHO” (Interview GEN5).

An important way forward is in African agency shaping policy of global actors such as the World Bank (including policy relating to PBF), then accessing and/or becoming part of informal networks. It is less clear *how* these networks can be accessed, and it is evident that much engagement occurs through those who are known to the institutions or those who know whom to engage within the institutions. Interviewees put forward that working in a more co-ordinated way across the African region was a potentially important mechanism: an effective means of African agency in institutions such as the World Trade Organisation (Lee, 2012:34-48). Regional co-operation could generate greater leverage in decision making and provide a source of information for those operating on the outside of the Geneva-Washington spectrum. However, such regional co-operation would depend on commonly defined interests and less competition for health financing available from these institutions.

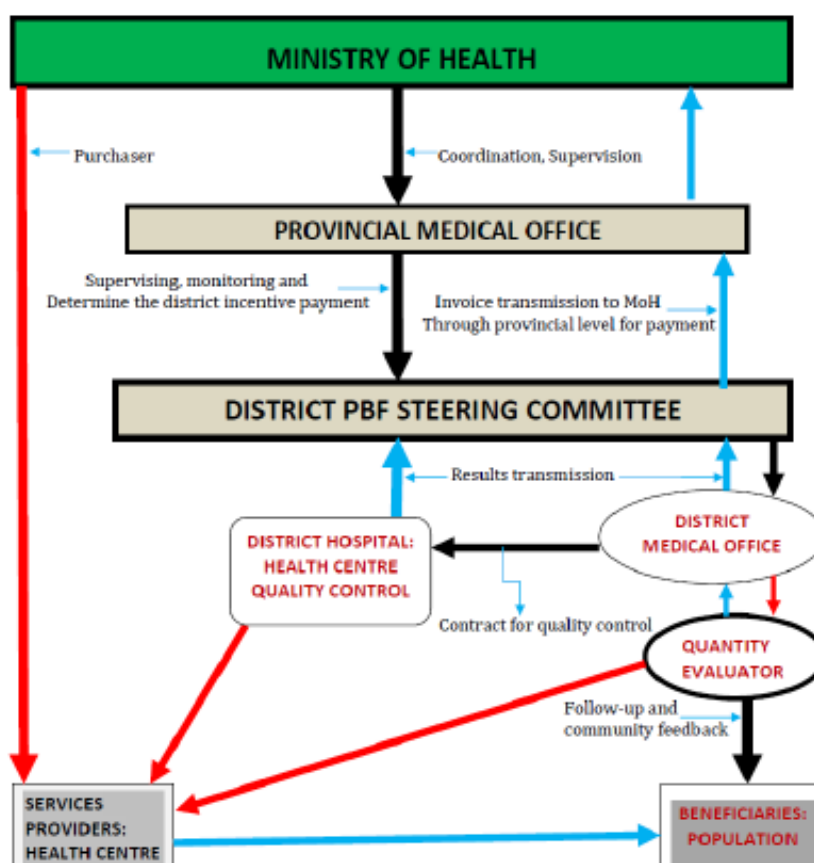
### ***National formal and informal spaces for participation***

At the national level a range of formal and informal spaces exist for African actors to participate in various PBF programmes. Technical working groups, review meetings, subcommittees and formal networks all exist within the formal system

of health governance in the three case study countries. These report and feed back to each other and provide institutionalised spaces for African actors – government ministers, civil servants, civil society organisations, development partners, and the private sector – to engage with one another and with local aid agencies. Development Partners’ Forums in each of the three countries provide a co-ordinating space for partnership among international funders that exist separately, but is supposed to feed into government decision-making processes.

In relation to the P4P project in Tanzania, the Ministry of Health has endorsed the P4P approach through the Health Sector Strategic Plan. This means that elements of P4P are approached and discussed within the day-to-day and institutionalised spaces that exist within the health system as part of the countries Sector-Wide Approach (or SWAp). At the same time, new project management bodies have also been set up to oversee the delivery of P4P. For example, advisory and steering committees have been established to offer strategic direction and a management team oversees operations and meets regularly. National and regional verification committees verify district and facility reports respectively (Borghi et al., 2013). In Zambia, formal mechanisms follow a similar referral process as demonstrated in *Figure 3*.

**Figure 3: Formal spaces for involvement in the Zambia PBF pilot**



Source: MoH, 2011.

Such formal mechanisms of engagement build on previous sector-wide or SWAp approaches to health governance. Hence, participation and partnership in PBF are based on pre-existing models in-country developed over the last 20 years.

There is a distinction between who talks and who listens in the formal spaces for participation set out above. In some cases, a divide exists between external funders and the government. Even though some external funding agencies are acutely aware of the need to let the government lead and participate as partners

(as stipulated in, for example, the Paris Declaration), in Tanzania and Zambia government officials preferred to co-lead or let external funders 'do the talking' at times. This was evident in the observation of annual programme reviews where external funders were keen for government to chair and lead break-out discussions and plenary debates. However, in practice, in Tanzania government representatives would wait to see how the development partners would articulate a specific issue before speaking: the government chair would first thank the external funders for supporting operations and then pause to let the development partners fill the silence and steer the discussion.

Many interviews with African delegates in Geneva suggested that economic conditions mattered and that a need for external funding created more structural dependence and thus limited the negotiating ability of some governments. Hence, the initial silence in formal spaces for participation. These interviews also suggested that African actors will purposely tailor their grants and proposals to mirror what they think funders want to hear and that this could obscure or hinder some national health objectives. For many then, the idea of participation came down to the financial relationship of one who pays and one who doesn't and thus that partnership is structured on this basis. The level of inequality within partnerships seemed to depend on the economic strength of the recipient country. In South Africa there seemed to be a greater ability and publicly stated confidence to push back against Global Fund demands than in Tanzania and Zambia. As a top official of the South African National AIDS Council stated:

*South Africa is unique in that we are not fully dependent, we could make do without them, this is not the same for a country say like Lesotho, where they need the economic support and as a result have limited power to alter the relationship (Interview SA1).*

In addition to formal spaces for participation, a range of informal mechanisms exist for interaction that offer opportunities to shape knowledge and perceptions about the way PBF can and should work, about who is involved in PBF processes nationally and about how targets are set, appraised, implemented and monitored (see below for more details). Examples of informal opportunities for interaction include: lunch meetings, phone calls, text messages, children attending the same schools, and personal friendships. Anyone 'in the loop' generally has the mobile phone numbers of a range of important stakeholders and can call upon these people when they need to, without appointment. In all three case studies (and at local through to global levels), informal networks of partnership were highly effective in shaping who participates and in making progress on issues. This risk here, however, is that informality creates an in/out culture between those in the loop and those who are not. These informal processes can generate ill feeling, particularly among civil society groups who feel a sense of being locked out of certain networks. At the national level, international funding partners have attempted to address this type of general situation by creating umbrella groups to represent certain sectors. Many civil society groups, however, seem to prefer direct relationships with their funding and implementing partners.

In relation to the Global Fund's system of PBF in particular, informal connections tend to have a significant effect in determining who is able to access Global Fund funding, with selection of recipients of funding shaped by political affiliation or political views. This has been apparent in relation to Global Fund processes in both Zambia and Tanzania, and was also perceived to be an issue in South Africa in the past, although mostly pre-2008/2009. For example, in South Africa SANAC was mentioned as having had favourite NGOs that were not always the most efficient or successful, with some NGOs being pushed out because they were not in line with government/minister's political views. Although multisectoral

participation within SANAC and the South African CCM was widely believed to have improved since 2009, concerns remain about the level of civil society inclusion and inclusion more broadly. As a top official at SANAC stated:

*Civil society groups are not as integrated as they should be... and finding legitimate CSOs is not always easy and there is a great deal of 'political wrangling' between various CSOs looking for access... [rebuilding partnerships] will not happen overnight and that future efforts to bring CSOs into SANAC will be made... at the moment there are more pressing concerns to get the CCM working again and focus needs to remain on this immediate concern (Interview SA1).*

Interviewees in all case study countries deemed important the inclusion of a wide range of actors and that there were examples of positive progress to broaden the basis for participation in health. Invariably, however, participation at the national level is shaped by many factors, including: local histories of engagement, pre-relationships on the ground and political events that occur outside the health system. In South Africa, almost all interviewees confirmed that the level of partnership at the national level in relation to the Global Fund had increased since SANAC was reformed and that this signalled an important step toward greater partnership between internal and external entities. As someone from the Clinton Foundation remarked:

*CCM meetings now allow for knowledge transfer (although with political sensitivity), a knowledge of who is working on what (NGOs, CSOs, Dept. of Health, SANAC, etc.) and there is a generally positive attitude between participants (Interview SA13).*

Almost all interviewees in South Africa argued for more input and evaluation from "independent civil society organisations" who can validate claims and who can let officials know "how things are going on the ground." In addition, nearly all interviewees said that strong CSOs "can increase pressure for transparency" and can "hold public officials to account in ways that formal PBF mechanisms cannot do alone" (Interview SA8).

Interestingly, in the South African case study more broadly, more effective opportunities for formal participation were believed to have existed since 2009. This has reinforced the perception of PBF as the dominant funding model in several ways. This ideational position remained present throughout the interviews despite deep scepticism about how PBF targets are designed, evaluated and balanced in relation to the needs of the national health system and the accounting demands of the Global Fund (see later below). The entrenchment of PBF as a legitimate management tool can be seen to have been furthered by the SAMoH move to bolster the co-ordinating role of SANAC and the creation of a Development Partners' Forum, which meets quarterly with all funders. These meetings are designed to avoid programme overlap and to make sure there is PBF target coherency between externally funded projects and internal national strategy plans. In conjunction with this forum, SANAC has invited NGOs, service providers and civil society organisations to be involved with all grant design. This not only helps to legitimate SANAC as the main co-ordinating CCM, but also in many ways allows PBF to retain its favoured position in relation to external funding. As a key service provider NGO claimed:

*SANAC is more multisectoral with 5 NGOs [all former Global Fund principle recipients] on the panel who are involved in the joint grant. Partners can bring their own grant ideas and deliberation between partners is very good and open. I think the relationship between NGOs and SANAC has improved, although we remain cautious about NGO's moving from service providers to*

*technical assistants, since no one knows what this means yet* (Interview SA12).

In terms of the overall participation of African actors, the Global Fund personnel suggested that there is good communication flows between the Technical Review Panel, the Global Fund Secretariat and the applicants. Although it is often the case that the TRP requests further clarifying information, or in drastic cases, suggests that reworking the application – the Global Fund interviewees insisted that all communication is in written form and records are kept for legal reasons. As one Global Fund respondent stated, “the substance of the grant is ‘nationally owned’ and the CCMs are not influenced by what they think the Global Fund wants to hear” (Interview GEN1).

### ***Per diems and paying for participation***

In addition to the inside/outside dynamics of participation that such informality brings, partnership and participation are also dependent on financial incentives and a per diem culture that is exacerbated by the incentive culture that PBF institutionalises. Per diems are a common feature of participation in Tanzania and the norm in Zambia. They can be paid for a variety of participatory processes such as attendance at meetings, attendance at a workshop, or a community visit. The amount of per diem depends on the location of the meeting, workshop or visit, the issue (e.g. AIDS pays more than TB), sector (i.e. health is seen to pay higher per diems because of the amount of actors and initiatives involved in the health sector at the moment) and the type of actor, (e.g. more if you are a government civil servant rather than a civil society worker). They are paid by the government ministry or by external funders. The general literature on per diems suggests several consequences of a per diem culture for the politics of participation. First, it creates an incentive towards meetings as a means of supplementing an income and thus the number of meetings proliferates. Second, work that does not receive an extra per diem, e.g. drafting strategy, filing reports, general administration, becomes secondary to that which is rewarded with money. Third, it can lead to those meetings where a per diem is not paid being ill-attended. Fourth, it creates an artificial market within the public sector where issues popular with the development community, e.g. health or MDG-related priorities, create a pay bubble separate to the banded pay scales of the civil service in these countries. Fifth, per diems create animosity between government, civil society and the public at large who resent government actors getting fat off the government and development aid. Per diems associated with PBF fit in many ways with Bayart’s depiction of the ‘politics of the belly’ in which *“the apparatus of the State is in itself a slice of the ‘national cake’ so that any actor worthy of the name tries to get a good mouthful. This partly explains the apparently excessive value attached south of the Sahara to the creation of new administrative structures: offices and public works... These institutions are in themselves providers of riches and wealth”* (Bayart, 2012: 90).

As was related in a number of interviews, as well as during the review workshop in South Africa, PBF incentive structures feed into the wider problem of the per diem allowances culture in the health sector, particularly in Tanzania and Zambia. PBF adds to a problem of financing, dictating health policy priorities because of the money it brings not only to clinical staff but staff working in health and associated ministries. New policies or ideas that are to be implemented generate extra meetings, workshops, and study tours, all of which are accompanied by payment as per diems or allowances for those who attend. As a result officials may not attend a different non-PBF meeting for a particular health policy without a per diem, or choose to attend the health initiative with the bigger per diem, e.g. it is further away from their office therefore the payment is bigger, rather than another meeting that may be of concern. As was related by several interviewees, PBF as a new trend in health policy contributes to this culture by first paying for

people to attend PBF workshops, training, study tours, meetings and second by contributing to the norm that paying extra for people to do their work is an acceptable mechanism of health provision. Those working in health ministries in these countries are complicit within such a system and the idea of incentivising performance because of the extra income it brings to those in elite position. Distortion can be straightforward such as the prioritisation of work towards indicators that are attached to payment reward (i.e. maternal health over other health issues), to more long-term and currently unknown effects of distorting health professional pay scales and long-term sustainability. For example, the health systems in Zambia and Tanzania run on public pay scales, grading workers according to their role and level of expertise and/or seniority; additional funds or bonuses could have the effect of distorting such scaling and result in the need to reassess health worker pay across the sector, or result in dissatisfaction across sectors, depending on how the division of labour is organised.

For some of the interviewees, participation and partnership structures that PBF operates within and contributes to is indicative of there being 'too much participation' within national-level partnerships in Tanzania and Zambia. Not only does it contribute to this situation of being hungry for aid monies, but it also sets up a situation in which not everyone can attend all meetings, at all times. Often, decisions need to be made about prioritising meetings, who are met with and /or who are sent to step in. This process can cause confusion within the health system, and also resentment or frustration by others who set up or are in attendance at the meeting. It also contributes to a two-tier level of partnership. PBF adds to this broader situation as it brings with it additional requirements to meet and attend, as suggested above. On the other hand, the per diem culture can be seen as evidence of African agency by elites working in the health system: per diems are in many respects the one area of policy and practice in the health sector that external funders who wish to reform or change find it difficult to do. Per diems are evidence of health sector elites using their agency to (not) attend meetings to gain from the international aid system.

Interestingly, this type of situation seemed less apparent in South Africa, perhaps because the health system has more resources. There also appeared to be less indication that external funders attempted to explicitly dominate meetings with provincial and national recipients of Global Fund monies.

### **3.7 Politics of PBF in practice**

This refers to SQ3, SQ4, SQ5.

In addition to the findings generated around the issue of participation in PBF programmes in the three case study countries, the research revealed some broader points about PBF, relating to the evidence base of PBF initiatives, the creation of health silos, and the interlocutor role of consultants and brokers involved in the delivery of PBF projects. Perhaps most importantly the research revealed a main sticking point over participation in PBF: the setting and judging of targets associated with such programmes. The process here was far from straightforward and revealed a clear asymmetry and hierarchy in participation and a closed space for African agency, particularly in Tanzania and Zambia.

#### ***Questioning the evidence base***

Whilst the use of 'evidence' was recognised as a key aspect within policy processes at the global level, interviewees suggested that the way evidence was generated and interpreted was important in shaping its subsequent application and use in policy debates, agenda setting and policy formulation. There was some level of agreement that most external funders are open to discussion regarding best evidence and, therefore, that if evidence showed that PBF was not

working or was only useful in certain sectors, then it could be replaced. As one interviewee indicated:

*There is a debate taking place and it is a matter of knowing what works and doesn't work. People are swayed by the evidence, the problem is having reliable evidence (Interview GEN6).*

Questions about the way evidence is being generated and interpreted in relation to PBF include whether there are opportunities to generate alternative evidence bases or other ways to improve health system performance (i.e. improved supervision/HR arrangements). Interestingly, despite a formal commitment to 'hard' research evidence, interviews with World Bank staff revealed that evidence comes in many forms: (*Quote asked to be removed by the World Bank*).

There are clearly spaces for African actors to engage in the process of interpreting evidence and, indeed, many African actors are employees of leading agencies such as the World Bank, WHO and Global Fund. The process of using evidence and formulating new policies relied on informal linkages and networks within and between these agencies and African actors situated 'outside', within national institutions. As one World Bank staff member indicated:

*I mean take our health strategy for example. That was put together over a period of many months that had, yes, there were formal consultations around that, but it was just as much shaped by multiple interactions that happen at the country level, the global level etc, conversations that help to evolve the team's thinking. And then you have iterative feedback both with outside partners and staff within the Bank so it goes to a process where you have a document that is reviewed by the senior management of the Bank and approved and sent to the Board for endorsement but that is after much informal and iterative processes (Interview WAS1).*

Nevertheless, given the nature of formal and informal processes of participation outlined above, this iterative process is often defined by those who are paying for the project in collaboration with those who fit with their vision of PBF. The key actors involved in such iteration are thus World Bank staff, the government insiders that fit with the vision, and the international consultants who develop the evidence base. Sources of evidence critical of the operations are acknowledged but not fully considered when reviewing PBF programmes. The evidence base that is acknowledged is that which supports the efficacy of PBF and provides a basis for justifying the wider application of such a reform strategy.

### ***Health silos, burden and confusion***

A common concern about the application of PBF was the bureaucracy, burden and confusion it generated in the health sector. Part of the objective of PBF is to reduce such confusion and cut through bureaucracy; however, it was seen to create a parallel system with regard to reporting, monitoring and evaluating and the indicators used. Respondents in each of the three countries often depicted it as just another new health initiative. Government officials who were familiar with existing research on PBF were concerned that these processes of implementation were reflective, or symbolic, of PBF as simply 'yet another' reform to African health systems that seem to be in a state of constant evolution.

In all three case studies there was a particular concern that the vertical nature of PBF funding could compound the already existing level of fragmentation within the health systems, given the large volumes of funding that PBF schemes tend to attract (e.g. the Zambian project is nearly US\$17 million). As one African health representative in Geneva suggested, "PBF creates 'health silos' that are well funded, but not necessarily integrated into the overall health system" (Interview



GEN6). For some, PBF was feeding into a parallel health system in Zambia and Tanzania where the health systems are weak, and this extra initiative of finance towards wider initiatives can have the effect of distorting the wider health system (see also the discussion above about the incentive structures that PBF brings). In Zambia, the Ministry of Health has recently been split, resulting in the setting up of a new Ministry of Community/Women – it is currently unclear how this wider shift will impact on the PBF scheme in terms of its current implementation, or on the wider impacts it will have.

Distortion in a country such as South Africa is perhaps less noticeable due to the more advanced level of the health system and the organisation of workers in the system. The belief that PBF could lead to increased fragmentation was apparent in all interviews within South Africa. In particular, there was a widespread belief that the past failures of SANAC to capture Global Fund grants had led to provinces and NGOs designing and implementing their own Global Fund programmes without national co-ordination. In other words, having multiple principle recipients operating independent Global Fund grants within South Africa created various inequalities in health distribution among provinces and created areas of neglect in terms of overall health services available. It was because of this patchwork system of health delivery across South Africa, and a general belief that this was unsustainable long term, that most interviewees expressed their willingness to work with a revamped SANAC to design a more uniform National Health Strategy (NHS).

External funders often requested African actors to alter reporting systems, sometimes without sufficient warning or detailed explanation. The P4P project in Tanzania was accompanied right from the start by a programme of work to amend the HMIS, so as to ensure that it would support the P4P process. In addition, it was commonly related that reporting systems could be changed mid-project with little consideration of the ramp-up time needed. In the South African case, there was a general sense that the Global Fund might no longer be worth the administrative hassle. According to different high level officials:

*The Global Fund has become overly cumbersome in terms of paperwork and the Global Fund continues to change the conditional regulations, but not always with sufficient warning' (Interview SA2).*

*The Global Fund gave one week notice that we were to implement a new system and they were unable to schedule the needed technical assistance until after the forms were due' (Interview SA4).*

As with the similar concerns articulated above, the ability to change reporting systems without consultation was seen as undermining effective programme implementation and the notion of genuine partnership. As a member of UNAIDS suggested:

*The Global Fund changes frameworks without notice or consultation. This causes confusion at the national level. This also forces us [UNAIDS] to provide additional assistance to help governments/NGOs understand the changes and this can cause shortages in UNAIDS capacity to help (Interview SA7).*

In relation to the perception of over-burdensome monitoring systems, when asked about their sense of partnership and national ownership with the Global Fund, several interviews revealed that although most targets were 'owned' and negotiated through internal mechanisms, the Global Fund does force 'conditional compliances' that are not nationally owned. Thus, although most interviewees felt that the national government can set health targets, there was widespread agreement that there was almost no ability to set 'conditional targets' such as accounting mechanisms, CCM design, evaluation tools, etc. In addition, nearly all

recipients and non-recipients interviewed in South Africa (other than from the Global Fund) suggested that the Global Fund is inflexible in this regard and there is constant external pressure to change existing governance systems to meet exact Global Fund demands (sometimes reasonably or unreasonably). As a negative example, the Global Fund required certain procedures for archiving records, yet this went against national privacy protection laws. When asked about what this means in terms of agency and partnership, one director of health suggested “this makes us question how mutual the partnership is, since the Global Fund would not budge on this condition despite the fact that it would violate local laws” (Interview SA4).

In principle, communities are supposed to participate in the Zambia World Bank PBF pilot, monitoring and evaluation and verifying patient satisfaction performance data, for example. In reality, however, community participation appears to have been variable and shaped by pre-existing histories of local participation and the pre-existing quality of the interface between facilities and local communities (Interview ZAM9). Zambia has for some time had some form of community participation built into the health system, in the form of neighbourhood health committees. However, these were mostly supported by user fees. When user fees were removed at the primary care level with the removal of the Central Board of Health, the level of community participation within the health system was affected, with structures for participation ceasing to function in some areas. The level of oversight and involvement exerted by communities in the PBF pilot is therefore shaped by this history and the pre-existing structures that are available for participation. While there has been anticipation that PBF will bring enhanced community participation, some local level interviewees seemed to narrowly conceive participation as working with communities to encourage women to deliver within facilities, rather than their involvement and oversight of the performance judgement process (Interview ZAM9). There appears to be a similar situation in Tanzania. While community participation is built into P4P project documents, with a role in the verification process, there appears to be an absence of mechanisms and resources to ensure community involvement in verification processes and some evidence of variability across the different districts involved in the P4P process (Ifakara, 2013).

Another common theme across the three case studies was a general perception that Global Fund monitoring systems were not “sufficiently able to be tailored to local situations”. In all three studies this was often attributed to the fact that local monitoring and evaluation systems were underdeveloped, poor performing and/or non-existent. However, there was also a general perception that Global Fund monitoring conditions were overly draconian and, at times, hindered already existing local systems that had to incorporate the external reporting mechanisms. The level of frustration at cumbersome reporting conditionalities was sometimes expressed in terms of ‘economic colonisation’ and a belief that the conditions on performance monitoring can be overly restrictive, limit rollout of programmes, consume vast administrative resources and act on the “assumption that fraud and corruption must exist” (Interview SA6). According to one interviewee, “this is not partnership and although PBF is good, it can’t be rolled out exactly the same way everywhere and better distinctions of capacity and localised strengths and weaknesses need to be made... their behaviour reminds me of the conditions associated with structural adjustments in the 90s” (Interview SA6).

### ***Targets: gaming and moving the goal posts***

A key aspect of PBF is the process of setting targets and the way in which PBF contracts or agreements are negotiated and approved. There are issues here relating to who is involved in target setting, what spaces are provided for being involved in target setting, the level of local ownership in this process, how different actors participate and how certain forms of knowledge are privileged

within this process (specifically financial) and, related to this, how this privileged knowledge shapes agency.

A number of those interviewed across all case studies suggested that in the process of developing a contract, and setting targets and indicators within PBF schemes, assumptions had to be made about the implementing capacity that existed within the health system in different areas or districts, and that monitoring and evaluation systems were robust enough to fulfil PBF reporting requirements. Often, however, this was not the case. Many interviewees suggested that poor pre-existing monitoring and evaluation systems within each of the case study countries caused several interrelated problems with PBF design (and also with monitoring and evaluation). First, it was widely held that without reliable health estimates it is difficult to know the scope of the problem from which targets should be set against at the design stage. Second, without reliable information regarding existing health delivery, it was seen as almost impossible to know specifically what gaps in service delivery existed and what new targets would best complement existing infrastructure. Third, without knowledge of existing systems and their effectiveness it was difficult for different actors to participate in the design of PBF targets and indicators, as it was hard to estimate reliably what targets are achievable and what targets are unrealistic. Fourth, without effective monitoring systems it was impossible to adequately evaluate the success of targets. Fifth, there was no clear way of differentiating between externally funded programmes and internal programmes in order to measure from which streams target results were generated or realised.

In the Zambian case study, it was widely suggested in interviews that the World Bank had effectively steered many of the types of targets used within the PBF pilot programme. As one Zambian official claimed, “the World Bank had a number of key interventions that they wanted to see implemented and they were very firm in their demands” (Interview GEN3). In this case, many interviewees believed that the reason why the World Bank pushed the pilot in Zambia is because they required more test trials to support their PBF evidence agenda. In setting final targets, most interviewees related that the Zambian government was able to push its own agenda, but that “the World Bank certainly had its own ideas” and that these had to be incorporated into the final PBF agreement (Interview GEN3). It seems that while this process for developing the PBF pilot, including the targets and indicators by which the performance of facilities and staff would be judged, involved members of the central Ministry of Health, there were few opportunities for facility and district level staff to participate at this formative stage. In some cases, this appeared to have shaped the way the scheme was received at this more local level. As one staff member in a clinic commented: “When PBF was starting, it was a challenge because to some of the staff it seemed as if they were just testing the people on their capability to do the work, but for now this is when we have seen the results” (Interview ZAM4).

There has been a similar situation in Tanzania. The P4P model favoured by the World Bank and CHAI did not fully draw on HMIS indicators or pre-existing targets and data. The research outlined in this report shows that when it comes to partnership in indicator setting indicators are not lead by the government but by the funders or third party consultants contracted through aid funding. The following quotes offer some contrasting examples of this:

*...you have some of the indicators that do not appear in HMIS (Interview ZAM7).*

*P4P, the original plans and the original design and all of that had no involvement from CHAI whatsoever, it was designed by Ifakara Health Institute, it was you know it came out of the agreement between Tanzania and Norway partnership initiative and CHAI was nowhere on the map there. I think part of the reason*

*maybe from Norway's perspective that they did approve or seek out CHAI was the work CHAI had done on HMIS strengthening in Mtwara, in Lindi, and so because also pay for performance was intended to augment and support and use the existing HMIS and also validate HMIS data to the point that they could be paid on, you can't bring on a partner that doesn't know HMIS to do P4P the way that it is designed. You know you could do a totally different design that didn't require that level of expertise, but since there was that level of investment in HMIS, because CHAI had existing experience and was, I should say, the most successful so far as getting the results that were wanted using the existing system for HMIS, it was seen as a natural extension that P4P could leverage that experience (Interview TNZ3).*

This is somewhat different than in the case of South Africa, where interviewees suggested what appears to be a greater ability to push back on external demands during initial negotiations about external funding and about PBF agreements, targets and indicators more specifically. The reasoning for this ability to push back was linked to South Africa having a stronger economy and less externally reliant health system. There was a general feeling from South African recipients, however, that external funders involved in the Global Fund process did attempt to informally steer deliberations toward certain target areas or target outcomes in-line with particular donor interests. Several interviewees suggested that the Global Fund itself (i.e. in Geneva) would make strong hints in relation to the type of outputs that would be "more likely to be approved by the TRP" and to firmly suggest what sorts of target deliveries would be deemed successful. In its most cynical form, one national health representative who was present in Geneva went so far as to suggest "that PBF is not a partnership or representative of 'national ownership'". This interviewee suggested that PBF targets and mechanisms might be fairly negotiated in some cases, but that in southern Africa, and indeed elsewhere, that funders often dictated the terms of agreement, change policy at the last second, scratch out line items from the grant, and "expect the applicant to do as they are told" (Interview GEN4).

During the process of negotiating PBF agreements there was evidence of 'gaming' during participation, in particular in relation to the Global Fund - a feature also observed in other PBF research (Ireland et al, 2011, Kalk, 2011). For example, there appeared to be a tendency for governments and/or civil society to overinflate or underinflate PBF targets for political reasons so as to please their constituents or to secure their performance ranking. This was particularly reported as an issue in South Africa. It was generally reported that NGOs had a tendency to underinflate their targets to assure output success. As one CEO of a NGO suggested, the possibility of future funding is dictated by how well targets are achieved. Since NGOs often rely on this funding for their survival there is a tendency to be conservative with targets to make sure the NGO scores highly. The reported implication of this tendency is that the output capacity of the NGO could be higher, yet remains underutilised to maintain output target success. In relation to governmental targets, many South African interviewees suggested that government officials tend to want to overinflate targets in order to appease their constituents and to make it look like they "take health seriously and are doing something about it". The problem with this, as one medical professional within the Ministry of Health claimed, is that targets can be set by politicians with or without evidence to suggest that these targets are realistic or achievable.

In the case of South Africa, nearly all respondents suggested that PBF incentivised output over outcome during implementation of health service work within the health system, although the scope of the problem was not clear and there was little official evidence to corroborate this general belief. In addition, all suggestions of trade-offs by interviewees were made in relation to other departments or service NGOs. As a result, not one interviewee claimed that

trade-offs took place within their own organisation, preferring instead to point fingers elsewhere. One explanation for a lack of evidence concerning trade-offs and an unwillingness to admit outputs at the expense of overall quality of care and health outcome was that PBF systematises a culture of omitting information to make sure funding continues without investigation. Ireland et al., (2011) and Kalk (2011) also voice their concern that PBF leads to such gaming or false reporting within the health system. That said, several NGOs suggested that trade-offs are less likely to occur within the NGO sector, since their need to maintain reputation for future funding acted as a “check and balance” on NGO behaviour (Interview SA14). As one NGO director explained:

*[Organisation] doesn't see a reduction of quality in relation to reaching outputs, but I see potential for this to occur elsewhere. I think those who have established records are less likely to reduce quality, since poor quality would leak out and destroy its reputation and any further funding (Interview SA12).*

In general, however, this practice of omitting problems was believed to be the case not only with those who wished to maintain funding, but also with funders such as the Global Fund, who also wished to look as if they were fully meeting their targets for their own global donors. As one interviewee explained, “target obsession can lose touch with the concept of care and can become too mechanised... [yet it is the] best of the worst systems I can think of” (Interview SA9).

In terms of target setting within South African Global Fund grants, general consensus held that the CCMs (both national and provincial) were able to set their own targets. As a result, for the most part, South African CCM members and health officials believed that there was a good sense of national ownership and that the setting of targets was done mostly through internally driven mechanisms. In terms of how targets were set, in all cases the targets corresponded to the National Strategic Plan (NSP). According to one interviewee, who was a consultant for SANAC and working on implementing the NSP, new grant targets reflected about 90% South African self-targets and 10% international targets, which are dominated by the MDGs or UNAIDS 3 Zero programme (although South Africa added a fourth zero). National targets were largely being set by national figures generated from the newly formed Department of Monitoring and Evaluation (although there was widespread agreement that this data was often incomplete) or through other external sources (UNAIDS, etc.) and consultations. In designing the NSP, a large integration programme called the Programme of U-committee was fostered. This programme sought to link sectors, namely academics, the top nine NGOs and the private sector. At the national level this was deemed by a majority of interviewees to be an effective partnership and deliberative process. Furthermore, discussions about grant targets with external funders have been deliberated through the Development Partners Forum, noted above, which meets quarterly with all external funders and the South African CCM. As a result of these forums, the general consensus was that “there is now a good marriage between the national and global, and the global targets are always discussed and taken into account” (Interview SA15). In addition, many interviewees claimed that there were “lot's of discussions and feedback loops” in setting targets and that local and global actors were acting more like genuine partners than previously (Interview SA10).

This presentation of target setting through locally lead multisectoral partnership resonated with the official presentation of PBF processes offered by the Global Fund within the Geneva interviews. In those interviews, stress was placed on the need for national ownership and organisation of targets. When asked who sets the performance targets, all Global Fund respondents said that it was from the recipients themselves and that it is the mandate of the Global Fund to make sure

that all grants are nationally owned. When asked whether they thought there was pressure for CCMs to adopt certain language or targets to secure grants, a senior Global Fund manager claimed:

*I imagine that some of that must take place since we see the use of similar language between grants. But it is not clear where this language is coming from, whether they are looking at past successful grants for ideas or getting generally accepted norms from foundations, the WHO, USAID or health consultants (Interview GEN2).*

Yet, in all interviews the Global Fund made a concerted effort to stress that it does not *tell* recipients what targets to set. The stated rationale is that targets must be nationally set since “local knowledge is crucial for success”. That said, it was acknowledged that the Global Fund would suggest when particular grant line items are not fitting with the mandate of the Global Fund. Furthermore, it was also admitted that the Global Fund demands that certain monitoring procedures are used and maintained. As one fund manager suggested:

*If we feel that the performance of a grant cannot be properly monitored and held accountable, then we will let that be known... both before the grant is approved or during the contractual phase (Interview GEN8).*

The Global Fund interviews also highlighted the fact that the TRP would make recommendations in terms of whether targets are too ambitious or not ambitious enough. The key, according to one TRP member, was “for the grant to be viable, tackle greatest need, and be able to deliver on its promises” (Interview GEN1). In terms of the criteria used by the TRP for basing its assessments:

*The Global Fund's system of performance-based funding was developed to: 1) Link funding to the achievement of country-owned objectives and targets; 2) Ensure that money is spent on delivering services for people in need; 3) Provide incentives for grantees to focus on programmatic results and timely implementation; 4) Encourage learning to strengthen capacities and improve programme implementation; 5) Invest in measurement systems and promote the use of evidence for decision making; 6) Provide a tool for grant oversight and monitoring within countries and by the Global Fund Secretariat; 7) Free up committed resources from non-performing grants for re-allocation to programmes where results can be achieved (Interview GEN1).*

Another aspect of all PBF initiatives is the dynamics during implementation and the participation of those involved in delivering on targets and overseeing the programmatic outputs and outcomes. Once PBF project agreements or contracts are formalised/ signed, the interactions or institutional structures for managing this process often shift and implementation becomes an iterative process between partners. In some cases, new targets and indicators are requested during this phase by external funding bodies (through a negotiated process) that may be outside the HMIS systems. Given that this process is often through a mixture of formal and informal channels, it is often difficult to say ‘no’ overtly as these shifting goal posts occur as part of the everyday of funding partnerships.

One particular finding that cut across all case studies relates to targets that the World Bank and the Global Fund, for example, often changed or amended last minute or during the implementation phase. These alterations could take the form of line items being struck from a grant document just before implementation or could take the form of requests to add certain provisions to official documentation as the PBF projects were scaling up. For example, in South Africa, a former principle recipient argued that the Global Fund often “changed the goal posts and as a result lost the trust of many partners” (Interview SA11). In addition, several private sector actors suggested “the private sector dislikes uncertainty, especially

when investment is involved” and that the Global Fund’s continued last minute alterations were threatening future public/private partnerships (Interview SA11). The problem with such alterations was that they were seen as unidirectional, where the external funders could make requests as conditions changed, but that recipients were not able to amend project targets easily as new information or as conditions on the ground changed. As a result, many interviewees questioned the quality of partnership, suggesting that “although we are participating in discussions, the effectiveness of those discussions is often not equally distributed” (Interview SA6).

Monitoring, judgement and evaluation of performance are key aspects of PBF, and, in principle, are entry points for different actors to participate. In practice, they can also be a *closing* point, given that non-performance will result in exclusion from the process. Given that PBF tends to involve the changing of goal posts after contracts/project agreements have been signed, it is sometimes difficult for actors to understand what constitutes adequate performance. As a result, it can be difficult for some African actors to participate in ways expected during implementation of PBF as they are not fully aware of what they need to do. Judgements about performance may not be well understood by facility level staff, at least partly due to their lack of involvement in the process and lack of involvement or opportunity for deliberation about performance outcomes. As different health workers in clinics in Zambia commented:

*I think that the challenges I may point out in respect to working with partners mostly is communication breakdown. There are times that we are not fully informed, or having the latest guideline pertaining to the same programme, so there is that gap in as far as conducting the service* (Interview ZAM9).

*...I feel that the assessment tools are not good, for example on the partograph, you may be questioned once you just forget to put a mark and for that they score you a zero out of 65 points. Basically, I feel that this is a discouragement because there is a need to be advising me than scoring me zero* (Interview ZAM4).

During implementation of PBF schemes, there was a general acceptance that the need to meet projected targets brought with it trade-offs during implementation in terms of whether efforts should be directed towards reaching specific health targets at the expense of quality of care. Examples of this were highlighted in all case studies, which supports the work a number of other studies also highlighting this issue (Ireland et al., 2011; Langenbrunner and Liu, 2005). One specific example of this sort of trade-off was reported in Tanzania, where a clinic claimed 100% target satisfaction for prenatal visits and services rendered; but under closer inspection, it was deemed that those visits were shortened and did not deliver the full range of expected care to patients (Interview TNZ2; IFAKARA, 2013). Another example relates to an ARV programme for children in South Africa, in which a target of 100% was set. Although the target was reached, the quality of care was reported as poor and the level of professional staffing was “not of a high standard”. As stated during an interview, “many corners were cut” and over time there was a risk that these poor practices will become the norm, making it harder to alter in the future (Interview SA9). While output targets were effectively met, this was believed to be problematic given that quality of health service provision can affect overall health outcomes over a longer period of time. Indeed, a distinction should be drawn here between ‘outputs’ and ‘outcomes’, where outputs denote the realisation of specific PBF targets (as exactly specified in a contractual agreement) and longer-term health outcomes.

Recurring themes among all case studies were a general belief that PBF can only be successful with proper monitoring and evaluation systems in place and that current systems were often held to be ineffective in capturing the necessary data

required to successfully set and evaluate targets. In the case of South Africa, nearly all respondents claimed the health sector did not have proper systems in place and further lamented that not all service providers had complimentary systems, which fundamentally hampered data coherency. In relation to setting targets, a person in charge of national statistics claimed:

*The most problematic element, however, is that there is not enough good data collection mechanisms in which to confidently set targets to. The quality of data is very poor and almost non-existent and the main problem is related to denominator issues. No one seems to know what denominator to use and it is a matter of guessimating. There will always be better ways to guessimate... but if the information is limited, your guess will be [limited] too (Interview SA9).*

There is evidence of reporting errors, especially in the South African case. These reporting errors can be explained in three ways: 1) governments will either alter target evaluations or bury them to avoid looking bad; 2) NGOs or health professionals will alter target evaluations in order to maintain funding and/or to protect interests; 3) the capacity for accurate monitoring and evaluation is non-existent or inadequate resulting in poor reporting (in the majority of cases).

In South Africa, problems with monitoring and evaluating targets were confirmed by a University of Western Cape study. During this 2010 evaluation, researchers wanted to look at 18 pilot sites, but could only conduct a survey on 3 sites. This produced limited results that provided weak indicators for evaluation. It was not until later in 2010, when funded by the Clinton Foundation, CDC and UNICEF, that a more systematic evaluation could be done. This cost around R20 million and the aim was to track reporting on the MDGs as well as how data filtered into new targets. The study ultimately determined that there was “no effective monitoring system in place” (Interview SA9). As one key governmental director confirmed, “there are very poor information systems and this is a major concern that needs to be addressed. This affects reliability throughout the process, from design, implementation and evaluation” (Interview SA1).

One common finding across nearly all interviews was the belief that there was “zero flexibility when it comes to meeting targets” (Interview SA2). This condition was stated to exist broadly beyond the three case studies. To illustrate the difficulty of altering target indicators, one interviewee from USAID gave an example of Indonesia where a target was changed due to imperfect information that was incorporated into the grant, but that was later discovered to be extremely inaccurate. To change the target midway through the grant, both the WHO and UNAIDS had to formally sign a declaration stating that the information was wrong due to no fault of the Indonesian government and that new evidence was more reliable. As the interviewee suggested, “this took a very long time and effected the roll out of the programme” (Interview SA7).

The further lack of Global Fund flexibility in the face of external circumstances beyond the control of recipients was illustrated:

*There is no flexibility in regards to external circumstances. This is particular problematic in cases of extreme currency fluctuations where funds can be reduced by 20% within a quick period of time leaving principle recipients underfunded, yet responsible to deliver the same targets agreed to prior to the economy tanking (Interview SA7).*

As an explanation for why the Global Fund has remained overly rigid in terms of evaluating judgements, one former Global Fund employee proclaimed:

*The Global Fund has made a religion out of PBF, losing sight of its overall spirit. The Global Fund has basically attempted to make the process purely technical (gave example of drop-down menu on reporting website), but in doing so it loses*



*sight of the fact that PBF should be tailored-made for national health priorities and contextual conditions on the ground (Interview SA1).*

Another common theme across the three case studies related to a general understanding that the current Global Fund auditing system “was not fit for purpose.” During interviews several reasons for this were given. First, there was nearly unanimous belief that the local fund agent (LFA) system is broken and there is no level of partnership when it comes to evaluating grants. Respondents held this view because there are no feedback loops in the reporting process, no ability to see LFA reports, poor management letter summaries given by the LFA, and no ability to discuss questions regarding the reports written by recipients before submission. As a result, recipients had no way of knowing how to improve the reporting and evaluation systems. In addition, it was often suggested that the accounting system is not thorough enough since “the LFA does no field visits and often fails to hire health professions, resulting in “accounting mechanism that are overly accountant focused” (Interview SA5). As one former KPMG employee who worked in South Africa claimed:

*There was absolutely no dialogue between the recipient and the LFA. The reporting system is not transparent on the LFA side and it is not possible to see their reports. As a result, there is no feed-back loop from which to learn and alter future practices. Furthermore, the LFA is reluctant to provide support during the report write up phase. Each report takes about 1.5 months to assemble and there is no partnership in this process (Interview SA5).*

In terms of evaluation and monitoring, one of the biggest problems relates to attribution. Namely, it is often not clear exactly what policy intervention is doing what and what impact it is having. For example, many interviewees suggested that the Global Fund will often claim that a result is due to their funding, yet their funding is only part of the picture and the national government may have been the primary reason for success (or other initiatives). As one interviewee stated, “separating impacts is difficult and therefore it is difficult to know exactly who is reaching targets” (Interview SA9). As an advisor for UNAIDS remarked:

*It is hard to tell what targets are being reached by Global Fund support and what targets are related to national or other organisational activities. The Global Fund has traditionally funded ‘activities’ and not necessarily ‘impact’ in terms of overall health system strengthening. As a result, pinpointing what affects the Global Fund has is difficult to know and it is increasingly difficult to link system-wide improvements to particular Global Fund activities (Interview SA7).*

As another senior member of the Ministry of Health in South Africa claimed:

*What the Global Fund claims on their website in terms of impact is false. They cannot make distinctions between what their money is actually doing and what the system as a whole is doing. For example, in South Africa, the Global Fund is roughly responsible for 1-5% of ARV needs, yet they claim higher numbers based on national statistics, which reflect the system as a whole. As a result, the national results skew Global Fund results... this is a massive problem with the Global Fund and one that the Global Fund knows about but is unwilling to face (Interview SA1).*

When asked why the Global Fund would not wish to tackle this issue, the interviewee claimed that it “would not go down well with external funders and it would effectively hurt the Global Fund in terms of donor support” (Interview SA1).

### **Consultants and brokers**

PBF design and evaluation involved consultative activities around participation and arbitration between external funders and recipients. These arbitration

processes included the government bodies of the three case studies. They also often included consultants, predominantly international accountants, and national research teams, who acted as the brokers or interlocutors between external funder objectives and government implementation of such objectives.

In the case of South Africa, it was widely suggested that professional health consultants and consultants from external organisations such as the Clinton Foundation, KPMG, DFID and USAID had too much influence on how targets were selected and on how to best meet those targets in relation to the Global Fund. As a senior official in the Ministry of Health lamented, “these consultants come in and say this worked in Rwanda or Nigeria, yet they cannot always explain why this is suitable for South Africa” (Interview SA1). The presence of such consultants and third party mediators was similarly felt in Tanzania. Third party mediators can take the form of accountancy firms that manage the grants and assess whether key indicators or targets have been met (Global Fund PBF); national laws governing the contracts or memorandum of understanding that underpin the transferral of aid; or NGOs or private companies that work with external funders at the national level to manage smaller NGOs or a region of health centres. These third parties in many ways have the most direct impact on how financial partnerships operate in practice as they decide or arbitrate on what constitutes performance. For example, PWC as Tanzanian local fund agent has a core role in adjudicating and interpreting indicators for the Global Fund:

*It's a bit of a challenge and again it will depend on which indicator you are talking about. Some indicators are also the information from the head office, other indicators are from information from local government authorities and that is always a challenge, if there is a mismatch between what you see and what is reported and what is seen from local government authorities. It is a challenge. And I think the countries are working with us are seeing that, but that is a challenge that has been there, since, if you look at the previous reports, you will see that some of the indicators are really targets, simply because some of the regions have them in their report this time or some will be there, probably the reporting period is not relating to the period under review (Interview TNZ4).*

The problem, according to several interviewees, is that the consultants are usually extremely instrumental in the final decision, and although this can capture elements of partnership when exercised in concert with government, it can also be a way for government officials to abdicate responsibility or for consultants to promote certain policy choices where there is weak internal organisation. In the opinion of one past Global Fund recipient, “this looks more like ad hoc trouble shooting by local authorities than a systematic effort to develop a long-term health system that can rely on itself” (Interview SA10). In addition, once a grant was in place, it was also often suggested that the mechanisms used by the Global Fund to monitor and track performance required the continued use of external consultants, which reinforced PBF logics and the reliance of recipients upon external organisations. As one interviewee stated, “this reliance is due to the fact that Global Fund requirements and paperwork are too complex and constraining and that some recipients find it is easier to hire consultants than do it yourself” (Interview SA6). In some interviews, the accounting agents used by the Global Fund (in the South African case KPMG) were held to be “useless” and blamed for delays in funding rollouts because KPMG had to “run everything through its US office” (Interview SA6).

In addition to consultants, UNAIDS has carved out a specific role in brokering between external funders and the government. This has long been a central function of UNAIDS that has often positioned itself as an ‘honest broker’ intermediary in the governance of HIV/AIDS (Harman 2010); however, UNAIDS has extended its role considerably with regard to working with governments on

securing Global Fund money: 1) It works with national governments to write the grant proposal - this is usually technical support and data provision (if requested); 2) The global fund TRP will ask UNAIDS how feasible the grant is and filter this into the overall decision for grant approval; 3) UNAIDS may be contacted to give evidence regarding the effectiveness of target reach. In this way, UNAIDS brokers through all three stages. When asked if this creates conflicts of interest, UNAIDS interviewees said no, and insisted that UNAIDS acts objectively and that as long as this is perceived by all sides, then UNAIDS' reputation will be enhanced and policy effectiveness increased (Interview SA7).

As a result, there was significant evidence to suggest co-operation and participation between African recipients and external funders. Nevertheless, there was also evidence to suggest that the use of consultants who have a brokerage role could undermine a sense of authentic partnership (i.e. altered the quality of participation) and that this raised broader health policy issues in relation to national ownership, path dependency and long-term sustainability. A particular area where brokerage is questioned is with regard to that of mediation over discrepancy between targets being met or not.

The use of indicators and mediation generates a legal question as to what the consequence is when indicators are not met or are seen to be met by the implementing country but not the external funder. Most donor-recipient agreements include arbitration clauses; however, there is some confusion as to which law these clauses pertain to. The assumption is that such contracts fall under South African/Tanzanian/Zambian law; however, this may depend on the country and funder. The idea that the default law is not that of the country in which the programme is implemented suggests a legal asymmetry to partnership that has not been fully explored in existing research on partnership.

*Most of the arbitration clauses start by saying that if there is a difference we will try and amicably resolve, which is the situation I told you about before. If it fails we will try the arbitration law of the implementing country so in this case we follow the arbitration act here in Zambia. And the arbitration act says you appoint an arbitrator who is mutually acceptable to both parties...There are times when the donor has insisted that the applicable law, there is a clause on the applicable law, so the applicable law will be like the US but we have refused. We have refused in most cases in almost all cases to say that is not correct because we want the applicable law to be in the implementing country, where the implementation of the project takes place. In this case the project is taking place in Zambia and the applicable law should be the law in Zambia. And that clause is in all our contracts (Interview ZAM1).*

In the case of South Africa, a lack of clear arbitration procedures appears to be exacerbating tensions between partners and may distort or negatively affect PBF. For example, the Ecumenical Foundation of South Africa (EFSA) was audited through a diagnostic report conducted by the Global Fund Inspector General. The LFA was brought in for support. In the end, the grant was suspended due to the report. In the end, however, the report was found to be incorrect and the LFA did not verify the Inspector General's account. This process cost one year of legal battles and no funds for seven months. As was suggested within the documentation, there was no independent verification of the report, little communication during investigation and following the legal proceedings, no feedback in the evaluation process, and the legal battle cost considerable time and money. Such an incident and the confusion over the legal basis for much of the PBF agreements show how the legal basis of African agency can come into question through such funding models.

### 3.8 Summary of key findings

Table 4 summarises the central findings of the research within the sub-questions:

**Table 4: Key findings in relation to research sub-questions**

Research sub-question	Key findings
(1) How has the idea of PBF emerged as a key idea in the reform of global health governance and development?	Idea gained prominence on the back of a participation and ownership agenda World Bank and network of actors pushing PBF has been central. Funding committed to 'selling' the idea globally – HRTIF key to this currently Participation has been key to spreading the idea within African states. This participation has, to some extent, been sponsored by external funders through paying for study tours of PBF sites in countries like Rwanda
(2) How do different actors understand and know about PBF and how do these understandings shape participation in the design, implementation and delivery of PBF?	Clear commitment to PBF at all levels based on positive understandings of PBF (and limited evidence of actual effectiveness) Positive understandings have shaped the way evidence is being generated and interpreted and way PBF is being implemented – it is seen as an initiative to 'roll out' and 'scale-up' There are questions about the spaces available for critical engagement at all levels of health governance (global to local)
(3) How have actors at country and regional levels participated in PBF processes in the World Bank and Global Fund? To what extent can east and southern African actors nationally and regionally extend their agency within these participatory spaces?	At the global level, there are limited formal structures – in the Global Fund/World Bank – for participation Informal interactions are very important in terms of shaping perceptions and views, interpreting evidence, prioritising and challenging views Funders are well organised with a tendency to want to 'lead' deliberations (agenda setting/target preferences) At the national level, there are relatively clear structures and procedures for dialogue with World Bank and Global Fund. Actors are clear about where and how they can participate. There is evidence that governments are articulating their needs and wants Different PBF policy schemes are 'layered over' each other, especially in Tanzania and Zambia. Creates a complex and confusing mix of spaces to participate in PBF agenda setting, implementation and evaluation
(4) What barriers and facilitators exist to participation?	Range of contextual factors important, which act as barriers/facilitators to participation: economic status/aid dependence (South Africa vs Tanzania/Zambia more aid dependent), domestic political environment, existing national institutional set up and norms of participating, strength of civil society and history of engagement in health, nature of global health institutions themselves – e.g. World Bank, historical relationship of global health institutions to African states
(5) Are there participatory opportunities that remain underdeveloped and underutilised?	Yes – regional bodies, informal networks, UN/WHO representatives Few opportunities to 'claim' new spaces or motivation at national level to do this One potential way forward for African actors is in knowing about PBF, what it can do, what it possibly can't do, what issues are and points of leverage (particularly the importance of 'the informal') (see recommendation Section 5).

## 4. Conclusion

The research outlined in this report has generated five central conclusions in response to the main research questions.

- 1. Informal spaces of partnerships give more meaningful opportunities for participation, however such spaces are skewed in the interests of elite African agents.** Formal spaces for participation at the global level are restricted and informal spaces the norm at both global and national levels of engagement. In all three case study countries there is a hierarchy of participation, with access to participate dependent on factors such as the positions of the individuals in government, their relationship to international funders, and awareness of the informal opportunity structures that shape participation. Participation is managed in a way that can block rather than enhance meaningful engagement by the use of consultants (usually accountants) and brokers (usually UN agencies). This adds to the financial drivers of participation that are bounded with systems of elitism within the state and the privileging of certain kinds of knowledge in the formation of PBF policy. This is exemplified in the identification, setting and management of performance targets in each of the three countries where national participation only matters if it fits with the intentions of the external funder.
- 2. Space for African agency for participating in PBF programmes is dependent on how well developed a country's health system is.** A key source of African agency is the ability to say no to external funders and to push back on some of the policy preferences articulated outside the country-context. Push back and saying no was evident in the South African case. Attempts to say no were evident in Tanzania; however, this had little long-lasting effect as PBF was implemented as a pilot rather than a country-wide initiative. The case of Zambia was perhaps the most interesting: those government agents currently working in PBF were keen to stress the Zambian aspect of the design and operation of the project; however, those that worked outside of the PBF team suggested this was a donor-led and donor-designed operation. The model developed in the Zambia case is similar to other models financed under the Bank's HRITF and sensitivity over this question when conducting the research suggests that the Zambian case is more fitting with regional efforts towards PBF driven by the World Bank. The less developed a health system, the easier it is to create a PBF programme and set up associated institutional structures with the risks of creating PBF silos in the health sector: the more developed a health system and the governance arrangements in place, as with the case in South Africa, the harder it is to develop PBF as a revolutionary system of health reform.
- 3. The concept of PBF provides political capital for health reform despite confusion as to its understanding and application.** PBF is a buzzword in global health policy: this is recognised by PBF advocates who are keen to stress the positive elements of the intervention and by those working within health systems who have health policy fad-fatigue and see it as just another external funder initiative. The buzz around PBF comes from the political capital it gives those working to promote it: for people working in the health sector it brings in external finance; for people working in monitoring and evaluation it reifies accountancy over public health; and for external funders it provides a means to follow where the money goes. Such political capital is devised less with a public health approach in mind than an accountancy and accountability approach to health policy reform. The reification of this model helps shape what PBF is or should be by those working within such a model and reduces contention as to its evidence base and different understandings

and applications of a model that existed in the three case study countries before the Global Fund and the World Bank's HRITF.

4. **PBF is framed in the language of South-South learning but this is subject to external funder capture and thus inhibits rather than enhances regional African agency.** External funders are keen to assert that the idea for PBF and the mechanism in which it is applied has its origins within sub-Saharan Africa, particularly Rwanda. This is an idea that is reproduced through study tours to Rwanda and externally funded workshops to promote South-South learning. Nevertheless, many respondents questioned this and the efficacy of the project in Rwanda. In some instances there was more competition over who was doing PBF best rather than collaborating and learning or grouping together into a regional bloc. Promoting the idea of Rwanda as the originator of the current strand of PBF in health sector reform, external funders inhibit African agency as it is misleading as to how this initiative came to Rwanda and shows a disregard for pre-existing PBF efforts in countries such as Zambia. African agency towards a country-based form of PBF in the three case study countries is replaced by a donor-driven commitment to the 'right kind' of PBF that is ahistorical and overlooks pre-existing efforts in the health systems of these countries. As a consequence, African agency is reproduced by external funders to give the impression there is South-South and regional collaboration when in practice this is externally funded not African driven and undermines the agency of the health sectors of these countries to articulate their own PBF strategies.
5. **Despite PBF being driven and led by external funders, there is considerable space for greater African agency in driving participation and the PBF agenda.** PBF is also applied to the operations of external funders and the functionality of the brokerage role played by UN agencies and international consultants. Hence, African agents – governments, civil servants, and civil society organisations – can hold such development partners to account for their own activities. Countries that have said no to external funders have enhanced rather than reduced their agency. See recommendations below. In addition, although the WHO has influence in setting the types of global targets, PBF initiatives could/should mirror at the national level; due to the bilateral nature of PBF, there is less scope for direct influence PBF modalities or on funding mechanisms more generally. The key to WHO alteration of PBF is by designing policies that must be responded to through the PBF preferences of the World Bank and Global Fund.

## 5. Recommendations

The points below summarise proposals for claiming a space for participating, as recommendations on the way forward for African actors.

### Know your PBF

- *What type of funding system do you want within your health system?* Attention needs to be given to whether PBF fits the specific contextual needs of the health system in question and what feasibility there is for successful outcomes. Thinking about ideal long-term funding streams will help determine the type(s) of PBF indicators needed and help locate nationally owned areas to focus on, as well as help determine whether or not PBF is suitable for a particular health system.
- *What do you want PBF to achieve?* (e.g. rapid reform, long-term change). There is evidence to suggest that PBF can generate rapid reform when targets are tightly focused (Type I) with clear monitoring and evaluation

systems in place. Evidence also suggests, however, that PBF can lead to the creation of long-term 'health silos' that can pull resources away from other health priorities. As a result, it is important to embed PBF within the overall long-term national strategic health plan and to be mindful of the fact that PBF may not affect the long-term change desired and could potentially create equity problems over time. Knowing your aims will help determine the scale and scope of PBF use.

- *Do you want it to be sustainable?* Evidence suggests that externally funded PBF programmes will not be self-sustainable once funding expires or if failures to meet targets result in the suspension of funds. As a result, it is important to consider how external funding will eventually be phased out or drawn-down and to have realistic plans in place to scale-up national take-over.

### **Know your evidence (what PBF can and cannot do)**

- *What is the evidence base to suggest this might work?* As our research highlighted, the evidence base regarding the effectiveness of PBF is still inconclusive and with mixed results. Consequently, it is important to thoroughly examine what sorts of programmes have worked elsewhere and under what general conditions.
- *What is the evidence to suggest this might not work?* It is important not to simply 'cherry-pick' favourable evidence to obtain PBF funding. As has been witnessed in all of the case studies in this report, there is often a bias toward thinking that PBF works or will eventually will work. This was the case even when there was limited or contradictory evidence. Thus, as much as it is important to know what has worked in the past, it is also important to know what hasn't worked. Furthermore, it is important to understand that what worked in Rwanda or Nigeria may not work elsewhere and that local background and capacity issues must be thought through when designing PBF schemes.
- *How has the evidence been produced and by whom?* As this report demonstrates, numerous parties are interested in furthering PBF projects for a range of reasons. In some cases, external funders promote pilots as a means to support evidence for PBF. In other cases, consultants and global funders have used other countries as models of best practice. Furthermore, payment for performance strengthens the position of some national sectors over others and thus there can be incentives to promote PBF out of self-interest. Because of this, it is important to know who has produced the research, who is pushing the evidence, who funded the research and why the evidence was collected in the first place. Knowing this will add to better knowledge about who is pushing the PBF agenda and why. As has been stated in this report, successful PBF schemes are operating in Africa, and the key seems to be about obtaining the best and most credible evidence for PBF design and evaluation.
- *What are the alternatives?* As suggested above, there is currently a bias toward PBF models despite the fact that questions remain regarding its effectiveness in terms of overall health system strengthening. As a result, it is prudent to explore all options available and to debate fully the pros and cons of each approach in relation to overall health system aims.
- *What does this mean you cannot do?* In other words, know the limitations. PBF is not a panacea and there are limits to what PBF can do in terms of system reform. As this research suggests, Type I programmes have had more success in terms of targets reached and positive perceptions of those interviews. This was not generally the case with Type II programmes and there were considerable doubts about what causal mechanisms related to successful outputs and how these related to longer term health system outcomes.

### **Know your points of leverage**

- *Who can you work and link up with informally on this?* (nationally, regionally and internationally). A key finding of this research is that multisectoral governance structures tend to score more highly in terms of legitimacy and effective outcomes. As a result, it is crucial to make robust links with key stakeholders nationally and with external institutions that can further mutual interests. In addition, there is considerable scope for better regional knowledge transfer, transnational grants and regional co-ordination in terms of WHO diplomacy. Yet, at the moment regional bodies are underused and underutilised. Making more of regional co-ordination and speaking with one voice on PBF properties would strengthen African agency and the autonomous agency of individual actors.
- *Which other sectors can/should you engage with?* Health has many social determinants. As a result, many national institutions and organisations (both governmental and non-governmental) will have the ability to impact health system strengthening. Because of this, it is important to develop multisectoral bodies in the design, implementation and evaluations phases of PBF. Leaving out key sectors may cause demand or resource side problems that will greatly affect long-term success.
- *What formal opportunities exist to engage in discussions?* (nationally, regionally and internationally). As discussed above, a key finding of this project relates to the positive influence multisectoral bodies had on PBF outcomes. Due to this, it is necessary to formally design forums (locally, nationally and regionally) so as to properly debate PBF programmes and to co-ordinate programmes between national and international stakeholders.

### **Know your capacity, context and funding**

- *Can you use domestic funding to gain extra leverage in discussions?* As illustrated in this report, the greater the economic independence from external funding the greater the ability to push back when designing, implementing and evaluating PBF programmes. As a result, how can national funds be strategically targeted in a way that increases agency and limits external influence?
- *Appropriate M&E and information systems.* A finding of this report is that robust monitoring and evaluation systems are crucial for setting realistic targets and for proper accounting and evaluation. This raises questions about how and when to use PBF and about how programmes are scaled up and designed (i.e. building M&E infrastructure before rollout or in parallel?).
- *People – number, knowledge and the context of your health system.* This report found that knowledge is often insufficient about ‘actual conditions on the ground’ and that general statistics regarding disease burden, existing capacities and available resources were not fully known. As a result, successful system strengthening via PBF (due to its reliance on matrixes) necessarily involves having better qualitative and quantitative knowledge of existing strengths and weaknesses.
- *Co-ordination - institutions talking to each other.* A finding of this research is that there is a general lack of communication between national institutions and co-members in regional organisations. As a result, PBF designs often miss out on input from relevant national institutions that were affected by PBF policies or that could directly affect the effectiveness of PBF programmes. Increasing communication and participation across sectors and between institutions will help limit incomplete or sub-par PBF design. In addition, learning could be generated between national governments and their individual experiences. Although this is evident, the mechanisms for real South-South learning at the moment are underwhelming and, at present, remain largely ineffectual. Increasing knowledge of best practice from other



programmes would provide valuable information for more successful PBF design and outcomes.

**Know that it might not work**

- *What systems exist for critical discussions nationally?* There is a tendency with PBF to not-rock-the-boat for fear of disturbing the flow of external funding. This tendency, however, creates negative externalities in terms of ignoring problems that will generate long-term failures. As a result, it is important not to ignore critical input that can help to modify PBF processes as programmes develop. As mentioned above, there is also good evidence to suggest that more multisectoral deliberative participation in CCMs and other PBF governance bodies increases the successes of PBF whereas the opposite was true of closed governance systems.
- *Do communities/patients/health professionals know how to give feedback within the health system?* A problem with PBF was knowledge of how it operated or knowledge of how to report failings within a given programme. Although in the short term, reporting problems will increase tensions with external funders and potentially threaten payments, in the long run, acknowledging and responding to problems will increase the likelihood of success both in meeting stated targets and national health goals.
- *What space is there to acknowledge that a particular system might not be appropriate?* When considering the use of PBF, ask if the right people are involved in those discussions and whether there are opportunities for genuine disagreement.
- *What space is there to acknowledge any problems or issues?* Part of ongoing evidence gathering is having proper feedback loops and forums for debate.

And finally, **Know how to say no**

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## List of acronyms

CBoH	Central Board of Health (Zambia)
CCM	Country Co-ordinating Mechanism
CHAI	Clinton Health Access Initiative
DfID	Department for International Development
ECSA HC	East, Central and Southern African Health Community
HMIS	Health Management Information System
HRITF	Health Results Innovation Trust Fund
LFA	Local Fund Agent
MCHCD	Ministry of Mother Child Health and Community Development
MDG	Millennium Development Goal
MoH	Ministry of Health (Zambia)
MoHSW	Ministry of Health and Social Welfare (Tanzania)
P4P	Pay for Performance
PBF	Performance-based Funding
PEPFAR	President's Emergency Plan for AIDS Relief
RBF	Results-based Funding
SWAps	Sector-Wide Approaches
TRP	Technical Review Panel (Global Fund)
USAID	United States Agency for International Development
WHO	World Health Organisation

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity-oriented interventions. EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care-oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair financing of health systems
- Valuing and retaining health workers
- Organising participatory, people-centred health systems
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

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