Abstract—This article presents the enablers and barriers to the scaling-up of results-based financing (RBF) programs. It draws on the Alliance for Health Policy and Systems Research’s multicountry program of research Taking Results Based Financing From Scheme to System, which compared the scale-up of RBF interventions over four phases—generation, adoption, institutionalization, and expansion—across ten countries. Comparing country experiences reveals broad lessons on scale up of RBF for each of the scale-up phases. Though the coming together of global, national, and regional contextual factors was key to the development of pilot projects, national factors were important to scale up these pilots to national programs, including a political context favoring results and transparency, the presence of enabling policies and institutions, and the presence of policy entrepreneurs at the national level. The third transition, from program to policy, was enabled by the availability of domestic financial resources, legislative and financing arrangements to enhance health facility autonomy, and technical and political leadership within and beyond the Ministry of Health. The article provides lessons learned on RBF policy evolution, emphasizing the importance of phase-specific groups of actors, the need to tailor advocacy messages to enable scale-up, the influence of political feasibility on policy content, and policy processes to build national ownership and enable health system strengthening.

INTRODUCTION

Output-based payment approaches, such as results-based financing (RBF), have been introduced widely in the past several years. These reforms have been championed by several major donors and technical agencies.\textsuperscript{1,2} This article describes the dynamics of RBF scale-up by comparing experiences from ten countries. It identifies phase-specific enablers and barriers for moving through the phases of generation, adoption, institutionalization, and expansion, in
line with the four-phase conceptual framework described in
the previous article. It also provides broader lessons on RBF
scale-up. Through this we hope to inform national-level deci-
sion makers and funders, our main target audiences, about
how to support RBF scale-up processes to contribute to
efforts to strengthen health systems.

Though there are significant variations across the countries
studied—in terms of political systems, levels of economic
development, preexisting health facility infrastructure, and
geography—there are several common features that enable
comparison. Eight of the ten countries analyzed are in sub-
Saharan Africa, with six clustered in southern and eastern
Africa. In most of the countries examined, RBF programs
were introduced to address issues of maternal and child
health (MCH). Finally, the RBF programs studied largely
focused on supply-side incentives to providers, a category
known as performance-based financing or PBF.

The next section briefly describes data sources and meth-
ods used in this comparative study. This is followed by the
findings, which present the enablers and barriers to transi-
tioning from one phase to the next. The article concludes
with lessons regarding RBF policy evolution.

DATA SOURCES AND METHODS

Ten country-level case study reports were prepared using
common conceptual frameworks and methods, as part of the
Alliance’s program of research Taking Results Based
Financing from Scheme to System. (An additional report
from Macedonia did not use the common methods developed
for the research program and was thus excluded from this
analysis.) The research program is introduced in the first arti-
cle of this special issue by Shroff et al.; the research pro-
cess, including the generation of the country-level case study
reports, is described in the previous article by Meessen et al.

For this article, we systematically reviewed each country
study. Each study report included data on four elements of
the policy process corresponding to Walt and Gilson’s frame-
work: policy actors, content, context, and processes, identify-
ing factors under each element that enabled or hindered the
scale up of RBF.

The ten countries included in this analysis are shown in
Table 1 grouped according to the four phases of the RBF
scale-up framework at the time of data collection. (Where
countries had features of more than one phase, particularly in
the phases of adoption and institutionalization, the decision
to place it in a given phase was based on author consensus.)

All ten countries passed through the first phase, generation,
which entails the development of RBF pilot projects. Seven
progressed to the phase of adoption, having gone beyond pilot
implementation. In all of these countries, there was progress
along the dimensions of population and service coverage, as
well as the development of significant national-level expertise
in RBF (progress on the knowledge dimension).

In five countries, RBF moved into the third phase of insti-
tutionalization, characterized by the provision of national
resources for RBF and progress along the dimension of
health system integration through incorporation of RBF into
national health financing strategies.

The findings presented pertain only to the first three
phases. Only Rwanda progressed to the fourth phase of
expansion, making it impossible to do cross-country compar-
isons for the fourth phase.

The phases are themselves spectrums, and countries
within a given phase may be in markedly different situations.
For instance, only one pilot was conducted in Chad, whereas
at least seven RBF pilots were implemented in Uganda,
although none went to scale when project data were being
collected. Cameroon recently entered the institutionalization
phase, whereas Rwanda has fully completed it.

The country project reports are a rich and largely com-
parable source of data; however, secondary analysis has
limitations. We sought to mitigate the limitations by hav-
ing all coauthors independently review the interpretations
presented.

No additional human subjects were contacted for the pur-
pose of this article beyond the individual case studies. Hence,
no additional ethics review was sought beyond the approvals
obtained for each case study.

FINDINGS

We present the findings of our analysis on the enablers and
barriers in each phase of scale-up for RBF in Table 2.

| Phase of Scale-Up | Generation (From Idea to Pilot), n = 10 | Adoption (From Pilot to Program), n = 7 | Institutionalization (From Program to Policy), n = 5 | Expansion (From Policy to System), n = 1 |
|-------------------|----------------------------------------|----------------------------------------|----------------------------------------|----------------------------------------|
| Rwanda            | Rwanda                                 | Rwanda                                 | Rwanda                                 | Rwanda                                 |
| Armenia           | Armenia                                | Armenia                                | Armenia                                | Armenia                                |
| Burundi           | Burundi                                | Burundi                                | Burundi                                | Burundi                                |
| Cambodia          | Cambodia                               | Cambodia                               | Cambodia                               | Cambodia                               |
| Cameroon          | Cameroon                               | Cameroon                               | Cameroon                               | Cameroon                               |
| Kenya             | Kenya                                  | Kenya                                  | Kenya                                  | Kenya                                  |
| Tanzania          | Tanzania                               | Tanzania                               | Tanzania                               | Tanzania                               |
| Chad              |                                       |                                       |                                       |                                       |
| Mozambique        |                                       |                                       |                                       |                                       |
| Uganda            |                                       |                                       |                                       |                                       |

TABLE 1. Countries that have Entered Each Phase of Scale-Up
Phase 1: Generation—Transitioning from an Idea to Pilot

The first stage of policy evolution we examined was generation, in which the idea of payment for results, rather than inputs, was translated into pilot projects implemented at the country level. All ten countries passed through this phase.

In the generation phase, pilots were typically funded and implemented by bilateral and multilateral agencies, faith-based groups, and international nongovernmental organizations (NGOs; over 20 entities in the countries studied; see Appendix 1 for list). Governments were engaged to differing degrees and at different levels in the various countries. In Armenia, Cameroon, and Tanzania, donors engaged with the Ministry of Health (MOH) and other government actors at the national level to establish the pilot. In Mozambique, however, the RBF scheme was largely at the provincial level. Projects in Uganda also tended to work with district-level structures, bypassing the national government.

The pilots also varied with respect to whether they focused on the public, faith-based, or private sectors as the providers of health services. Uganda’s large private not-for-profit sector (composed mainly of facilities run by faith-based groups) served as service providers for several initial RBF programs. In Cameroon, however, the RBF scheme encompassed public, private, and faith-based providers.

Though the processes by which the pilots were developed differed by country, there were several common enabling factors, as described in the following subsections.

Enabling Factor in the Global Context: Health and the Aid Effectiveness Agenda

The adoption of the Millennium Development Goals in the year 2000 helped put health high on the global development agenda, incentivizing countries to move toward the achievement of these goals by 2015. There was an increasing recognition that despite significant resources invested in health, improvements in health outcomes had been inadequate or even stagnant in a number of settings, leading to the prioritization of an aid effectiveness agenda. As mentioned in the reports from Armenia, Cameroon, and Tanzania, innovative health financing mechanisms, centered on pay for performance, were put forth by several donors.

The concept gained considerable support through the establishment of the World Bank’s Health Results Innovation Trust Fund in 2007 with funding from the governments of Norway and the United Kingdom. The World Bank and Health Results Innovation Trust Fund played a significant role in promoting the RBF agenda, particularly in sub-Saharan Africa. They supported pilot projects and collated learning from pilots to develop national programs in Burundi, Cameroon, Chad, Kenya, Rwanda, Tanzania, and Uganda.

Enabling Factor in the National Context: Addressing “Felt Needs”

At the national level, RBF pilots were often established to respond to entrenched and difficult-to-resolve health issues.

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**TABLE 2. Phase-Specific Enablers to the Scale-Up of RBF**

| Phase | Enabler | Description |
|-------|---------|-------------|
| Generation | Global development context prioritizing aid effectiveness (Armenia, Cameroon, Tanzania) | Existence of favorable preexisting policies and institutions (Armenia, Cameroon, Kenya) |
| Adoption | RBF perceived as addressing a “felt need” at the national level (Armenia, Burundi, Cambodia, Cameroon, Chad, Kenya, Mozambique, Rwanda, Tanzania, Uganda) | A political context favoring transparency and results (Cameroon and Rwanda) |
| Institutionalization | RBF’s success in Rwanda as a policy example (Burundi, Cameroon, Chad, Mozambique, Tanzania, Uganda) | Critical mass of key actors with technical capacity in RBF at the national level (Burundi, Cameroon, Rwanda, and Tanzania) |
| | Global health financing experts convince funders and implementing agencies (Burundi, Cambodia, Cameroon, Mozambique, Rwanda) | Presence of national policy entrepreneurs (Cameroon, Tanzania) |

*aRBF indicates results-based financing.*
In seven of the ten countries (Burundi, Cambodia, Cameroon, Chad, Rwanda, Tanzania, Uganda), stagnant or worsening health indicators, often in the area of MCH, were identified as a significant motivation for pilot implementation of RBF.

RBF’s potential to address low motivation among health workers was cited as key in Armenia, Burundi, Kenya, and Tanzania. Respondents in Mozambique also emphasized RBF’s ability to attract and retain health workers in rural areas as central to interest in the approach. Additionally, in Burundi, Cambodia, and Rwanda, RBF was seen as a potential solution to rebuild health systems after conflicts and genocide had destroyed health infrastructure and scattered or killed health workers.

Enabling Factor at the Regional Level: A Successful Example

Among African countries, an additional regional-level factor was noted. Rwanda’s experience in piloting RBF was cited as being very influential by key informants in the other African countries. Individuals working on RBF in Rwanda—both international experts and Rwandans—began highlighting and sharing the Rwandan experience at meetings and workshops. Study tours of MOH officials from other countries, often organized by funders such as the World Bank, were brought to Rwanda to observe the program. A policy maker in Cameroon stated:

When we came back from Rwanda in 2007, we made a presentation to all the officials in the Ministry. What they saw was that we were enthusiastic, though they were not sure that what Rwanda was doing would succeed in Cameroon.

Enabling Factor: Global Health Financing Experts

Members of the global community of health financing experts were important actors in the initial process of transitioning RBF from idea to pilot. Their roles in the initial design of pilots is clear in the studies from Cambodia and Rwanda; they also played an important role in taking the ideas from the Rwandan project to other countries, including Burundi, Cameroon, and Mozambique.

In summary, a heterogeneous set of funders, implementers, providers, and levels of government was engaged in moving RBF from idea to pilot. Their efforts were enabled by a convergence of global, regional, and national contextual factors.

Other literature has pointed to the specific role of global health financing experts, particularly in bringing together a range of funding and implementing agencies to support the introduction of performance-based contracting and RBF in the health sector of LMICs. This has been attributed to their earlier experiences of using these approaches, particularly in Cambodia.7

The common health financing principles and practices that formed the foundation for the pilots reflected agreement among the small group of experts involved in designing them.4 Their consensus grew out of a cumulative process of field testing in Cambodia, Rwanda, and Burundi.8 By leveraging the priority being placed on aid effectiveness in global development and combining it with the needs of national and local governments, these individuals were able to promote the idea and played seminal roles in designing and implementing the initial pilot projects, particularly in sub-Saharan Africa.

Phase 2: Adoption—Moving From Pilot to National Program

Of the ten country reports reviewed, seven countries (Armenia, Burundi, Cambodia, Cameroon, Kenya, Rwanda, and Tanzania) passed through this phase. The other three countries (Chad, Mozambique, and Uganda) introduced RBF pilots but failed to move to the next phase. The second phase, adoption, is marked by a transition from one or more pilot projects to a national program. Below we discuss the enablers of this transition. One critical enabler was the proof of concept that RBF is feasible in a given context. This factor is an essential enabler, which we argue is established by the process of going through the first transition and implementing the pilot (see previous article by Meessen et al.3)

The shift from pilot to program has been usually driven by a single agency taking the lead and directly supporting RBF rollout through financial and technical support, as well as facilitating the alignment of projects (as occurred in Cameroon, Kenya, Rwanda, Burundi, Armenia, and Tanzania). This is in contrast to the generation phase, in which multiple agencies or NGOs often operated parallel pilot RBF programs at district or at decentralized levels, as in Burundi, Cambodia, Rwanda, and Uganda.

The dominant agency driving adoption was most often an international one, although in all countries the MOH was involved in key aspects of program design and financial support. The transition to adoption typically entailed the development of what was variously termed a task force, national RBF unit, or steering committee to facilitate RBF design and implementation through the coordination and alignment of various stakeholders and projects.

Several common factors enabled the countries to move through this phase of adoption; they also faced common barriers to moving from pilot to program.
Enabling Factor at the National Level: Related Policies and Institutions Exist in Context

The existence of favorable preexisting programs, policies, and institutions was an important enabler of the transition from pilot to program. Examples of programs and policies include direct facility funding in Kenya, which entailed direct cash transfers to facilities to improve performance; the open enrollment policy in Armenia, which catalyzed all patients registering with providers and improved information systems; as well as successive strategies and frameworks for contracting for health in Cameroon from the year 2000 onwards. Examples of autonomous institutions include Cameroon’s Regional Funds for Health Promotion; these bodies included the MOH, representatives of beneficiary communities, and donors and served as participatory bodies for health system governance. They were well suited to serve as national-level purchasing institutions as the RBF scheme evolved to a national program.

Enabling Factor at the National Level: Political Context Emphasizing Transparency and Results

The country studies show that moving RBF from a pilot to a program was easier when presented as a reform that would enhance transparency and focus on achieving results in countries where other national agendas were also emphasizing these issues. In Cameroon, for example, the expansion of RBF was aligned with the government’s anticorruption drive and mandate to enhance accountability. Similarly, in Rwanda, RBF’s results-centric agenda aligned well with the overall political culture of performance, something prioritized by the country’s president. Matching RBF with the wider political agenda could help to hasten the process of moving from a pilot to something larger and longer term, but it was not necessary for eventual and long-term success, a point that is discussed below with respect to Cambodia.

Enabling Factor at the National Level: Critical Mass of Key Actors with Technical Capacity in RBF

Human resources with technical and management capacity at the national level were critical to enabling evolution from pilots to national RBF programs as shown in the cases of Rwanda and Burundi. In addition to hands-on practical experience gained at the pilot stage, human resource capacity was also built in other ways; for countries that came to RBF later (e.g., Cameroon and Tanzania), training workshops were cited as key enablers to a move to national programs. As a counterexample, the Kenya study reported the inadequate development of local-level implementation capacity (linked to a concurrent devolution reform bringing in new actors into RBF) as a factor that could potentially slow down the scale-up of the initial pilot.

Enabling Factor at the National Level: Committed Policy Entrepreneurs

The development of national programs in Cameroon and Tanzania was enabled by the emergence of national-level policy entrepreneurs, defined as those “individuals who were willing to invest resources to push forward” for RBF. These individuals, often associated with the implementation of pilot programs, were able to engage with key stakeholders within and beyond the MOH to obtain buy-in for RBF scale-up.

Barrier at the National Level: Pilots Developed or Implemented Without Sufficiently Engaging National MOHs

The case studies showed that the level of government engaged during pilot implementation processes had important implications for later scale-up. Additionally, what enabled one transition could later hinder a subsequent one. This was evident from the experiences of Mozambique and Uganda. In Mozambique, the pilot project was established almost entirely in collaboration with provincial-level actors, with little involvement of the national MOH. Provincial health departments saw RBF as a way of bringing in new funding to improve infrastructure and pay staff; this enabled a quick establishment of pilots. Later, however, it proved to be a barrier in moving the pilot to the national level, because actors in the MOH had neither been engaged with the initial design and implementation nor been sensitized about RBF concepts, design, and mechanisms. These examples demonstrate that engagement solely at the district and provincial levels may impede success at the national level, reflecting differing incentives and governance arrangements.

Similarly, the location of the management and administration of the RBF pilot in Chad—within the Ministry of Economics and International Cooperation—did little to foster program ownership by the MOH and was cited as an important reason for the program’s abrupt discontinuation.

Barrier at the National Level: Pilots Implemented Without Engaging Public Providers

The Ugandan experience highlights the long-term implications of implementing pilots largely separate from the public
system. The country’s large private not-for-profit sector was eager to implement pilots coinciding with the concomitant structural difficulty of engaging with the public sector due to conflicting public financial management rules. Though this hastened the establishment of the pilots, over the longer term this limited MOH experience with RBF schemes in Uganda. The lack of familiarity with the pilots potentially hindered the MOH’s ability to play a guiding role needed to establish a national program.

Barrier at the National Level: Pilots Focused on Particular Diseases or Implemented by Agencies with an Interest in Particular Diseases

Choices made early on—such as who implements the pilot (the implementing agency and its policy, financial, political, and technical influences) as well as the pilot’s content (in terms of whether it is narrow and focused on a particular disease or has a broader focus on health systems strengthening)—were found to alter the perception of the intervention and ultimately buy in from the MOHs. In Mozambique, the pilot initially focused significantly on HIV/AIDS indicators and was implemented by an agency that worked largely on HIV/AIDS. This led RBF to be perceived as a vertical program, with negative implications for MOH adoption, unlike the examples of Cameroon and Rwanda, where pilots focused on a broad range of indicators relevant to MCH.

Phase 3: Institutionalization—Moving from National Program to National Policy

RBF undergoes institutionalization when it becomes an integrated purchasing strategy underpinning the health financing system, progressively covering the entire country. Five countries (Armenia, Burundi, Cambodia, Cameroon, and Rwanda) had moved to this phase at the time of the research program. On the other hand, at the time of data collection, Kenya and Tanzania had not moved through this phase.

A commitment to a sustained level of public funding was key to moving to this stage, often requiring RBF supporters at the national level to engage beyond the MOH with the Ministry of Finance and other ministries. The country studies showed that the level of funding was only one component; incorporating RBF principles into national policy also required legal changes to public finance procedures to enable output-based payments and legislation of institutional arrangements to give autonomy to health facilities and purchasers.

Enabling Factor at the National Level: Making Domestic Financial Resources Available

Institutionalization was often enabled by an increased level and sufficient security of financial resources for RBF. In particular, funding from domestic sources under the budget (as opposed to standalone project funding) was important. In Cambodia, the move to a new contracting mechanism, called special operating agencies, was enabled by the government’s commitment to increase its budgetary contribution by 10% annually, gradually replacing donor funding. This was similar to Armenia, where the full implementation of RBF as a national policy was preceded by its inclusion in the government’s medium-term expenditure framework and budgetary funding for RBF was provided from 2011 onwards. In Burundi, public resources were accessed through a merger of the RBF policy with a preexisting selective free health care policy for pregnant women and children under the age of five years.

Enabling Factor at the National Level: Legislative and Financing Structures that Enhance Facility Autonomy

Institutionalization of RBF as a purchasing strategy within the national financial management system often required legal changes to these systems. In Cambodia, RBF scale-up was enabled by a larger public financial management reform in 2009, in which many health districts and provincial hospitals were designated as semi-autonomous special operating agencies.

In Armenia, full national implementation of RBF was enabled by several decrees that the RBF program could then build on, including decrees enabling open enrollment (allowing patients to choose their primary care provider) and mandating the transition of all primary health centers to enrollment-based financing. In Burundi, RBF benefited from a national policy on contracting introduced in 2006. And in Cameroon, RBF scale-up was enabled by 2007 changes to public finance laws enabling results-based budgeting, as well as continuous legal changes such as those allowing for the transfer of the purchasing function to national agencies. This measure, essential to sustainability, was enabled by the passage of an act that allowed the autonomous Regional Funds for Health Promotion to take over this function.

Enabling Factor at the National Level: Strong Political and Technical Leadership Within the Ministry of Health and Beyond

Institutionalization is characterized by having national-level political and technical leadership for RBF, building
on the development of national-level capacity that began in phase 1. In Armenia, this was apparent in the strong leadership and expertise displayed by the MOH and the State Health Agency. Cambodia likewise built up RBF expertise, increasing domestic responsibility for the management of health institutions using contracting arrangements, as described by Khim et al.,11 and developing greater national control.

The move to institutionalization was also enabled by government ownership beyond the Ministry of Health. The Ministry of Finance, as the source of new funds, often played an important role, as in Rwanda. Additionally the role of local governments was noted in both Armenia and Rwanda.

**Enabling Factor at the National Level: Expanded National Ownership and Policy Influence**

Institutionalization was also defined by a high level of national ownership of the policy content, reflected in greater domestic financing and in country-level influence on policy design. This was observed in several examples, such as internal contracting in Cambodia and the development of community PBF in Rwanda.

**Barrier at the National Level: Insufficient Political Engagement with Key Stakeholders**

The country studies showed that insufficient ongoing political engagement with key stakeholders had negative implications for scale-up. In Tanzania, despite the involvement of a national policy entrepreneur in program development, at the time of data collection there appeared to be insufficient engagement of the RBF program with the Prime Minister’s Regional Office and Local Government, the branch of government tasked with the implementation of health services. The country report calls this body “unusually silent and detached” on the RBF reform, the design and implementation of which appears to have been confined to a small group in the MOH.12 A similar concern has been expressed in Kenya, where insufficient sensitization of key political actors at the county level was noted as a potential barrier in scaling up RBF within the newly devolved health care system in Kenya.

**Barrier at the National Level: Absence of Domestic Resources**

In contrast to countries where RBF scale-up was marked by the investment of domestic resources, which helped build national ownership, at the time of data collection RBF programs in Kenya and Tanzania had little or no domestic funding. This indicates that RBF was not necessarily a priority for the government, potentially impeding its further scale-up.

**Lessons on Policy Evolution Learned from Scaling Up RBF**

This analysis of the enablers and barriers across the four phases of RBF scale-up in ten countries revealed the following general lessons on scaling up RBF.

**Key Actors Need to Be Identified, Provided with Relevant Technical Capacity, and Supported**

Specific types of actors, with varying interests, are central to each phase of the scale-up process. Effective scale-up requires understanding the key actors at each stage, including their underlying interests, and working with them through the provision of technical support to enable the scale-up process. International technical experts can have great credibility during the earlier stages of generation and implementing the pilot; however, in later phases, and as a critical mass of national expertise develops, national actors with their greater understanding of context and national processes and power in national-level structures would tend to gain influence and be important to scaling up.

**Context Must Be Understood so the Policy Content—and the Advocacy Arguments—Can Be Tailored**

Arguments to convince policy and decision makers to scale-up an RBF program need to be tailored over time. Though the potential to immediately address a pressing public health need is likely to be attractive to national policy makers and ensure their buy-in for an initial pilot, developing mechanisms to ensure compatibility and harmonization with preexisting institutional arrangements (such as purchasing and payment arrangements) is more difficult. Additionally, ensuring a smooth transition to the new arrangements, as well as long-term budgetary sustainability, will be increasingly important to move through the phases of scale-up.

In addition, rhetoric and framing are critically important. In a number of settings, RBF programs were promoted as enhancing transparency and as part of an agenda emphasizing results. As noted above, this helped move forward scale-up processes in Cameroon and also the development of the program in Rwanda, where this aligned well with a larger domestic political agenda.
Emphasizing transparency or results, however, may not always work, especially if it conflicts with the status quo, a point raised by the research from Uganda. Indeed, in a number of settings, this rhetoric may be seen as privatization and thereby hinder scale-up. Developing RBF approaches through inclusive policy processes may promote transparency, but they might also slow or completely stall the establishment of an RBF policy.

**Balancing Optimal Policy Content with What Is Financially Sustainable and Politically Feasible**

Trade-offs are required to balance a technically “best” intervention design, as defined by health financing experts, with what is financially sustainable and politically feasible. In some cases, what technical experts consider suboptimal interventions may be the right choice over the long term, if they result in increased government buy-in and long-term sustainability for RBF.

We are not suggesting that political feasibility should supersede technical excellence. It is also possible that vested interests wishing to preserve the status quo could derail new initiatives by making them politically unfeasible. Policy entrepreneurs for RBF must find technically valid solutions that can potentially align with, or at least not conflict with, long-term government goals. One good example of this is Cambodia’s choice of the hybrid contracting model over contracting out approaches, in the interest of financial sustainability and the long-term development of national technical capacity in contracting.

The findings from this program of research highlight the need for careful analysis of the political situation. Stakeholder analysis can help to gauge the most appropriate framing for RBF approaches to fit in the national context before deciding to introduce an RBF pilot, and to identify policy entrepreneurs among national level stakeholders, particularly within the MOH, to take the process forward.

**Donors Must Engage in Processes to Build National Ownership and Avoid Project-Based Interventions**

Donors played a vital role in technically supporting and financing pilots and programs in all of the countries examined. As mentioned above, they organized study tours and other opportunities for countries to learn from the Rwanda example; this proved a significant enabler to the spread of RBF pilots across Africa. However, the perception that a reform is a donor-driven reform can also hinder its uptake and scale-up, due to countries feeling unready for a reform, concerns about long-term financial sustainability, and a lack of national ownership. This pattern was clearly seen in Uganda, where stakeholders expressed skepticism about whether health facilities had in place the operational capacity to implement RBF. In Uganda and Mozambique, strong concerns were raised about the long-term financial sustainability once donor funds were withdrawn. A sense of a donor-driven reform leading to weak national ownership was also noted in the design and implementation of the pilot in Tanzania, also reported in work by Chimhutu et al.\(^\text{13}\)

Second, as we have seen from the examples of Chad and Mozambique, conceptualizing RBF as a vertical program, in terms of either its design (Mozambique) or administration and implementation (Chad), had negative implications for long-term program sustainability.

This finding highlights the importance for donors to develop clear terms for engagement with national stakeholders and ensure that the design and implementation of pilots contributes to strengthening health systems by addressing structural issues as opposed to undermining them.\(^\text{13}\)

**CAVEATS AND LIMITATIONS**

A first limitation of this study is the model of scale-up developed and used. Though the four-phase framework for RBF scale-up is described in neat terms with linear transitions between the phases, reality is, of course, messier. Policy change is an evolutionary process with much back and forth. This is exemplified by the case of Cambodia, where ongoing negotiations between the government and donors led to several contracting approaches being piloted while progressively increasing national control, as discussed by Khim et al.\(^\text{11}\) A second limitation of the model is that a factor that enables one phase may hinder the next or a later phase. This was seen in Mozambique and Uganda, where provincial-level engagement helped rapidly establish pilots but the lack of involvement of the MOH became a barrier in moving from pilot to national program. Third, what happens during each of the phases has become increasingly blurred over the past few years. Issues of sustainability and scale are important even during the development of pilots. Enabling legislation and institutional changes have been cited as important to the success of pilots carried out under the Nigeria State Health Investment Project.\(^\text{14}\)

It is important to note that our categorization of countries that have moved further along the four phases of scale-up as success stories is a normative judgment. The failure to scale up may well be a reflection of an inappropriate country context or a health system that would not effectively implement RBF. This could be due to insufficient national ownership.
(as seen in Chad, Uganda, and Mozambique), genuine MOH concerns about sustainability of financing after the donor leaves, or concerns about using a vertical approach prioritizing a particular disease as a means to strengthen the health system. In other words, what we describe as a failure may be seen as something positive or a success in a particular country at a particular instance in time.

Though we have identified specific enablers and barriers for each phase, one given factor may be relevant for another phase as well. Hence, though national policy entrepreneurs have been identified as enablers in moving from pilot to program, the move from program to policy also needs national-level policy entrepreneurship. A factor that enables a given phase may be preexisting or develop as part of program scale-up; for instance, legal changes in the form of public financial management reform were often key enablers to institutionalization. These may precede the pilot (as in Cameroon) or be introduced during the phase of institutionalization itself (as in Cambodia).

An additional limitation of this comparative study is that the enabling and impeding factors were identified by analysis of the country reports. Factors not mentioned in the country reports were not necessarily absent, but they were not considered among the most important reasons identified by the country research teams.

A final limitation is that this research depended significantly on interviews, which may have introduced an element of bias. The underlying interests of those who participated in the interviews could likely influence how they perceived and reported things.

CONCLUSION

In this article, we identified enabling and hindering factors that affected RBF scale-up across four phases in ten countries. We hope that the lessons learned will be useful to those looking to scale up this approach in other countries and sectors. The research program that formed the basis of this comparative analysis was largely focused on processes to scale up RBF, but we would also like to comment on RBF as a substantive policy.

RBF approaches have much to offer in improving the performance of health systems and have been able to serve as entry points to reforms in service delivery, management information systems, and health governance. However, we caution against viewing these reforms as secondary or spillover effects of RBF interventions implemented as vertical programs. In line with Soucat et al., we argue that RBF design and implementation should focus their attention on how they can contribute to the broader goal of health systems strengthening. We hope that the articles in this special issue bring home to the reader the importance of dynamic, ever-evolving intersections of RBF interventions with underlying health systems.

Ultimately, more research is needed to better understand the evolution of scale-up and the integration of RBF schemes. In particular, as more countries attain middle-income status and national-level financing becomes increasingly available, the dynamics of scale-up may be markedly different in settings without a major international donor (such as the World Bank in almost all the African countries examined, USAID in Armenia, or the initial role of actors including the Asian Development Bank in Cambodia in our sample). These could include a national government playing a donor-like role, through incentivizing RBF mechanisms using matching grants in large federal countries, as has been done in the example of Argentina. There is also greater likelihood of cross-national transmission of ideas among middle-income countries (without international agencies transmitting the knowledge), as well as learning from sub-national to national or across sub-national entities within countries for RBF approaches, as has been the case with health insurance programs in India. This multicountry research program is hence just a beginning, and much remains to be done globally in understanding the successful scale-up and integration of innovative health financing arrangements moving toward universal health coverage.

DISCLAIMER

The authors are staff members of the World Health Organization and are themselves alone responsible for the views expressed in the Article, which do not necessarily represent the views, decisions, or policies of the World Health Organization or Taylor & Francis Group.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

Zubin Cyrus Shroff is a staff member of the Alliance for Health Policy and Systems Research, WHO. Maryam Bigdeli is a former staff member of the Alliance for Health Policy and Systems Research, WHO. The authors are themselves alone responsible for the views expressed in the article, which do not necessarily represent the views, decisions, or policies of the World Health Organization.

Bruno Meessen contributed to the emergence of PBF as a global health policy, through technical assistance, research, and knowledge management. He is the lead facilitator of the
PBF Community of Practice. He holds minority shares in Blue Square, a Belgian/Burundian firm developing software solutions for countries implementing PBF solutions.

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APPENDIX 1. LIST OF DONORS FOR RBF IN STUDY COUNTRIES

| Country     | Donor                                                                 |
|-------------|------------------------------------------------------------------------|
| Armenia     | USAID, World Bank                                                      |
| Burundi     | CORDAID                                                                |
| Cambodia    | Asian Development Bank, French Development Agency, AusAid, Belgian Technical Cooperation, DFID, Swiss Red Cross, UNFPA, UNICEF, World Health Organization, World Bank |
| Cameroon    | CORDAID, World Bank                                                   |
| Chad        | World Bank                                                             |
| Kenya       | World Bank                                                             |
| Mozambique  | Elizabeth Glasser Pediatric AIDS Foundation                            |
| Rwanda      | Belgian Technical Cooperation, GIZ, Dutch Government, SIDA, World Bank, USAID |
| Tanzania    | Norad, World Bank, USAID                                               |
| Uganda      | Belgian Technical Cooperation, Bill and Melinda Gates Foundation, CIDA, CORDAID, DFID, Global Partnership for Output Based Aid (consortium of bilaterals and multilaterals administered by World Bank), Saving Mother Giving Life initiative (funded by U.S. Global Health Initiative and partners including Merck/MSD, the American College of Obstetricians and Gynaecologists, Every Mother Counts, ELMA foundation), USAID |

*RBF indicates results-based financing. This list is based on project reports and is not an independent inventory of all funders of results-based financing in the specified countries.

Note: USAID = United States Agency for International Development; AusAid = Australian Agency for International Development; DFID = Department for International Development; UNFPA = United Nations Population Fund; UNICEF = United Nations Children Fund; GIZ = Gesellschaft für Internationale Zusammenarbeit; SIDA = Swedish International Development Cooperation Agency; Norad = Norwegian Agency for Development Cooperation; CIDA = Canadian International Development Agency; Merck/MSD = Merck Sharp and Dohme

APPENDIX 2

Unless a citation is provided, all data in the Findings section are from the ten country project reports. Please see list below. The reports can be found at the following link: http://www.who.int/alliance-hpsr/projects/rbf/en/

1. Taking results-based financing from scheme to system: Armenia case study. Research report. Curatio International Foundation and American University of Armenia, October 2015.

2. Performance-Based Financing: from the pilot project phase to the integration at the health systems level: case study, Burundi 2004–2014. Research report, Burundi. Bregmans Consulting and Research, December 2015. (Le Financement Basé sur la Performance: De la phase de projet pilote à l’intégration au niveau du système de santé: Etude de cas du Burundi 2004–2014. Rapport de Recherche, Burundi).

3. Factors driving changes in arrangements and scaling up of health schemes: the case of Performance-Based Financing in Cambodia 1997–2015. Research report, Cambodia. University of Health Sciences, December 2015.

4. Challenges of integrating an innovative health financing scheme into the health system: lessons from Performance-Based-Financing (PBF) in Cameroon (2006–2015). Research report, Cameroon. Research for Development International, Cameroon and the Centre de Recherche du Centre Hospitalier de l’Université de Montréal, November 2015.

5. Analysis of bottlenecks in scaling up results-based funding in Chad after the pilot phase. Research Report, Chad. Centre de Support en Santé Internationale, November 2015. (Analyse des goulots d’étranglement à la mise à l’agenda du financement basé sur les résultats au Tchad après la phase pilote. Rapport de recherché, Tchad).

6. Scaling up Performance-Based Financing in health-care in a devolved governance system: experiences from Kenya. Research report, Kenya. Maseno University, December 2015.

7. Performance-Based Financing in Mozambique: an analysis of cross-cutting factors influencing provincial and national buy in. Research report, Mozambique. Colaboracion Desenvolvimento de Mozambique, October 2015.

8. National diffusion of a policy: the experience of Rwanda with exploiting, extending, and sustaining Performance-Based Financing for better health outcomes (2005–2015). Research report, Rwanda. The University of Rwanda, College of Medicine and Health Sciences, School of Public Health, November 2015.

9. Evolution of results based financing policy and programs in Tanzania: 2006 to 2015. Research report, Tanzania. Ifakara Health Institute. October 2015.

10. Learning from multiple results-based financing schemes: an analysis of the policy process for scale-up in Uganda (2003–2015). Research report, Uganda. Makerere University School of Public Health, October 2015.