The World Bank’s Program for Results Instrument:
A Case Study of its Preparation in Ethiopia

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1. Introduction

The quality of aid is more important than the quantity. We know what needs to be done and how to do it. But we cannot do it without flexible, predictable financial support. Give us the money and we will account for it and deliver results. Dr Tedros A. Ghebreyesus, Former Minister of Health, 2012

Over the last decade, Ethiopia has emerged as a benchmark country for health sector performance. The country has experienced strong economic growth and has made tremendous progress in improving human development. The proportion of people living below the national poverty line of $1.25/day declined from 45.5% in 1995 to 27.8% in 2012. Child mortality reduced 28.4% between 2004 and 2011 and the percentage of households with access to clean water more than doubled between 2007 and 2012. Ethiopia’s Health Extension Program, a frequently cited model for community health initiatives in Africa and beyond, has deployed Health Extension Workers throughout the country for the provision of essential services in communities. As the first country to develop and sign an International Health Partnership (IHP+) Compact, Ethiopia also serves as an example of how donor harmonization and aid effectiveness can be improved within the national health sector.

Despite these significant improvements, challenges remain. At 676 per 100,000 births, Ethiopia has one of the highest maternal mortality rates in Africa. The country remains one of the poorest countries in the world and its large and widely dispersed population makes access to services in rural areas difficult.

Ethiopia follows a federal system of governance that involves devolution of powers and mandates to regions, woredas (districts), and kebeles (villages). The Government of Ethiopia’s (GOE’s) five-year development plan, called the Growth and Transformation Plan (GTP), is focused on broad-based development and achievement of the Millennium Development Goals. The Health Sector Development Program (HSDP) provides the

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3 Ibid.
strategic framework for the health sector and is currently in the fourth round (HSDP IV), covering the years 2010-2015. HSDP IV was the first sector plan in Ethiopia that was developed with the Balanced Scorecard Framework—a strategic planning and management system that helps an organization increase its focus on strategy, performance, and results, instead of specific tasks.

Ethiopia is a major recipient of Official Development Assistance (ODA). In 2011/12, the flow of ODA to Ethiopia accounted for approximately 11% of the country’s national budget. The health sector is a primary recipient of ODA with 35% of the country’s total expenditure on health in 2010 coming from external resources. The GoE harmonizes donor support for health primarily through two well-established mechanisms: 1) the MDG Performance Fund (MDG PF), channeled through the Federal Ministry of Health (FMoH); and 2) block grants to regional states, provided by the Ministry of Finance and Economic Development (MoFED). Development partners in Ethiopia also give earmarked funding to the FMoH for priority initiatives as well as significant “off budget” support.

The GoE prefers two particular channels of financial support for health because these channels allow the government to set priorities and strengthen government management systems. The first preferred financing channel is the MDG PF. The second is Component 1 of the Promoting Basic Services (PBS) package that is part of the MOFED block grants to regional states. PBS, now in its third round, is a fund set up by development partners and managed by the World Bank in consultation with FMoH. The MDG PF and PBS support the delivery of health services at various levels of the health system and are aligned with national health plans and strategies.

Ethiopia has increasingly moved toward a focus on results, and the GTP and HSDP IV formally anchor the country’s progress toward a results-based approach. However, even prior to the launch of these documents in 2010, the late Prime Minister of Ethiopia, Meles Zenawi, had challenged donors—including the World Bank—to focus more on results in the support it provides to the GoE.

Dialogue between the GoE and the World Bank began in late 2009 about the possibility of utilizing a results based operation in Ethiopia. Discussions between the GoE and Bank technical advisors started in late 2010 about the design of a nationwide performance-based contracting approach at multiple levels of the public health system. An implementation proposal was drafted but the approach proposed a monetary incentivization of health workers that would have required integration into the Civil

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6 FMoH (2013). Ethiopia’s health sector: Excellent returns on your development funding.
7 The Bank’s involvement in the Program for Basic Services (PBS) program began in 2006; the institution has supported programs in Ethiopia since 1991.
Service System and equal application to all civil servants.\textsuperscript{10} As the Civil Service System was in the process of being reformed, implementation did not proceed.\textsuperscript{11} Discussions subsequently turned to the Bank’s new Program for Results (PforR) instrument, and whether this instrument could be utilized to support Ethiopia’s health strategy.

2. The Program for Results (PforR) instrument

2.1 The World Bank’s new PforR financing instrument

As Ethiopia was moving toward a results-based approach, the World Bank was also looking for ways to more closely align with national systems and shift its operations to a focus on outcome (instead of input) oriented programming.\textsuperscript{12} At the time, the Bank had two types of financing instruments: 1) Investment Project Financing, also known as traditional investment lending, which supports specific projects and disburses against specific transactions; and 2) Development Policy Lending, which supports policy and institutional reforms. With its increasing focus on results, the Bank began to include Results-Based Financing (RBF) projects within larger investment lending projects. The Bank also started developing a new, third financing instrument called Program for Results (PforR). The PforR instrument was officially approved by the Bank’s Board in January 2012, after extensive discussions in countries, including Ethiopia.

PforR is distinct from the Bank’s other financing instruments in that disbursements are linked to results, instead of inputs, and the instrument works through government systems instead of setting up parallel systems (for example, for procurement). PforR instruments a) support national strategies; b) disburse against verified achievement of results rather than inputs; c) focus on strengthening institutional capacity to implement; and d) provide assurance that the Bank’s financing is used appropriately and that environmental and social impacts are adequately addressed.\textsuperscript{13} In addition, PforR seeks to foster increased collaboration with development partners through pooling of resources in support of government programs.\textsuperscript{14} PforR is different from the Bank’s RBF programs embedded within investment lending projects in that it is a stand-alone financing instrument wholly focused on results, supports the government’s larger national program, and works through government systems (rather than Bank systems), including for verification of results. In PforR, achievement of results triggers disbursements to government at the national-level. This differs from the Bank’s RBF programs that are focused on individual health facilities, in which achievement of results triggers payments at the facility level.

PforR also differs in how it addresses risks. For traditional investment lending, the Bank has a number of mechanisms by which to assess risk and build safeguards. Assessments

\textsuperscript{11} Ibid; Interview 3 with FMoH official, Addis Ababa, December 16, 2013.
\textsuperscript{12} \textit{Inputs} are defined as the resources provided for an intervention and \textit{outcomes} are the intermediate effects generated by the outputs.
\textsuperscript{14} Ibid.
pinpoint specific weaknesses in financial, procurement, and other relevant systems, and trigger a series of Bank policies and prerequisites conditional to receipt of funding. PforR likewise requires assessments but the assessment activity ends in the production of three reports: a) Technical Assessment; b) Integrated Fiduciary Assessment merging financial management and procurement risk assessment; and c) Environmental and Social Systems Assessment (ESSA) combining environmental and social systems assessment.

These reports analyze not only the weaknesses relevant to particular programs and projects, but also constitute a broad analysis of overall government systems. If weaknesses are found, no specific policies or safeguards are triggered. Rather, the Bank works with the government to address problems in different ways. For example, the weakness might be made into an indicator linked to disbursements (such as a disbursement that occurs after the development of a protocol or survey). The weakness might also be addressed by a formal agreement between government and the Bank that stipulates that problems will be addressed within a time frame (dated covenant). Specific actions required to address the identified weaknesses might also be included in the Program Action Plan that is referenced in the financing agreement. Finally, the weakness might be given special attention in the implementation support phase.\(^\text{15}\)

The Bank approved the first two PforR instruments in June 2012. One was in Nepal for a bridge improvement and maintenance program; the second was in Morocco for improving services and economic opportunities in poor communities.\(^\text{16}\) The PforR operation in Ethiopia, approved in February 2013, marked the first time this financing instrument would be used in the health sector.

2.2 Millennium Development Goals Support Program for Results (PforR) Operation in Ethiopia

The Millennium Development Goals Support PforR Operation in Ethiopia is a five-year program (2013-2018) that seeks to improve the delivery and use of a comprehensive package of maternal and child health services. Total Bank financing for the project is $120 million—consisting of a $100 million credit from the Bank’s International Development Association (IDA) and a $20 million grant from the Health Results Innovation Trust Fund (HRITF). Bank disbursement of funds is tied to results, following verification of disbursement-linked indicators (DLIs). Each DLI has one or more dates of verification depending on when data collection is planned. Ethiopia has until the end of the five years to make achievements on any indicator.

The PforR guidelines allow provision of advances and payment for prior results (results that are achieved between the concept note and signing of the program legal

\(^{15}\) Interview 1 with World Bank official, Addis Ababa, December 15, 2013.

\(^{16}\) The list of World Bank PforR operations can be found at: http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTS/0,,contentMDK:23223752--pagePK:41367--piPK:51533--theSitePK:40941,00.html
The Bank agreed to give $10 million (8.3% of the total allocation) to the GoE in advance for prior results. This prior results allocation was for establishment of a baseline for immunization coverage and development of a survey protocol for annual facility assessments. In addition, the Bank agreed to an advanced payment of $26 million (21.7% of the total allocation) to support inputs and institutional development activities towards the achievement of DLIs (see Table 2 for more information about financing for prior results and advances for each DLI.)

The Bank and GoE preparation of the PforR instrument involved a series of steps. In the first step, the Bank’s Task Team—led by Dr. G. N. V. Ramana and Dr. Huihui Wang—developed concept documents with the FMoH. This process began in January 2012 and the Task Team submitted documents for Bank Concept Review on March 13, 2012. At Concept Review, the decision was taken to proceed with preparation of the PforR instrument. The Task Team then moved on to developing the Program Appraisal Document (PAD) and submitting it for the Bank’s Decision Review Meeting. As part of developing the PAD, which occurred between March and December 2012, the three PforR assessments were conducted and legal agreements drafted. The Decision Review Meeting in November 2012 was followed by appraisal and negotiations with the GoE in which agreements were made and documents finalized. These final documents were then submitted to the Bank’s Board, which approved the operation in February 2013.

This case study documents the process of preparing the PforR instrument in Ethiopia. It is based on World Bank program documents as well as semi-structured, in-depth interviews with 18 stakeholders who were involved in the preparation stage of PforR in Ethiopia. Interviewees were selected purposively, based on recommendations from the PforR Task Team Leaders, and interviews were carried out between December 15, 2013 and January 15, 2014. Interviews followed a guide based on four thematic categories: 1) the context of launching PforR in Ethiopia; 2) the content of the technical design; 3) the process of moving the program towards Board approval and implementation; and 4) lessons learned. The data was analyzed with qualitative content analysis, in which researchers systematically reviewed and coded the transcript texts, and identified themes.

The case study identified four key challenges that were encountered by the Bank’s Task Team and GoE stakeholders during the preparation stage: 1) deciding to move ahead with PforR; 2) identifying the program scope; 3) reaching agreement on DLIs, targets, and verification mechanisms; and 4) conducting and finalizing assessments. Each challenge is discussed separately below, and then conclusions and recommendations are suggested.

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17 The Bank’s PforR guidelines allow an advance payment of up to 25 percent of PforR financing for one or more DLIs that have not yet been met. When the DLI for which an advance has been disbursed is achieved, the amount of the advance is deducted from the amount due to be disbursed under the DLI.

18 The researchers interviewed 13 people in Ethiopia (nine at the Bank’s office in Addis Ababa and four at FMoH). Another person, formally of the Ethiopia country office, was interviewed in Kampala, Uganda. An additional four interviews were conducted by telephone—three with World Bank staff members in Washington, D.C. and one with a consultant based in Ethiopia. Several other key stakeholders were no longer working at the Bank, or were on leave, so were unavailable for interviews during the time allotted for the study.
3. Deciding to move ahead with PforR

As mentioned previously, the World Bank in Ethiopia began dialogue with government counterparts on potentially using the new PforR instrument in Ethiopia because of its results-focused approach and focus on country systems strengthening, both priorities for the GoE. One FMoH official explained their interest in the new instrument, “When we look at previous Bank instruments, these were not bad, but the focus is largely on Bank procedures. This is a waste of time and incurs large costs. You can’t improve the health system because the focus is on how to manage programs and projects. So the change [with PforR] is to focus on results and help a country to utilize systems. It actually serves as a push for the country to improve its own systems.”

This official also felt that PforR was more aligned with Ethiopia’s IHP+ Compact and its emphasis on country ownership, use of country systems, and a focus on results.

Despite their support for these features of the PforR instrument, some GoE officials were cautious. The GoE was used to the investment lending approach and procedures of the PBS project. As one Bank official observed, “the government was happy with the PBS project and did not want to change.” Furthermore, some GoE officials worried that they were taking on a big risk with PforR because if they failed to achieve results, the money would be lost. As an FMoH official explained, “PforR is really dependent on our performance and if our performance is low it would endanger the whole process.”

Bank officials from both the country office in Addis Ababa and the Bank’s headquarters in Washington, D.C. visited FMoH and MoFED to talk through these concerns. A key event was a visit by the World Bank Director of the Human Development Group for the Africa Region. She joined a government retreat and met with both the Finance Minister and the Health Minister. Her involvement was critical to buy-in by both MoFED and FMoH.

In dialogue, Bank officials emphasized that compared to traditional investment lending, PforR allows the GoE to use its own systems for the project (including those for procurement and verification of results), allowing the GoE to avoid lengthy Bank procedures. To address Ethiopia’s concern about failing to achieve results and losing the money, Bank officials clarified that the PforR instrument provides for scalable results that allow partial disbursements if only partial results are achieved. For example, at the start of PforR, only 10% of births in Ethiopia were attended by a skilled birth provider. If, at the end of five years, Ethiopia achieves its PforR target of 18% of births attended, the total proportion of funding earmarked for the DLI (in this case US $20 million) would be disbursed. However, if Ethiopia only achieves smaller improvements, it would still receive an increment of the funds for every 1% improvement over the existing 10% indicator.

After two years of dialogue, the GoE and Bank signed an agreement in September 2011 to proceed with PforR preparation. Bank officials in Washington, D.C. felt that since

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19 Interview 6 with FMoH official, Addis Ababa, December 18, 2013.
21 Interview 5 with FMoH officials, Addis Ababa, December 18, 2013.
PforR was new to both the Bank and the client, an experienced Task Team Leader was needed. Dr. G. N. V. Ramana, a Lead Health Specialist based with the Bank in Kenya, was asked to take over as Task Team Leader for the preparation process. A few months later, Washington, D.C.-based Dr. Huihui Wang joined as co-Task Team Leader. Dr. Mieraf Tadesse, Extended Term Consultant based in Addis Ababa, engaged the client and was supported by Dr. Mohamad Ali Kamil, Senior Health Specialist. Together they led a team of 29 Bank staff and consultants located in Addis Ababa and Washington, D.C.

The dialogue process highlights the importance of establishing relationships and developing trust between Bank and GoE officials in an environment where PforR was new to government officials. As will be discussed in more detail below, the way in which PforR was presented to the GoE during these early dialogue sessions had implications for how GoE officials expected preparation to unfold, both in terms of timing and process.

4. Identifying the Program Scope

As preparations began, a decision had to be made about PforR’s scope—the boundaries that define the extent of the program’s area of focus, applicability, and operation. The Task Team and the FMoH began the concept development stage with a focus on the HSDP IV. As outlined in the concept document, the proposed objectives for PforR in Ethiopia “are a subset of the HSPD IV mission statement which aims to reduce morbidity, mortality and disability and improve health status of the Ethiopian people through providing and regulating a comprehensive package of promotive, preventive, curative and rehabilitative health services via a decentralized and democratized health system.”

As will be discussed in a later section, once the Task Team began working on the PAD, they realized that the assessment process would be difficult because the assessments would need to consider all national systems relevant to the HSDP IV. Additionally, the FMoH learned about a procurement rule related to PforR that would have major implications for the HDSP IV. This procurement rule involves a cap on high-value contracts—contracts with estimated values exceeding the monetary amounts that require mandatory review by the Bank’s Operations Procurement Review Committee (OPRC). The rule came about when PforR was first approved because the Bank’s Board did not want PforR financing to be used for high value procurement. The Board planned to revisit the necessity of this regulation after the first two years of launching the PforR instrument. Applying this cap on high value contracts to the entirety of Ethiopia’s HDSP IV strategy meant that all procurement over the cap would have to go through Bank procedures for procurement—something the FMoH did not want to do.

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Because of these implications of defining PforR’s scope in terms of the HDSP IV, the Task Team began to consider ways to narrow PforR’s scope. They wanted to ensure that the scope was not so narrow that it became a project. They knew that the GoE preferred two main channels for funding: the MDG PF and block grants. Together with the GoE, a decision was made to focus on the MDG PF—an existing, multi-donor fund, large enough to house the financing. Table 1 shows the MDG PF donors and projected financing for the five-year duration of PforR.26

<table>
<thead>
<tr>
<th>Donor</th>
<th>USD (millions)</th>
</tr>
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<tbody>
<tr>
<td>UK DFID</td>
<td>413.00</td>
</tr>
<tr>
<td>Netherlands Government</td>
<td>43.60</td>
</tr>
<tr>
<td>Australian AID</td>
<td>43.00</td>
</tr>
<tr>
<td>Spanish Development Corporation</td>
<td>34.10</td>
</tr>
<tr>
<td>Others (UNICEF, UNFPA, Irish AID, WHO, Italian Cooperation)</td>
<td>22.40</td>
</tr>
<tr>
<td>World Bank (IDA/HRITF)</td>
<td>120.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>676.10</strong></td>
</tr>
</tbody>
</table>


Many of the donors in the MDG PF were intrigued with the results focus of the PforR instrument and were watching closely how preparation and implementation of the operation proceeded in Ethiopia. Yet these donors had already agreed to a set of harmonized procedures for the MDG PF and some donors were concerned that PforR financing was not aligned with these existing procedures. In particular, they were concerned about the cap on high value contracts since the FMoH used a significant amount of the MDG PF funding for procurement.27

Many meetings were held within the Task Team itself, and with officials in Washington, D.C., stakeholders within the FMoH, and donors in the MDG PF. A decision was made to resolve the problem with PforR’s cap on high-value contracts by establishing a subaccount in the MDG PF specifically for the PforR financing. This provides better tracking of Bank funds. Both FMoH and some Bank officials felt frustrated with the procurement cap because of the time it took to reach a solution to the problem, and the fact that the rule contradicts the Bank’s commitment to work through government systems with PforR. As one FMoH official stated, “This [cap] proves that the World Bank has not let go completely.”28

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26 Interview 12 with World Bank official by phone, January 14, 2014.
27 Interview 10 with World Bank official by telephone, January 7, 2014.
28 Interview 5 with World Bank officials, Addis Ababa, December 18, 2013.
5. Reaching agreement on Disbursement-Linked Indicators (DLIs), targets, and verification mechanisms

Another key step in the preparation process was reaching agreement on the DLIs, targets, and means of verifying the achievement of targets. Linking disbursements to results was a new model for the Bank and meant that the Task Team had to focus on the collection and presentation of evidence to help the FMoH identify indicators and set targets, as well as on the assessment of the strengths of potential verification institutions (like the Central Statistics Agency). This process of agreeing on the DLIs, targets, and verification systems took the Task Team and FMoH two to three months to complete, with the group encountering several stumbling blocks along the way.

5.1 Agreeing on DLIs

People wanted a lot of indicators, but we need only a few and then we can focus on these and learn. We can add later.\textsuperscript{29}

Within the GoE and within the Bank, there were lengthy discussions about which DLIs to choose for PforR. Some stakeholders within the GoE lobbied for DLIs relevant to their own program interests.\textsuperscript{30} The ongoing lack of clarity regarding program scope (whether PforR should be tied broadly to the HSDP IV or more narrowly to the MDG PF) also contributed to the debate over which DLIs should be chosen, and how many. At one point, over 20 DLIs had been identified. The Bank and the FMoH worked together to narrow down the number of DLIs that were initially proposed so they could be realistically monitored and credibly verified. Eventually, the DLIs were reduced to eight indicators, as shown in Table 2. These were divided equally between what the Bank’s Program Appraisal Document (PAD) refers to as “program development objectives” and “intermediate results” indicators to ensure a balance between attaining measurable maternal and child health results and building strong GoE systems to improve the evidence base.

\textsuperscript{29} Interview 6 with FMoH official, Addis Ababa, December 18, 2013.
Table 2: DLIs for Ethiopia’s Millennium Development Goals Support Program for Results

<table>
<thead>
<tr>
<th>Program Development Objective DLIs</th>
<th>Baseline</th>
<th>HSDP IV Base Case Scenario Target</th>
<th>PforR Target</th>
<th>Value US$ (million)</th>
<th>Verification Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Deliveries attended by skilled birth providers (%)</td>
<td>10.0</td>
<td>65.0</td>
<td>18.0</td>
<td>20.0 (25% advance payment)</td>
<td>Year 2 - Mini DHS Year 4 – Full DHS (CSA/EHNRI with TA from ICF-Macro)</td>
</tr>
<tr>
<td>2. Children 12-23 months immunized with Pentavalent 3 vaccine (%)</td>
<td>65.7</td>
<td>88.0</td>
<td>75.7</td>
<td>19.0 ($6 million for prior results; 25% advance payment)</td>
<td>Year 3 &amp; 5 Cluster Survey EHNRI</td>
</tr>
<tr>
<td>3. Pregnant women receiving at least one antenatal care visit (%)</td>
<td>42.6</td>
<td>76.0</td>
<td>56.0</td>
<td>14.3 (25% advance payment)</td>
<td>Year 2 - Mini DHS Year 4 – Full DHS (CSA/EHNRI with TA from ICF-Macro)</td>
</tr>
<tr>
<td>4. Contraceptive Prevalence Rate (%)</td>
<td>28.6</td>
<td>66.0</td>
<td>35.0</td>
<td>20.5 (25% advance payment)</td>
<td>Year 2 - Mini DHS Year 4 – Full DHS (CSA/EHNRI with TA from ICF-Macro)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intermediate Results DLIs</th>
<th>Value US$ (million)</th>
<th>Verification Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Health Centers reporting HMIS data in time (average number for four quarters)</td>
<td>5.0 (25% advance payment)</td>
<td>Semiannual country-wide HMIS data validation (Policy, Plan &amp; Finance General Directorate)</td>
</tr>
<tr>
<td>7. Development and implementation of Annual Rapid Facility Assessment to assess readiness to provide quality MNCH services</td>
<td>14.0 ($4 million for prior result)</td>
<td>Annual random quality checks. (EHNRI with technical support)</td>
</tr>
<tr>
<td>8. Improved transparency of the Pharmaceutical Fund and Supply Agency (PFSA) procurement processes)</td>
<td>7.0 (25% advance payment)</td>
<td>Annual review of PFSA website (external consultant hired by FMoH with technical support).</td>
</tr>
</tbody>
</table>

5.2 Setting Appropriate and Accurate Targets

Once agreement on DLIs was reached, the next step was to set targets. The FMoH wished to align the PforR instrument as much as possible to the HSDP IV which itself sets very high targets in health. In the early stages of preparation, the FMoH felt that PforR targets on health outcomes should be as ambitious as possible. But since PforR disbursement was linked to the achievement of targets, the Task Team was concerned that, if the FMoH fell short, it would be impossible to release the funds.

In order to help the FMoH set targets that were challenging but could also be realistically met in the five-year timeframe, the Task Team emphasized that other ODA could be used to support the FMoH’s HSDP IV goals and objectives and that PforR could add value by contributing to incremental achievements toward the HSDP IV targets. They also gathered global evidence on the annual percentage increases for outcome DLIs in developing countries, as well as on the past trends in Ethiopia. This evidence helped champions within the FMoH to make a case for more realistic, achievable outcome targets. For example, the HSDP IV has a target of 65% deliveries attended by skilled birth providers. After studying the international benchmarks and national-level evidence on annual percentage increases in deliveries attended by skilled birth providers, the FMoH ultimately decided that the PforR target should be 18% since the baseline was 10% (as shown in Table 2).

An additional issue was whether targets should be at the national or subnational level. Discussion about the DLIs took place entirely at the national level but the implementation of services to achieve outcomes, as well as the collection of data about results, would occur largely at woreda level. One FMoH official explained that the Ministry collects subnational data and is aware of regional disparities but that setting “DLIs…linked to regions, [is] like playing a game. Because some regions can’t meet targets.” The decision was made to focus PforR on national-level targets with the hope that once these targets were met, the GoE could begin to address inter-regional equity.

5.3 Selection of Verification Systems

After selecting DLIs and setting targets, the focus moved to verification systems. Both the FMoH and the Task Team acknowledged that existing verification systems in Ethiopia are weak, but there was a difference of opinion as to the best remedy. The GoE preference was to strengthen existing government systems through the PforR financing. Ethiopia already collects routine HMIS data at the facility level, including data on antenatal visits, deliveries by skilled birth providers, and contraceptive use. They carry out Expanded Program on Immunization (EPI) cluster surveys every five to six years with technical support from UNICEF, the most recent of which was in 2012. There is

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33 Interview 6 with FMoH official, Addis Ababa, December 18, 2013.
also a full Demographic and Health population survey (DHS) every five to six years, the most recent of which was in 2011, implemented by the Central Statistics Agency (CSA) in partnership with ICF-Macro. However, the Bank team was concerned about the quality and completeness of HMIS data, and the next full DHS was not scheduled until 2016. The Task Team felt that some external verification activities should be included in the PforR instrument.

A solution was devised in which the Ethiopia Health and Nutrition Research Institute (EHNRI) would carry out more frequent EPI cluster surveys in 2015 and 2017, while CSA/ICF-Macro would conduct a mini-DHS in 2014 to provide a midterm measure of deliveries by skilled birth providers, antenatal visits, and contraceptive use. The Bank would make a prior results disbursement following the development of a survey protocol for annual facility assessments of readiness to provide services. In the meantime, more rigorous monitoring of routine HMIS and facility-level data collection would also lead to disbursement against process DLIs and improve measurement of outcome DLIs.

The establishment of the new mini-DHS and the reliance on additional cluster surveys to supplement gaps in the existing verification system means that the PforR verification strategy does not rely solely on existing government systems, as was initially promised by the Bank to the GoE. As one FMoH official said, “All [of these activities] may generate important information, but additional data collection represents a burden for the country.”

The additional verification measures require meetings, discussion, and negotiation with a number of different groups as no single office or organization handles data collection. The hope of both the FMoH and the Bank team is that the process DLIs will improve existing systems enough to ensure that in the future the relevant verification activities can be run entirely through existing government institutions and timetables.

6. Conducting and Finalizing Assessments

It’s a balance. You have to follow the Board mandate on one hand. But you also have to follow the spirit of the [PforR] instrument. You have to balance how much you dig into a systematic assessment with what is the minimum needed within the system to disburse.

A key step in developing the Program Appraisal Document (PAD) in PforR preparation is conducting three assessments of government systems (as noted above): a Technical Assessment, an Integrated Fiduciary Assessment merging financial management and procurement risk assessment, and an Environmental and Social Systems Assessment (ESSA). The assessment period for PforR in Ethiopia took seven months and proved to be a contentious process.

34 Interview 5 with FMoH officials, Addis Ababa, December 18, 2013.
36 Interview 4 with FMoH officials, Addis Ababa, December 17, 2013.
6.1 Understanding the PforR Instrument and Assessment Scope of Work

We worked with the client to convince them on PforR even before the [PforR] document was ready. It [the financing instrument] hadn’t even been approved yet. But a similar thing did not happen internally [within the Task Team].

PforR in the health sector was the Bank’s first time preparing this new financing instrument in Ethiopia. While the Bank, both in Addis Ababa and Washington, D.C., had given significant time to securing GoE buy-in for the PforR instrument, less emphasis was given to briefings and discussions within the Bank’s Task Team itself to ensure members understood the instrument and their role in the preparation stage.

This was particularly the case for Task Team members working on financial management, procurement, and environmental and social assessments. Under traditional investment lending, these team members conducted assessments using checklists and guidelines to identify precise problem areas and implement safeguards within the context of a specific project. PforR assessments required them to broaden their assessments to look at systems unrelated to the specific maternal and child health interventions targeting the DLIs. This change of focus represented a paradigm shift for the Bank’s Task Team members whose professional identity involved a commitment to identifying risks and implementing appropriate safeguards. Team members spoke of confusion about the scope of work for PforR assessments and the difficulty of understanding national systems within a very tight assessment timeline.

One member of the Integrated Fiduciary Assessment team attended a Bank workshop in Tanzania that was held for financial management staff so they could learn more about the new PforR instrument. While this workshop was helpful in learning more about the instrument, it focused primarily on Tanzanian activities and experiences and provided little opportunity for participants to think about how to operationalize these lessons in their own assessments. Another Task Team member noted: “When PforR was introduced, there were lots of guidelines and trainings but people didn’t get what it was they needed to do, how to start preparing, whether certain policies that applied to traditional investment lending also applied to PforR. It wasn’t relevant to everyone on the team.” Some assessment team members did not have a clear sense of what the assessments were supposed to accomplish, divorced as they were from the remedies that were triggered in investment lending when problems were encountered.

Continued change of the program scope of the PforR instrument in Ethiopia added to the tension felt by Task Team members conducting assessments because when the

40 Interview 11 with World Bank official, January 7, 2014.
41 Interview 7 with World Bank official, Addis Ababa, December 18, 2013.
assessments started, they were initially asked to assess national systems relevant to the entire HSDP IV. Debate ensued between the technical members and supporting members of the Task Team about how to narrow the focus so that the assessments would not be overwhelming, and would not lead to unnecessary impositions on government.

6.2 Data Availability

Once it was decided that the program scope would be narrowed to the MDG PF, it became evident that a significant portion of the fund’s resources goes to the Pharmaceuticals Fund and Supply Agency (PFSA) for procurement purposes. This meant that the Integrated Fiduciary Assessment team needed to obtain data from PFSA. Even after repeated trips to the PFSA, they were unable to obtain all the data needed to meet the Bank’s assessment guidelines. The ESSA team also experienced problems with data collection and availability. Carrying out an ESSA for national systems was an entirely new process for the team members in Ethiopia—an external consultant was hired to lead the assessment but the availability of data, and the time it would take to collect it, were both underestimated. A second safeguard specialist from the Bank (based in Washington DC) ultimately completed the assessment. Because of data availability, the final ESSA focused on a few issues, including medical waste, for which national-level data exists.

An additional challenge was that national financial accountability institutions—such as the Public Procurement and Property Administration Agency and the Federal Ethics and Anti-Corruption Commission—are not specific to the health sector. In the assessments, then, the FMoH felt it was necessary to defer discussions on many issues related to financial management and auditing to these institutions. This created a number of challenges for those team members conducting assessments. As one Task Team member explained, “You discuss with outside agencies which have no power to make improvements to the health sector, while the health sector can’t guarantee accountability because other institutions do this work.” Moreover, “these other agencies also need resources. So we are asking these agencies to ‘check on this’ but they will not be receiving money from PforR. Cross-sectoral cooperation [within government] was a big challenge.”

There was also a conflict between members of the assessment team and the FMoH over the type of information the Bank was asking for. For example, the assessment team wished to look at internal audit reports from the PFSA. The FMoH felt that these reports were for internal management purposes and the focus of the assessment should be the MDG PF as this is where PforR funds would be disbursed. The FMoH also pointed out that there were existing auditing arrangements within the MDG PF, agreed upon by development partners, which allowed for preliminary financial management assessment.

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and routine reporting. The fiduciary team felt these reports were not sufficient to complete the assessment, according to the Bank’s PforR assessment guidelines.

An existing Memorandum of Understanding between the Bank and the GoE was eventually used as a means of bridging demands by the assessment team and the concerns of government on meeting the PforR requirements for fraud and corruption. However, in the absence of up-to-date, detailed, financial and procurement information, the Integrated Fiduciary Assessment team ended up utilizing data that was either very basic or out-of-date. A first draft of the fiduciary findings was initially presented in July 2012 and the presentation was badly received by the FMOH, which felt that the document did not represent how financial management was actually working at either the highest level of government, or at the grassroots level.

Ultimately, the fiduciary assessment document ended up going back and forth between the Bank and the FMOH multiple times in order to achieve language that was acceptable to government. Consequently, the FMOH perceived that their systems were being inaccurately portrayed and unfairly criticized. It aggravated feelings of mistrust by FMOH stakeholders who were suspicious as to why the assessment was digging into particulars of the PFSA and felt the fiduciary team was looking for excuses to halt preparations.

6.3 Producing an Integrated Fiduciary Assessment Report

The data from the procurement and financial management assessments then had to be integrated into a single report. Team members note that other organizations routinely produce integrated assessments with little difficulty and that the Bank is increasingly moving toward Integrated Fiduciary Assessment for traditional investment lending. However, PforR represented the first time the Bank in Ethiopia carried out integrated assessment, and this integration required negotiations between the two separate procurement and financial management risk assessment models. The integration process led to a conflict of ideas as to what should go into the report, differences of opinion about what topics should be prioritized, and diverging perceptions as to risk levels. Team members expressed frustration at the lack of cohesiveness of the integration process, and the fact that there was no clear leader coordinating integration.

In order to fulfill the Bank’s instructions for Integrated Fiduciary Assessment (the instructions themselves were over 30 pages long) and accommodate concerns from procurement and financial management experts, the completed document came to over 70

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49 Ibid.
pages. As the report was meant to be only 15 pages, a substantial amount of time was taken up within the Ethiopia country office, and in negotiations with Washington, D.C., about what information to cut from the report.

6.4 Consequences of Assessment Challenges

The challenges encountered in the assessment period added significantly to the preparation timeline. The process of data collection started in June 2012, yet the PAD could not be finalized until December. The length of the timeline was a function of both the assessment challenges but also the multiple levels of decision-making required by the Bank—within the sector, Country Management Unit, and the region—before the PAD could be finalized. One assessment team member noted, “We ended up promising dates and timelines that were not realistic, and we promised them to both external stakeholders and internal management.”\(^{50}\) There was a recognition that given the workload of Task Team members conducting the assessments, external consultants could have sped up the process considerably.

The assessment process created further tension with the GoE, as the government felt that it had been misinformed about the purpose of PforR. One of the key features of the financing instrument that Bank officials used to gain buy-in from the GoE was that it would utilize existing government systems and decrease the parallel information and reporting burden required by traditional investment lending. The GoE viewed the assessments as a contradiction to the value added of PforR since they were externally driven by the Bank, focused specifically on weaknesses, and lacked corrective guidance. As one Bank official in Washington, D.C. summarized: “The [GoE] wanted this. But what they didn’t reckon with was that this instrument can also be very ponderous in its own way. The perspective of the government during this time was that what was supposed to be a streamlined process became a protracted one.”\(^{51}\) There was also dissatisfaction within the assessment teams with the outcomes of the assessment, as team members pointed out that there are no real means by which to enforce risk reduction, as money is only tied to outcomes, not to implementing safeguards.\(^{52}\)

Task Team members characterized the assessment stage as a period of conflict within the team itself.\(^{53}\) The internal conflict was evident to the GoE: “It [the assessment process] was honestly very terrible, even within the Bank. I could see it even during discussions, these divisions within the Bank. Some groups within the Bank don’t want to use this new instrument. Some felt the government would not handle it very well.”\(^{54}\) Some team members felt that with better coordination and communication within the Task Team,

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\(^{50}\) Interview 7 with World Bank officials, Addis Ababa, December 18, 2013.

\(^{51}\) Interview 10 with World Bank official by telephone, January 7, 2014.

\(^{52}\) Interviews 7 and 8 with World Bank officials, Addis Ababa, December 18, 2013.


\(^{54}\) Interview 6 with FMoH official, December 18, 2013.
more realistic timelines could have been set, the standard of work improved, and the level of conflict kept to a minimum.\textsuperscript{55}

7. Conclusions and insights

\textit{We call PforR ‘high maintenance preparation’.}\textsuperscript{56}

\textit{PforR requires a shift in thinking and practice..., from hardwiring to be risk averse in certain core functions to an institutional drive for outcomes, results, and reasonable risk.}\textsuperscript{57}

The process of preparing PforR for the Ethiopian health sector has already resulted in important changes to the way Task Team members approach results-based financing and how they work with government and with each other. Many of the lessons learned during preparation of PforR in the health sector have been applied to the preparation of PforR for Ethiopia’s urban sector. Task Team members anticipate that PforR preparation will become easier with experience—both in Ethiopia, and across Africa.\textsuperscript{58}

The context in which PforR preparation took place is specific to Ethiopia, and therefore the experience is not directly generalizable to other country contexts. There are, however, a number of lessons learned from PforR preparation in Ethiopia that may provide lessons for other Task Teams embarking on preparation of PforR in other countries.

- **Ensure PforR is an appropriate financing instrument for the context**

\textit{On one hand [PforR] provokes [government]: ‘You are on your own. Let us see what you can do.’ And it supports systems, which is what we in developing countries need. But are we ready as a developing country to really fly on our own?}\textsuperscript{59}

Since PforR works through government systems, it may not always be relevant in every context or to every sector. Before proceeding with preparation, the Bank must assess the robustness and readiness of government systems, and consider whether risk mitigation strategies and systems-related DLIs are sufficient remedies for weaknesses in systems. Some governments may recognize that they lack the capacity to manage PforR funds or that they cannot improve their verification systems quickly enough to demonstrate results. To achieve measurable outcomes and simultaneously build capacity in the sectors in which those outcomes are going to be achieved may require different models of financing.


\textsuperscript{57} Interview 10 with World Bank official by telephone, January 7, 2014.

\textsuperscript{58} Interview 10 with World Bank official by telephone, January 7, 2014; Interview 11 with World Bank officials, January 7, 2014.

\textsuperscript{59} Interview 11 with World Bank officials, January 7, 2014.
• Allocate sufficient time to engage in high-level dialogue with the client about PforR in order to build relationships, trust, and an understanding of Bank requirements for the preparation process

In countries where the PforR instrument has not been previously utilized, time should be allocated for high-level dialogue about what the PforR instrument is, its differences with other financing instruments, why it is important in the country context, and particular rules (such as the cap on high value contracts) that may prove challenging. It is also important to have strong local staff who can sustain the dialogue between the missions. The assessment process—what the assessments are, why they are needed, what data will be required to conduct them, and how the findings will be used—should be made clear to government during the early dialogue phase. As was discovered in Ethiopia, the content of discussions in early dialogue between the Bank and the client has important implications for the client’s expectations for the PforR preparation period, both in terms of timing and process.

• Invest time in gaining buy-in for PforR within the Bank’s Task Team

The Ethiopia case demonstrates the importance of spending as much time building internal buy-in for PforR within the Task Team as achieving buy-in from the client. Time must be allocated to briefings and discussions within the team to ensure members understand the instrument and their role in the preparation stage.

• Make a decision about program scope as a first step in the preparation process

A clear program scope must be agreed to in dialogue between the Bank and the government before selecting DLIs so that indicators can be directly related to PforR objectives, increasing the likelihood that funding will be linked to results. Also, the program scope must be decided prior to conducting assessments and be fully communicated to Task Team members involved in assessments.

• DLIs should be limited in number, challenging but achievable, and verifiable

The process of selecting DLIs requires focusing on a reasonable number of indicators that strike a balance between program development objectives and intermediate systems-level results that help improve government systems for verifying results. Targets should be challenging but realistic to achieve within the project timeline, and under the direct control of the government. The Bank’s Task Team can provide valuable support to the client by providing international and national evidence for target setting. When possible, verification mechanisms should use existing government systems, with both PforR disbursements and DLIs targeting the improvement of those systems.
• Allocate adequate time, human, and financial resources for the PforR assessments

For team members involved in assessments without prior PforR experience, well-planned, operational trainings can help them prepare for assessment. The Bank’s PforR guidelines for assessment should be appropriate to the expected content and length of the assessment report. A pool of external, independent consultants should be engaged to provide technical support for both assessment data collection and for merging the integrated fiduciary assessment. Coordination and leadership issues related to data collection and integration of assessments should be worked out in advance.

• To prepare and implement PforR, the Bank must change how it works, both conceptually and practically

From the point of view of IHP+, the central principle is to let countries own the process and use their own systems and focus on results. There is no way to do this without changing the way you do business. 60

PforR is a powerful financing mechanism through which the Bank can add value to its clients. Governments are becoming increasingly frustrated with partners that require parallel systems for projects, and with projects that fail to tie inputs to measurable results on the ground. PforR requires a trust in government systems that even government itself may view as not functioning efficiently or transparently. The Bank as an institution has traditionally focused on the provision and safeguarding of inputs. The paradigmatic, procedural, and logistical changes required to prepare and implement PforR in countries such as Ethiopia are enormous and require the Bank to transform the way it does business with its clients. As one Bank official stated, “The focus on outcome-based financing requires people to move from saying something is bad or risky, to proposing how to make it work. It is about managing risks. Just because an instrument has zero tolerance for fraud doesn’t mean it has zero tolerance for risks.” 61

• Be realistic, and do not expect perfection

“You have to be realistic. You are carrying out the program in countries that are obviously imperfect. If they were perfect, then why carry out the program in those countries?” 62

PforR requires Task Team members to shift their focus to utilizing existing government systems and disbursing on the achievement of results. In PforR, the Bank no longer monitors fiduciary, governance, environmental, and social risks across the duration of the program. For some of the Task Team members for Ethiopia PforR, accepting this change in the Bank’s role has been challenging. Yet as officials in both the Bank and the FMoH stated, if government systems were perfect, there would be no need for PforR in the first place.

60 Interview 6 with FMoH official, Addis Ababa, December 18, 2013.
61 Interview 10 with World Bank official by telephone, January 7, 2014.