Annotated literature review: African actors, global health governance and performance-based funding

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Executive summary

Performance-based funding (PBF) has become increasingly popular in global health financing. It is defined essentially as the transfer of resources (money, material goods) for health on condition that measurable action will be taken to achieve predefined health system performance targets such as particular health outcomes, the delivery of effective interventions (such as HIV prophylaxis), utilisation of services (like HIV counselling and testing), or quality care. Due to the apparent incentives that tailored resource transfers offer, PBF is increasingly promoted by leading global actors as a way to efficiently and effectively reform the way health systems are planned, financed, co-ordinated and steered, particularly in low- and middle-income countries. Importantly, key funding agencies such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the World Bank also argue that PBF will promote reform in a way that is locally owned and accountable, given that performance targets and indicators will be developed through *active participation* of local actors from the bottom up, rather than being set by global agencies from the top down.

This annotated literature review has been prepared for the research programme led by the Regional Network for Equity in Health in East and Southern Africa (EQUINET) on Global Health Diplomacy and the specific focus on African actors and global health governance. Despite the predominance of PBF within the global health lexicon, there remain several contentious and underdeveloped aspects related to its use in supporting health system strengthening as well as its ability to foster increased participation from stakeholders. This review highlights the key strengths and weaknesses associated with PBF schemes in their use in low- and middle-income countries. It illustrates the theoretical thinking behind PBF implementation. It also seeks to draw out analysis of the role of African actors in global health diplomacy and decision-making surrounding PBF.

Despite an extensive and expanding literature on PDF, the review suggests that many areas remain underdeveloped. Key research gaps identified in this review relate to:

- A lack of research confirming the assumed causal pathways between PBF and positive health outcomes;
- Limited literature about why PDF has come to dominate the development lexicon;
- A lack of research on how the agendas and preferred performance targets of global actors, like the World Bank and Global Fund, become embedded in, and potentially *re*shape, local forms of state governance, participation and authority;
- A lack of research on how actors (particularly African actors) – governments, civil society, individuals and the private sector – have participated in the design, implementation and delivery of PBF initiatives, either in deliberations or decision-making processes about whether and why such strategies are adopted, about how and to what ends they are applied, about what targets are set, about who sets these targets, what is measured and what constitutes 'good' performance;
- A lack of research addressing the relationship between PBF outputs and social justice outcomes.

In short, there is limited systematic research evidence to confirm that PBF is (or is not) an effective strategy for reforming health system governance in a participatory, universally equitable and sustainable way. Using this review as its basis, this project in association with EQUINET will seek to help address these gaps.

1. Introduction

This annotated literature review has been prepared for the research programme led by the Regional Network for Equity in Health in East and Southern Africa (EQUINET) on Global Health Diplomacy and the specific focus on African actors and global health governance. The project seeks to analyse the role and participation of east and southern African actors in the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the World Bank and the World Health Organisation (WHO) through a case study on negotiating and decision-making at global level on the design, implementation and delivery of performance-based funding activities. The project focuses on three countries and their experiences with performance-based funding: Tanzania, Zambia and South Africa.

Performance-based funding has become increasingly popular in global health financing. It is defined as the "transfer of money or material goods conditional upon taking a measurable action or achieving a predetermined performance target" (Eldridge and Palmer, 2009:160). In the reviewed literature, various terms were used to signify this type of funding modality, including:

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

This review used performance-based funding to denominate this type of funding scheme.

The review is presented in two parts. Sections 1-8 address the methodology for the review, the research strategies used in the study of performance-based funding (PBF), the reported outcomes of PBF, actors involved in PBF schemes (focusing on the Global Fund, the World Bank and local actors), global health diplomacy and PBF, theories used to explain the ways PBF functions and gaps identified in the literature. Section 9 is a reference list of both annotated sources and nonannotated sources (those deemed of interest but less directly relevant). Appendix 1 presents an annotated bibliography of the most relevant sources, summarising them in a tabulated format. This section is divided into sources that are relevant to PBF schemes and sources relevant to participation in global health governance.

The review draws out the key strengths and weaknesses associated with PBF schemes, particularly in relation to their use in low- and middle-income countries. It illustrates the theoretical thinking behind PBF implementation. It also seeks to draw out analysis of the role of African actors in global health diplomacy and decision-making surrounding PBF. While the literature on PBF is extensive and ever expanding, many areas still require investigation, particularly in relation to the involvement of local stakeholders in the various stages of performance-based funding processes. This project in the programme of work in EQUINET on GHD seeks to address some of these areas.

2. Methodology

The literature included in this review was found through an extensive online search focusing on the concept of performance-based funding. Using key words in Google Scholar and the PubMed and Medline databases, literature was found that pertained to the use of performance-based funding schemes in sub-Saharan Africa and more theoretical examinations of the strengths and weaknesses of PBF. As noted in the introduction, performance-based funding is termed differently depending on the author's preference, hence searches were conducted using different variants of the term, all signifying the same concept. Furthermore, searches were conducted for literature examining the involvement of the Global Fund and the World Bank in implementing PBF schemes and their partnerships with local actors. A search was also conducted to find any literature pertaining to the role of African actors in global processes relating to PBF, e.g. how national and regional organisations are able to participate in and influence decision-making surrounding PBF implementation. Results were narrowed down based on publication titles and abstracts, from which relevance was determined. A time period was not defined in the initial search in order to determine when PBF began to emerge in the thought and practice surrounding global health funding. However, it became apparent that relevant literature generally emerged after 2005, as PBF schemes became more widespread and studies examining their effectiveness were carried out.

A snowballing technique identified other key or widely cited literature referenced in the articles found online. Inevitably, a saturation point was reached where the same sources started to appear in multiple bibliographies, or where the articles found did not have relevance to the key aims of this project. Many of the references found by snowballing are included in the Further References section of this review, but not in the annotated bibliography, depending on their degree of relevance to the project. The amount of literature on PBF is vast, and it is possible that relevant and interesting insights into this funding modality exist that did not appear in the online searches or emerge through snowballing.

The discussion that follows picks out key themes, concepts and data presented in the reviewed literature. It addresses the strengths and shortcomings of PBF and the participation of African actors in global health diplomacy and identifies gaps in the literature and areas that need further research. Some of these gaps will be filled by this project implemented in the EQUINET GHD research programme, while others require further research if the possibilities and/or shortcomings associated with performance-based funding and the involvement of African actors (or lack thereof) in global health policy are to be fully understood.

3. Research strategies on performance-based funding

3.1 Research designs and methods

The publications included in this review employed a variety of qualitative and quantitative methods to assess performance-based funding schemes from an empirical and theoretical perspective. A range of case studies have been carried out to determine the effects of PBF schemes on health care in a variety of contexts, from low- and middle-income countries to high-income countries such as the United Kingdom and the United States (Doran et al. 2006; Melkers and Willoughby, 1998). The highly context-specific nature of PBF schemes and the focus of this project mean that only certain case studies were considered in the annotated bibliography and this evaluation; citations for some other, less relevant, case studies can be found in the Further References section.

Case study relevance was determined based on either geographical location (i.e. whether the case study took place in one of the three countries – Tanzania, Zambia and South Africa – included in the EQUINET study) or what the study illustrates about the effectiveness (or ineffectiveness, as the case may be) of PBF. Case studies found to be relevant included a qualitative analysis of 43 in-depth interviews of health workers and district management team members from fifteen health facilities across five districts in the Pwani region of Tanzania (Mamdani et al. 2012); interviews with members of civil society in Tanzania (Kelly and Birdsall, 2008); household surveys administered in Rwanda in 2003 and 2005 to illustrate changes in attitudes towards health care, health expenditures and health-seeking behaviour (Soeters et al. 2006); analysis of the failures of PBF schemes in Uganda, coupled with a theoretical evaluation of these failures (Ssengooba et al. 2012); and an impact evaluation of PBF schemes in Rwanda comparing the health outputs of an intervention group and a control group (Basinga et al. 2011).

Some publications focused on a broader evaluation of PBF schemes, analysing data spanning many countries. A study by Toonen et al. (2009) undertook data collection and analysis from Afghanistan, the Great Lakes region and Haiti ,which have implemented PBF schemes. Their analysis also includes interviews with stakeholders such as health-care workers, community representatives, government officials and civil society figures. Brenzel et al. (2009) reviewed 40 PBF schemes – 28 active, twelve closed – funded by the World Bank. Another study analysed 370 active PBF grants from 130 countries (Low-Beer et al. 2007). As is discussed further on in this review, these studies noted several improvements in health service provision in areas where PBF programmes were implemented and draw lessons from these programmes for future implementation. However, they also note that confounding factors and variables other than the incentives associated with PBF schemes may have had an effect on these improvements.

Other sources based their findings on reviews of pre-existing literature, including a review of economic evaluations of PBF as a funding modality (Emmert et al. 2012); evaluations of case studies of PBF implementation (Oxman and Fretheim, 2009); a review of literature specifically dealing with funding and support for civil society in Tanzania combined with three fieldwork visits and the above-mentioned interviews (Kelly and Birdsall, 2008); other, more general reviews of PBF literature (Eldridge and Palmer, 2009; Ireland et al. 2011); and even a publication that reviewed other previously published reviews (Eijkenaar et al. 2013).

Finally, a range of literature takes a more theoretical approach to performance-based funding and global health financing. This includes: an evaluation of multidisciplinary theories that can help determine the applicability of – or analyse the outcomes of – PBF (Trisolini, 2011); a theoretical approach to PBF combined with summarised details of case studies (Eichler, 2006); a theoretical examination of the relationship between funders and providers of health services (Langenbrunner and Liu, 2005); and the application of anthropology and sociology to PBF schemes (Magrath and Nichter, 2012).

3.2 Shortcomings of research strategies

There is a vast range of literature on PBF and the publications mentioned above are just a selection of the most relevant examinations of this funding modality and its applicability in the developing world. However, what is made apparent by all these case studies and reviews is that research is still insufficient and inadequate when it comes to analysing PBF vis-à-vis the professed goals of those that seek to implement it in global health care. A body of literature has emerged alongside studies of PBF schemes critiquing these studies. Various flaws have been pointed out in PBF scholarship. First, much of the presented evidence is inconclusive, flawed or low in quality (Emmert et al. 2012; Witter et al. 2012). Second, effects of financial incentives (i.e. of PBF) are not isolated

from effects of other reforms and mixed results have been reported by various research projects (Eijkenaar et al. 2013; Oxman and Fretheim, 2009). Because PBF schemes are often implemented along with other reforms such as increased health-care funding, improved technical support and training, new IT systems and changes in management, the lack of isolation of effects and control groups means that little evidence exists to support the effects of PBF independent of these other reforms (Oxman and Fretheim, 2009; Eldridge and Palmer, 2009).

The one notable exception to this methodological flaw is the aforementioned impact evaluation of PBF schemes in Rwanda, conducted by Basinga et al. (2011). Recognising the shortcomings of various other studies (Meessen et al. 2006, 2007; Soeters et al. 2006; Doran et al. 2006), Basinga and colleagues incorporated a control group in their field research in Rwanda. An intervention group of 80 health facilities was randomly assigned by coin toss to begin PBF schemes while a control group of 86 facilities continued with input-based funding schemes for 23 months after the study baseline. The incentive effect was isolated from a mere increased resource effect by increasing the control group's budgets by the average PBF payments made to the intervention group. In this manner, the research showed that PBF schemes "led to increased use and quality of several crucial maternal and child health care services' (Basinga et al. 2011:1425). Widely cited, this study remains the most convincing empirical study of the impacts of PBF in a low- and middle-income country.

However, even a study like that conducted by Basinga et al. raises questions about performance-based funding that are left unanswered. Existing literature has shown that PBF **can** be, and has been, effective in bringing about a change in health care provision, but not **why**. What design features and context led to the positive (or negative) outcomes of the PBF schemes? Witter et al. (2012) lament that conclusions about PBF have been drawn based on case studies that use too varied methods of PBF and were undertaken in too disparate settings to warrant the drawing of any general conclusions. Similarly, Ssengooba et al. (2012) critique the use of 'black-box' approaches to evaluating PBF, which focus on the magnitude of effects on health interventions rather than the causes of these effects. These approaches fail to consider the impacts of PBF schemes on broader health systems and draw assumptions about linear programme logics and simple causal chains between PBF interventions and their effects. They advocate an 'open-box' approach that focuses on how and why the effects of an intervention come about. In this sense, despite the large volume of studies of PBF, the distinct gap in knowledge requires more quantity and quality of research with longitudinal components, as some scholars have pointed out (Emmert et al. 2012; Witter et al. 2012). This review will identify additional gaps in the literature pertaining especially to the question of participation in PBF schemes.

4. Reported outcomes of performance-based funding

4.1 Health and process outcomes

The publications included in this review highlight a broad array of outcomes – both positive and negative – of performance-based funding schemes for health care. Among the health and process outcomes noted were increases in access to, and utilisation of, priority health programmes and improvements in quality of care (Brenzel et al. 2009; Soeters et al. 2006; Mamdani et al. 2012). There are also indications that PBF can be quite cost-effective at community and sub-national levels, though its effectiveness at national level is unsubstantiated by the same report (Fryatt et al. 2010). These outcomes lead one to draw favourable conclusions on the effectiveness of PBF in terms of affecting positive health and process outcomes (Low-Beer et al. 2007; Meessen et al. 2011).

However, as previously highlighted, various studies contest the nature of evidence in support of these outcomes due to inconclusive, flawed, and low-quality evidence (Emmert et al. 2012; Eijkenaar et al. 2013; Eldridge and Palmer, 2009; Ireland et al. 2011; Magrath and Nichter, 2012; Montagu and Yamey, 2011; Scheffler, 2010; Witter et al. 2012). Alternatively, even where the evidence may have indicated improvements in process outcomes, the lack of isolation of effects of PBF and lack of controls means that those changes cannot be solely attributed to PBF schemes, if at all, as other reviews have pointed out (Eijkenaar et al. 2013; Eldridge and Palmer, 2009; Mæstad, 2007; Witter et al. 2012).

The aforementioned trial by Basinga et al. (2011) reported various positive outcomes in the intervention group of health facilities in Rwanda. Amongst other improvements, they noted an increase in the quality of prenatal care, the number of deliveries carried out in health facilities, and the number of preventive care visits amongst children up until the age of five. They found the greatest impact of the PBF interventions to be on outcomes for which the facilities received the largest financial incentives, and services over which facilities had greater control (e.g. quality of care as compared to the health-seeking habits of patients).

However, as Montagu and Yamey (2011) highlight, these are process outcomes rather than health outcomes: an "increase in service provision and quality of care does not necessarily translate into an improvement in population health." Similarly, Eldridge and Palmer (2009:164) ask whether "meeting targets reflect[s] progress in overall health system development?" Intuitively, there is likelihood that it does – especially when it comes to increased quality of care – but such conclusions cannot be drawn without more thorough research. Furthermore, other impact evaluations have found that the effects and benefits of incentives diminish and dissipate over time (Werner et al. 2011).

4.2 Strengthening health systems, governance and participation

The concept of participation underpins much of the thinking surrounding the idea of PBF and new ways of thinking about global health governance. This is evident both in the 2005 Paris Declaration on Aid Effectiveness, which emphasises concepts such as ownership, alignment, and accountability, and the Millennium Development Goals, which have as an explicit goal "to develop a partnership for development" (UN, 2010). In terms of PBF, Low-Beer et al. (2007: 1309) state that: "performance-based funding is based on radical country ownership of targets and implementation." Nevertheless, as will become apparent below, in terms of governance and participation, the *actual* impact of PBF remains under-analysed, although the literature deals with the theoretical impact extensively.

Many of the publications included in this review argue that PBF can have a positive impact on the strengthening of health systems and their governance, as well as local participation in the design and implementation of funding schemes. For instance, Meessen et al. (2011) counter-critique those that focus too much on PBF as a method of payment rather than as a source of health system reform. They argue that because PBF schemes form contractual relationships rather than hierarchical ones, each organisational unit involved in the process must account for its performance and, as a result, accountability and efficiency should increase. Levine and Oomman (2009) see PBF as a way to overcome issues associated with resource pooling due to an overwhelming concentration of health care funding towards HIV/AIDS programmes, by setting targets that strengthen health systems in general.

Other studies highlight the importance of participation to the PBF process. Eldridge and Palmer (2009) draw parallels between PBF and donor conditionality in the 1980s and the

failures of the Bretton Woods institutions in this area. The lack of local control of the schemes exhibited at the time provides important lessons for PBF, they argue. Other studies similarly emphasise that participation and local ownership of the process is vital for the successful implementation of PBF schemes. First, autonomy for health providers and other local stakeholders in preparing and implementing schemes is important as it encourages entrepreneurial spirit, leads to better human resource management and increases collaboration with the private sector, all of which enhance performance (Toonen et al. 2009; Soeters et al. 2006). Second, funding must be aligned with the priorities of recipient governments and stakeholders. National ownership ensures schemes are embedded within over-arching strategies rather than isolated in a vertical approach (Levine and Oomman, 2009; Toonen et al. 2009). Third, PBF schemes require institutional and political support that can only be achieved if partners at all levels of operationalisation are involved in identifying problems, priorities and strategies to address these (Oxman and Fretheim, 2009; Toonen et al. 2009).

However, there is a distinct lack of scholarship on **actual** participation in the decision-making processes related to performance-based financing. In fact, there is a general lack of consensus regarding where the concept of PBF came from or its ideational ascendance within the global health lexicon. These are curious intellectual gaps given that much of the rationale behind PBF is that it works effectively **if** local ownership of the process is maintained, as highlighted above. Further, the concepts of partnership and participation are meant to guide efforts to fulfil the Millennium Development Goals so the lack of quantification of these concepts and research into what might constitute an ideal 'level' of partnership needs addressing (Barnes and Brown, 2011). This knowledge gap on actual participation and who sets the PDF agenda extends beyond the local level, as shall become apparent in Section 5.

4.3 Unintended consequences

Several of the reviewed studies have predicted or observed initial indications of unintended consequences of PBF in their research (Eijkenaar et al. 2013; Fryatt et al. 2010; Ireland et al. 2011; Kalk, 2011; Langenbrunner and Liu, 2005; Meessen et al. 2011; Oxman and Fretheim, 2009; Scheffler, 2010). These consequences or side effects could have short- and long-term impact on the structural capacity, processes and outcomes of health service provision. Among the concerns raised were that PBF can: distort priorities of national health systems due to the targeting of services (Ireland et al. 2011; Scheffler, 2010); lead to 'gaming', false reporting of results and 'cherry-picking' of patients by health care workers (Ireland et al. 2011; Kalk, 2011); give rise to 'perverse incentives' (Fryatt et al. 2010); lead to a focus on quantity over quality of service (Ireland et al. 2011; Langenbrunner and Liu, 2005); perpetuate inequity as areas where health systems are particularly underdeveloped (and thus unlikely to reach outcome targets) might be overlooked for funding (Ireland et al. 2011); and carry debilitating hidden costs due to the resources needed to establish PBF systems and monitoring mechanisms (Kalk, 2011). One specific concern raised by multiple studies is the impact that PBF might have on the intrinsic motivation of health care workers (Eijkenaar et al. 2013; Ireland et al. 2011; Kalk, 2011; Langenbrunner and Liu, 2005). The concern amongst these commentators is that financial incentives might crowd out the high levels of idealism in the health sector, thus leading to the de-motivation of health-care workers.

These predicted consequences are significant given that participation and local ownership is meant to be the driving force behind PBF schemes. Financial incentives undermine the capacity and motivation for local populations to take ownership of the processes. As with so many other aspects of PBF, these side effects need further extensive research to determine their exact causes, their actual impact on health system provision and participation, and whether or not PBF schemes can overcome them.

5. Actors involved in performance-based funding

5.1 Global Fund

Some of the literature included in this review presents the ways in which various actors implement and participate in performance-based funding schemes. Amongst these is the Global Fund to Fight AIDS, Tuberculosis and Malaria, one of the global actors that are the focus of this project.

Several commentators note the positive impact the Global Fund has had on health governance. For example, the Global Fund has been lauded for affecting a paradigm shift in development by engendering a dual commitment to domestic sustainability of schemes and to international support (Ooms et al. 2010). Fryatt et al. (2010) commend the Global Fund's Debt2Health programme for strengthening health systems, while Low-Beer et al. (2007) laud the benefits of the Global Fund's 'diagonal financing' system which does not just provide 'vertical financing' for a specific disease or 'horizontal financing' of broader health systems, but both. As such, the Global Fund has "a sharp focus on achieving disease goals while allowing finance to more broadly strengthen the supporting health sector" (Low-Beer et al. 2007:1310).

In terms of participation and partnership at country level, the Global Fund's country co-ordinating mechanisms (CCMs) are mentioned as points of access to health governance for local stakeholders. Although Biesma et al. (2009) have pointed out that CCMs have had early negative system effects as they establish parallel co-ordinating bodies to those of the host country, with little or poor co-ordination, harmonisation and alignment of functions, they find that in the long run stakeholder participation is widened. Buse and Harmer (2007) also argue that the Global Fund has taken positive steps to address stakeholder underrepresentation. Kelly and Birdsall (2008) point to the restructuring of the CCM in Tanzania into a national co-ordinating mechanism that incorporated the US President's Emergency Plan for AIDS Relief (PEPFAR) and World Bank resources as a success in broadening participation and partnership. Similarly, Feachem and Sabot (2006) argue that the Global Fund model has empowered civil society in many countries, Zambia amongst them, by providing points of access to decision-making processes – in 2006, 40% of CCM members came from civil society. Finally, Sridhar and Batniji (2008) point to the unique nature of the Global Fund board, which includes substantial developing-country representation. Yet studies on participation within PBF models more generally are limited, and there are few cross-country comparative studies examining stakeholder participation beyond CCMs. It is the aim of this study to start to fill this lacuna.

5.2 World Bank

The World Bank is another global actor that has implemented PBF schemes for health-care in sub-Saharan Africa and elsewhere. Compared to the Global Fund, it is less clear how the World Bank's governing structures and decision-making processes provide points of access for local stakeholders. Little scholarship is available that links the World Bank's projects and the design and implementation of PBF schemes to participation and partnership. The focus has been on the objectives of the World Bank – improving health system outputs such as access, utilisation and quality of health care and improving specific outcomes (e.g. reduced infant mortality rates) and whether these objectives have been fulfilled, rather than how they have been fulfilled (Brenzel et al. 2009). However, Harman (2007) does point to the failures of the World Bank's Multi-Country AIDS Programme (MAP) as being partly due to a waning commitment to multisectoral participation in the fight against HIV/AIDS. The initial success of MAP had been based on bringing HIV/AIDS to the top of the political agenda and promoting multisectorality to increase local participation and ownership. However, the programme began to fail due to

limited direct dialogue between the World Bank and civil society, and the subsequent marginalisation of civil society organisations in decision-making and strategy formulation.

In terms of PBF as a funding modality, because World Bank projects combine PBF with other sorts of financing and support, it is difficult to isolate the effects of the Bank's PBF schemes. As noted previously, the failure to isolate these outcomes is a shortcoming of the literature on PBF in general. However, Atun and Kazatchkine (2009) have noted that similarly to the Global Fund, the World Bank's 'buy-downs' (a form of PBF) have been conducive to the strengthening of health systems.

5.3 Local actors

Commentators agree that national and sub-national ownership of health programmes and political commitment to them is vital to the design, implementation and sustainability of schemes (Atun and Kazatchkine, 2009; Brenzel et al. 2009; Eichler, 2006; Eijkenaar et al. 2013; Levine and Oomman, 2009; Low-Beer et al. 2007; Magrath and Nichter, 2012; Oxman and Fretheim, 2009; Toonen et al. 2009). As such, participation and partnership have normative value, as we have seen, as well as practical relevance. For example, Low-Beer et al. (2007) argue that civil society is an efficient implementer of PBF as 83% of the programmes implemented by civil society in their study performed strongly. Furthermore, increased community involvement improves overall health governance as service providers become more accountable to the communities they serve and ensures that schemes are scaled up to reach less accessible groups (Atun and Kazatchkine, 2009).

However, it appears that participation and partnership fall short in practice when it comes to performance-based funding. For example, while they found that the national co-ordinating mechanism in Tanzania widened participation as mentioned above, the study by Kelly and Birdsall (2008) also found that civil society organisations (CSOs) in Tanzania feel that their roles have been prescribed by external actors as a direct result of funding modalities. Because assistance via PBF is tied to short-term targets, little or no funding is afforded for the **development** of civil society. Leadership capabilities within civil society therefore remain underdeveloped. Thus, while CSOs are afforded a big participatory role in service provision, they are excluded from involvement in strategy and policy development.

As such, Biesma et al. (2009) propose greater alignment with the Paris Declaration when it comes to health care aid and funding, especially in relation to country ownership and local capacity building. Sridhar and Batniji (2008) echo this call: they find that donors, rather than recipients, largely define health priorities. They also highlight that other aid sectors have been more effective than the health sector at complying with the Paris Declaration and focusing on country ownership. They argue that political economy analysis of donor institutions would aid understanding of their decision-making processes, and further highlight the need for "the development of country ownership, particularly planning and priority setting" (Sridhar and Batniji, 2008:1189).

Furthermore, the forms of country ownership also require further examination. The Kelly and Birdsall (2008) study shows that at the time of their research, nearly 80% of Global Fund funding went to the Tanzanian Ministry of Finance, with the rest going to CSOs. Brown (2009) also raises concerns that non-governmental organisation participation on CCMs is recommended rather than required. What does this balance of funding indicate about participation and points of access for local and regional actors **besides** states to PBF scheme design and implementation? Kelly and Birdsall clearly think this is to the detriment of civil society, but in many other studies questions like this are unanswered. Worse still, from the point of view of participation, they often are unasked.

6. Performance-based funding and global health diplomacy

Literature pertaining to the impact of PBF schemes on participation at the local level and the roles of actors involved in implementing PBF at country level has already been examined, but this project seeks to determine how African actors are able to access decision-making processes for **global** health policy. In other words, are African actors involved in influencing and negotiating the design of performance-based funding programmes and in promoting this type of funding as a viable and effective form of funding for health systems?

Several studies have raised concerns about the governance structures of some of the global actors examined in this project, and how these marginalise southern actors and limit their participation in global health diplomacy. Bartsch and Kohlmorgen (2007) focus on different types of power and interfaces where interactions occur between actors involved in global health diplomacy to illustrate if and how southern actors can access decision-making processes for global health within various global organisations. At the organisational interface of the WHO, they argue, southern actors have a lot of access due to the 'one country, one vote' governance structure. However, in practice, given that WHO activity in developing countries is often financed by extra-budgetary funds, donor countries can exercise their resource-based power and effectively control WHO policy, clearly marginalising southern actors. As for the World Bank's organisational interface, states have access to decision-making through their voting rights, but given that these are proportional to fund contributions resource-based power again favours donor countries. Furthermore, given the World Bank's extensive discoursive power, donors, not recipients of health funding, largely dictate the agenda setting in global health governance.

Turning to the Global Fund, Bartsch and Kohlmorgen point to the composition of the Global Fund board (five constituencies comprised of representatives from industrialised countries, the private sector, developing countries, civil society and a non-voting group) as giving state and non-state actors from the global south decision-making power. Brown (2009; 2010) agrees that **in principle** the Global Fund board offers points of access for southern actors to participate in decision-making processes, but that in practice it is dominated by economically and politically strong members. Due to a "colonisation of unequal advantage" (Brown, 2010:522) by donor states, the Global Fund has not managed to maintain a deliberative and participatory governance structure, with donor states wielding an effective veto power over board decisions due to their economic advantage. Furthermore, in addition to the deliberative deficit at board level, there are disconnects between board representatives and their constituencies as stakeholders not on the board have little or no access to the deliberative and decision-making process.

Hwenda et al. (2011) take a human security approach to global health policy and argue that low- and middle-income countries need to participate in setting the global health security agenda. These states have been reluctant to frame health policy as a matter of security due to fears that doing so would provide a justification for bypassing national sovereignty in the interest of ensuring health security. However, by not doing so, these states have seen their interests marginalised by the vested interests of developed states, exemplified by the focus of global health security agendas on bioterrorism and a limited number of infectious diseases. The authors argue that regional organisations such as the Southern African Development Community (SADC) could provide an avenue for African states to participate in the formulation of global health policy more effectively than individual states are able to. Along those lines, Onzivu (2012) finds that regional organisations such as the East African Community are increasingly using diplomacy to

promote African interests in global health governance. However, it remains unclear from this literature whether these attempts at agenda setting have been effective.

Essentially, from the reviewed literature it appears that southern actors, both national and regional, are marginalised as objects, not subjects, of policy-making processes for global health. This is because of the structure of funding for health programmes and the power relationships that underpin it (Bartsch and Kohlmorgen, 2007; Brown, 2009; Brown 2010; MacLean and Maclean, 2009). This project will further research this apparent marginalisation and determine how it affects the participation of African actors in decision-making for PBF schemes in particular and in global health diplomacy in general.

7. Theoretical underpinnings of performance-based funding research

As mentioned previously, authors in a range of literature have attempted to apply various theories and conceptual frameworks to their study of performance-based funding. Theories have been drawn from multiple disciplines such as sociology, anthropology and economics and applied to PBF. These theoretical and conceptual approaches attempt to explain the positive and negative impact PBF has on health service providers and their motivations, and engage with questions relating to the successful implementation and predicted outcomes of PBF schemes.

In terms of health provider motivation, Herzberg's two-factor theory from the field of psychology has been used to explain the undermining of intrinsic motivation caused by PBF schemes, by relating the schemes to motivating factors and elements that act as disincentives or barriers to meeting targets (Trisolini, 2011; Herzberg, 1966). Additionally, the sociological deprofessionalisation theory has been applied to PBF. Trisolini (2011) and Cockerham (2007) raise concerns that the involvement of multiple non-medical actors in health-care provision can de-motivate health-care professionals due to fears of deprofessionalisation of the field, with negative consequences for care practices.

Several theoretical approaches have emerged that begin to explain the importance of widespread participation and local ownership to the successful implementation of PBF. For example, Magrath and Nichter's (2012) anthropological approach using Bourdieu's (1977; 1986) 'habitus' framework emphasises the importance of adaptation and context-specific PBF schemes. The habitus framework distinguishes between economic, social, cultural and symbolic capital and illustrates how these forms of capital are acquired and converted from one form to another. This can potentially be useful for explaining the impact of PBF on motivation depending on the design of funding schemes, especially in terms of power structures and reward systems and how different actors have access to these types of capital within the schemes. Alternatively, some publications see scope for organisational theory and its focus on factors such as ownership, cultural context, and institutional layers as a tool to explain the impacts and potential impacts of PBF schemes (Eldridge and Palmer, 2009; Trisolini, 2011; Town et al. 2004). Further, theories such as complex adaptive systems theory and contingency theory illustrate and emphasise the impact that context has on programme implementation. They argue that organisations must adapt their structures, cultures, systems and staff according to the environment and institutional relationships in which they are situated (Ssengooba et al. 2012; Leykum et al. 2007; Plsek and Wilson, 2001; Trisolini, 2011; Shortell and Kaluzny, 2006). Although not explicitly related to participation of local actors, these theories and frameworks touch upon some of the reasons that it is deemed important to PBF implementation.

Other theories, such as principal agent theory and expectancy theory, have been used to explain the benefits of the contractual approach of PBF and the underlying mechanisms and perceptions that link incentives to pre-specified tasks (Eichler, 2009; Eldridge and Palmer, 2009; Ssengooba et al. 2012; Lawler, 1971; Lawler, 1989). Based on these theoretical approaches, various frameworks have been constructed for the design and implementation of PBF. Eichler (2006) suggests a nine-step approach to PBF design, while Scheffler (2010) constructs a framework for the evaluation of PBF schemes that dually analyses the quality and efficiency of schemes. Yet again, participation is implied as an important factor, yet not explicitly dealt with in theory or in the design recommendations and frameworks.

8. Gaps in the literature on performance-based funding

Several areas that need further research can be drawn from this literature review. In terms of the actual impacts of performance-based funding, the current evidence base does not sufficiently support the widespread implementation of PBF schemes (Eijkenaar et al. 2013). Ireland et al. (2011) perceive a favourable bias towards PBF amongst policy-makers and scholars, which has led to the overlooking of negative consequences and the sweeping attribution of positive outcomes to PBF schemes without consideration for other factors. Evaluations of the long-term impact of PBF schemes on health outcomes are lacking (Eijkenaar et al. 2013) as is appreciation for the context-specific nature of scheme implementation. PBF might have been a success in Rwanda, for example, but this does not necessarily make it transferable to all contexts, given the specific socio-political context of Rwanda – i.e. a small country with a strong centralised government with extensive control of health service provision, receiving substantial amounts of flexible external aid for health (Montagu and Yamey, 2011). In evaluations of performance-based funding – as Ireland et al. (2011:695) state – "the focus should be on the reasons why and how the intervention is working rather than whether or not it is working".

Furthermore, there is little research examining where the concept of PBF has come from, who is setting the PDF agenda, and how PBF evolved to become the preferred funding modality in global health governance. There is also strikingly limited research delineating the roles key actors play within national and regional settings and how these actors can shape the design, implementation and evaluation of PBF modalities.

In terms of this project, this literature review illustrates that some local and regional actors and stakeholders appear to be marginalised when it comes to the design and decision-making process for performance-based funding schemes, even if they are heavily involved in their implementation. It remains the case that due to the prescribed requirements for national ownership, national governments are generally involved in the design, implementation and evaluation of PBF schemes, even if their ability to negotiate PBF schemes may vary. However, some NGOs and CSOs are marginalised at various levels of the PBF process and there is a lack of research indicating which ones are afforded points of access to decision-making and with what real input. Finally, regional bodies are seemingly completely marginalised from decision-making at the global level. This marginalisation is under-theorised, and there is a general lack of clarity in the literature as to what actors have a real input in PBF schemes and at what stage they can participate in the PBF process. This intellectual gap is clearly at odds with the normative value placed on participation and partnership as a key policy concept for global health governance. The role and points of access that African actors are afforded in organisations like the Global Fund and the World Bank need further examination to

highlight a) who is driving the PBF process and b) whether commitments to country ownership are fulfilled.

To respond to existing research gaps this collaborative project will: trace the emergence of and theory behind PBF; explore the rationales for and understandings of PBF, and how this shapes African participation; examine how African actors participate in the design, implementation and delivery of HIV/AIDS PBFs; and, specifically, to locate the diplomacy spaces that exist for African participation in processes associated with the Global Fund and World Bank. By examining these policy spaces this project will consider the impact that PBF processes are having on health system governance, including on local accountability, capacity and sustainability, with specific focus on the treatment and care for HIV/AIDS.

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Note reference numbers refer to publication numbers in the annotated bibliography

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APPENDIX 1: Annotated bibliography

Publication Number: 4	Basinga P, et al. (2011) 'Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation', *Lancet* 377:1421-1428.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of PBF	Impact evaluation of PBF schemes (referred to as P4P in article).	
Variables:		
i. Context		
ii. Process	Implementation of PBF schemes and continuation of input-based funding in a control group.	
iii. Actors	Health facilities in Rwanda.	
iv. Content		
v. Outcomes	Results on intervention group: - 23% increase in institutional deliveries. - 56% increase in preventive care visits by children aged <23 months. - 132% increase in preventive care visits by children aged >24 months, <59 months. - No change in number of women completing the prescribed 4 prenatal care visits. - No change in number of children receiving full immunisation. - 0.157 standard deviation increase in quality of prenatal care, based on Rwandan guidelines for clinical practice.	
vi. Other		
Research strategy	Impact evaluation of PBF (P4P) schemes. Comparative study with control group using direct observation and reviews of medical records.	
Tools used	Study of 166 facilities. Intervention group (n=80) randomly assigned by coin toss to begin PBF schemes between June and October 2006. Control group (n=86) continued with input-based funding for 23 months after study baseline. Outcome measures: prenatal care visits, institutional deliveries, quality of prenatal care, child preventive care visits and immunisation. Incentive effect isolated from resource effect by increasing control group's budgets by average PBF payments made to intervention group. Multivariate regression used to analyse results.	
Key findings	PBF schemes 'led to increased use and quality of several crucial maternal and child health care services'. Improved quality of prenatal care is most significant outcome of PBF schemes. No effect on prenatal care visits and completion of immunisation schedules. Study shows that PBF had the greatest impact on the outcomes for which facilities receive larger financial incentives, and also those services over which facilities have greater control (e.g. quality of care as compared to the health-seeking behaviour of patients, i.e. their timely visits to the facilities). Lack of impact of immunisation schemes partly explained by a national vaccination campaign that raised the already-high baseline immunisation rates from 65% to 78% at the same time as this study was carried out. Authors make some recommendations: - Larger incentive payments for crucial health services and for services where more provider effort (as opposed to patient effort) is needed. - Potential for incentives to be given directly to patients to influence their care-seeking behaviour. - Provide incentives for health-care workers to identify and encourage patients to visit facilities.	

Other comments	

Publication Number: 6	Brenzel L, et al. (2009) *Taking Stock: World Bank Experience with Results-Based Financing (RBF) for Health*. World Bank: Health, Nutrition and Population Unit, available at http://www.rbfhealth.org.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of PBF	Effects of World Bank PBF schemes.	
Variables:		
i. Context	World Bank implementation of PBF.	
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Review of PBF schemes for health care approved by the World Bank between 1995 and 2008.	
Tools used	Total of 40 projects (28 active, 12 closed) using PBF for health care were reviewed using Project Appraisal Documents, Staff Appraisal Reports, Project Information Documents, Implementation Completion Reports, and any other relevant information.	
Key findings	World Bank projects had two categories of objectives: - Improved health system outputs – access, utilisation and quality of health care - Improved specific outcomes – e.g. reduced infant mortality rates. Review observed improvements in terms of: - Access to and utilisation of priority health programs - Quality of care - Institutional and policy frameworks in the health sector - Enrolment of insurance beneficiaries Reviewers aware that cases do not control for other factors, hence improvements cannot be attributed solely to PBF. Lessons learnt and conclusions drawn include the following: - World Bank level of support for PBF schemes expected to increase. - National and sub-national ownership of PBF process, and political commitment vital to design, implementation and sustainability of schemes. - All relevant stakeholders must be included in design process to improve understanding and success of schemes.	
Other comments	Article refers to PBF as results-based financing (RBF). World Bank projects combine PBF with other sorts of financing and support, difficult to isolate specific effects of PBF.	

Publication Number: 9	Brugha R, et al. (2004) 'The Global Fund: managing great expectations', *Lancet*,364:95-100.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of PBF	Effects of PBF and Global Fund CCMs.	
Variables:		
i. Context	Implementation of PBF in: - Mozambique - Tanzania - Uganda - Zambia	
ii. Process		
iii. Actors	Local stakeholders, CCMs, national	

	governments.	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Qualitative analysis.	
Tools used	Semi-structured interviews with 137 respondents across the four countries included in the study. Respondents were members of CCMs or otherwise majorly involved in Global processes.	
Key findings	In all four countries issues of representation and participation in the CCMs were reported. Issues included: - Poor constituency consultation - Dominance of government officials - Poor attendance at CCM meetings Disbursement of funds was delayed in all four countries included in the study. Some tensions reported with the national AIDS authorities in the study countries, due to lacking coordination of organisational fit and function. Coordination problems with other financing initiatives, including the World Bank and the Clinton Foundation.	
Other comments	Study conducted very early in the implementation process.	

Publication Number: 11	Eichler R (2006) 'Can "Pay for Performance" Increase Utiliziation by the Poor and Improve the Quality of Health Services?', *Discussion Paper*, first meeting of the *Working Group on Performance-Based Incentives*, Center for Global Development.	
	In the paper	Reference(s) cited in paper
Theory	Principal Agent Theory	Grossman S and Hart O (1983) 'An Analysis of the Principal Agent Problem', *Econometrica*, 51: 7-45. Kreps D M (1990) *A Course in Microeconomic Theory*, (Princeton: Princeton University Press). Rogerson W (1985) 'The First Order Approach to Principal-Agent Problems', *Econometrica*, 53:1357-1358.
Conceptual Framework	Adaptation of a framework used for the contracting of private providers to deliver services to PBF design.	Mintz P, La Forgia G M and Savedoff W (2001) *Contracting Health Services: Getting from Here to There*, (Washington DC: The World Bank).
Aspect of PBF	Effects of PBF on equity and quality of care.	
Variables:		
i. Context		
ii. Process		
iii. Actors		
iv. Content	Overview of what PBF is, including problems it can address, the economics of PBF, some illustrative cases, and steps to design and implement schemes.	
v. Outcomes		
vi. Other		
Research strategy	Theoretical approach combined with summarised details of case studies.	
Tools used		
Key findings	Eichler uses principal agent theory to explain the use of PBF. Because the principal cannot continually and perfectly monitor the use of its funds by agents, the principal must design a contract that makes it in the agents own interest to perform they way the principal requires.	

	Creates a nine-step conceptual framework to design and implement PBF schemes (24): - 'Specify performance problems, underlying causes, and chosen P4P interventions' - 'Assess the feasibility of paying for performance' - 'Gain political and institutional support' - 'Define service specifications' - 'Select performance measures' - 'Define payment methods' - 'Select providers and maximize competition' - 'Ensure the capacity for contract management' - 'Evaluate, revise and refine the approach'
Other comments	

Publication Number: 12	Eijkenaar F, et al. (2013) 'Effects of pay for performance in health care: A systematic review of systematic reviews', *Health Policy* Article in Press: http://dx.doi.org/10.1016/j.healthpol.2013.01.008.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of PBF	Effects of PBF.	
Variables:		
i. Context	Lack of a comprehensive overview of the effects of PBF. Fragmented evidence on PBF.	
ii. Process		
iii. Actors		
iv. Content	Comprehensive overview of PBF (P4P) literature.	
v. Outcomes	Compiles data from other reviews on: - Effectiveness of PBF - Cost-effectiveness of PBF - Unintended consequences of PBF - Inequalities narrowed or widened by PBF - Impact of non-financial incentives on schemes - Impact of program design – what elements are important?	
vi. Other		
Research strategy	Systematic review of twenty-two previously published reviews.	
Tools used		
Key findings	Extensive data availability does not translate into strong conclusions due to research designs not isolating effects as well as mixed results exhibited by the different reviews. Program design emerged as an important factor amongst the PBF schemes that showed improvements. Important factors included: - Involvement of providers in the design of the program - Outcome measures are easy to track, and have large scope for improvement - Larger payments are made Overall, authors conclude that current evidence base does not sufficiently support widespread implementation of PBF schemes. Evaluations of long-term impact of PBF schemes on health outcomes are lacking. There is also some evidence to suggest that PBF has several unintended consequences, especially related to loss of intrinsic motivation. Further study is required across all aspects of PBF.	
Other comments	The reviews included deal with studies from all over the world, difficult to extract information relevant to low- and middle-income countries. PBF	

	implementation is simply too context-specific.

Publication Number: 13	Eldridge C and Palmer N (2009) 'Performance-based payment: some reflections on the discourse, evidence and unanswered questions', *Health Policy and Planning* 24:160-166.	
	In the paper	Reference(s) cited in paper
Theory	Touches upon organisational theory	
Conceptual Framework	Reference to the principal-agent framework of organisational theory.	
Aspect of PBF	Discourse and evidence surrounding PBF	
Variables:		
i. Context	Increasing support for PBF as a tool to improving health care systems in low-income countries.	
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Literature review.	
Tools used	Literature review of both published and grey literature from 1990 to 2008.	
Key findings	Authors point out that there is much enthusiasm surrounding PBF, but it is unclear from where that enthusiasm originates. Raise several concerns: - Consensus and consistency on the meaning and use of the term 'PBF' is lacking - Clear evidence on the effect of PBF in low-income countries is lacking. Largely due to lack of controls in studies. - Conflation of PBF with the impact of contracting out of service delivery. Contracting is the *tool* used to implement PBF. Merits/detractors of contracting are separate to merits/detractors of PBF.	
Other comments	Refers to PBF as performance-based payment.	

Publication Number: 14	Emmert M, et al. (2012) 'Economic evaluation of pay-for-performance in health care: a systematic review', *European Journal of Health Economics* 13:755-767.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of PBF	Economic efficiency of PBF schemes.	
Variables:		
i. Context	Increased use of PBF schemes in health care systems in developed countries.	
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Review of literature on economic evaluations of PBF.	
Tools used		
Key findings	Efficiency of PBF schemes could not be demonstrated on the basis of these studies due to inconclusive and flawed evidence, and scarcity of research.	
Other comments	PBF referred to as pay-for-performance (P4P) in this article. This review analysed research carried out in high-income countries such as the United Kingdom and the United States of America. No reference to the efficiency of PBF in low- and middle-income countries. Therefore its applicability to the EQUINET study is limited.	

Publication Number: 18	Fryatt R, Mills A and Nordstrom A (2010) 'Financing of health systems to achieve the health Millennium Development Goals in low-income countries', *Lancet* 375:419-426.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of PBF	Effects of Global Fund and World Bank PBF schemes.	
Variables:		
i. Context	Underfunding of health systems and the impact this has on the achievement of the MDGs.	
ii. Process	Creation of a High Level Taskforce on Innovative International Financing for Health Systems in 2008.	
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy		
Tools used		
Key findings	Authors believe that Global Fund's Debt2Health initiative and World Bank's buy downs (both a form of PBF) are conducive to the strengthening of health systems. Community and sub-national implementation of PBF schemes have been cost-effective. Find the effects of PBF at the national level to be less substantiated by evidence. Taskforce recommended the expansion of WB results-based funding, but under careful management as 'perverse incentives' might arise.	
Other comments	PBF referred to as 'buy-downs' – 'turning a loan for specific health MDG results into a grant when verified results have been achieved' (422).	

Publication Number: 24	Ireland M, Paul E and Dujardin B (2011) 'Can performance-based financing be used to reform health systems in developing countries?' *Bulletin of the World Health Organization*, 89:695-698.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of PBF	Problems with PBF: side-effects, efficiency, and lack of evidence in its favour.	
Variables:		
i. Context	Increased belief that PBF is a viable solution to poor performance of health care systems and health worker deficits in low-income countries.	
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Overview of literature on PBF.	
Tools used		
Key findings	Perceived favourable bias for PBF in literature. Negative consequences are overlooked. Little evidence to support claims about the potential and achievements of PBF. Any changes to health systems where PBF has been implemented sweepingly attributed to its effects with no consideration for other factors.	

	Improvements could simply be down to increased funding, not the method of funding – 'Arguably, the focus should be on the reasons why and how the intervention is working rather than whether or not it is working' Side-effects include: distortion of priorities due to targeting of services, gaming, cherry-picking of patients to meet targets, focus on quantity over quality of service, perpetuating inequity by funding facilities best placed to meet targets, demotivation due to 'crowding-out' of intrinsic motivation. Point to Rwanda as a key success story of PBF schemes, but highlight that this is one specific context and does not necessarily mean success is replicable elsewhere.
Other comments	Interesting point that PBF has become popular in policy circles 'because it fits neatly into the Millennium Development Goals aid paradigm for rapid progress on a few key indicators'.

Publication Number: 25	Kalk A (2011) 'The costs of performance-based financing', *Bulletin of the World Health Organization* 89:319.	
	In the paper	Reference(s) cited in paper
Theory	'Crowding out': incentives may have a negative effect on motivation.	Deci E L and Ryan R M (1985) Intrinsic motivation and self-determination in human behaviour, (New York: Platinum Press).
Conceptual Framework		
Aspect of PBF	Negative impacts of PBF.	
Variables:		
i. Context		
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy		
Tools used		
Key findings	Three main arguments against PBF: - Health sector involves high levels of idealism, introducing financial incentives based on performance may have a demotivating effect, so-called 'crowding out'. - Focus on certain indicators to classify performance may lead to 'gaming' – focus on renumerated aspects of healthcare and neglect of non-renumerated ones, as well as false reporting. - Considerable hidden costs of PBF in terms of funds and working hours invested to establish PBF systems and monitoring mechanisms.	
Other comments	Brief treatment of problems of PBF: editorial rather than in-depth analysis.	

Publication Number: 26	Kerkhoff L v and Szlezák N (2006) 'Linking local knowledge with global action: examining the Global Fund to Fight AIDS, Tuberculosis and Malaria through a knowledge system lens', *Bulletin of the World Health Organization* 84:629-635.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework	Knowledge system framework.	
Aspect of PBF	Incorporation of local knowledge into PBF scheme design.	
Variables:		
i. Context	Implementation of Global Fund PBF schemes and the focus on country ownership and local knowledge.	
ii. Process		
iii. Actors	The Global Fund, local stakeholders.	
iv. Content		

v. Outcomes		
vi. Other		
Research strategy	Qualitative approach, with examples taken from China, Haiti and malaria research to support argument.	
Tools used		
Key findings	Country control of the application process for Global Fund funding means that local knowledge is incorporated in the plans for PBF implementation. However, the overall process still characterises recipient countries as 'knowledge recipients' rather than 'knowledge generators' meaning the process remains somewhat externally driven.	
Other comments	Early stages of Global Fund PBF implementation, other authors have argued that the Global Fund has made improvements in these areas.	

Publication Number: 29	Langenbrunner JC and Liu X (2005) 'How to Pay? Understanding and Using Payment Incentives', in Preker AS and Langebrunner JC (eds), *Spending Wisely: Buying Health Services for the Poor*. The World Bank: Washington, DC.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework	Three categories of relationships between funders and providers of health services: - Reimbursement approach - Contract approach - Integrated approach	Oxley H (1995) *New Directions in Health Care Policy*, (Paris: Organisation for Economic Cooperation and Development).
Aspect of PBF	Theory behind payment incentives.	
Variables:		
i. Context		
ii. Process		
iii. Actors	Funders and providers of health care, and patients.	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Theoretical examination.	
Tools used		
Key findings	Reimbursement approach: *retrospective* funding of providers is mostly beneficial to (among other things) issues of access, quality of enhancement, and patient selection. Contract approach: *prospective* payment agreements optimize service levels, cost containment and efficiency. Each form of payment incentive brings about different outcomes that benefit patients, providers and purchasers differently. Context is key to determining the most suitable form of incentives. EU health systems have converged towards a mix of mechanisms, but author stresses that this may not be pertinent in the developing world. PBF may be well suited to low- and middle-income countries where the institutional capacity make complicated payment incentives and systems disproportionately cumbersome compared to their benefits. Warns that intrinsic motivation and quality of care might be harmed by PBF schemes.	
Other comments	PBF referred to as performance-related pay (PRP) in this article.	

Publication Number: 30	Levine R and Oomman N (2009) 'Global HIV/AIDS Funding and Health Systems: Searching for the Win-Win', *Journal of Acquired Immune Deficiency Syndrome (JAIDS)* 52:S3-S5.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		

Aspect of PBF	PBF as a tool to overcome skewed funding priorities.	
Variables:		
i. Context	Increased health funding, and concentration of those funds in projects targeting HIV/AIDS.	
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy		
Tools used		
Key findings	Health funding has increased steadily in the last decade or so, but funding is heavily skewed towards HIV/AIDS prevention and care, especially in countries where PEPFAR and the Global Fund have concentrated their efforts. Realisation that HIV/AIDS funds also need to strengthen health systems in general, as health system weaknesses pose barriers to sustainable and long-term response to the HIV/AIDS pandemic. Author suggests that PBF could be a way to overcome this skewed resource pooling by setting targets with broader health implications, including the strengthening of health systems in general. Main conclusion drawn in article is that whatever form funding takes, it *must* be aligned with priorities of recipient governments and stakeholders. As the authors state: 'health system development is a function of social choices and political processes that are constructed at the national and local levels, not driven primarily by technocratic and/or supranational aims'.	
Other comments	Examination of PBF is very brief and superficial.	

Publication Number: 31	Low-Beer D, et al. (2007) 'Making performance-based funding work for health', *PLoS Medicine* 4(8):e219.doi:10.1371/journal.pmed.0040219.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of PBF	Results of Global Fund PBF schemes	
Variables:		
i. Context	PBF implementation in 130 countries.	
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes	- 75% of programs reached targets. - 21% of programs showed inadequate results but had sufficient potential to achieve targets in the future. - 4% of programs showed unacceptable results.	
vi. Other		
Research strategy	Analysis of Global Fund PBF schemes.	
Tools used	Quantitative analysis of the effects of PBF across 370 Global Fund grants in 130 countries.	
Key findings	Several lessons were taken from program performance: - Civil society is an efficient implement of PBF. 83% of programs implemented by civil society performed strongly. - Tuberculosis programs performed well. Authors put this down to effective coordination with the Stop TB Partnership – lessons to be learnt from HIV and malaria programs in terms of partner support and coordination.	

	Global Fund provides 'diagonal financing' – not just 'vertical financing' of specific diseases (HIV/AIDS, TB, malaria) or 'horizontal financing' of broader health systems but both. Global Fund has "a sharp focus on achieving disease goals while allowing finance to more broadly strengthen the supporting health sector". Draw strong conclusions in favour of PBF. Targets must be set and owned by countries, not international funders, otherwise poor countries and weak health systems are penalised.
Other comments	

Publication Number: 33	Magrath P and Nichter M (2012) 'Paying for performance and the social relations of health care provision: An anthropological perspective', *Social Science & Medicine*, 75:1778-1785.	
	In the paper	Reference(s) cited in paper
Theory	Sociology and anthropology applied to PBF and health care workers.	Bourdieu P (1977) *Outline of a theory of practice*, (Cambridge: Cambridge University Press). Bourdieu P (1986b) *The logic of practice*, (Stanford, California: Stanford University Press).
Conceptual Framework	'Habitus' framework – dispositions of actors are learned behaviours formed through socialisation and past experiences that frame attitudes, actions and perceptions. Motivation is a disposition that leads actors to improve performance.	Bourdieu P (1977) *Outline of a theory of practice*, (Cambridge: Cambridge University Press). Bourdieu P (1986b) *The logic of practice*, (Stanford, California: Stanford University Press).
Aspect of PBF		
Variables:		
i. Context		
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Application of anthropological research strategy to PBF schemes.	
Tools used		
Key findings	Adaptation of PBF (P4P) schemes to local contexts is vital. Ethnographic research ought to be undertaken with collaboration from local stakeholders to assess the applicability of PBF in each context, in order to: - Assess readiness for PBF implementation: how will schemes interact with current policies and initiatives? - Minimize or avoid side-effects of schemes. - Plan for 'crowding out' and 'gaming' by aligning performance measures with context-specific values and professional norms to maintain intrinsic motivation and by setting appropriate targets. - Create sustainable programs in conjunction with complementary reforms. - Identify key variables for monitoring and evaluating performance. - Assess how to stimulate *and* maintain motivation in the long term. Evidence in support of theoretical merits of PBF (based on organisational theory, rational choice theory etc.) has come from agencies undertaking PBF themselves, and focused on targeted outcomes, not broader implications for local populations and health services. Both pro- and con-arguments have been based on starting positions without substantial empirical support. Bourdieu's 'habitus' framework and his distinction between economic,	

	social, cultural and symbolic capital and how these forms of capital are acquired and converted from one form to another can be useful for understanding the impact of PBF on motivation depending on the structure of society – especially in terms of power structures and reward systems. Therefore useful in context-specific analysis of the suitability of PBF.
Other comments	Interesting examination of PBF from an anthropological perspective. Provides insights not offered elsewhere. Focus on social relations and cultural differences that will impact attitudes towards PBF. A framework that could be built on.

Publication Number: 34	Mamdani M, et al. (2012) 'The Role of a 'Pay for Performance' (P4P) Scheme in Motivating Health Workers at Different Levels of the Primary Health Care (PHC) System in Tanzania', Poster presented at the Second Global Symposium on Health Systems Research, Oct. 31st-Nov. 3rd, 2012, in Beijing, China. Produced by the Ifakara Health Institute and the London School of Hygiene and Tropical Medicine. Available at: www.ihi.or.tz.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of PBF	Results of a PBF scheme in Tanzania.	
Variables:		
i. Context	Implementation of a PBF scheme aimed at improving maternal and newborn health in the Pwani region of Tanzania.	
ii. Process		
iii. Actors	Health care workers and district management workers.	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Case study.	
Tools used	Qualitative analysis of 43 in-depth interviews of health workers and district management team members from 15 health facilities across five districts in the Pwani region. Interviews conducted between December 2011 and March 2012.	
Key findings	Attitudes of health workers and management team members indicated the following about PBF: - Incentives stimulated changes in facilities, and interviewees noted improved quality of care. - Rates of pay for health workers providing targeted and non-targeted care must be similar to avoid decreased cooperation between workers. - PBF most effective in facilities with adequate supplies, staff and supervisors and where all staff is involved in scheme implementation and receive performance payments. - Existing constraints may not be overcome by PBF – 'better-off' facilities are better equipped to address constraints, therefore equity concerns are valid. - Facilities will seek to overcome systemic constraints by implementing cost-sharing schemes.	
Other comments	Interesting as it deals with attitudes of health workers rather than outcomes as most other studies seem to do. A more thorough treatment of the interviews and results is needed. Evidence is somewhat anecdotal. PBF referred to as pay for performance (P4P) on this poster.	

Publication Number: 35	Meessen B, Soucat A and Sekabaraga C (2011) 'Performance-based financing: just a donor fad or a catalyst towards comprehensive health-care reform?' *Bulletin of the World Health Organization* 89:153-156.

	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of PBF	PBF as a driver for health-care reform.	
Variables:		
i. Context	PBF implementation in low-income countries.	
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy		
Tools used		
Key findings	Authors believe PBF could overcome some of the structural problems faced by global health governance. Authors counter-critique critics of PBF who focus too much on PBF as a mechanism of payment, rather than viewing it as a source of health system reform. Key strengths of PBF: - Accountability – healthy facilities financed according to output, pressure for results means facilities more likely to tailor treatment initiatives to local population in order to satisfy users. - Efficiency – Allocative efficiency improved as central health administrations prioritize to reach MDGs and other important goals. Technical efficiency improved due to incentives to increase quality and quantity of services. - Spill-over effect – impact in health sector may transfer into other sectors and encourage more widespread public sector reform. PBF gives more autonomy to organisational health units. PBF forms contractual or regulatory relationships rather than hierarchical ones – each organisational unit must therefore account for performance.	
Other comments	Authors big proponents of PBF, but point out some limits: some aspects of performance hard to quantify and thus renumerate; design and implementation is difficult; side-effects of processes, both long and short term.	

Publication Number: 36	Montagu D and Yamey GM (2011) 'Pay-for-performance and the Millennium Development Goals', *Lancet* 377:1383-1385.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of PBF	Effectiveness and replicability of PBF schemes.	
Variables:		
i. Context	Response to the positive results of the Basinga et al. study of PBF schemes in Rwanda.	Basinga P, et al. (2011) 'Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation', *Lancet*, 377: 1421-1428.
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Comment on the Basinga et al. study	
Tools used		
Key findings	Lauds the study of Basinga et al. for evaluating PBF in a low-income	

	country, for incorporating a credible control group, and for isolating the effect of pay incentives on service delivery. Basinga et al. study also provides data on why incentives fail or succeed. However, Montagu and Yamey point out that Basinga et al. study still has shortcomings: - Process outcomes, rather than health outcomes are measured. An increase in service provision due to incentives does not necessarily mean a reduction in maternal or child mortality, for example. - The 'pro-poor' effect of PBF remains unclear, as the study did not suggest whether incentives led to an increase in facility-based births among the poorest quintile of women. - Other impact evaluations (see Werner et al.) have found that that the effects and benefits of incentives diminish and dissipate over time. - The specific socio-political context in Rwanda (a small country with a strong centralized government with extensive control over the provision of health services, and that receives substantial amounts of flexible health financing from donors) means that the study does not indicate whether PBF would be successful and replicable elsewhere.
Other comments	

Publication Number: 37	Mæstad O (2007) 'Rewarding Safe Motherhood: How can Performance-Based Funding Reduce Maternal and Newborn Mortality in Tanzania', *CMI Report* R2007:17.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of PBF	PBF implementation to reduce maternal and newborn mortality.	
Variables:		
i. Context	Implementation of PBF schemes in Tanzania.	
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Qualitative and quantitative analysis of maternal and newborn mortality rates in Tanzania and of the potential for PBF schemes to address these rates.	
Tools used	Analysis of published data on maternal and newborn mortality rates in Tanzania.	
Key findings	PBF and conditional cash transfers can alter the health-seeking habits of pregnant women by addressing demand-side issues (such as high costs), and improve quality of care by providing incentives for health workers. PBF was not useful in addressing structural problems like poor infrastructure, shortage of health workers, and delayed drug and equipment supplies. Additional challenges to PBF include reliable reporting of performance measures, and ensuring that performance rewards are paid in a timely manner. Author recognises need for further research, both in terms of quantity and quality.	
Other comments		

Publication Number: 40	Oxman AD and Fretheim A (2009) 'Can paying for results help to achieve the Millennium Development Goals? A critical review of selected evaluations of results-based financing', *Journal of Evidence-Based Medicine* 2:184-195.	
	In the paper	Reference(s) cited in paper
Theory		

Conceptual Framework		
Aspect of PBF	Effects of PBF schemes on health sectors and the fulfilment of the MDGs.	
Variables:		
i. Context		
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Critical evaluation of case studies of PBF implementation in health sectors in low- and middle-income countries.	
Tools used		
Key findings	PBF schemes have been implemented as part of reforms that have included increased health-care funding, improved technical support and training, new IT systems and changes in management. Effects of financial incentives cannot be isolated from effects of these other reforms; hence little evidence exists to support the effects of PBF schemes. Nevertheless, authors make suggestions for PBF design, including: - Identification of a health system's problems and their underlying causes. - Specification of priorities and strategy to deal with root causes. - Set targets, indicators, magnitude and recipients of incentives, and identify other necessary funds. - Assessment of the feasibility of design in each context. - Ensure institutional and political support for schemes. There is data suggesting that PBF schemes may have unintended consequences.	
Other comments	PBF is referred to as results-based financing (RBF) in this article.	

Publication Number: 41	Scheffler RM (2010) 'Pay For Performance (P4P) Programs in Health Services: What is the Evidence?' *World Health Report*, Background Paper, No. 31.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework	Develops a framework for the evaluation of PBF schemes.	
Aspect of PBF		
Variables:		
i. Context		
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes	Constructs a basic framework for the evaluation of PBF schemes.	
vi. Other		
Research strategy		
Tools used		
Key findings	Finds evidence for effectiveness of PBF to be lacking and/or weak. Literature on PBF is vast and rapidly growing, but research is preliminary. Begins to construct a framework for the evaluation of PBF schemes. Measures for evaluation of schemes split into quality and efficiency measures. Three conceptions of efficiency which PBF seeks to address: - Allocative efficiency: aims to maximize the output of funds spent on healthcare systems. Allocative efficiency seeks benefits to population health - Technical efficiency: 'minimizing costs and maximizing quality' - Dynamic efficiency: 'Is the rate of technological change in the healthcare system optimal'?	

	Quality evaluated in terms of structure, process and outcome: - Structure: use of equipment and technology, and improvements in health care facilities. - Process: routine procedures such as vaccinations and disease screening - Outcome: most valued measure, e.g. the successful delivery of a baby. Outcome can be difficult to measure so intermediate outcomes can be used. Patient satisfaction is an outcome measure that can be used to evaluate PBF. PBF also seeks to achieve equity goals. Possible unintended consequence of PBF is that rewarded measures may favour treatment of one type of patient over another. Equity may benefit or suffer due to PBF schemes as a result.
Other comments	PBF is referred to as pay for performance (P4P) in this report.

Publication Number: 42	Soeters R, Habineza C and Peerenboom PB (2006) 'Performance-based financing and changing the district health system: experience from Rwanda', *Bulletin of the World Health Organization* 84:884-889.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of PBF		
Variables:		
i. Context	Performance-based funding in Rwandan health system.	
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes	Organisational changes in district health system to facilitate PBF process.	
vi. Other		
Research strategy	Case study: Cyangugu province, Rwanda.	
Tools used	Two household surveys in 2003 and 2005 (sample sizes of 240 and 320 households respectively) detailing household health expenditures, attitudes towards health user fee payments, proportion of women delivering in a health facility.	
Key findings	Between 2003 and 2005, among other findings, household health expenditures decreased by 62% to $3.45, attitudes towards health user fee payments improved (respondents calling fee payments 'catastrophic' decreased from 2.5% to 0.7%), and the proportion of women delivering in a health facility increased from 25% to 60%. Advocate an institutional set-up where district health authorities are in control of the PBF system, and an independent and transparent 'fundholder' organisation implements the contract in accordance with agreed targets. Autonomy of service providers (health facility managers) is important – encourages entrepreneurial spirit, leads to better human resource management and collaboration with private sector. All enhance performance. Output indicators (goals that must be reached for funding) should not exceed 25 to avoid disproportionate administration procedures. Subsidies should *not* replace (nominal) user fee payments. Important accountability measure for patients: provides incentive for providers and empowerment for the user. Several issues raised as a result of research: - Suitable organisations to act as fundholder: should it be an NGO, a semi-public organisation, a for-profit organisation or an insurance	

	organisation? Authors suggest a private sector solution would be best due to flexibility and potential for competitive pressure through contract renewals. - How to transfer PBF knowledge/practice into other sectors (e.g. sanitation and water supply). - How to integrate PBF into other health care schemes, for example community-based health insurance schemes.
Other comments	

Publication Number: 43	Songstad N G, et al. (2012) 'Assessing performance enhancing tools: experiences with the open performance review and appraisal system (OPRAS) and expectations towards payment for performance (P4P) in the public health sector in Tanzania', *Globalization and Health* 8(33):1-13.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of PBF	Impact on health worker motivation.	
Variables:		
i. Context	Implementation of a review and appraisal system and of PBF schemes in the Tanzanian public health sector.	
ii. Process		
iii. Actors	Health care workers in the Tanzanian public health sector.	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Qualitative study of health worker motivation.	
Tools used	Focus group discussions and in-depth interviews with clinicians, nursing staff, and administrators in the public health sector. Study conducted in the Mbulu district in northern Tanzania. Study conducted in multiple phases between April 2007 and May 2010.	
Key findings	Health workers expressed 'great expectations' towards P4P, mainly due to the incentive of increased salaries. Two main factors considered important for motivation by the interviewees: - Level of salaries and allowances - Recognition of good performance	
Other comments		

Publication Number: 46	Ssengooba F, McPake B and Palmer N (2012) 'Why performance-based contracting failed in Uganda – An "open-box" evaluation of a complex health system intervention", *Social Science & Medicine* 75:377-383.	
	In the paper	Reference(s) cited in paper
Theory	Complex adaptive system theory	Leykum L K, Pugh J, Lawrence V, et al. (2007) 'Organizational interventions employing principles of complexity science have improved outcomes for patients with Type II diabetes' *Implementation* Science, 2 (28): 2-28. Plsek P E and Wilson T (2001) 'Complexity, leadership, and management in healthcare organisations', *British Medical Journal*, 323: 746-749.
	Expectancy theory	Lawler E E (1971) Pay and organizational effectiveness: A psychological view, (New York: McGraw-Hill).

		Lawler E E (1989) 'Pay for performance: making it work', *Compensation Benefits Review*, 21: 55-60.
Conceptual Framework		
Aspect of PBF	Failure in design and implementation.	
Variables:		
i. Context	Failure of PBF schemes in Uganda	
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes	Two-fold: - An outline for an evaluative approach that supports PBF design and implementation. - Illustration of the empirical dynamics in implementation of PBF	
vi. Other		
Research strategy	Case study research. Theory-based evaluation (explicitly stated in the article).	
Tools used	"Open-box" approach that focuses on how and why effects of an intervention come about.	
Key findings	Authors highlight that existing literature shows that PBF *can* and has been effective, but not *why*. What design features and context led to effective (or ineffective) outcomes? Critique use of "black-box" approaches to evaluating PBF, which focus on the magnitude of effects on health interventions, rather than causes of effects. Point out three main flaws in data on the effectiveness of PBF: - Lack of consideration for impacts on the broader health system - Unrealistic nature of assumption that PBF implementation coincides with linear program logic. - Unrealistic nature of assumptions that the intervention and its effects are linked by simple causal chains. Authors highlight two theories that ought to be used to explain the main components and outcomes of PBF: - Complex adaptive system theory (complexity theory): predicts non-linear routes to program outcomes and illustrates how context shapes the evolution and adaptation of an intervention. - Expectancy theory: explains the underlying mechanisms and perceptions that link incentives to pre-specified tasks.	
Other comments	This article refers to PBF as performance-based contracting (PBC). While not a case study in one of the three countries in this EQUINET project, this article still flags up the potential shortcomings of PBF schemes. Also relevant due to its theory-based evaluation of PBF.	

Publication Number: 48	Toonen J, et al. (2009) *Learning lessons on implementing performance based financing, from a multi-country evaluation*, *A Synthesis Report.* Royal Tropical Institute: Amsterdam.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of PBF	Outcomes of PBF schemes in multiple countries.	
Variables:		
i. Context	PBF implementation in: - Democratic Republic of Congo - Tanzania - Zambia - Burundi - Rwanda	
ii. Process		

iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Focus on lessons learnt from PBF schemes. Sampling not representative but focused on cases with extensive information on lessons learnt.	
Tools used	Data collection and analysis from areas where PBF schemes have been implemented. Interviews with stakeholders: health-care workers, community representatives, government officials and civil society figures. Individual country reports developed from which a meta-analysis of results and lessons learnt was conducted.	
Key findings	Authors note that performance measures did increase in several programs. This included 'remarkable' results in terms of utilisation of health services for institutional deliveries, antenatal services and family planning. Some programs showed little or no effect. Stress that confounding factors (influence of other variables) should not be discounted. Key determinants for the successful implementation of PBF: - Autonomy for health providers and other local stakeholders in terms of preparing business plans etc. (i.e. local participation and control). - National ownership of PBF schemes. Embeds the schemes within over-arching strategy rather than isolating them in a vertical approach. - Contractual agreements involving partners and actors at all levels of operationalisation. - Presence of local fund holders. - Shared responsibility of service providers, fund holders and regulators. - Effective monitoring of outputs and quality of services.	
Other comments	Authors point out that potential for community involvement and participation is great within PBF, but needs a clear strategy and concept to guide it. Set out a comprehensive research agenda for further study. Issues that need addressing include: - Contributing factors – what changes can actually be attributed to PBF? - What potential perverse effects and unintended consequences are associated with PBF? - What size schemes are optimal? Local, regional, national? - How can PBF schemes become sustainable? What are the viable exit-strategies for NGOs if the long-term goal is complete local ownership?	

Publication Number: 49	Trisolini MG (2011) 'Theoretical Perspectives on Pay for Performance' in Cromwell J, Trisolini MG, Pope GC, Mitchell JB and Greenwald LM (eds), *Pay for Performance in Health Care: Methods and Approaches,* RTI Press publication No. BK-0002-1103. RTI Press: Research Triangle Park, NC.	
	In the paper	Reference(s) cited in paper
Theory	Economics (principal-agent theory)	Golden B and Sloan F (2008) 'Physician pay for performance: Alternative perspectives' in Sloan F and Kasper H (Eds.), *Incentives and choice in health care,* (Cambridge, MA: MIT Press): 289−318.
	Sociology (deprofessionalisation theory)	Cockerham W (2007) *Medical sociology, 10th Ed.,* (Upper Saddle River, NJ: Prentice Hall).
	Psychology (Herzberg's two-factor theory)	Herzberg F (1966) *Work and the nature of man* (Cleveland: World Publishing).
	Organisational Theory	Town R, Wholey D R, Kralewski J

	Contingency Theory	and Dowd B (2004) 'Assessing the influence of incentives on physicians and medical groups', *Medical Care Research and Review*, 61 (3 Suppl): 80S−118S. Shortell S M and Kaluzny A (2006) *Health care management: Organization design and behavior, 5th Ed.*, (Clifton Park, NY: Thomson Delmar Learning).
Conceptual Framework		
Aspect of PBF	Theoretical explanations for the effects of PBF	
Variables:		
i. Context		
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Evaluation of multi-disciplinary theories that can help determine the applicability or analyse the outcomes of PBF schemes.	
Tools used		
Key findings	PBF (P4P) schemes are influenced by a variety of factors hence author advocates a multidisciplinary theoretical approach touching upon economics, sociology, psychology and organisational theory to explain the benefits and disadvantages of PBF. - Economics: principal-agent problem of health-care professionals using the asymmetrical information levels of their patients for their own advantage. - Sociology: involvement of multiple non-medical actors in PBF schemes may lead to fears of deprofessionalisation amongst medical professionals, with negative impacts on care practices. - Psychology: Herzberg's two-factor theory of a) motivating factors that encourage productive work and b) dissatisfiers. Can also be classified as intrinsic and extrinsic (de)motivators. Potential for financial incentives to undermine intrinsic motivation. - Organisational Theory: factors such as a) ownership, b) quality improvement and change management, c) cultures and d) institutional layers can help explain impacts and potential impacts of PBF schemes. Author suggests 'contingency theory' as an appropriate theoretical framework to approach multidisciplinary analysis of PBF. Essentially, contingency theory argues that organisations must adapt their structures, cultures, systems and staff according to the environment and institutional relationships in which they are situated. Facilities thus react to their specific contexts, while applying any lessons that are universally applicable.	
Other comments		

Publication Number: 50	Witter S, et al. (2012) 'Paying for performance to improve the delivery of health interventions in low- and middle-income countries', *Cochrane Database of Systematic Reviews*, Issue 2, Art. No.: CD007899. DOI: 10.1002/14651858.CD007899.pub2.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of PBF	Review of evidence of the effects of performance-based financing on health care in low- and middle-income states.	
Variables:		
i. Context	Implementation of PBF in:	

	- Vietnam - China - Uganda - Rwanda - Tanzania - Democratic Republic of Congo - Burundi - The Philippines	
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Review of studies addressing PBF in relation to any of: performance of health-care providers; outcomes for patients; unintended effects of PBF; changes in the use of resources as a result of PBF. Studies must have been conducted in low/middle-income countries as defined by World Bank and used one of following research designs: - Randomised trial - Non-randomised trial - Controlled before-after study - Interrupted time series study	
Tools used		
Key findings	Authors found that evidence on PBF was low to very low in quality. The case studies used too varied methods of PBF and were undertaken in too disparate settings for any general conclusions to be drawn. Authors identify a large gap in knowledge that needs more quantity *and* quality of research. Highly uncertain impacts on quality of care, antenatal care, institutional deliveries. Mixed results reported on preventive care for children; immunisation rates increased in some studies, decreased in others.	
Other comments		

Participation in global health governance

Publication Number: 1	Atun R and Kazatchkine M (2009) 'Promoting Country Ownership and Stewardship of Health Programs: The Global Fund Experience', *Journal of Acquired Immune Deficiency Syndrome (JAIDS)* 52 (Supplement 1):S67-S68.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of Participation	Country ownership of Global Fund PBF schemes.	
Variables:		
i. Context		
ii. Process		
iii. Actors	Global Fund to Fight AIDS, Tuberculosis and Malaria. Governments and civil society organisations in recipient states.	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy		
Tools used		
Key findings	Authors talk of 'positive benefits' and 'catalytic effects' of Global Fund schemes on local governance of HIV programs and health leadership. Point out five ways this has been achieved: - Country Coordinating Mechanisms (CCMs) have ensured that the health priorities of a wide set of stakeholders are incorporated in	

	schemes, thus developing local capacity in health care. - Global Fund model of funding encourages involvement of a diverse set of actors (government, civil society organisations, faith-based entities, community organisations) in health care leadership. - Investing in community systems encourages involvement of community leaders in mobilizing demand for services and scaling up schemes to reach less-accessible groups. - Increased community involvement also improves health governance, as service providers are more accountable to the communities they serve. - Diversity and inclusiveness of CCMs improve country coordination capacities amongst a range of actors. These benefits are based on 'early evidence'.
Other comments	

Publication Number: 2	Barnes A and Brown GW (2011) 'The Idea of Partnership within the Millennium Development Goals: context, instrumentality and the normative demands of partnership', *Third World Quarterly* 32(1):165-180.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of Participation	Addressing the under-theorizing of the idea of 'partnership'.	
Variables:		
i. Context	Emergence of 'partnership' as a key normative driver for development assistance in the aftermath of the Cold War and the poor performance of Structural Adjustment Programs (SAPs). In this context aid agencies were losing both political support in donor countries and their funding and legitimacy.	
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy		
Tools used		
Key findings	Partnership is 'the key normative concept' underpinning the organisation and governance of the Millennium Development Goals. However, there is no clear conceptual framework delineating what 'partnership' actually means. 'Partnership' is not quantified – when is a sufficient level of partnership reached? Partnership must be, at the root, acceptable to all partners. This in turn has practical implications as it provides the basis of procedural guidelines for partnership in development. Partnership idea useful for addressing two key concerns: - Response to criticisms of paternalism and unjust coercion. Addressing power relationships. - 'Partnership' broad enough to encompass *both* donor behaviuor *and* recipient behaviour.	
Other comments		

Publication Number: 3	Bartsch S and Kohlmorgen L (2007) 'The Role of Southern Actors in Global Governance: The Fight against HIV/AIDS', *GIGA Working Papers*,

	No. 46.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework	Apply a conceptual framework of global governance to health policy. In authors' view, global governance consists of "non-hierarchical forms of regulation and cooperation, but also power structures and hierarchical top-down processes" (8). Refer to and further develop Norman Long's concept of social interfaces.	Long N (2001) Development Sociology: Actor Perspectives, (New York: Routledge).
Aspect of Participation	Influence of Southern actors on global health governance.	
Variables:		
i. Context		
ii. Process		
iii. Actors	International organisations and public/private partnerships (WHO, World Bank, Global Fund), civil society organisations, Southern actors, Northern actors.	
iv. Content	Examination of possibilities for Southern actors to access decision-making processes in various different interfaces.	
v. Outcomes		
vi. Other		
Research strategy	Qualitative analysis.	
Tools used		
Key findings	Differentiate between four different types of interfaces where interactions occur between actors: - Discoursive interfaces - Organisational interfaces - Legal interfaces - Resource-transfer interfaces Analyse interactions along these interfaces to illustrate the points of access for Southern actors to influence global governance. Make several observations about access for Southern actors: - At the organizational interface of the WHO, Southern actors have a lot of access due to the 'one country, one vote' governance structure, but as activity in developing countries is often financed by extra-budgetary funds, donor countries can exercise their resource-based power and effectively control WHO policy. - The World Bank's organizational interface also provides points of access to nation states, but voting rights are proportional to fund contributions, hence resource-based power again favours donor countries. World Bank also exercises extensive discoursive power and can influence agenda-setting in global health governance. - The composition of the Global Fund Board (five constituencies divided into two voting groups and one non-voting group: 1) Donor group: eight reps from industralised countries and two reps from the private sector; 2) Recipient group: seven reps from developing countries and three reps from civil society; 3) Non-voting group: WHO, World Bank, UNAIDS and a Swiss member) gives state and non-state actors from the South decision-making power. - In terms of resource-transfer interfaces, Southern actors are marginalised as objects, not subjects, of policy-making processes due to the structure of funding for health programs.	
Other comments		

Publication Number: 5	Biesma RG, et al. (2009) 'The effects of global health initiatives on country health systems: a review of the evidence from HIV/AIDS

	control', *Health Policy and Planning* 24:239-252.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework	Build on framework for analysing system-wide effects of the Global Fund, developed by Bennett and Fairbank to produce a draft health systems framework.	Bennett S and Fairbank A (2003) The System-Wide Effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria: A Conceptual Framework, (Bethesda, MD: Partners for Health Reform Plus).
Aspect of Participation	Impact of global health initiatives on health systems in low- and middle-income recipient countries.	
Variables:		
i. Context		
ii. Process		
iii. Actors	The Global Fund to Fight AIDS, TB and Malaria, US President's Emergency Plan for AIDS Relief (PEPFAR), and the World Bank Multi-country AIDS Program (MAP).	
iv. Content		
v. Outcomes	Positive outcomes: - Rapid increase in HIV/AIDS service delivery - Increased stakeholder participation - Channelling of funds to NGOs and other non-governmental stakeholders. Main negative outcome was the distortion of recipient countries' national priorities and policies.	
vi. Other		
Research strategy	Review of key documents.	
Tools used	Search databases and research archives of global health research institutes. 'Snowballing' to find additional papers. Draft health systems framework developed to analyse impact. Composed of three key functions: - Policy development - Policy implementation - Service delivery (not included in analysis due to a lack of published evidence).	
Key findings	Impact of GHIs on policy development: - Progress made by GHIs in aligning their activities with national priorities and strategies of recipient countries. - Global Fund increasingly supports programmes reflecting country ownership and local priorities. PEPFAR has rigid budget allocations, which limits its ability to align with recipient country health priorities. Impact of GHIs on policy implementation: - Early negative system effects as GHIs establish parallel coordinating bodies with poor coordination, harmonisation and alignment with recipient country counterparts. E.g. Global Fund Country-Coordinating Mechanisms (CCMs) have conflicted and contested National AIDS Councils and other pre-existing bodies. - In the long-run stakeholder participation is widened, and GHIs have improved in their coordination with, and utilisation of country systems. CCM's provide a point of access for local stakeholder participation in Global Fund activities. - Human resource shortage experienced in sub-Saharan Africa as multiple funding sources compete for a limited number of health professionals, draining human resources from the public sector. Increased recognition of this problem on the part of GHIs has led to	

	higher levels of attention and funding given to training of health workers. Authors propose greater alignment with the Paris Principles for Aid Effectiveness. Especially in relation to country ownership, local capacity building, coordination of donor investment, and addressing human resource shortages.
Other comments	

Publication Number: 7	Brown GW (2009) 'Multisectoralism, Participation, and Stakeholder Effectiveness: Increasing the Role of Nonstate Actors in the Global Fund to Fight AIDS, Tuberculosis and Malaria', *Global Governance* 15:169-177.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of Participation	Gap between stated aims of the Global Fund to Fight AIDS, Tuberculosis and Malaria and its actual practice with regards to incorporating non-state actors in governance process.	
Variables:		
i. Context		
ii. Process		
iii. Actors	Global Fund, non-state actors.	
iv. Content	Discussion of the role of non-state actors within the Global Fund.	
v. Outcomes	Recommendation for CCMs to meet minimum threshold of 40% multisectoral participation and NGO membership. Also, strict monitoring of compliance with Global Fund's eligibility requirements a necessity.	
vi. Other		
Research strategy	Qualitative analysis.	
Tools used		
Key findings	Global Fund commitment to partnership not always fulfilled in practice: - CCMs and Global Fund board dominated by economically and politically strong members. Others marginalized. - Global Fund accountable to donor states, not recipient states, implementing NGOs or local health experts. - NGO participation on CCMs is recommended rather than required – no minimum threshold. - Multisectoralism on CCMs not always fulfilled, at times dominated by governmental elites. Funding on an *ad hoc* basis means that economic power dictates Global Fund activities. Global Fund has deliberative procedures in place to enhance participation but accountability to constituents is lacking.	
Other comments		

Publication Number: 8	Brown GW (2010) 'Safeguarding deliberative global governance: the case of The Global Fund to Fight AIDS, Tuberculosis and Malaria', *Review of International Studies* 36:511-530.	
	In the paper	Reference(s) cited in paper
Theory	Theories of deliberative democracy.	
Conceptual Framework		
Aspect of Participation	Multisectoralism and deliberative governance within the Global	

	Fund.	
Variables:		
i. Context		
ii. Process		
iii. Actors	Global fund, governments, non-state actors.	
iv. Content	Outline of deliberative theory and linking of theory to Global Fund governance structures to argue that there is a deliberative deficit in the Fund's governance.	
v. Outcomes		
vi. Other		
Research strategy	Qualitative analysis.	
Tools used		
Key findings	Despite its aims, the Global Fund has not managed to maintain a deliberative and participatory governance structure. Deficits in equality in terms of: - Stakeholder participation - Deliberation between stakeholders - Power relationships Power structures and traditional multilateral governance has undermined the deliberation process of the Global Fund. A 'colonisation of unequal advantage' (522) undermines deliberation at the Board level of the Fund. E.g. representatives of donor states meet before Board meetings and set political strategy and organise voting caucuses. Donor states wield effective veto power over Board decisions due to their economic advantage. Donors can threaten to withhold funding, thus overriding Board decisions. Stakeholders not on the Fund's Board have little or no access to the deliberative and decision-making process. Not only is there a deliberative deficit at Board level, there are disconnects between Board representatives and their constituencies.	
Other comments		

Publication Number: 10	Buse K and Harmer AM (2007) 'Seven habits of highly effective global public-private health partnerships: Practice and potential', *Social Science & Medicine* 64:259-271.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of Participation	Public-private health partnerships and global health governance.	
Variables:		
i. Context	Emergence of public-private partnerships to combat global health problems.	
ii. Process		
iii. Actors	Public-private global health partnerships (e.g. Global Fund	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Systematic review of the governance structures of 100+ global health partnership initiatives that involve both public and private sector representatives in decision-making.	
Tools used		
Key findings	Main positive contributions of GHPs - Agenda-setting: increasing saliency of health issues.	

	- Mobilisation of funds. - Encouraging research and development. - Improving health-care access. - Augmenting national health policies. - Improving health service delivery capacity. - Setting international standards and norms in health care. 'Unhealthy habits' of GHPs: - By imposing priorities of donor partners GHPs may skew national health priorities. - Stakeholders (especially from low- and middle-income countries) are underrepresented in decision-making processes (Global Fund, among others, has addressed this habit). - Poor governance: lack of transparency, effective performance monitoring and clear delineation of partner roles and responsibilities. Especially pertinent where conflicts of interest exist (Global Fund, again, has done well to overcome this issue). - Disregard for comparative advantages of the public sector versus those of the private sector. Public sector side-lined even when it could be more effective at achieving goals. - Over-commitment and under-funding. GHPs make commitments that exceed their funding. - Ineffective harmonisation with national health systems and other partnerships and donors, leading to resource wastage. - Human resource mismanagement. Staff must be given a degree of freedom by their host organisation to work on external projects (within the partnership). These seven 'unhealthy habits' must be addressed to create effective partnerships.
Other comments	

Publication Number: 15	Esser DE and Bench KK (2011) 'Does Global Health Funding Respond to Recipients' Needs? Comparing Public and Private Donors' Allocations in 2005-2007', *World Development* 39 (8):1271-1280.	
	In the paper	Reference(s) cited in paper
Theory	Not stated, but references to studies that argue that global health funding is determined by political considerations as much as, if not more, than health priorities.	Ravishankar N, Gubbins P, Cooley R, Leach-Kemon K, Michaud M, Jamison D, et al. (2009) 'Financing global health: Tracking development assistance for health', *The Lancet*, 373: 2113–2124. Shiffman J (2008) 'Has donor prioritisation of HIV/AIDS displaced aid for other health issues?' *Health Policy and Planning*, 23: 95–100. Périn I and Attaran A (2003) 'Trading ideology for dialogue: An opportunity to fix international aid for health?' *The Lancet*, 361: 1216–1219. Perlman D and Roy A (Eds.) (2009) *The practice of international health*, (Oxford: Oxford University Press).
Conceptual Framework		
Aspect of Participation	Difference between public and private participation in global health funding.	
Variables:		
i. Context	Increased global health budgets and funder diversity.	
ii. Process		

iii. Actors	State donors, private donors and recipient states.	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Comparative analysis of the responsiveness of public and private donor health funding to recipient needs.	
Tools used	Statistical analysis using datasets on official development assistance (ODA), 2,800 private donor grants, disease burdens and perceived health priorities in 27 low- and middle-income countries.	
Key findings	Disease burdens in recipient countries to do not explain public or private funding flows between 2005 and 2007, as there is only weak correlation between funding and health priorities. Support the authors' hypothesis that political considerations and ideologies are the main drivers behind global health funding. ODA is more attuned to health priorities of recipient countries than private funding is.	
Other comments		

Publication Number: 16	Feachem RGA and Sabot OJ (2006) 'An examination of the Global Fund at 5 years', *Lancet*, 368:537-540.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of Participation		
Variables:		
i. Context	Fifth year since the inception of the Global Fund to Fight AIDS, Tuberculosis, and Malaria.	
ii. Process		
iii. Actors	The Global Fund to Fight AIDS, Tuberculosis and Malaria. Governments and civil society in recipient countries.	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Quantitative and qualitative evaluation of the Global Fund's performance in its first five years of operation.	
Tools used		
Key findings	Initial indications that fragile states, despite concerns, are capable of efficient management of increased funding from the Global Fund. Authors find that Global Fund performance-based funding has been effective in rewarding good performance and vice-versa. Grants to Nigeria and South Africa were stopped due to poor performance, and grants to Ukraine and Uganda were suspended, and then restructured, due to misuse. Approximately 40% of Country Coordinating Mechanism members were from civil society in 2006. Authors argue that Global Fund model has empowered civil society in many countries, including Zambia.	
Other comments		

Publication Number: 17	Fidler DP (2007) 'Reflections on the revolution in health and foreign policy', *Bulletin of the World Health Organization* 85 (3):243-244.	
	In the paper	Reference(s) cited in paper
Theory	Passing reference to rational-choice theory.	
Conceptual Framework		
Aspect of Participation		
Variables:		

i. Context	Relationship between health and foreign policy.	
ii. Process	Transformation of health from a national to a global concern.	
iii. Actors	Foreign policy-makers and global health policy-makers.	
iv. Content		
v. Outcomes	Increased saliency of health in global politics.	
vi. Other		
Research strategy		
Tools used		
Key findings	Argue that a global social contract for health is required to counter governance problems. Future relationship between foreign policy and global health will depend on how health community are able to contextualise global health as a national interest to policy-makers.	
Other comments	Very short and superficial treatment of topic – a summary of the state of global health rather than a guideline for action.	

Publication Number: 19	Garrett L (2007) 'The Challenge of Global Health', *Foreign Affairs* 86(1):14-38.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of Participation	General article about global health concerns. Does highlight problem of 'stovepiping' and its effect on participation.	
Variables:		
i. Context	Difficulty in responding to global health challenges.	
ii. Process		
iii. Actors	Donors (governments, inter-governmental organisations and non-governmental organisations) and recipients of aid.	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy		
Tools used		
Key findings	Highlights the problem of 'stovepiping' in global health financing: aid is dispersed down narrow channels focusing on a specific disease or program. Large amounts of funds are made available for certain initiatives, but funding is not flexible and therefore does not benefit the wider health system. Stovepiping reflects the interests and policies of the donors, not of the recipients. Less 'visible' or salient health concerns receive little attention, even if they are a greater overall health risk.	
Other comments		

Publication Number: 20	Global Fund to Fight AIDS, TB and Malaria, The (2012) *Report on Mapping of Partnerships in Tanzania Mainland*. The Global Fund to Fight AIDS, TB and Malaria, January 2012.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of Participation	Partnership in Global Fund schemes in Tanzania.	
Variables:		
i. Context	Global Fund grants in Tanzania.	
ii. Process		

iii. Actors	Global Fund; local stakeholders.	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Mapping of partnerships involved in the implementation of Global Fund grants in Tanzania.	
Tools used	Desk review of Global Fund literature and reports, semi-structured interviews and stakeholder discussions.	
Key findings	Identify main partnership-related challenges: - Inadequate coordinating mechanisms between the Tanzanian National Coordinating Mechanism (TNCM – the restructured CCM for Tanzania) and other stakeholders. - Lack of long-term technical assistance and capacity building strategies. - CSOs lack capacity to sufficiently take part in PBF implementation. - Problems with effective communication and information sharing amongst stakeholders - Lack of system-wide accountability mechanisms. - CSOs not involved beyond PBF implementation. Marginalised in design and decision-making processes.	
Other comments		

Publication Number: 21	Handler A, Issel M and Turnock B (2001) 'A Conceptual Framework to Measure Performance of the Public Health System', *American Journal of Public Health* 91 (8):1235-1239.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework	Based on the work of Donabedian: "links structure, processes, outputs, and outcomes in a model for quality assessment and systems monitoring".	Donabedian A (1980) Explorations in Quality Assessment and Monitoring: The Definition of Quality and Approaches to Its Assessment, Vol. 1. (Ann Arbor, Michigan: Health Administration Press). Turnock B J and Handler A S (1997) 'From measuring to improving public health practice', *Annual Review of Public Health*, 18: 261–282.
Aspect of Participation	Health system performance.	
Variables:		
i. Context	Lack of a conceptual framework that links health system outcomes to organisation capacity and processes.	
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy		
Tools used		
Key findings	Conceptual framework is made up of four system components: - Mission - Structural capacity - Processes - Outcomes These are affected by the macro context, the fifth component. In more detail: **Mission**: philosophy and goals and operationalisation of those goals. **Structural capacity**: aggregate of resources and relationships needed to fulfil goals and processes of public health. Includes information / organisational / physical / human and fiscal resources).	

	Processes: these are the "essential public health services", whereby practitioners seek to identify and address population health problems and prioritize the health systems structural capacity in order to do so. Includes monitoring and identifying community health problems, enforcing laws to ensure health and safety, accessibility and quality control of health services, and informing, educating and empowering the population about health problems. **Outcomes**: the output of the processes, structural capacities and mission of the health system. Essentially improvements in overall population health. "Outcomes can be used to provide information about the system's overall performance, including its efficiency, effectiveness, and ability to achieve equity between populations". **Macro context**: includes social, political and economic forces; need and demand for health services; population's social values; external forces such as federal-state-local relationships and technological advances. These external factors may affect any stage of the health system framework.
Other comments	

Publication Number: 22	Harman S (2007) 'The World Bank: Failing the Multi-Country AIDS Program, Failing HIV/AIDS', *Global Governance* 13:485-492.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of Participation	Partnership and local ownership commitments of the World Bank.	
Variables:		
i. Context	Failure of the World Bank's Multi-Country AIDS Program (MAP) and its consequences for coordination of efforts to fight AIDS and for multi-sectoral participation in this fight.	
ii. Process		
iii. Actors	The World Bank, national governments, civil society.	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Qualitative analysis.	
Tools used		
Key findings	Initially, the MAP was successful in bringing HIV/AIDS to the top of the political agenda in sub-Saharan Africa, and in engendering a multisectoral approach that increased local participation and ownership of the fight against HIV/AIDS. Subsequently the MAP began to fail in several aspects: - National AIDS authorities began to lack institutional support and clarity as to what their role within broader government structures were. - Commitments to multisectorality waned: funding for civil society organisations was insufficient and delayed, dialogue between civil society and the World Bank was very limited leading to the marginalization of the organisations in terms of decision-making and strategy formulation.	
Other comments		

Publication Number: 23	Hwenda L, Mahlathi P and Maphanga T (2011) 'Why African Countries Need to Participate in Global Health Security Discourse', *Global Health Governance* 4(2):1-24.	
	In the paper	Reference(s) cited in paper
Theory		

Conceptual Framework		
Aspect of Participation	Agenda-setting for global health policy.	
Variables:		
i. Context	Securitisation of global health policy. Failure of African countries to participate in formulation of health priorities.	
ii. Process		
iii. Actors	High-income countries, low- and middle-income countries, international organisations, regional organisations.	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Qualitative analysis.	
Tools used		
Key findings	Argue that low- and middle-income countries (LMICs) need to participate in global health security agenda-setting as their interests will otherwise be marginalised by the vested interests of developed states – exemplified by the focus of global health security agendas on bioterrorism and a limited number of infectious diseases. LMICs have been reluctant to frame health policy as a matter of human security due to fears that doing so would provide a justification to bypass national sovereignty in the interest of ensuring health security. Regional organisations such as the SADC could provide an avenue for African countries to participate and affect global health policy more effectively than individual states are able to.	
Other comments		

Publication Number: 27	Kelly K and Birdsall K (2008) *Funding for Civil Society Responses to HIV/AIDS in Tanzania: Status, Problems, Possibilities*. Centre for Aids Development, Research and Evaluation: Johannesburg, South Africa.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of Participation	Impact of PBF and external funders on Tanzanian civil society.	
Variables:		
i. Context		
ii. Process		
iii. Actors	Tanzanian civil society. International donors (including the Global Fund and the World Bank).	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Review of literature on funding and support for civil society in Tanzania. Three fieldwork visits between September and November of 2007.	
Tools used		
Key findings	Tanzanian National Coordinating Mechanism formed by restructuring the Global Fund's CCM to incorporate PEPFAR and World Bank resources. Tanzania ahead of other countries in terms of addressing aid effectiveness and donor harmonisation. Civil society organisations (CSOs) feel their roles to be prescribed due to funding modalities. 'Vibrant and independent civil society' is undermined, in turn undermining its strengths in responding to community needs. Because assistance is tied to short-term targets (i.e. PBF), little or no funding is afforded for the *development* of civil society. Thus, leadership	

	capabilities of civil society remain underdeveloped, excluding them from participation above the level of mere service provision. CSOs are afforded a big role in direct involvement in service provision, but excluded from involvement in strategy and policy.
Other comments	Principal recipient of Global Fund funding (to date of publication) was the Ministry of Finance (total of USD 85.1 million). Civil society organisations Pact Tanzania (USD 7.9 million), Population Services International (USD 2.4 million) and the African Medical and Research Foundation (USD 13.2 million) also received funds. What does balance of funding indicate about participation and points of access to scheme implementation? Authors highlight the impact of the 2005 Paris Declaration on Aid Effectiveness on bilateral donors and the way they fund projects. Also highlight that the Paris Declaration does *not* indicate how civil society will be funded, instead there is an assumption that funding will reach civil society through government relations with civil society.

Publication Number: 28	Kirigia JM and Kirigia DG (2011) 'The essence of governance in health development', *International Archives of Medicine* 4:11.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework	A broader framework than that proposed by Siddiqi *et al*. In addition to factors such as strategic vision, participation, transparency, health legislation (all part of the framework proposed by Siddiqi *et al.*) the authors would include factors such as political and macroeconomic (in)stability in assessing health development governance.	Siddiqi S, Masud T I, Nishtar S, Peters D H, Sabri B, Bile K M and Jama M A (2008) *Framework for assessing governance of the health system in developing countries: gateway to good governance* (Cairo: World Health Organization Regional Office for Eastern Mediterranean).
Aspect of Participation	Governance in health development.	
Variables:		
i. Context	Governance deficiencies in health development.	
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes	A Health Development Governance Index (HDGI) to help identify inadequate governance and improve it. Would include indicators such as: - Leadership responsibilities - Intersectoral action - Existence of health-related legislation and more.	
vi. Other		
Research strategy	Review of existing governance frameworks.	
Tools used		
Key findings	Argue for a broader health development governance framework than those of the UNDP, the WB, WHO, and that proposed by Siddiqi *et al*. Authors' framework includes political and macroeconomic factors. Found that many health leaders and managers were not adequately trained in governance and leadership.	
Other comments		

Publication Number: 32	MacLean SJ and MacLean DR (2009) 'A 'New Scramble for Africa': The Struggle in Sub-Saharan Africa to Set the Terms of Global Health', *The Round Table: The Commonwealth Journal of International Affairs*

	98(402):361-371.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of Participation	Difficulty faced by African actors in setting the agenda for health interventions and policy in sub-Saharan Africa.	
Variables:		
i. Context	Increasing involvement of external actors in setting the agenda for health policy in sub-Saharan Africa. Emergence of public/private partnerships, large philanthropic funders that engage with global health policy.	
ii. Process		
iii. Actors	Public/private partnerships (e.g. the Global Fund), international organisations (e.g. WHO), philanthropic enterprises (e.g. Bill and Melinda Gates Foundation), local stakeholders.	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Qualitative analysis.	
Tools used		
Key findings	Emphasis of donors and other external actors operating in the health sector in sub-Saharan Africa continues to be on biomedical/pharmaceutical solutions to health problems rather than a simultaneous emphasis on addressing the social conditions that threaten population health. Monetary power marginalizes African actors and captures global health discourse and practice.	
Other comments		

Publication Number: 38	Onzivu W (2012) 'Regionalism and the reinvigoration of global health diplomacy: Lessons from Africa', *Asian Journal of WTO and International Health Law and Policy* 7(1):49-76.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of Participation	Relationship between regional and global health diplomacy, with focus on African regional organizations.	
Variables:		
i. Context	Increased engagement shown by African regional organizations towards health diplomacy at the global level.	
ii. Process		
iii. Actors	Various global and regional actors: - World Health Organisation - The African Union - The East African Community - Economic Community of West African States - Common Market of Eastern and Southern Africa	
iv. Content	Analysis of various actors' health agendas and diplomacy efforts.	
v. Outcomes		

vi. Other		
Research strategy	Qualitative analysis.	
Tools used		
Key findings	Author finds that African regional organizations are increasingly using diplomacy to promote African interests in global health governance. Uses the example of the negotiations that led to the World Health Organisation's Framework Convention on Tobacco Control, in which African interests were represented by the African Union. African delegates successfully pushed for the adoption of a strong convention. Points to the example of the East African Community (EAC) which has worked to harmonise the foreign policy pursuits of its member states, including health policy as an indication of the increasing regional weight placed on health diplomacy. Finds that regional organisations have marginalized civil society groups, except for trade groups. Still some resistance towards fully incorporating non-state actors in priority-setting and decision-making processes.	
Other comments	Rather than explore how effective these regional organisations are at agenda-setting on a global level, the article limits itself to a discussion of whether or not the organisations deal with health-specific issues.	

Publication Number: 39	Ooms G, et al. (2010) 'Financing the Millennium Development Goals for health and beyond: sustaining the 'Big Push'', *Globalization and Health* 6(1):1-8.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of Participation	Critique of current aid practice.	
Variables:		
i. Context	Failures at achieving many of the Millennium Development Goals with the 2015 target date fast approaching.	
ii. Process		
iii. Actors		
iv. Content		
v. Outcomes		
vi. Other		
Research strategy		
Tools used		
Key findings	Critique of current aid practice: - Aid is often short-term – disease specific initiatives and easily demonstrated outcomes. - Aid goals do not align with needs of recipient populations, long-term goals not targeted or threatened by aid volatility Praise for the Global Fund for affecting a paradigm shift in development: dual commitment to domestic sustainability and sustainability of international support. Global Fund created a wealth redistribution mechanism with great success. Authors suggest this needs to be expanded to broader health issues *and* social justice issues.	
Other comments		

Publication Number: 44	Sridhar D and Batniji R (2008) 'Misfinancing global health: a case for transparency in disbursements and decision making', *Lancet* 372:1185-1191.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of Participation	Donor rather than recipient driven health priorities due to funding modalities.	

Variables:		
i. Context	Increased global health funding and lack of transparency of funds, priorities and decision-making.	
ii. Process		
iii. Actors	Four largest donors in health care (World Bank, Bill & Melinda Gates Foundation, the US Government and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria).	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Creation of a disbursement database to track donor funds in 2005. Disbursements were classified according to donor, type of recipient, disease, region, and type of investment. Total of 1006 grants were considered.	
Tools used	Analysis of annual reports and budgets of four largest donors in global health care.	
Key findings	Found that data on global disease burdens are incomplete and imperfect. Information gap should be addressed by reporting funding in a complete and standardised manner. Lack of good estimates for rates of non-disease-specific deaths, e.g. deaths caused directly or indirectly by the lack of access to adequate health care. Makes it difficult to formulate priorities when compared to specific data on HIV/AIDS deaths, for example. Donors, rather than recipients, largely defined health priorities. Authors urge health sector aid to comply with Paris Declaration of 2005, as other aid sectors have done, by focusing more on recipient ownership of health policies.	
Other comments	By authors' own admission, a political economic analysis (which was not included in report) would have aided understanding of the decision-making process of the donor institutions. Authors believe such an analysis would reinforce their perceived need for "the development of country ownership, particularly planning and priority setting" (1189).	

Publication Number: 45	Sridhar D and Craig D (2011) 'Analysing global health assistance: The reach for ethnographic, institutional and political economic scope', *Social Science & Medicine* 72:1915-1920.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of Participation	Changing nature of global health assistance and impact on participation.	
Variables:		
i. Context		
ii. Process		
iii. Actors	New actors involved in global health assistance: - Multilateral institutions - Civil society organisations - Transnational Corporations - Regional organisations - Philanthropists	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy		
Tools used		
Key findings	See four major trends in global health system: "new actors; new sectors; new money; new institutional modalities" (p. 1916).	

	- New actors: include civil society organisations, transnational corporations and philanthropists. New actors are not neutral – have their own orthodoxies and internal institutional contexts which impact their approach to health care: positive in that it can bring out best practice, negative in that locally embedded actors might be sidelined and alternate views might be ignored. - New sectors: increasingly inter-sectorial (impact of health care on other sectors and vice-versa). - New funding: huge surge in funding for global health. Downside is lack of human resources to administer funding surge – health talent drawn to specific programmes (e.g. PEPFAR) to the detriment of other areas of health. Some diseases and health concerns combated more effectively, other measures in decline, including primary care and diarrhoeal disease response. - New institutional modalities: globalisation of health care means that health systems pick up institutional modalities of international society in general – e.g. neoliberal ideas and so on. Accountability is weakened as funding is often provided from external sources, technocratically allocated instead of in response to voter demands. Many unintended side-effects that are not fully understood yet.
Other comments	

Publication Number: 47	Starling M, Brugha R and Walt G (2005) *Tracking the Global Fund in Tanzania*, London School of Hygiene & Tropical Medicine: London.	
	In the paper	Reference(s) cited in paper
Theory		
Conceptual Framework		
Aspect of Participation	Participation in Global Fund programs in Tanzania.	
Variables:		
i. Context	Setting up of the Global Fund to Fight AIDS, TB and Malaria in: - Mozambique - Tanzania - Uganda - Zambia	
ii. Process		
iii. Actors	The Global Fund, the Global Fund Country Coordinating Mechanism (CCM), local stakeholders (government, CSOs, faith-based organisations, NGOs).	
iv. Content		
v. Outcomes		
vi. Other		
Research strategy	Descriptive, qualitative study. Tracking study of the activities of the Global Fund in Tanzania.	
Tools used	53 interviews with local stakeholders including government officials and representatives of civil society and multi-lateral and bilateral organisations. Non-participant observation at several funding proposal meetings and at a Country Coordinating Mechanism retreat. Study conducted between 2003 and 2004.	
Key findings	Despite Tanzania's successful application for various funding rounds, CCM was perceived by stakeholders to have been ineffective or inadequate for various reasons: - Lack of engagement of several ministries of the Government of Tanzania - Inadequate participation of CSOs in meetings and inability of CSOs to adequately represent the interests of their constituencies. - Poor dissemination of information and communication within the CCM. The CCM was perceived to be an external imposition, hence there was a lack of support towards it.	
Other comments		

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

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

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

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