Impact Evaluation of RBF pilot in BENIN: proposition to add a "pure" control group

1. Current Impact Evaluation design

In the current design of the Impact Evaluation (IE) of the Result-Based Financing (RBF) pilot in Benin, a combination of two interventions is tested:

- RBF "conditional rewards" (credits linked to results achieved by health centers) versus "unconditional" rewards (credits not linked to results achieved).
- Management autonomy versus no management autonomy.

Therefore, there are currently four groups in the IE:

	RBF treatment (Additional budget linked to performance) (100 HF)	**RBF control (Additional budget not linked to performance) (100 HF)**
Management autonomy treatment (100 HF)	T1 500 HH (50 HF)	T2 500 HH (50 HF)
Management autonomy control (100 HF)	T3 500 HH (50 HF)	C1 500 HH (50 HF)

HF: health facility HH: households

These interventions are applied at facility level and not district level. Consequently, facilities are allocated randomly across these four groups, whichever district they belong to.

Note that all facilities from these 4 groups will receive additional funding (half unconditional for half of facilities and conditional on performance for the other half). To ensure that reported results have been actually achieved, they will intensively monitored by external entities as well as Community-Based Organizations (CBOs).

2. Justification for an additional control group

Adding a "pure control" group to the impact evaluation will allow better assessing the impact of the RBF pilot interventions.

No specific intervention (i.e. no additional funding) will be applied to this pure control group. More precisely, for this group of health facilities, there will be:

- No additional funding (and therefore no Result-Based Financing);
- No management autonomy;
- No specific monitoring of results (aside – naturally - the annual assessment for Impact Evaluation).

One concern justifying this "pure" control group is that the difference in results between our current treatment and control groups could be not significant. Indeed, the motive behind our current IE design is that we suspect that rewards, conditional or unconditional, can have a similar impact. In this case, it would be essential to show a real difference with a group of facilities which do not benefit from any intervention.

3. Size of the “pure” control group

It makes sense to have a fifth group (i.e. the “pure” control group) with a size similar to the other 4 groups.
As the other ones, the pure control group will therefore includes 50 health facilities. For the Impact Evaluation, all these 50 health facilities will be surveyed and 10 households per HF will be interviewed.

4. Selection of the facilities within the pure control group

Ideally, the 50 facilities for this new control group should be selected randomly in all the 26 health districts outside the current IE design.
Unfortunately, this would be quite impractical from logistical and financial points of view, as surveyors would have to survey 3 facilities in one district, then 4 in another one, and so on.
In addition, some districts have to be ruled out, so as to avoid possible biases.

Consequently, we propose here to:

(i) Select 5-6 districts around the 8 districts included in the main impact evaluation and circled on the map in annex, in order to have districts similar to districts T1-2-3 and C1)
(ii) Randomly select 50 health facilities in those districts, but excluding health facilities located less than 15km from the T1-2-3 and C1 districts in order to avoid potential contamination from the PBF experiment.

We acknowledge that, as the selection of health facilities is not random for reasons explained above, this identification method is not as rigorous as for the four other groups.

5. Ministry of Health commitments

After discussions with the Ministry of Health, we do not expect specific interventions by the Ministry or other donors in the “pure control” health facilities before 2012. If such interventions take place, we will carefully measure them using health facility and administrative data and we will account for it in the analysis.
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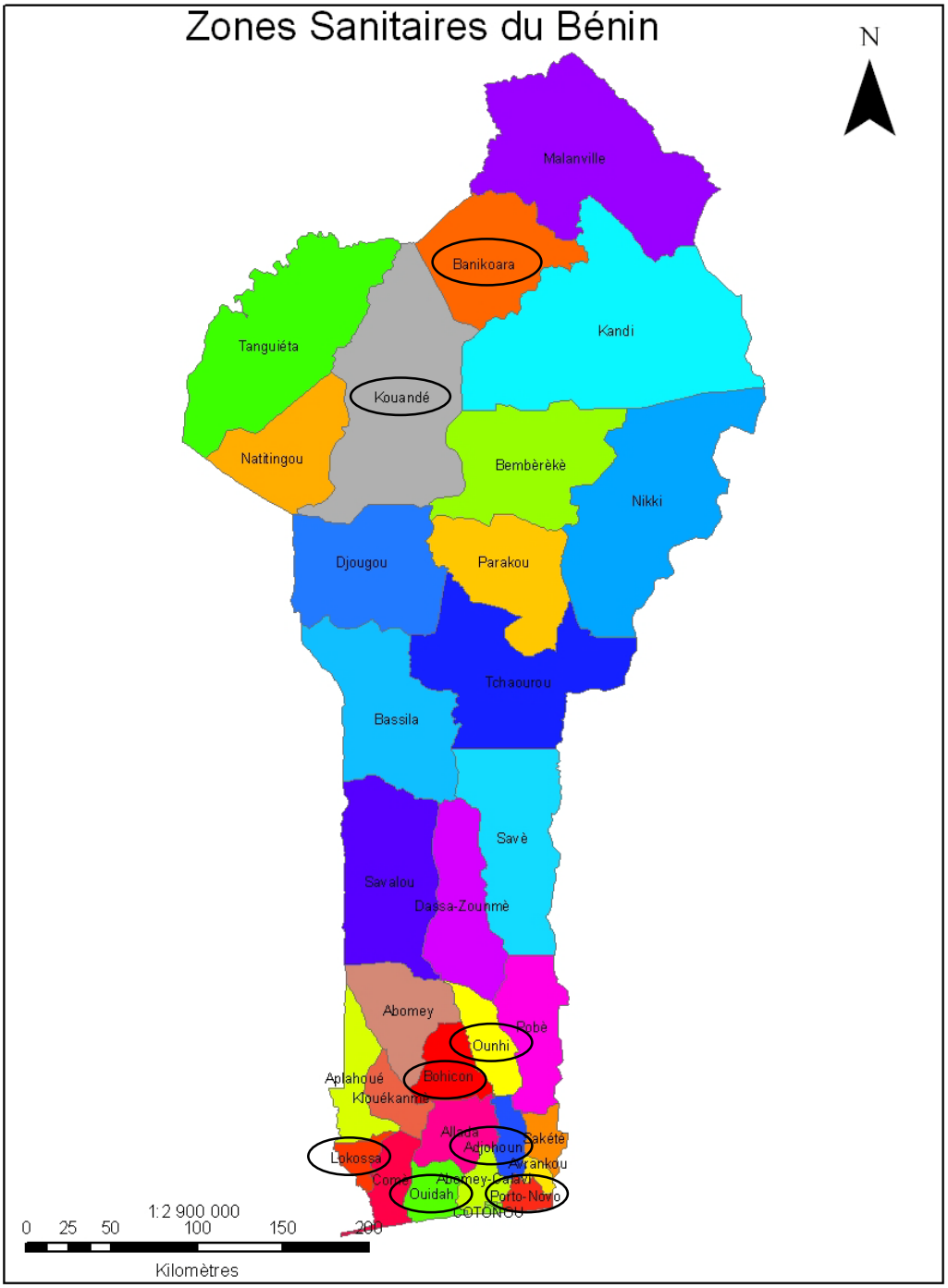
6. Budget

The cost of adding 2 health districts in the baseline survey is estimated at 120 000 US$.

Annex 1 – Map of Benin health districts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