



Zimbabwe: Results-Based Financing

Knowledge & Learning Case Study

Abbreviations

DHE—

District Health Executive

DSC—

District Steering Committee

GOZ—

Government of Zimbabwe

HCC—

Health Centre Committee

HDF—

Health Development Fund

MOFED—

Ministry of Finance and Economic Development

MOHCC—

Ministry of Health and Child Care

NPA—

National Purchasing Agency

NSC—

National Steering Committee

PCU—

Programme Coordinating Unit

PFMS—

Public Finance Management System

PHE—

Provincial Health Executive

PIM—

Program Implementation Manual

RBF—

Results Based Financing

RMNCAH-N---

Reproductive, Maternal, Newborn, Child, Adolescent Health, and Nutrition

WB—

World Bank

Before You Begin

Case Study Purpose & Objectives

The purpose of this Knowledge & Learning Case Study is to share Zimbabwe's experience with the Institutionalization of Results Based Financing so that other countries can learn from it.

After reflecting on their experience, the Zimbabwe team has shared their successes, challenges, and lessons learned. We hope that you will use and adapt this knowledge in your own country to:

- **Gain** insight into the GFF Results Based Financing process in the context of real-world experiences
- **Identify** challenges or setbacks you might face when undergoing similar processes
- **Consider** new ideas and perspectives
- **Build** competence around Results Based Financing
- **Foster** discussion among your country team
- **Compare and contrast** Zimbabwe's situation with your own country's context



Focus Questions

Think about these questions as you review the case study. After reviewing the case study, you will have an opportunity to discuss these and other questions with your country team.

- What **strategies** did Zimbabwe use to institutionalize RBF?
- What particular **challenges** did they face?
- What were their **keys to success**?
- How did some key stakeholders **move** from resistance toward RBF to being a proponent of results-based financing?

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Zimbabwe: Results Based Financing

Introduction

Results Based Financing Overview

About

In 2011, the Government of Zimbabwe (GOZ), in collaboration with the World Bank, initiated Results Based Financing (RBF) in Zimbabwe. RBF was designed to support the Ministry of Health and Child Care (MOHCC) in increasing the availability, accessibility, and utilization of quality health care services to improve maternal, newborn, and child health (PIM, 2019). As of 2021, GOZ has made progress with the institutionalization of RBF in all 60 Districts



What is RBF?

Results Based Financing--

Results-based financing (RBF) refers to any program that provides rewards to individuals or institutions after agreed-upon results are achieved and verified. Results Based Financing focuses on improving poor populations' access to health services by (1) reducing financial barriers; (2) strengthening quality of services by improving health facility performance and management; and (3) promoting results orientation. (4) Increasing community engagement and involvement. All of this makes providing health service more sustainable.

RBF links money to output measures with the end goal of improving health outcomes (Cyrus, et. al. 2017). RBF includes pay for performance at both the community and district level health facilities; community RBF; vouchers (urban); and incentives.



What is Institutionalization?

Institutionalization—

Institutionalization is a continuum that does not follow a single or specific path; rather it is comprised of core components that are compatible with political and public administration systems. RBF Institutionalization requires:

Key Components

- Integration of RBF principles of separation of functions, fiscal decentralization, autonomy and payment for results into healthcare policies and systems including budget initiatives by both internal and external audiences.
- Legislation [policies] in place by the central government to both support implementation of RBF and require evaluations using well-defined methodologies that are widely accepted and understood.
- Ensuring reforms in public financial management system to make provision for payment for results (Output based financing)
- Incremental expansion of RBF to every level of the health system from the community to the Central Hospital level.
- Being financially supported by the government in a substantive way.
- Deliberate planning for and setting up structures to support RBF.
- Provision for knowledge generation, learning and adaptation

Key Success Factors

- Being country led or managed.
- Receiving strong acceptance and buy-in from stakeholders, policy makers, implementers, and donors.
- Openness and accountability by the health systems and local, district, and national levels to developed unbiased evaluations, and share findings and results of independently run evaluations with stakeholders and donors.
- Clear definitions of roles and responsibilities of key actors in government, civil society organizations and development partners
- Support from the Ministry of Finance & Budget Office



Zimbabwe: Results Based Financing

Background

Political Economy Impact on Healthcare in Zimbabwe

- Prior to RBF, Zimbabwe had been in a decade-long recession. Emerging from the economic meltdown of 2008, the health system was severely constrained in all its pillars. A government of national unity came together in 2009 and adopted a multi-currency system, paving the way for resuscitation of the country, including health infrastructure and services. The Ministry of Health developed an investment case in 2010 to promote investment into the system. In response to this investment case, the Ministry of Health and Child Care (MOHCC) received support from the World Bank (WB) to introduce a Results Based Financing program (RBF) in Zimbabwe in 2011.
- Initial public resistance to RBF was fueled in part by perceived threats to worker remuneration equity, a strong health policy initiative in Zimbabwe post-Independence (Witter, et.al., 2019). Initial resistance among leadership was due to highly educated, skilled, and experienced staff in strategic and policy management positions perceiving that RBF would need to be adapted to be successfully implemented in Zimbabwe settings. Their resistance motivated changes to the implementation process, which was adapted to the structure, existing systems, and needs of Zimbabwe.



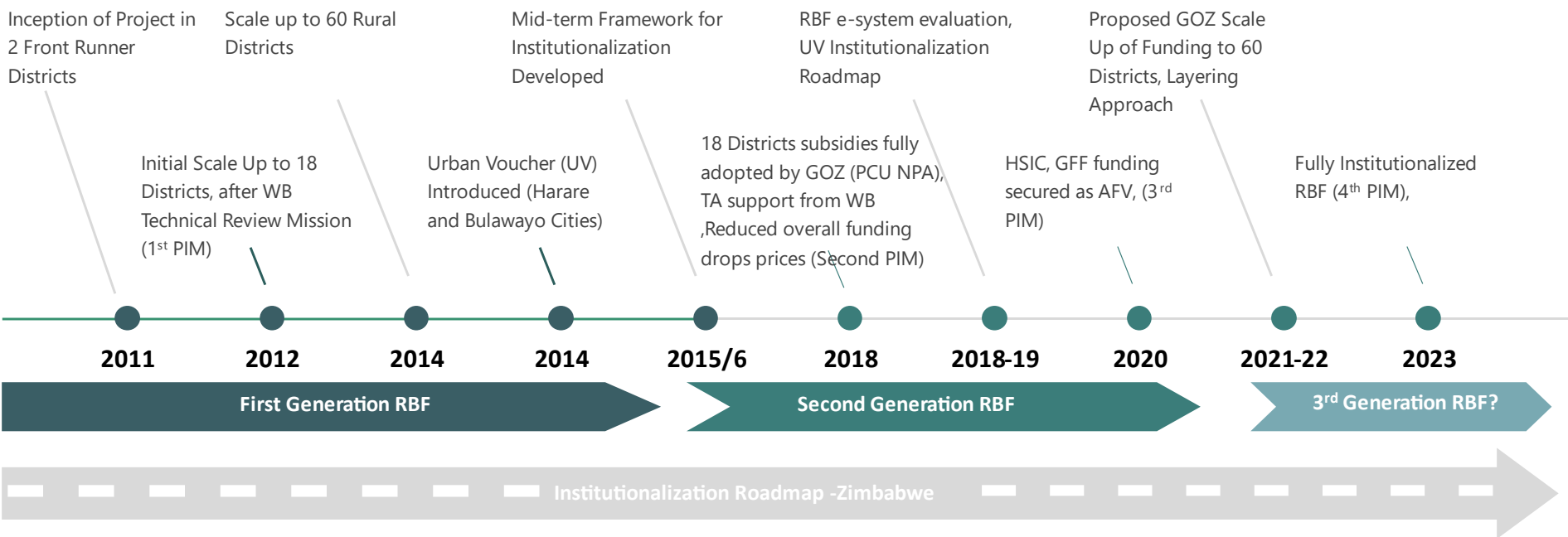
Political Economy Situation

Impact on Healthcare in Zimbabwe (cont'd)

- The initial pilot was done in two (2) frontrunner rural districts, and after a WB-led technical review, the MOHCC, the Government of Zimbabwe (GOZ), approved the scaling up of RBF to an additional 16 rural Districts with funding from the World Bank via the Health Results Innovation Trust Fund. The Catholic Organization for Relief and Development Aid was selected as the Project Implementation Entity of the Health Sector Development Support Project (HSDSP).
- In 2014, based on results of the Impact Evaluation on the RBF participating districts, the Government decided to expand RBF to more rural districts. With funding from the Health Development Fund (HDF), Crown Agents became the National Purchasing Agency (NPA) for the remaining 42 rural districts while CORDAID continued to be management and purchasing agency for the 18 districts. Implementation was guided by one Project Implementation Manual (PIM) and one National Steering Committee, providing clarity and focus.
- In 2015, the Medium-Term Strategic Framework was done, demonstrating the potential sustainability of RBF and its impact on the key Reproductive, Maternal, Newborn, Child, Adolescent Health, and Nutrition Strategy (RMNCH-N) indicators and the entire health system. Thus, institutionalization of RBF was strongly recommended. The GOZ then developed a policy position of institutionalization to inform any future design and implementation of RBF. In this second-generation institutionalized RBF, the MOHCC Programme Coordinating Unit (PCU) became the National Purchasing Agency (NPA) acting on behalf of the GOZ. The GOZ which initially contributed \$1 million as counterpart financing for HSDSP Additional Financing (AF) 1, progressively increased its financing as the WB began to scale down its funding for RBF subsidies in subsequent AFs.



Institutionalization Timeline



Evolution of RBF: Institutional Arrangements for Separation of Function

- Separation of function has been clearly spelled out in each Program Implementation Manual since 2013. The stewardship and oversight role for RBF is conducted by the National Steering Committee (NSC) and the Districts Steering Committees (DSC). The health system has national, provincial, and district level governance structures, and RBF adopted a three-tiered system with a National Steering Committee, District Steering Committee, and a Health Centre Committee (HCC) in 2013. The NSC reports to the Permanent Secretary MOHCC. The RBF governance system is aligned with the Public Health Act and its structures such as the HCC, which derive their powers from the act, while the DSC is a social services subcommittee. This alignment with local government and public health has made these structures sustainable.
- In the first and second generations of RBF, the role of DSC has been implementation oversight, but consensus is emerging on the DSC being a strategic purchasing hub. This committee could play a much stronger stewardship role in the future, if the selection and pricing of RBF indicators for health facilities at the district level become a management instrument for the DSC in collaboration with the District Health Executives (DHE) and Provincial Health Executive (PHE). As of end 2017, the DSC was not optimally functional in some of the districts. The link with the NSC is being strengthened .
- The HCCs' functioning has experienced challenges, varying from attrition to conflict of interest among members. The current RBF implementation has allowed facilities to have bank accounts as sub-accounts to the district temporary deposits accounts, to develop their operational plans and budgets, to procure commodities, and to use the tools for paying personal incentives. Their operation is semi-autonomous, as the plans, budgets and procurement processes are subject to approval by the DHEs and PHEs, and HCCs cannot hire and fire staff.

Evolution of Funding and Purchasing Arrangements to Support Institutionalization

Funding Streams:

At its inception, RBF was fully funded by the World Bank in two frontrunner rural districts. Initially intended to be scaled up after a year, an assessment by the WB and demonstration of results led to early adoption and scale up. At the same time, government buy in led to a co-financing arrangement, with the government contributing to the subsidies on an ascending sliding scale. In 2014, the Health Transition Fund (a multi-donor funding mechanism mostly focused on input health support) was reviewed, resulting in the Health Development Fund (HDF). RBF success in the 18 rural districts led RBF being made strategic purchasing pillar of the HDF, which adopted the remaining 42 rural districts. All rural districts in Zimbabwe were then effectively under RBF. Cordaid, which had been the National Purchasing Agency in the 18 districts, continued with Crown Agents assuming the NPA role in the 42 rural districts. Despite the economic shocks that affected the country, the government continued to provide co-financing increasing from the initial \$1.0M to a \$7.2M annual allocation by 2019.

Inflation-Mitigation Measures to retain value:

When the local currency was reintroduced in 2018 and inflation began to affect subsidies, the government began to allocate RBF funds in USD which were then changed at the interbank rates at the time of disbursement to retain value. From 2019, the World Bank focused on providing funding for technical support to the MOHCC in the Institutionalization of RBF with \$2M and an additional 1 million going toward the Urban Voucher program, while the government assumed full financing of subsidies in the 18 rural districts.



Evolution of Funding and Purchasing Arrangements to Support Institutionalization (cont'd)

Fundholding and fund flow – intergovernmental connection:

RBF is now included in the Public Finance Management System (PFMS). The PCU received a separate status within MOHCC, and its separation is safeguarded by an agreement between MOHCC and MOFED, where the PCU will have an account into which MOFED deposits RBF funds. PFMS has been configured to allow payments into the various service delivery facilities' Temporary Deposit Accounts from Provincial Accounts. RBF funds are included in the MOHCC budget based on subsidy and program management estimates for the 18 districts under the PCU. It is now included in the blue book as a stand-alone budget line. To support and facilitate this process, both CORDAID and Crown Agents have been providing strategic capacity building of the PCU and MOHCC at national, provincial, and district levels in RBF-related financial processes. This culminated in a new version of RBF Finance Management Guidelines, which were adopted as a policy document in 2019.

Sustainable Program management: PCU-The solution within:

The PCU assumed full purchasing function in 2018, initially with Cordaid assisting in implementation directly for Q1 and Q2 before it fully shifted only to technical assistance. For this to work, the PCU with the support of the WB has filled in the positions outlined in the Institutionalization Roadmap. All the five Full Time Employees (FTE) needed at the central PCU office and eight staff at the regional PCU embedded within PHEs have been employed.

Local Purchasing Function-PHEs as Regional LPAs:

The Local Purchasing Function of the PCU has been embedded within the PHE through key personnel. This function has significantly improved PHE's ability to manage funds, and the Global Fund has approved the assumption by PHEs of the role of Sub-Recipients. This further cements the strategic position of the PCU as the NPA, as it harnesses resources availed through both GF and WB to further enhance RBF institutionalization.

The Evolution of Indicator Package: Alignment to National Strategy and Priorities

When it began in 2011, RBF's focus was **quantity indicators**, as informed by the 2010 ZDHS and the 2010-2013 National Health Strategy. Use of health services and uptake of long-term family planning services was at an all-time low, so the package of indicators was skewed toward addressing these issues, along with maternal health services. **Quality** was included from the start, but the focus was also infrastructural, though this gradually shifted to a greater clinical focus. Also, the quality bonus (derived from supply side quality and client satisfaction scores) was a simple add-on to the output bonus.

While every indicator rapidly improved, by 2014 they had plateaued. From 2015 to 2020, the MOHCC worked on the NHS to prioritize **quality of services as outcomes**, though progress on quality -remained poor even with the improved coverage. The RBF Indicators therefore began to

include both quantity and quality. Earnings for facilities gradually began to increase, though the effect of quality was not significant in high-volume facilities.

The health facilities rapidly adjusted to the quality standards, and **quality indicators were improved over time**. At the same time, the expansion of RBF into all 60 districts was challenged by funds being limited to those covering the total required subsidies.

The next PIM revision therefore implemented a **de-linking of quality and quantity** and hence flatlined earnings while redistributing them across more facilities. The NSC approved an updated package of indicators in 2017 that included HIV/TB and Malaria, which led to even more alignment with the 2015 NHS.



The Evolution of Indicator Package: Alignment to National Strategy and Priorities (cont'd)

As the institutionalization of RBF proceeded in 2018, and more disease control programs got involved, it became necessary to reassess the indicators and the quality and quantity split. This led to the 2019 PIM revision where the Mid-Term Review of the NHS prioritization and the Health Sector Investment Case were utilized.

Ultimately, indicators were chosen based on a life course approach rather than a disease-focused approach. Quantity indicators were reduced from 26 to 20. The MTR and the HSIC provided the rationale for including a pilot on quality-focused RBF at tertiary and fourth-degree levels of care while introducing a Community RBF pilot aligned to the recently concluded Community Health Strategy in the ongoing HSDSP AF V with financing from the Global Financing Facility and the GOZ.

Ownership of RBF systems allowed RBF-enabled health facilities to be versatile when COVID-19 hit. Especially at primary level, health facilities could continue offering services, as they were able to procure their own PPEs. Ownership of the RBF systems made it easier to adjust the tools for quality assessments to add Covid-19 specific Infection Prevention and Control (IPC).



Sustainable Systems and Robust Verification: Quantity and Quality

■ **The RBF Management Information System: Integration for Institutionalization:**

The RBF processes require a robust information system to allow timely and easy verification of results for payment. From the inception of RBF until 2017, the RBF verification and quality assessments were all manual and cumbersome. In 2016, the first RBF system based on District Health Information Systems 2 (DHIS2) was developed. This was then upgraded in 2018 as part of institutionalization as the server was moved to the MOHCC data centre. Part of the technical support staff hired included a DHIS2 programmer to improve the system for better integration with MOHCC DHIS2. The various paper tools were migrated to Open Data Kit (ODK) and linked to DHIS2 through a form server. All these systems were built with specifications developed by the MOHCC Health informatics and Information, Communication, and Technology departments for seamless integration. Currently the RBF management Information Systems is housed in the MOHCC data centre, and there are plans to improve bandwidth for better stability and ease of use.

■ **Results Verification – opting for a cost-effective lighter version:**

During evaluation, verification was established as the cost driver that threatened the viability of RBF as a strategic purchasing mechanism. To refine RBF, Zimbabwe undertook an approach to verification called risk-based verification, which was evaluated by the WB and found to remain effective while cutting costs by more than 50%. This was a major contributor to the government's positive attitude toward RBF as the conversations around sustainability progressed. Zimbabwe is aggressively rolling out Electronic Health Records, which may eventually remove the need for verification as it has been traditionally done.



Sustainable Systems and Robust Verification: Quantity and Quality (cont'd)

■ Results Counter verification:

Counter verification is critical for the integrity of any RBF mechanism. From inception until 2017, this function was done by the University of Zimbabwe, a private entity and academic institution. As part of the institutionalization, the NSC sought to have a more cost-effective entity with sufficient institutional capacity and independence to carry out this function. The Health Professions Authority (HPA) was identified from its legal mandate and institutional capacity. The HPA is already mandated with the regulation of all health institutions and draws from its councils, a multi-disciplined team to do counter-verification. This was envisioned to drive lower the cost of counter-verification while maintaining its independence and robustness. The UZ assessed it and laid out a capacity building plan for the HPA.

■ Health System wide quality assurance and improvement:

Quality assurance and improvement actions are being conducted within and outside the RBF realm. The RBF quality checklist, formally called the Quality Supportive Supervision Checklist, has proven to be an instrument of value to the system and will continue to undergo revisions as different methods of assessing quality need to be explored. By 2017, most DHEs and PHEs had fully mastered the use of the ODK quality app in supervision. However, challenges have been identified in the feedback mechanisms, seamless follow up of identified gaps, and practical assessment of quality during the visits and quality dashboards.



The Evolution of Incentives Structure: Sustainable Motivation

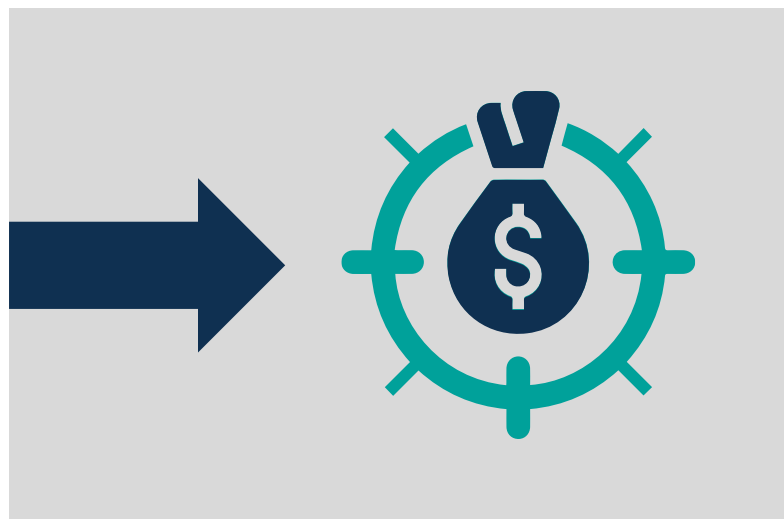
RBF is designed to incentivize providers to go the extra mile in achieving agreed upon outputs. When RBF was adopted by the Government of Zimbabwe, health worker salaries were significantly flatlined after the economic meltdown. The government did not want to create biases in health worker earnings, so in terms of incentives, the generic RBF design autonomy did not apply to health facilities.

After the initial two years of no incentive payments, the government started paying health workers incentives based on an incentive calculator for 25% of total RBF earnings while 75% went to the facility. The RBF Impact Evaluation done in 2014 showed that health workers had multiple pathways to improved satisfaction beyond personal earning and this contributed to expansion of RBF to more districts. In 2017, these incentives were linked to quality scores.

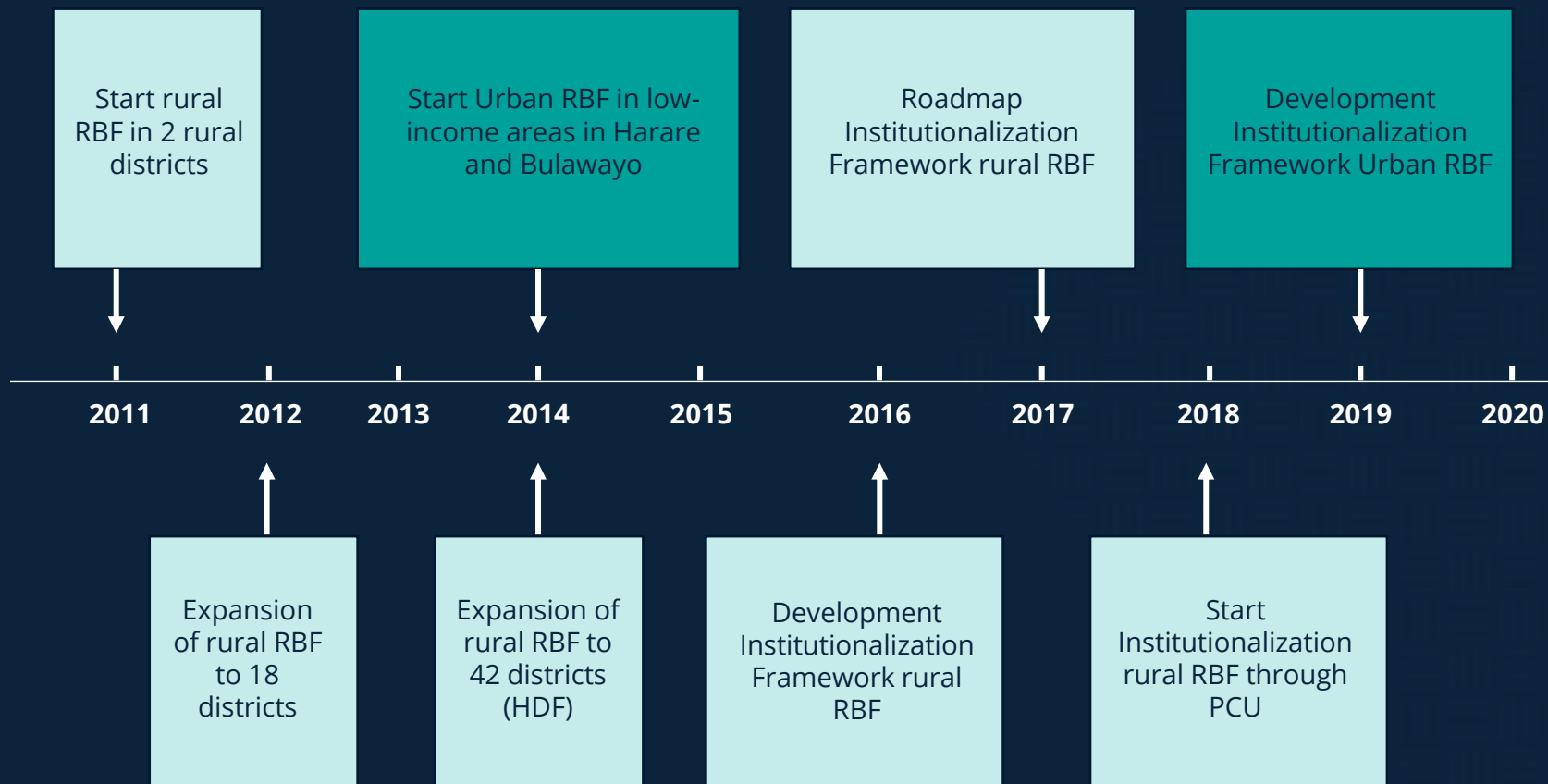
As the total funding basket decreased in 2016, the earnings continued to drop, and this became worse in 2019 when the local currency (ZWL) was reintroduced and in the 18 rural districts the funds were in ZWL. To mitigate the worsening inflationary pressures on the incentives, the government began to disburse the subsidies using the prevailing interbank rate while calculating them using

USD.

A review of the retention systems done by UNDP in 2019 demonstrated that it was not just the incentive to individuals that was valued by the health workers but also the subsidies that went to the facilities, as it made their work easier through better equipment and locally driven decisions in purchasing. Processes are underway to provide justification to the Global Fund to use the incentive calculation system to pay retention allowances, which would link all health worker support to performance, in line with the government's RBM system.



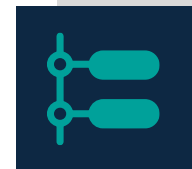
Timelines and Key Milestones: Urban Voucher to Urban RBF Program



Timelines and Key Milestones: Urban Voucher to Urban RBF Program

The RBF urban sub-component started in 2014 and introduced a financing mechanism that aimed to protect the poor from financial catastrophe due to Maternal, Neonatal and Child Health (MNCH) emergencies, while enhancing the revenue of health facilities and quality of services by providing incentives based on attainment of targets for quality indicators. In consultation with City Health Departments, two low-income districts were selected, one in Harare and one in Bulawayo to pilot three interventions:

- An urban voucher (UV) targeted at poor households focused on MNCH services, and a performance-based payment mechanism was used to strengthen the quality of services offered by the municipal health providers in the pilot districts. A performance-based contracting mechanism, which strengthens community and 'grassroots' organization involvement in building health awareness and changing health seeking behavior, as well as in monitoring and supervision was also brought into play.
- The Process Monitoring Evaluation of the Maternal, Neonatal and Child Health Urban Voucher Scheme of the Zimbabwe Results Based Financing Project in February 2020 showed that Urban RBF was successful. The voucher component successfully targeted poor women, reducing inequalities to health access in low-income urban settings. The pay-for-quality component succeeded in improving the quality of the services at the participating health facilities. Meanwhile, the community component encouraged poor women to deliver their children in a health facility, implemented client satisfaction surveys, and provided feedback to health staff.
- As part of the institutionalization conversation, both the City Health Departments and the MOHCC demonstrated interest in ensuring quality of services, as well as financial sustainability of the interventions targeted to the urban poor. In 2019, the GOZ requested World Bank (WB) support to develop options for scaling-up and institutionalizing the urban RBF program. From 2019, the GOZ as part of supporting Urban RBF Institutionalization Framework, began to contribute counterpart financing with the expectation of cities to co-finance the urban RBF scheme.



Steering Committees

- **The National Steering Committee (NSC) has been responsible for the stewardship and oversight of the RBF since its inception.**

The RBF National Steering Committee (NSC) was appointed by the MOHCC to oversee planning and implementation and to ensure good governance of RBF in Zimbabwe.

- **CBOs/NGOs are contracted to collect feedback from communities through client satisfaction surveys and exit interviews as a means of strengthening governance, transparency and accountability.**

RBF requires household-level verification of the extent to which subsidized services took place, and assessment of client satisfaction and perceived quality of care also takes place at the household level.

- **The District Steering Committee is a multi-stakeholder oversight and advisory structure for a given RBF district.**

The DSC falls under the existing GOZ structure and consists of an equally balanced number of government ministry and department officials and community members. The PHE and the DHE together steer the process of constituting DSCs.

- **The Health Centre Committees (HCCs) are the governance structures for Health Centers and have been in existence since Independence in 1980.**

These were established according to the Public Health Act and are constituted of members from the community, the Nurse-in-Charge, and the Environmental Health Technician working at the HC who are non-voting members.

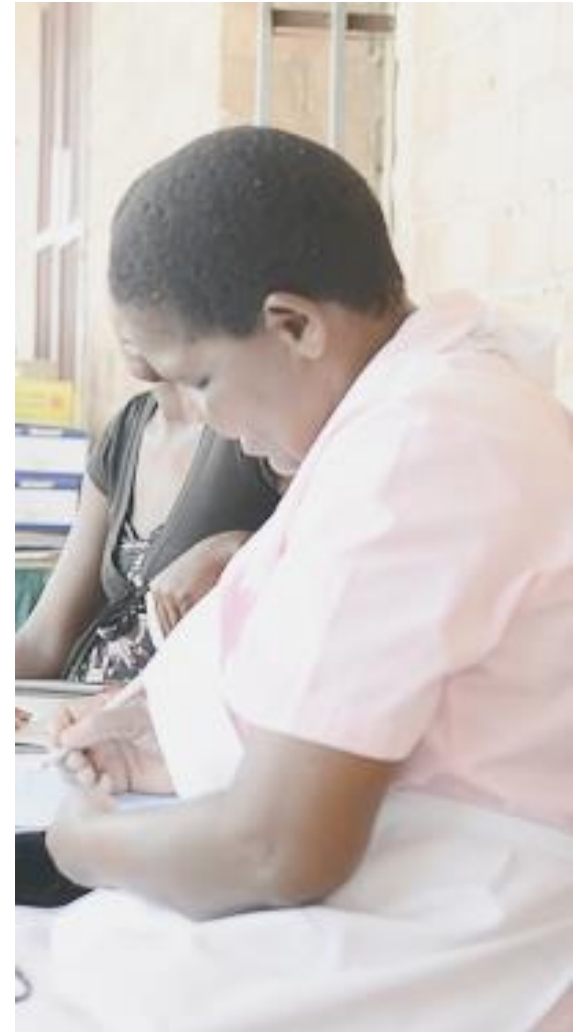
External Verification: From the University of Zimbabwe (UZ) to the Health Professions Authority (HPA)

The counter verifier is an agency that provides an independent verification of all services provided and paid for under RBF.

Initially the counter verifier was the University of Zimbabwe, and institutionalization discussions in 2015 suggested the Health Professions Authority (HPA), the National AIDS Council (NAC) and the Health Services Board (HSB) as potential counter verifiers within MOHCC governance structures. In the Mid-Term Framework, the Health Professions Authority (HPA) was identified as a suitable fit for this purpose, in view of its strategic position and function as a regulator for Health in Zimbabwe, as well as its independence.

CORDAID contracted the UZ to carry out an assessment of the HPA to identify its capacity and capacity needs. The outcome defined the gaps that HPA has, which covered areas of training in both RBF and Counter Verification. The HPA has within its councils and its members the skill sets necessary to carry out the Counter Verification. As part of the RBF institutionalization process, the HPA was delegated by the MOHCC to take over Counter Verification, and they have conducted one round of counter-verification in 18 districts thus far. They will scale up to the 62 RBF districts once they prove proficiency.

The technical role of Counter Verification is aligned to the mandate of HPA of inspecting and accrediting Health Facilities. The HPA draws from a large pool of health professionals and will be able to form multiple teams that can cover the country. Mainstreaming the functions presents a natural fit, in view of regulatory mandate of HPA and its councils.



Implications of RBF Governance Institutional Arrangements

The governance structures in the MOHCC are defined in the Public Health Act, a law that guides all operations of the public health sector. The RBF governance institutional arrangements did not pose a major threat to the governance status quo because they emerged from existing structures within MOHCC.

A Mid-Term Framework for the Institutionalization of RBF was developed in a participatory approach in 2016 to guide the process. Key Informant Interviews were conducted with important stakeholders, and their views guided the selection or repurposing of governance structures to align to RBF functions.

The transparent process of RBF governance institutionalization removed any anxieties and fears associated with such changes, especially in government bureaucracies. The most important players, namely, Sisters-In-Charge of health centres/HCCs, DMOS/DHEs, PMDs/PHEs and PS office were highly in favor of institutionalization of RBF governance; therefore, the process was not difficult in MOHCC, though RBF was still under criticism by other development partners at that point.

The RBF National Steering Committee did not pose any threats to the then Health Transition Fund as evidenced by representation of the HTF (now HDF) in the NSC. The DSC incorporated members from existing management and governance structures in MOHCC and Ministry of Local Government. Health Center Committees whose existence is a statutory requirement were revived.



Zimbabwe: Results Based Financing

Institutionalization

What Helped Institutionalization Happen

Funding

- The government showed commitment by mitigating inflation of RBF subsidies, keeping the funds denominated in USD and only converting them to ZWL (local currency) at point of release. Over time, the Government managed to reduce delays in releasing funds on a quarterly basis. To secure additional funding from the Global Fund, they went in with evidence and information, along with both short- and long-term incentives to motivate the staff.
- The GOZ agreed to finance 18 rural districts after the pilot, but they had to use a scaled back model of RBF with less funding, so that they can eventually take over financing of RBF in the remaining 42 districts.
- They GOZ suppressed high user fees by having RBF be facility based and engaged with local facilities to reduce fees by adapting policy to enable health facilities at the primary care level to have bank accounts and manage their own resources. Also, there is a mandate that health facilities that participate in RBF should not charge fees.
- In order to introduce innovations in the way RBF was delivered, Crown Agents would get seed funding from the Crown Agents Headquarters to run pilots of the program. This would avoid the limitations associated with the contract and the budgeted activities.
- When the World Bank was considering funding RBF, the initial resistance from some donors was overcome by evidence of the impact. One could physically see the changes at the health facilities. Evidence was also published and shared. In addition to the 2014 impact evaluation, evidence included reports on how the money was being spent (medicine, equipment, renovations etc.). The changes were in stark contrast to the same facilities under input financing.

Training

- Training people at all levels to truly understand what RBF was, how it worked, and the benefits of it was the single biggest factor in the institutionalization of RBF in Zimbabwe.
- In the Midlands province, they selected the Provincial Nursing Officer to conduct the training, effectively managing the hierarchical culture in the nursing fraternity. Most of the health center staff are nurses, who are very versatile and aware of the Zimbabwe policies.

What Helped Institutionalization Happen (cont'd)

Creating a sense of ownership in the community & with stakeholders

Medical staff felt they had control over their work environment, which was new and empowering, and the Environmental Health Technicians, responsible for preventative community health, became heavily involved. Healthcare workers spread word of the benefits, advantages and disadvantages of RBF, which helped build acceptance and pride. Most districts at the ground level were proponents of RBF after noting the health facility improvements that had occurred in the frontrunner districts.

Zimbabwe had a strongly linked health system but having the autonomy to make plans and decisions on what to buy was new. When they started, MOHCCV made sure people knew that RBF was government-level remuneration, but they could now be in charge of that funding at a local level. With the autonomy to spend the incentives as needed, people used it for basic infrastructure, fences, painting, essential medicines, benches, etc. Being able to get what they needed built confidence, trust, and a sense of pride in the system.

The District Steering Committee helped identify policy constraints that needed to be reviewed, and the MOHCC worked on improving infrastructure, because that was visible. They also provided incentives for quality of service. When they were able to take a trip and see RBF working, they started getting buy in.

Cordaid took RBF institutionalization seriously and put people physically (seconded staff) in the MOHCC. They were genuine and honest in their efforts and worked to build capacity in the MOHCC.



What Helped Institutionalization Happen (cont'd)

ADAPTABILITY

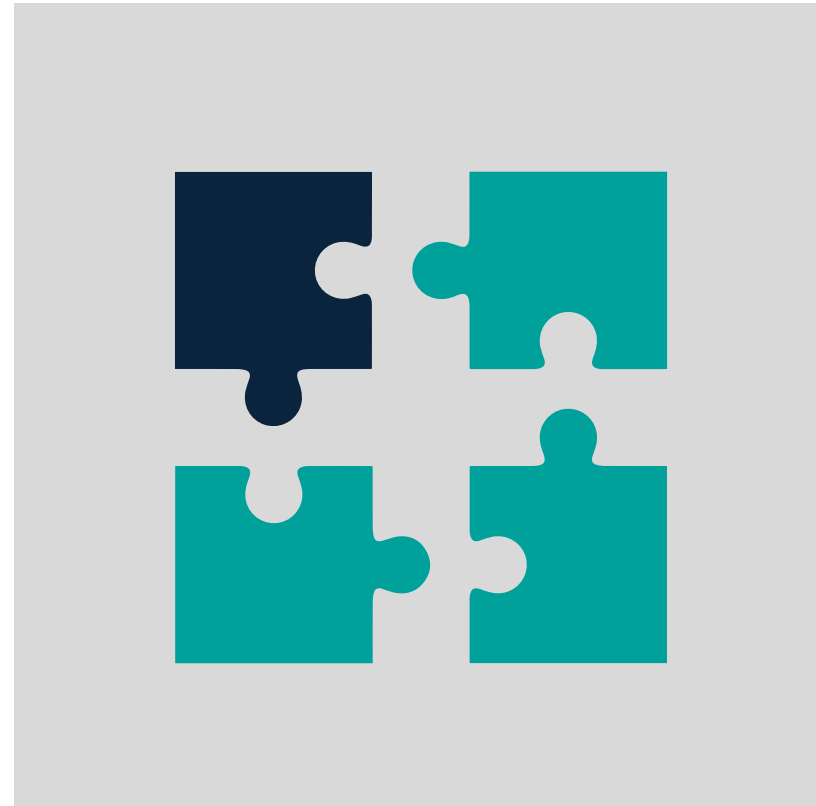
COMMUNICATION

LEADERSHIP SUPPORT

INFRASTRUCTURE

VERIFICATION

- 1) Due to the initial resistance, the Bank team was flexible with its implementation approach, which let RBF be tailored to Zimbabwe's structure, culture, and people. Deliberate strategies were put in place to implement RBF, including use of existing structures and reliance on tools health providers were already using. This made the implementation and institution of RBF possible. The Bank team also developed innovative implementation tools such as the electronic incentive calculator, which made payment of incentives faster and better managed.



What Helped Institutionalization Happen (cont'd)

ADAPTABILITY

COMMUNICATION

LEADERSHIP
SUPPORT

INFRASTRUCTURE

VERIFICATION

- 2) Open, honest, and regular communication was key to the acceptance of RBF. Cordaid produced a quarterly RBF best practice bulletin that was widely circulated to demonstrate which districts were successful and which were lagging behind. The booklet was distributed to all the health facilities.



What Helped Institutionalization Happen (cont'd)

ADAPTABILITY

COMMUNICATION

LEADERSHIP
SUPPORT

INFRASTRUCTURE

VERIFICATION

- 3) After the initial resistance, the government became a proponent of RBF, having seen the early tangible benefits such as resources coming through at facility level, structural changes including a creation of maternal waiting homes, and how the system allowed for the tracking of benefits early. The Provincial Medical Director in the Midlands province was a proponent of RBF and felt it was coming to strengthen their health system, which also helped momentum for RBF.



What Helped Institutionalization Happen (cont'd)

ADAPTABILITY

COMMUNICATION

LEADERSHIP
SUPPORT

INFRASTRUCTURE

VERIFICATION

- 4) GOZ developed checklists to help improve aspects of healthcare such as availability of supplies and medicine, sufficient training of healthcare providers, maternal healthcare, reduction of complications (sepsis, eclampsia, etc.), etc. The checklists were developed to help facilities and provide mentorship locally to help them improve.

Cordaid having an office directly in the MOHCC helped the GOZ take full ownership and use Cordaid as an advisor.



What Helped Institutionalization Happen (cont'd)

ADAPTABILITY

COMMUNICATION

LEADERSHIP
SUPPORT

INFRASTRUCTURE

VERIFICATION

- 5) An alternative verification mechanism was needed, which Cordaid developed with the support of the Bank. Having the counter verification done independently, but within the country by the University of Zimbabwe and eventually by the Health Professions Authority, allowed for unbiased verification without relying on outside agencies. The continued ability to adapt to needs has been critical to institutionalization.



Zimbabwe: Results Based Financing
**Transitioning the Institutionalization
of RBF to Other Countries**

Lessons learned from Zimbabwe on Institutionalizing RBF



Lessons learned from Zimbabwe on Institutionalizing RBF

Training & Adaptation

- Zimbabwe found training and orientation were key to institutionalization being successful. Everyone involved in the process needed to understand the health system in the country and understand RBF, so they could adapt it to fit their challenges, needs, and structure. Thus, everyone that came in contact with RBF was given at least basic training on what RBF was, the policies, why it is effective, how it will help, what their role is, and how to measure effectiveness. They also found it useful to provide annual refresher training and to provide guidance with a single Program Implementation Manual.
- Zimbabwe's ability to adapt to the existing structure, tools, and processes already in use in the country was a key to success. They did not introduce many new things that didn't already integrate with the existing system. They understood the operational environment they were working in and were able to revise and adapt. For example, resistance allowed the RBF system to be adapted to Zimbabwe. If resistance had not occurred, it would have been implemented "as is," and would have failed.

■ Stakeholder/Donor support

Stakeholder/Donor support

- GOZ found an RBF program can use external entities for support, but it must be internally driven and involve the stakeholders. They ensured that the voice of the community was represented, and that the stakeholders' perspectives were included in the development of the framework, keeping them engaged throughout the process. The Ministry of Finance and the World Bank are key stakeholders in any country. While it could have moved faster without including them, it would not be as successful. Also, they had bi-lateral discussions between Bank and stakeholders to identify what would be next, and had the partners involved in design of impact study to help build buy in. The National Steering Committee was also key. They held regular meetings, had clear actions, shared updates and briefs, and traveled to districts to keep an eye on RBF.

Lessons learned from Zimbabwe on Institutionalizing RBF (cont'd)

Communication

- Zimbabwe found that key leaders and influencers needed excellent interpersonal and persuasive skills. This meant that they needed to be adaptable in their communication style to work with different stakeholders; to be able to coordinate stakeholders and work effectively with the Ministry of Health and Child Care the Ministry of Finance and Economic Development; to be able to persuade others to buy in to RBF, including the highest levels of leadership; and to be able to prepare effective policy briefs for different stakeholders.
- They used existing platforms and made sure that all stakeholders could participate and be involved. They engaged people by sharing the design and process with the community and keeping everyone informed regularly with updates. They did not assume that everyone had the same understanding and tried to make everything simple and less complicated to build that common understanding. They were open and flexible to promote to trust.
- They found setting a change management plan that focused on strategic thinking, stayed ahead of the change, and set a plan to win the hearts and minds of the people at all levels was critical to success.

Pilot testing

- Pilot testing and being able to adjust what needed to change and adapt was critical to institutionalization. The pilot gave an opportunity to adapt and make the program successful.

Leadership

- The government ownership of results-based financing across the country was key to sustainability. Leadership needed to come from the Ministry of Health. They put structures in place that defined clear roles, responsibilities, and governance. They nested RBF within the existing systems in the country and had someone in leadership liaise with the World Bank to keep funding moving.

Finance & Procurement

- The key to success in this area involved a solid understanding of financial skills, a good working

relationship with the Ministry of Finance, incorporating RBF in the public financial management system, and understanding the procurement process.

Monitoring, Evaluations, & Verifications

- The MOHCC found that whatever indicators they used, that they needed to be sure that those on the ground agreed and understood them. People needed to be okay with identifying deficiencies, thinking outside the box, and making RBF work for their circumstances. They made sure the measures were as objective as possible and focused on quality measures and not just quantity measures. They also ensured they had effective output measurement tools to guide the process. People needed to see results of RBF to be invested in it. Finally, they made improvements in the DHIS2 to strengthen and link it to the RBF information system.

Zimbabwe: Results Based Financing

Discussion

Discussion Questions

- **What** aspect of the country's case did you find most interesting? Why?
- **What** new things did you learn?
- **Did** this case broaden your perspective about a particular issue or topic? Which one?
- **Which** of the challenges described could you most relate to?
- **What** is different from your own situation?
- **Which** of the strategies employed did you find the most innovative?
- **Which** strategies could be tried in your country? How would they need to be adapted?
- **What** questions do you still have?

