Learning From Implementation

Process Monitoring and Evaluation II of Zimbabwe’s Results Based Financing Project: The Case of Mutoko, Chiredzi, Nkayi and Kariba Districts

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CONTENTS

1. Introduction and Background ............................................................................. 1
   1.1 Introduction ........................................................................................................ 1
   1.2 Background to Process Evaluation in RBF ...................................................... 1
   1.2.1 PME Objectives .............................................................................................. 2
2. Methodology/Technical Approaches .................................................................... 3
   2.1 Conceptual Framework and Logic of Enquiry .................................................. 3
   2.2 Technical Design Details of the Study .............................................................. 4
      2.2.1 Design and Approach .................................................................................. 4
      2.2.2 Study Population .......................................................................................... 5
      2.2.3 Sampling Strategy and Sample Size ............................................................. 5
      2.2.4 Outcome and Study/Mediating Factors ...................................................... 6
      2.2.5 Mediating Factors ....................................................................................... 6
   2.3 Process and Implementation Summary ............................................................ 6
      2.3.1 Data Collection Methods and Tools ............................................................. 6
      2.3.2 Data Collection ........................................................................................... 6
      2.3.3 Data Analysis ............................................................................................... 7
3. Findings .............................................................................................................. 9
   3.1 Summary of Facility Characteristics (General and Performance) ..................... 9
   3.4 Discussion on Factors Affecting Performance ............................................... 15
      3.4.1 Intervention Design Factors ....................................................................... 15
      3.4.1.1 Use of Data for Decision Making ............................................................ 15
      3.4.1.2 Human Resources for Health ................................................................. 16
      3.4.1.3 Program Targets ..................................................................................... 22
      3.4.1.4 Pricing of Services ................................................................................. 23
      3.4.1.5 Roles and Responsibilities of DHE, DSC and Facility Staff ...................... 24
      3.4.1.6 Role of DHE in Clinic Supervision and Factors Affecting Supervision ....... 25
      3.4.2 Immediate Effects and Mediating Factors .................................................. 27
      3.4.2.1 Community Participation, Ownership and Role of the HCCs .................... 27
      3.4.2.2 Responsiveness to Community Needs ..................................................... 31
      3.4.3 A Summary of Contextual Factors Influencing Performance of Health Facilities ................................................................. 34
4. Conclusion and Recommendations ..................................................................... 36
   4.2 Recommendations ............................................................................................ 38

List of Tables and Figures

Table 1: Summary of Facility Characteristics (General) ............................................. 11
Table 2: Summary of Facility Characteristics (Performance) .................................... 12
Table 3: ANC and Deliveries Trend Directions March 2012 to March 2014 ............. 14

Figure 1: PME Round II Conceptual Framework ..................................................... 4
Figure 2: Lost Revenue Due to Data Errors ............................................................. 22
<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ASRH</td>
<td>Adolescent Sexual and Reproductive Health</td>
</tr>
<tr>
<td>BEmONC</td>
<td>Basic Emergency Obstetric and New Born Care</td>
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<tr>
<td>CBO</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>CMAM</td>
<td>Community Management of Acute Malnutrition</td>
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<tr>
<td>CWGH</td>
<td>Community Working Group in Health</td>
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<tr>
<td>DEHO</td>
<td>District Environmental Health Officer</td>
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<td>District Health Executive</td>
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<td>EHT</td>
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<td>Expanded Program of Immunization</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>GI</td>
<td>Group Interviews</td>
</tr>
<tr>
<td>GOZ</td>
<td>Government of Zimbabwe</td>
</tr>
<tr>
<td>IDI</td>
<td>In-depth Interviews</td>
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<td>Integrated Management of Neonatal and Childhood Illnesses</td>
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<td>Health Facility</td>
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<td>Human Resources for Health</td>
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<td>Health Sector Development Support Project</td>
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<td>Maternal and Child Health</td>
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<td>Ministry of Health and Child Care</td>
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<td>Masters in Public health</td>
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<td>Mothers Waiting Home</td>
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<tr>
<td>NIC</td>
<td>Nurse In-Charge</td>
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<td>NSC</td>
<td>National Steering Committee</td>
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<tr>
<td>OPD</td>
<td>Outpatient Department</td>
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<td>Primary Care Counselor</td>
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<tr>
<td>PCN</td>
<td>Primary Care Nurse</td>
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<tr>
<td>PIE</td>
<td>Project Implementing Entity</td>
</tr>
<tr>
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<td>Project Impact Pathways</td>
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<td>Provincial Medical Director</td>
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<td>Process Monitoring and Evaluation</td>
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<td>Post Natal Care</td>
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<tr>
<td>STIs</td>
<td>Sexual Transmitted Infections</td>
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<td>QC</td>
<td>Quality of Care</td>
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<td>Results-Based Financing Program</td>
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<tr>
<td>RDC</td>
<td>Rural District Council</td>
</tr>
<tr>
<td>RGN</td>
<td>State Registered Nurse</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>VHW</td>
<td>Village Health Worker</td>
</tr>
<tr>
<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>ZNFPC/CBD</td>
<td>Zimbabwe National Family Planning Council/Community Based Distributor</td>
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1. Introduction and Background

1.1 Introduction

1. This report presents the second cycle of the process monitoring and evaluation (PME) for the Results-Based Financing (RBF) project in Zimbabwe, formally the Health Sector Development Support (HSDS) Project. The study’s findings demonstrate the linkages between the first and second PME evaluations. The study prioritizes performance of incentivized indicators, quality of care (QoC) and expenditure/payment data aspects of the health system and program components.

2. The overarching goal of the PME study is to help the Ministries of Health and Child Care (MOHCC) and Finance and Economic Development (MOFED), Cordaid, the World Bank Task Team and interested local and international stakeholders learn from the RBF project; make mid-course adjustment to the technical design and operational processes; and enhance evidence-based project management decision making. Given that quantitative performance of health facilities is monitored every quarter, the study seeks to go beyond the quantitative performance trends to better understand qualitative factors at district, health facility, health worker and community levels that explain performance under the RBF project. This PME is an exploration of the causal pathways from implementation to results. It is a study of the links between activities, outcomes and context of the RBF project. In a way, the study unravels the “black-box” of implementation of performance-based financing interventions in a bid to deepen knowledge of the RBF intervention in Zimbabwe and how reality links with the original design and theoretical assumptions with which the Government, Cordaid and the Bank worked when the intervention was conceptualized.

3. The RBF project design is anchored on three components: 1) results-based contracts, 2) management and capacity building, and 3) monitoring and documentation. It is anticipated that through this project, both supply and demand for health services—particularly maternal and child health—will be significantly improved, contributing to a reduction in maternal and child mortality and morbidity. The project’s monitoring and evaluation activities are currently tracking the performance of incentivized indicators, QoC and expenditure/payment data. While this ongoing analysis has provided very useful insight into the performance of the project to date, it is essential to go beyond the numbers and explore the underlying processes and dynamics in the trajectory of change. For example to fully understand variation in performance by facility or district it was essential to explore non-quantitative factors in order to deepen knowledge of RBF so as to improve outcomes further; enhance it for sustainability and future application and adapt to other contexts. See Annex 1 Project Design Summary.

1.2 Background to Process Evaluation in RBF

4. PME seeks to explore the micro-causal pathways from implementation to results. It is a systematic study of the links between activities, outcomes and contexts of an
intervention. PME aims to capture whether interventions are implemented as planned as well as explore the salient factors that affect the achievement of targeted performance outcomes. PME explores the external and internal factors at various stages of policy and programmatic processes (e.g. context, design, implementation and monitoring). Such an unveiling of program implementation is essential in interpreting program outcomes for informed decision making. The approach enables stakeholders to understand issues with the existing context and the changes required in pre-conditions to achieve project goals. It can also help in developing and improving programs from an early stage, when opportunities for influence are likely to be the greatest.

5. In the context of the Zimbabwe RBF project, the PME II employed a sequential mixed-methods (i.e. both quantitative and qualitative) design to enable in-depth exploration, triangulation and generalization of evaluation. This approach enables better understanding of the contextual factors linked with quantitative performance data. The mixed methods approach enabled the PME II research team to take advantage of the complementary benefits of qualitative and quantitative data. In the preliminary phase, the PME team collected and analyzed quantitative data to identify health provider performance trends based on a set of core indicators from the package of RBF services. The PME data analysis combines the strengths of the relative methodologies to create a clearer picture of the challenges, barriers, strengths and processes of RBF needed to inform the national level scale up and sustainability.

1.2.1 PME Objectives

6. The objectives of this second round of the PME were to:
   i. Assess the extent to which the RBF project is implemented as intended and planned, as well as examine unintended implementation changes and effects.
   ii. Identify changes facilitated by the project, including facility performance and perceptions on equity.
   iii. Examine factors influencing quality of care, including linkages with supportive supervision and health worker motivation.
   v. Examine best practices and challenges from the current mechanism for health worker motivational allowance (25% of total earnings); explore ways this can be replicated at scale.
   vi. Explore factors influencing changes from different perspectives including supply (provider) and demand (community).

7. This report is divided into five sections. The first section provides an overview of the program as well as purpose and scope of the PME. This is followed by a summary of the methods and logic of enquiry. The findings are then presented, after which a set of conclusions and recommendations are proffered to the different RBF stakeholders.
8. In the initial stages of the PME II it was agreed with the World Bank and the MOHCC that the primary focus of the study would be Objectives 1, 2, 3 and 6, and that Objective 4 would be examined to the extent possible given that a thorough examination of worker performance required the existence of shared performance standards and expectations—which was not yet the case. It was agreed that a focus on Objective 5 was beyond the scope of this part of PME II and would best be done at a separate time, as any discussion with staff that might give them the impression that their incentive arrangements were being reordered could undermine the whole process.

2. Methodology/Technical Approaches

9. The study team included two international qualitative research experts from KIT, two local qualitative research consultants from the World Bank, two MPH graduate interns from the College of Health Sciences at the University of Zimbabwe and one MOHCC representative designated as a Technical Advisor for PME II.

2.1 Conceptual Framework and Logic of Enquiry

10. Within a traditional results chain framework, the RBF approach requires a set of inputs including: human resources (health workers, village health workers [VHWs], administrative personnel, technical support staff and managers); material resources (vehicles, facilities, training equipment, stationery, etc.); and finances for operational costs. These inputs facilitate the undertaking of specific processes linked to, in particular, the contracting of facilities, training and capacity building and health service provision. It is anticipated that these processes result in the improved availability, accessibility and acceptability of maternal and child health (MCH) services in the short term. In the medium term (outcome level), this is envisaged to culminate into improved quality of care and increased uptake of the health services—ultimately resulting in improved health results at the impact level, i.e. reduction in MCH related morbidity and mortality.

11. In reality, the transition from inputs to results is not linear, but rather a complex web of factors within the operational space. The trajectory of change can, however, be traced within a Conceptual Framework, which is based on the RBF model’s Theory of Change as reflected in the Figure 1 below.
12. The realization of the output, outcomes and impact related to the intervention depends on the interplay of intervention design (i.e. RBF model) factors, the immediate effects of the action, and the influence of mediating and contextual factors. Intervention design factors are those that the model set out to introduce and implement in order to effect positive change. The immediate results of these actions—such as improved availability of services—may influence the attainment of medium term results. Mediating factors further aid or hinder attainment of results while other contextual factors beyond the intervention’s direct control also influence results.

13. In view of this framework, it is through tracking and validating the program impact pathways (PIPs) that we can better understand factors influencing the performance of facilities under the RBF program. A logical start point for the enquiry was therefore to establish the status of the study’s outcomes of interest (QoC and utilization of services) and then assess the extent to which the factors on the left (three boxes) and contextual factors influence the realization of these results. This to a large extent validates the conceptual framework, facilitates its adaptation and enables the documentation of processes that may have led to the observed outcomes in specific context—all of which enables understanding on how to adapt RBF to context.

2.2 Technical Design Details of the Study

2.2.1 Design and Approach

14. PME II applied a retrospective study design and a theory-based evaluation approach. The retrospective design allowed for classification of observations according to the outcomes of interest and retrospectively assessing their exposure and interaction with
specific study factors e.g. contextual factors and intervention design factors. This is facilitated by the theory-based evaluation approach, which examines the interaction between the context, the actors and the intervention, and then attempts to explain how this interaction works to produce the outcomes of the intervention by interrogating the intervention’s formal Theory of Change. The theory-driven approach is fit for examining complex interventions implemented in a complex environment as it explores the influence of contextual factors on interventions and its outcomes.

15. The enquiry used a mixed methods approach, i.e. both quantitative and qualitative data, to identify plausible explanations for the occurrence of certain specific outcomes of interest. The quantitative approach involved gathering data on utilization of services, which is routinely collected by the MOHCC, as well as via the District Health Executive (DHE) Quality Supervision Checklist which informed the last assessment (Q2 2014). Health facility data is routinely collected using T5 form from the outpatient department (OPD) and various registers from antenatal care (ANC), deliveries and the primary care counselor (PCC). The data, which spanned from inception 1, was pre-analyzed to generate specific sub-questions of the study that were further qualitatively explored together with aspects on the process of implementation, context and changes observed using primary data collection techniques. Sub-questions were generated to get detailed explanations on trends and patterns of health facility performance with regard to selected incentivized and non-incentivized indicators.

2.2.2 Study Population
16. DHE teams, health facilities, health center committees (HCCs) and health facility catchment communities within World Bank-funded RBF districts constituted the sampling frame. Health workers and HCC members for these health facilities as well as community members in the facility catchment areas constituted the population of individuals from which primary qualitative data was collected.

2.2.3 Sampling Strategy and Sample Size
17. A multi-stage sampling approach was used. In the first stage, purposive sampling was used to select three provinces from the eight rural provinces. The criteria for selection was based on geographical spread to ensure representation of the geo-regions. The eight rural provinces were allocated into three geo-regions based on their proximity: Western, Middle and Eastern Regions as outlined in Annex 2. Furthermore, poverty prevalence was considered in the selection of three provinces.

18. Purposive sampling was again applied to select one district from each province among those districts that did not participate in the first round of PME. These three districts were selected based on their identification as cases of interest by the project implementing entity (PIE), CORDAID, and/or the MOHCC. A district was regarded as a case of interest based on, among other things, operational performance, quality issues

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1 Program was rolled out in 16 districts following a pilot in two front-runner districts
and levels of program compliance on both on the positive and negative side. The fourth district was selected because it participated in the first round of PME.

19. The third stage of sampling involved the selection of one high and one low performing facility from each district. Classification of the eight facilities into high and low was based on their average earnings relative to their target earnings in the first quarter of 2014 with the extreme ends being selected for inclusion in the study as high and low performer facilities respectively.

20. All health facility staff present at the facility were interviewed. The sampling strategy used to select villages that were near and far was based on whether the village was within 8 kms for near and farther than 8 kms for far. Selection of the village was random but selection of groups of respondents residing in the selected villages was purposive focusing mainly on people in the reproductive age group. A total of 373 individuals comprised of 115 DHE members, 31 health workers, 42 HCC members, three community leaders, 154 women and 126 men participated in this second PME.

2.2.4 Outcome and Study/Mediating Factors
21. The outcomes of interest were facility utilization performance and QoC as assessed using the rural health center quality supervision checklist. The choice of this performance/outcome metric is reflected upon in Section 3.

2.2.5 Mediating Factors
22. Analysis of the variations of the above outcomes and assessment of factors that influence them involves assessing the influence of a set of RBF related and contextual factors as articulated in the study conceptual framework and in particular the Theory of Change.

2.3 Process and Implementation Summary

2.3.1 Data Collection Methods and Tools
23. The research team collected primary data through in-depth interviews (IDIs), focus group discussions (FGDs) and group interviews (GIs). Semi-structured IDIs, FGDs and GI guides were developed for each of the target groups (i.e. health managers, facility staff, HCCs and communities). All interviews and discussions were facilitated by one of the researchers and were recorded using a voice recorder.

2.3.2 Data Collection
24. A trained team of researchers comprised of two qualitative consultant researchers and two Masters in Public Health (MPH) students collected data in the four districts. These researchers worked in close collaboration with two international health systems researchers and a public health specialist nominated by the Permanent Secretary as the MOHCC focal person for the study.
2.3.3 Data Analysis
25. Two international experts on qualitative research in health trained the research team on qualitative analysis methods. A four-stage analysis model was applied in the analysis and interpretation of the qualitative data obtained in the study:

   Step 1: Collect data and process data (per health facility)
   Step 2: Write case studies (one per health facility)
   Step 3: Read all case studies and identify trends
   Step 4: Write study report based on themes and trends in common threads

26. The basic principles of analyzing qualitative data were applied to each of the steps above. In particular, the processing of data for each facility made use of a desktop matrix analysis of themes drawn from both the conceptual framework and others emerging from the transcripts. This involved populating transcript contents for each facility in line with identified or emerging themes. A comparison of this qualitative data across facilities and cognizant of performance levels as defined by the quantitative performance status enabled the research team to identify common threads and peculiarities between high and low performing facilities. The analytic review of this data aided by peer critical appraisals through recorded discussions resulted in more in-depth unpacking of the data.

3. Findings
   Reflections on the Definition of Performance
27. In this report, the high and low performer status of facilities was assigned during the sampling based on how much the facility either surpassed or was short of the target earnings (drawn from both quantity and quality earnings information).

   Box 1: Operational Definition of Performance: Performance was regarded as the average deviation of a facility’s earnings from the targets for Q4 2013 and Q1 2014. Considering that facility earnings are based on quantity and quality scores, both elements are considered in the performance determination. The facility with the least negative variance or most positive variance to target was regarded as the high performer, while that with the most negative variance or least positive among all positives was considered as the low performer. This definition was agreed upon through extensive consultation with the World Bank and the MOHCC.

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2 This operational definition of facility performance has evolved, drawing from the basics of the RBF concept through lessons in application in PME I. RBF recognizes performance at the levels of quantity and quality indicators, which can be jointly assessed through earnings. PME I made use of quantity using only three weighted tracer indicators, which to a large extent was problematic as it was not fully reflective of performance as perceived by both service providers and users.
28. Discussion on utilization performance is specific to the quantity indicators only and is informed by the trends of four key predefined incentivized (paid for) tracer indicators: OPD, normal deliveries, ANC4+ visits and PCC immunization. Of primary importance in this analysis were the month-to-month changes in the time series (trends) as well as performance in relation to targets for each indicator. Cordaid calculates targets by using a target calculator and based on the catchment population. It also uses national ratios. From a quality perspective, performance of the health facility is reflected by the DHE quality of care assessment score drawn from the newly introduced Quality Checklist, which is comprised of both structural and clinical process indicators. Both components constitute the composite score using a weighting of 65% (clinical) to 35% (structural). Performance assessed in terms of a facility’s quarterly earnings—based on a combination of the amount earned for the incentivized quantity (i.e. utilization) indicators and that earned from a quality score derived from the DHE Quality Supervision Checklist and the CBO Patient Tracer Survey—was envisaged to be adequately reflective of a facility’s performance. However, as noted in the discussion, there are some variations in utilization and/or quality performance even among facilities within the sub-groups of high and low performers. This therefore indicates that this probably was not the most appropriate selection criteria as discussed further in this report. The model used in the determination of performance status during the sampling and selection was based on the variance to target earnings and can be summarized in the mathematical notation below:

\[
\frac{(Uti\_Earnings_{Actual} + Qual\_Earnings_{Actual}) - (Uti\_Earnings_{Target} + Qual\_Earnings_{Target})}{(Uti\_Earnings_{Target} + Qual\_Earnings_{Target})} \times 100
\]

\[\vdash\text{Decision Rule - the most positive variance to target is a high performer and least positive or most negative is a low performer.}\]

29. This study identified other factors that hold pertinent additional reflection in the definition of performance of a facility, particularly going beyond assessing only those aspects that are within the influence and control of the health workers’ efforts. While the above section’s description and formula for determining performance take into account a considerable number of factors such as the changes in utilization, population, client satisfaction and QoC as determined by the QoC assessment, there are opportunities to consider contextual factors that have a bearing on facility performance. These factors include distance, proximity to a hospital for easy referral, being near centers that charge user fees, HCC relations and others.

30. In view of the above considerations, the findings below are not presented along the lines of dichotomy of high and low performing districts; rather, the PME II presents regularities and patterns encountered across facilities.

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3 The program uses a Graduated Threshold Model to calculate the amount earned from the quality score (Appendix II)
31. This section presents the findings as they address the objectives of the PME II study. Table 1 summarizes the characteristics and performance of all the health facilities studied as part of PME II; this summary serves as a background for the various analytical themes presented and discussed in the findings section. Table 1 is followed by a presentation and discussion of key issues and findings, organized with a view to address the four objectives of PME II. We begin with an assessment of if and how the RBF project contributes to improvement in QoC; follow with an assessment of the factors influencing QoC, facility management, supportive supervision and health worker performance; and drawing on these findings, appraise the extent to which the RBF project is implemented as intended and planned. We discuss each set of issues and findings and present the main conclusions and implications for the RBF program going forward.

3.1 Summary of Facility Characteristics (General and Performance)

32. The two tables below summarize characteristics and performance of eight health facilities. Table 1 shows the general characteristics of three government-owned and five council-owned facilities. The catchment areas have varied primary economic activities including fishing, farming and game ranching. The settlement patterns also range from being nucleated in villages to dispersed settlements typical of large commercial farms. All the health facilities except one qualified for a remoteness bonus under the RBF program. However, out of the eight facilities three have 50% of the population living beyond 8km. The district referral hospitals for six of the clinics are more than 70km away with the furthest distance being more than 300km away. Due to long distances, bad terrain and other factors some facilities prefer referring their patients to nearby or neighboring district hospitals. For example, Fc8 clinic prefers referring patients to a mission hospital, which is 45km instead of the district hospital, which is 110km away. Most roads connecting these facilities as depicted in Table 1 are not good and almost impassable during the rainy season, making it difficult for transport to operate. The telecommunication system is notably good for six facilities although cellphone networks are 500m and a kilometer away from two of the clinics.

33. Table 2 summarizes the performance of the eight health facilities. Income of the four high performing facilities either met or surpassed their target income and the income of the four low performing facilities had actual incomes lower than their targets as shown in Table 2. Discussions on resource allocation are done in monthly internal review meetings by the health staff and then in the HCC for inclusion in the quarterly operational plan which guides how the earnings are to be used to improve the services at the facility. To improve the QoC, 65% of clinic incentives are spent on items that directly benefit beneficiaries as per the new policy. Most facilities managed to renovate infrastructure and purchase both clinical and non-clinical items that have helped to improve quality using monthly RBF earnings. Data in the table shows that health

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4 Remoteness bonus of a clinic is awarded following DHE assessment of the clinic against 6 set remoteness indicators. Final computation of clinic’s quarterly earnings is done taking cognisance the remoteness bonus percentage. The maximum bonus that can be awarded to a clinic is 30%.
facilities managed to buy medicines using RBF funds. Clinics bought medicines such as magnesium sulphate, oxytocin, atenolol, nifedipine, diazepam and dextrose, which are mostly used in the maternity unit.
<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>Fc1</th>
<th>Fc2</th>
<th>Fc3</th>
<th>Fc4</th>
<th>Fc5</th>
<th>Fc6</th>
<th>Fc7</th>
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<td>Catchment Population</td>
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<td>4702</td>
<td>4606</td>
<td>8318</td>
<td>6154</td>
<td>2445</td>
<td>7703</td>
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<tr>
<td>Catchment Area</td>
<td>Villages, fishing, tourist lodges</td>
<td>Villages, tourist lodges, fishing camps</td>
<td>Villages and game area</td>
<td>Villages</td>
<td>Villages and small holder farms</td>
<td>Villages, commercial farms, urban</td>
<td>Villages</td>
<td>Villages</td>
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<tr>
<td>No of Villages &gt; 8km</td>
<td>3/16</td>
<td>1/6</td>
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<td>14/32</td>
<td>19/29</td>
<td>-</td>
<td>2/8</td>
<td>7/14</td>
</tr>
<tr>
<td>Remoteness Bonus Status</td>
<td>28%.</td>
<td>19%.</td>
<td>15%.</td>
<td>9%.</td>
<td>24%.</td>
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<td>18%.</td>
</tr>
<tr>
<td>Telecommunication</td>
<td>Network 1 km outside clinic</td>
<td>Fairly good</td>
<td>Good</td>
<td>Good</td>
<td>Network 500m outside clinic</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>District Hospital access</td>
<td>Kariba Hospital over 300km</td>
<td>90km by road 35km by boat.</td>
<td>70km.</td>
<td>85km</td>
<td>43km</td>
<td>2 km</td>
<td>110km.</td>
<td>76km.</td>
</tr>
<tr>
<td>Ownership</td>
<td>RDC</td>
<td>Government</td>
<td>RDC</td>
<td>Government</td>
<td>RDC</td>
<td>RDC</td>
<td>Government</td>
<td>RDC</td>
</tr>
<tr>
<td>Nearby Other Facilities</td>
<td>Siyakobvu Rural Hospital 35km</td>
<td>-</td>
<td>-</td>
<td>Chikombedzi Hospital 30km</td>
<td>-</td>
<td>3 private doctors, dental surgery, a Mission HF. Dist. Hosp</td>
<td>St Luke's Hospital (Lupane District)</td>
<td>Mbuma Hospital 45km</td>
</tr>
</tbody>
</table>
## Table 2: Summary of Facility Characteristics (Performance)

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>Fc1</th>
<th>Fc2</th>
<th>Fc3</th>
<th>Fc4</th>
<th>Fc5</th>
<th>Fc6</th>
<th>Fc7</th>
<th>Fc8</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Average Quality Score</td>
<td>71%</td>
<td>71%</td>
<td>75.7%</td>
<td>75.7%</td>
<td>71.1%</td>
<td>71.1%</td>
<td>76%</td>
<td>76%</td>
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<tr>
<td>Quality Score for 2nd Quarter 2014</td>
<td>66%</td>
<td>Not assessed</td>
<td>74.4%</td>
<td>72.8%</td>
<td>69.1%</td>
<td>68.7%</td>
<td>76.3%</td>
<td>79%</td>
</tr>
<tr>
<td>Structural score</td>
<td>68.3%</td>
<td>Not assessed</td>
<td>87.6%</td>
<td>74.5%</td>
<td>73.1%</td>
<td>76.6%</td>
<td>81%</td>
<td>86%</td>
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<tr>
<td>Clinical score</td>
<td>64.5%</td>
<td>Not assessed</td>
<td>67.3%</td>
<td>71.8%</td>
<td>69.9%</td>
<td>64.5%</td>
<td>73.4%</td>
<td>75%</td>
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<tr>
<td>OPD Target</td>
<td>380</td>
<td>133</td>
<td>294</td>
<td>288</td>
<td>514</td>
<td>385</td>
<td>153</td>
<td>481</td>
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<tr>
<td>OPD Average Utilization</td>
<td>862</td>
<td>502</td>
<td>879</td>
<td>922</td>
<td>303</td>
<td>1395</td>
<td>548</td>
<td>339</td>
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<tr>
<td>ANC4+ Target</td>
<td>25</td>
<td>10</td>
<td>20</td>
<td>19</td>
<td>35</td>
<td>26</td>
<td>8</td>
<td>26</td>
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<tr>
<td>ANC4+ Average</td>
<td>24</td>
<td>7</td>
<td>18</td>
<td>17</td>
<td>8</td>
<td>31</td>
<td>15</td>
<td>5</td>
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<tr>
<td>PCC immunization Target</td>
<td>14</td>
<td>5</td>
<td>11</td>
<td>11</td>
<td>19</td>
<td>14</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>PCC average Utilization</td>
<td>3</td>
<td>0.5</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>19</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Normal Deliveries Target</td>
<td>17</td>
<td>6</td>
<td>13</td>
<td>13</td>
<td>24</td>
<td>17</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>Normal Average Deliveries</td>
<td>15</td>
<td>4</td>
<td>7</td>
<td>12</td>
<td>4</td>
<td>7</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Target income for 1st quarter of 2014</td>
<td>$1,964.36</td>
<td>$443.00</td>
<td>$4,710.43</td>
<td>$1,327.22</td>
<td>$2,661.85</td>
<td>$1,473.59</td>
<td>$1,021</td>
<td>$3,227</td>
</tr>
<tr>
<td>Actual income</td>
<td>$1,154.61</td>
<td>$1202</td>
<td>$1,843.79</td>
<td>$2,525.29</td>
<td>$994.57</td>
<td>$3,369.76</td>
<td>$1,678</td>
<td>$703</td>
</tr>
<tr>
<td>Performance Status</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>High</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Allocation to Investments</td>
<td>Kitchen for mothers, medicines, cleaning items, stationery, detergents, plumping, garden tools, maintenance work, water pump mattresses, linen, blankets, curtains, BP machines and medicines</td>
<td>Curtains, water pump, maintenance work, medicines, painting</td>
<td>Suction machine, diabetes testing machine, furniture</td>
<td>Beds and mattresses, maintenance work, equipment for resuscitation, medicines</td>
<td>Completing maternity wing, renovations, medicines</td>
<td>Kitchen for mothers, mattresses, renovations, detergents, patient waiting shed, medicines</td>
<td>Maternity waiting home, curtains, BP machines, renovations, weighing scales, drugs</td>
<td></td>
</tr>
</tbody>
</table>
34. The availing of RBF funds for transportation of medicines at a clinic ensured a constant supply of vaccines from the district. Some clinics converted existing rooms and others completed building Maternity Waiting Homes (MWHs). The MWHs are meant to enhance monitoring of women during the last weeks of pregnancy to better manage complications and emergencies. In addition to addressing this clinical aspect of care, their availability resulted in more women delivering in the facilities as it addressed one of the major reasons for home deliveries—the delay in getting to the facility. Investments in equipment such as sphygmomanometers, diabetes testing kits, adult weighing scales and baby resuscitation kits were also made to improve the QoC in an effort to increase utilization and patient outcomes. The availability of equipment and medicines contributed to increased utilization in 6 health facilities for ANC services. Furthermore the efforts to improve utilization goes beyond the quest for earnings as efforts are also made to improve maternal care ensuring that mothers make use of the service to reduce home deliveries as this is accepted by health professionals as a major cause of maternal mortality.

35. Structural scores were relatively good in most facilities because their initial earnings were invested in structural improvements as compared to the clinical scores. All the health facilities in the study typically have quality scores below their district average as they lost marks on the clinical component. The low clinical scores were mainly a result of the low scores for the Family and Child Health sub-component which largely arose from the absence of some essential medicines for the emergency tray, such as Diazepam and Dextrose, and poor documentation of clinical processes (for example not documenting severity status of diarrhea) including Integrated Management of Neonatal and Childhood Illnesses (IMNCI) clinical processes.

36. However the DMO (not actively involved in supervision) in one district reported that some of the scores in facilities suggest a questionable scoring system, which is biased, and largely subjective depending on the DHE. The DMO questioned how a facility had improved drastically over a short period of time in one quarter. The research team also observed that the supervision checklists for the same district were not properly compiled with so many cancellations and some missing pages suggesting a questionable scoring system. Furthermore, a comparison of health facility checklists and on-site observations revealed that one DHE team seemed more lenient giving scores for items that were not working such as sphygmomanometers and HCC meetings that were not held by the committee which was dysfunctional due to political issues.

37. New OPD consultations, one of the four incentivized key tracer indicators, has six clinics, two of which are low performers, surpassing the target. The indicator shows very high volumes, which are double to four times the monthly target of patients in some clinics and these are contributing immensely to the clinic resource base although they attract a low fee. Main reasons contributing to high OPD attendance
include accessibility, servicing clients from outside the catchment area, high malaria prevalence in summer, perceived availability of some types of medicines and the availability of a train from outside their catchment area that comes to the clinic every Thursday, a day coinciding with a big market day at the center. Two low performing facilities, which were performing below the target for the indicator, had staff shortage issues and close proximity to a mission hospital with a qualified medical doctor on staff and free services at the point of care. Patients preferred going to the mission hospital due to the perceived better QoC compared to the clinic.

38. Two high performing clinics have the number of clients completing ANC 4+ visits surpassing their targets. Three facilities are below targets and three not very far from reaching their targets. Only one health facility surpassed its target for PCC immunization due to its urban setting. One of the high performing facilities was nearly on target but six were below target. Those that performed below target were mainly due to the absence of refrigerators to store vaccines, the need to wait for adequate numbers of children before opening a vial and outreach teams not supplying data to the clinics. While it is expected that there will be a gap between women completing four ANC visits and women actually delivering at the clinic (for many reasons – including but not limited to the fact that women may choose to deliver somewhere else, or might need to deliver somewhere else for medical reasons), the difference is still wide for most facilities.

39. Although facilities were initially categorized as high or low performing, some patterns in utilization performance were observed to cut across all facilities. Although the majority of the facilities did not achieve ANC targets, six of the eight facilities had a positive (increasing) trend line. Whilst OPD and ANC trends were typically increasing for nearly all of the facilities, the trend for Institutional Deliveries fluctuated with either a stagnant or declining trend line for seven of the eight facilities regardless of overall performance status as indicated in Table 3 below.

Table 3: ANC and Deliveries Trend Directions March 2012 to March 2014

<table>
<thead>
<tr>
<th>Facility Code</th>
<th>Performance Status</th>
<th>ANC</th>
<th>Deliveries</th>
<th>OPD</th>
<th>PCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fc1</td>
<td>High</td>
<td>I</td>
<td>S</td>
<td>I</td>
<td>I</td>
</tr>
<tr>
<td>Fc2</td>
<td>High</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>I</td>
</tr>
<tr>
<td>Fc3</td>
<td>High</td>
<td>I</td>
<td>S</td>
<td>I</td>
<td>S</td>
</tr>
<tr>
<td>Fc4</td>
<td>High</td>
<td>I</td>
<td>D</td>
<td>S</td>
<td>I</td>
</tr>
<tr>
<td>Fc5</td>
<td>Low</td>
<td>I</td>
<td>D</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>Fc6</td>
<td>Low</td>
<td>I</td>
<td>D</td>
<td>I</td>
<td>S</td>
</tr>
<tr>
<td>Fc7</td>
<td>Low</td>
<td>D</td>
<td>D</td>
<td>S</td>
<td>I</td>
</tr>
<tr>
<td>Fc8</td>
<td>Low</td>
<td>I</td>
<td>I</td>
<td>D</td>
<td>I</td>
</tr>
</tbody>
</table>

Key
40. The declining trend in institutional deliveries is of concern given that facilities were putting most of their resources toward improving MCH services. Based on the population and the WHO standard estimation of expected deliveries, i.e. 3.4% of the population, three clinics reached or were almost on target. There were extreme cases whereby one had target deliveries of 24 and the other 22 but both of them had only four actual deliveries. Declining or stagnant trends in institutional deliveries are a result of many factors. Findings revealed that these include: perceptions about the clinic, such as a belief that the clinic is haunted; unavailability of staff where there is shortage of staff and the nurses houses were located far from the clinic; and the presence of a ‘white’ doctor who the communities believe was more committed to his work and willing to stay in a remote area. On the supply side some MWH had been completed but the communities were yet to be sensitized, and there was also the absence of staff for night duty and despite training in BEmNOC nurses were not yet confident of handling deliveries hence high institutional deliveries. Some nurses especially, primary care nurses (PCNs), did not have midwifery training (as illustrated in individual Facility Case Studies).

41. Both health workers and community members acknowledged that there were home deliveries in the catchment area, and that a further increase in institutional deliveries should be achievable. Issues at a local level can be addressed in order to increase institutional deliveries. These include the reorganization of services at facility level, such as having skilled nurses and having nurses on night duty at the clinic, and listening and addressing far community concerns, such as resupplying food to a mother in the MWH. From the above perspective it is noted that the program is not sufficiently adapted to the context hence there is need for HCCs to come up with innovative community programs to support families who have social problems that prevent them from accessing safe deliveries at clinics. For example, some young mothers did not have someone to leave their children with during their stay at MWH or could not afford to divide their food supplies between for their own use in MHW and for their families at home.

3.4 Discussion on Factors Affecting Performance

3.4.1 Intervention Design Factors

3.4.1.1 Use of Data for Decision Making

42. Declining trends in income lost due to data errors is strong evidence that RBF is strengthening the management of health information, primarily through the verification mechanisms. Data collected and verified at health facilities is being used in decision making for RBF, particularly on how the health facility and health
workers are assessed. Verification at the different levels ensures that data collected and synthesized at the clinic level tallies with reported data while data at the district level is the same as that documented at a clinic level. Although there has been an acknowledged and commendable improvement in the accuracy and timely reporting of data, it is still important to ensure that this data is well utilized and timely and feeds into the decision-making processes at various levels.

43. The study findings indicate that facilities do make use of available data to reflect on performance, although they differ in the extent to which they utilize it for decision-making. PME II findings suggest that the use of data for decision-making does help to strengthen responsiveness and enhance uptake. The majority of facilities undertook some form of demand generating initiatives. Two facilities in one district demonstrated how they made use of performance data to craft some social marketing strategies to improve performance. The facilities, having performed poorly from RBF inception to September 2013, strengthened their efforts in health education to raise awareness on early treatment for malaria to avoid complications during the malaria period as well as on the importance of early booking and delivery at the facility. In addition, the facility used its subsidies to conduct community outreach activities for child immunization. The effects of these efforts could have contributed to their positive trend and above target performance for OPD utilization, sharp increases in ANC visits and immunization—though the facility’s deliveries remained stagnant. Similarly, a range of contextual factors influenced the poor performance of other facilities—particularly in OPD utilization and expanded program of immunization (EPI) coverage, as we show later.

“At one time many of the children of religious objectors were dying of measles and the clinic carried out outreach programs to reach the communities”. FGD men near

44. At one clinic, health staff wrote exact review dates on baby cards to remind mothers about upcoming visits; through health education the mothers are now used to the routine exercise of monitoring the growth of their children through the VHWs, who uses the registers as reminders for women to attend for EPI at the clinic.

3.4.1.2 Human Resources for Health

45. The achievement of desired results of the RBF program relies, among other intervention design factors, on the availability of a health workforce with the capacity to deliver quality services. The numerical adequacy, skill and attitudes of health workers are a crucial line of inquiry in assessing factors influencing performance. PME II findings show that while efforts to balance the skills mix relevant for the program’s focus are present at a stewardship level as discussed below, the real or perceived inadequacy in the number of staff and associated challenges presents a significant risk to program effectiveness. All clinics have busy days for specific programs such as HIV/ART distribution with three of the clinics attending to more clients than expected. QoC was perceived by the communities to
be low in low performing facilities and this included the bad staff attitude, long waiting hours, favoritism in the issuing of drugs, delays in responding to emergencies, turning patients away without attending to them after closing at 4.00, long breaks, delays in opening the clinic and absence from duty. There were higher OPD utilization numbers than expected that resulted in long waiting hours and negative staff attitude due to fatigue. One low performing clinic had only one PCN; this resulted in her being overworked and affecting attendances as patients failed to use the clinic as they did not know when she would be off duty. Although high performing facilities were not necessarily associated with perceived good QoC, their performance was not supported with adequate staff. Contextual factors contributed to high health facility usage. For example facilities were next to a non-RBF districts and serving clients outside its catchment area. Despite good performance one of the facilities experienced drug shortages. Thus factors such as HRH and staff attitudes alone do not explain health facility performance; performance is also influenced by contextual factors.

Staffing at Facility Level
46. Discussions with one DHE revealed that government clinics were well staffed than rural district council (RDC) clinics and all government clinics in the district had been allocated state registered nurses (RGNs). The DHE in this district noted that RDC clinics were not performing well as shown in Table 2 Fc5. The other three districts had human resources distributed equally between the RDC and government clinics. In two districts both the RDC and the government clinics were given the RGNs who are more skilled nurses than PCNs. The clinics started recording increases in ANC and PCC immunization. In another district an RDC clinic was given a RGN nurse with midwifery skills to address MCH needs given that the nearest hospital did not have doctors. However one district had problems in that the government clinics had more skilled staff than the RDC clinics when the RGNs were deployed after the government unfroze the RGN posts.

47. Discussions with health workers in almost all the health facilities revealed the problem of perceived staff shortages and their implications on community confidence; severe staff shortages resulted in low attendance. For example at one clinic where there was a PCN and a general hand the clinic performed below target in all selected indicators. Seven facilities had a minimum of two PCNs. One health facility had one PCN and a general hand. Nurses in charge (NICs) in almost all health facilities confirmed that in carrying out duties rarely did they operate as a full team as staff members so frequently go off duty, attend workshops or go on study leave.

Perceived Workload and Distribution of Tasks
48. In all health facilities nurses (who may be an RGN or a PCN) perceive they have a heavy workload because they need to divide their attention between supervisory, administrative and clinical duties. They are involved in the consultation and
dispensing of drugs to OPD and inpatient (i.e. patients for observation). They also attend MCH duties that include ANC, family planning (FP) and labor, deliveries, PNC, immunization and nutritional assessments. They participate in HCC meetings every month or twice a month and also in the ward meetings. Moreover, they are expected to attend community events that include commemorations, for example on World Health Day. In addition, they review and resupply medicines to patients with chronic diseases such as HIV. Sometimes they are also involved in non-core activities:

“As staff we take turns to fetch water. We use the wheelbarrow. We wake up in the morning sometimes 5 o’clock to fetch water before we start work. Then after 4 we also go to fetch water,” –NIC

49. RBF is viewed by health workers as having increased their workload due to its emphasis on better record keeping, financial and administrative duties. As secretaries in the HCC, NICs are also bank signatories and involved in collecting bank statements and reconciling them with clinic cash books.

“The workload has increased especially the registers, operational plans, contracts, quarterly reviews. The paper work involved when you want to buy items is too much, requisition, voucher…” –Health staff

50. NICs, however, allocate duties on the dispensing of drugs, weighing of babies and taking of temperatures in order to cope with the increasing workload on specific busy days; the VHW (when needed) and nurse aid alternate duties. These strategies reduce patient waiting time. The VHW collects names from the EPI register to monitor the immunization status of children in their respective districts. At four health facilities the staff adjusted their working hours depending on how busy the clinic was. For example the staff forgo their breaks and lunch and instead of finishing at 4.00 they extend by an hour to cope with the increased workload, serve their patients and ultimately earn more money from incentivized services. At one high performing facility the staff extend to 5.30:

“As a team we are just working harder, instead of knocking off at 4 now we get up to 5 or 5.30, we do not hire any locum nurses so we are in need of more staff”. Health staff

51. One low performing facility which had one PCN, a general hand was tasked with dispensing drugs, weighing babies and taking temperatures while the PCN performed other duties. This was not safe protocol as the person was not trained but the arrangement was generally accepted given no other choice. This was also on a short-term basis as the regular staff had gone for training, workshops or off duty. The DHE had not ensured that the facility had adequate skilled staff to avoid the use of unqualified staff as this compromised quality.
Typical Day at a Rural Health Center (Manned By Three Nurses)

Opening time 7.30 am
Morning: Damp dusting, Allocation of duties
Duties allocated:
1. One nurse attends to OPD consultations
2. One nurse dispenses medicines + EPI
3. One nurse undertakes bookings of ANC cases and requisite investigations
   - Number 3 will also be attending to emergency cases
   - Whoever will have finished his/her tasks will provide HIV counseling and tests and counseling services. On Mondays nurses collect bloods for CD4 count.
   - ART resupplies are given and registers updated
   - NB: If nurses complete their tasks they go and fill in gaps
   - Each and every nurse fills in the registers of tasks they were assigned to on that particular day and updates them regularly.
   - Every month end staff compile statistics and then verify each other’s work.
   - HCC meetings are held in the afternoon and the dates for the next meeting are set during the meeting. Compiling of administrative and financial records is done once a month but quotations and purchases can be done any time.
   - The EHT is responsible for disease surveillance and WASH
   - The General Hand is usually assigned to clean then taking temperatures, BP and growth monitoring
Closing time 4.00 pm

52. The box above gives a chronological overview of tasks on a typical day at a rural health center. The duty roaster is followed when everyone is present to attend to patients. The clinic has two General Hands staff. One of the General Hands usually takes temperature and weighs babies, especially on busy days. When one nurse goes for a workshop the remaining staff alternate duties. On a busy day staff increase their efforts. VHWs visit the clinic only once or twice a month and are given the task of weighing the babies and testing for malaria.

Teamwork
53. Staff in 7 health facilities exchanged information to make progress toward improving services. For example, in their internal review meetings health workers discussed issues pertaining to each department of health care service delivery. For example the EHT updated the team on his work and at one high performing facility the NIC reported that the EHT—through his disease surveillance activities and documentation—kept the clinic informed of disease outbreaks. Staff discussed feedback from the DHE guided by comments on the supervision checklist with the aim to improve on areas of concern. Recommendations were to be implemented in preparation for the next DHE visit. One low performing health facility, on the other hand, lacked teamwork because of power dynamics in which an RGN higher-level nurse was imposed as a NIC at a clinic where a State Certified Nurse (SCN) held
the post. Friction between the two members affected staff coordination at the clinic because the SCN resented teaching the new NIC management and operations of the clinic. The EHT at the same clinic was always absent, lacked supervision from the DHO, did not participate in staff meetings and was not coordinating her work with other clinic activities; the clinic consequently scored badly in her area of responsibilities. The DHE recommended in the supervision checklist for this clinic that all health staff be present on the day of supportive supervision for proper assessments and team building. The friction between the staff was not the only factor affecting performance of the clinic; there was also a lack of teamwork between staff and the HCC because some of the HCC members were not effective as they had low literacy levels, not trained in RBF and were not able to understand their role appropriately resulting in a lack of respect by the health staff, in addition to having low literacy levels, were also not trained in RBF.

**Motivation and Satisfaction**

54. Discussions with the seven health facilities revealed that rewarding effort motivated health workers on a personal level. Health workers worked at making improvements at facilities in order to improve performance. The availability of equipment and drugs contributed to motivation, as did the autonomy to develop plans and to make decisions regarding the purchase of equipment in response to the observed needs of the clinic. The opportunities for training on short courses for nurses motivated the staff as it improved their way of operation. Courses attended by nurses included BEmONC, Integrated Management of Neonatal Childhood Illnesses (IMNCI) PMTCT, Jadelle insertion, monitoring and evaluation (M and E), HIV integrated management, adolescent sexual and reproductive health (ASRH), drug management Infant and Young Child Feeding (IYCFT) and Community Management of Acute Malnutrition (CMAM). In one district Nurse Aides underwent a drug dispensing course. This was not the case for all other staff like the EHTs and counselors who were not given professional development opportunities through courses even though they played a significant role in the MCH program. For example EHTs mobilize and monitor the community for EPI and are also responsible for disease surveillance. In one district with primary care counselors, they are responsible for PMTCT and all other HIV counseling. The counselor reported that he was now overworked as his duties have now extended beyond his mandate to include issues such as bereavement, child abuse and domestic violence.

55. Staff from all health facilities but one were motivated by the incentive, which they got after 25% calculation from facility RBF earnings. They now do not mind working overtime as this increases their incentive. Prior to RBF price changes, staff in high performing facilities received high earnings and more incentives, which enabled them to buy bigger items. At one clinic one of the nurses managed to buy a car with the incentive. Price changes have resulted in the reduction of their incentives and to a certain extent their motivation. The system of distribution rewarded on seniority with the NIC getting the most because of the responsibilities
associated with that office. NICs expressed satisfaction that the distribution of money was transparent despite it being done at the district level. However, at one facility there was tension around how the incentive is distributed and shared as some feel that the EHT is not doing as much work as the others.

56. However staff motivation was limited by the remoteness of the area, lack of employment opportunities in the country, limited public transport, limited cell phone networks, irregular DHE supportive visits, inadequate accommodation for them to stay with their families and unfavorable weather conditions.

57. Health facilities have managed to retain staff even from before RBF because of limited transfer opportunities and due to the government policy of freezing posts. Due to the emphasis on MCH, staff members are eager for midwifery training to fully manage the deliveries at their facilities, be able to identify difficult cases and refer appropriately to higher levels. Staff have also managed to stay at the clinics due to good relations with the community. Staff relations were generally reported to be good except at one clinic and this was a contributing factor in lack of staff retention.

<table>
<thead>
<tr>
<th>Conclusions and Program Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Nurses perceive they have a heavier workload than before RBF because they are now expected to perform better in financial and administrative duties. The NIC would be better able to undertake the tasks with better in-service training and hiring of more nurses.</td>
</tr>
<tr>
<td>• Almost all health facilities revealed problems of staff shortages and high workload. Workload should be further tracked and classified to give a better picture of actual versus perceived workload.</td>
</tr>
<tr>
<td>• Handing over tasks to the nurse aides, VHWs and General Hand must be done with caution as these people are not well trained for these additional tasks, but it is generally accepted that there is no other choice. The MOHCC should ensure that all facilities have adequate skilled staff to avoid the use of unqualified staff, which compromises quality at health facilities.</td>
</tr>
<tr>
<td>• To relieve health staff of financial and administrative duties the MOHCC can allow locums at rural health facilities. The HCC can also use RBF subsidies to hire temporal administrative clerks to manage paperwork for these subsidies.</td>
</tr>
<tr>
<td>• DHEs should support clinic staff in their team efforts and mediate when problems between staff occur; DHEs can benefit from capacity building in this area.</td>
</tr>
<tr>
<td>• The DHE should ensure equitable distribution of staff in all districts—taking into account the specific needs of the facilities.</td>
</tr>
<tr>
<td>• There is need for the RBF National steering committee (NSC) to debate the shortage of staff crisis in some facilities.</td>
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3.4.1.3 Program Targets

58. The program has established a system that ensures proper record keeping without the worry that paying for certain targets will encourage people to falsify data in order to receive the incentives. The purchaser, Cordaid, verifies data monthly or quarterly depending on how the clinic is performing with more visits to underperforming clinics. Initially clinics tended to underreport and lost revenue; for example one clinic for recorded 27 clients instead of 50 for ANC4+ and lost $150. A clinic that over or under reports data for an indicator beyond the +/-5% margin of error loses earnings at a pre-established rate. There was a huge improvement from 2012 in seven clinics; when RBF started when they were losing about 90% of income as shown for one clinic in Figure 2.

Figure 2: Lost Revenue Due to Data Errors

59. Some health workers and DHEs in three districts viewed the quality supervision checklist scoring system as flawed; at times loss of marks was due to absence of an item (for example drugs for the emergency tray) unavailable nationally, yet still the clinic would be marked down for failing in an area beyond their control.

60. There are also various contextual factors affecting clinic performance both positively and negatively. One clinic had OPD utilization of 862 patients, which was almost three times its program target of 380 cases per month. Contextual factors such as: disease patterns e.g. high malaria prevalence in summer, accessibility, informal settlements population not included in the catchment population, being close to a referral hospital, patients coming from districts not yet enrolled in RBF seeking free services, and the presence of other facilities in the area not fully functional were not taken into consideration in the original determination of program targets—an issue summarized in the last section. On the other hand, another clinic performing below its OPD targets had a monthly average of 303 OPD cases compared to a target of 514 patients. Targets were set with the presumption that 60% of the population would utilize the health facility without consideration of
factors such as: preference for another facility with a doctor offering free services, or challenges accessing the facility in terms of distance and lack of public transport.

61. Although it would be anticipated that with the RBF program’s focus on MCH there would be increases in incentivized indicators such as ANC4+, deliveries and PCC for immunization, data shows that generally health facilities were not reaching their set targets. Program design and contextual factors had implications on progress toward targets of the incentivized indicators. Targets are not feasible and lead to frustration when contextual factors are beyond the clinic’s control. For example, a rural health facility located near a mission hospital with better services and a doctor resulted in patients bypassing the clinic, which failed to reach its targets. Targets are feasible when it is possible to have DHE, community and RBF program input to overcome the negative spiral of lack of skills, housing and transport and limited telecommunications.

62. There is need to revisit how targets are set. Facilities that failed to reach their targets particularly for MCH indicators lost earnings since calculation of the target income to be earned by health facility was based on achieving the target population for each incentivized indicator. This meant a clinic had fewer resources for undertaking improvements at the clinic. For example, one low performing clinic did not have much investment in the six months period prior to the study, hence failed to resuscitate the solar electricity system donated by their former member of parliament. They also failed to repair the water pump, resulting in pregnant women having to collect water from the river for their own use and making the facility unattractive to the community. In such cases most health facility improvements are undertaken by mobilizing resources through requesting disadvantaged communities to contribute financially through their village heads.

3.4.1.4 Pricing of Services
63. The MOHCC in collaboration with the World Bank conducted a rapid review of the RBF subsidy pricing structure in May 2013. This was in the context of a pertinent need to institute some cost-containment mechanisms in the program as initial projections of payments to health facilities varied significantly from the original pricing model of 2011. The review entailed stakeholder consultations and modeling based adjustments of the existing prices taking into account the program focus and economic rationale.

64. The data gathered during this review suggests that price changes were effected without notifying health workers in all facilities, be it at the district or facility level, and staff only noticed the changes on receipt of income. The research team noted widespread disappointment with how the process was handled. Performance earnings were greatly affected by the price changes for some paid for incentivized indicators. For example one of the highest earning indicators, the long-term FP method, Jadelle, was reduced from $50 to $5. Health workers in all the facilities
indicated that the reduction in prices of the indicators seriously affected their operational plans and required them to postpone their projects several times. For example, Fc6 could not build accommodation for nurses at the clinic, so most of the maternity cases were referred to the nearest hospital. Health workers were also concerned about the impact of the price changes on their incentives, as these were greatly reduced. It is however important to note that the long term FP method had originally been priced at $5 and a review of the recent pricing report showed no solid evidence to justify the huge jump in price in the preceding price review. This incident offers potential earnings for the RBF program. The process of pricing and setting incentives could offer opportunities to the RBF program for improving internal transparency, health worker engagement and eventually overall performance. This could be done by involving representatives of districts and facilities in setting prices and by developing a clear communication strategy to inform all involved when any RBF program changes occur.

65. DHEs in all districts appreciated RBF subsidies though they said there were not enough to cover costs incurred in providing services for all claims because government is not providing adequate grants to DHEs or RDCs to finance provision of health services. Concerns were raised about RBF pricing mechanisms, as they do not cover for services being rendered. For example, RBF pays less for maternity than what was collected when mothers used to pay for services, resulting in expenditure deficits.

### Conclusions and Program Implications

Facilities face financial deficits when they use RBF subsidies to procure at cost some essential items that would ordinarily be availed by government but are in some cases unavailable. RBF prices are not based on full cost-recovery, so facility earnings are in some cases below the operational costs. There is need to review the pricing and consider adjusting it upwards in view of that some inputs are purchased by health facilities from private markets and the RBF is the only income in many facilities due to limited government health sector disbursements to districts. It is essential that future reviews of subsidies for the program take into account the envisaged flow of funds/resources from other sources, particularly the GoZ, to establish the overall projected fund flow in relation to a minimum threshold that allows for quality service delivery. A clear communication strategy that takes into account existing reporting structures and turnaround times for disseminating information on review exercises and program changes is essential in order to minimize misperceptions of price reviews and ensure stakeholder buy-in.

### 3.4.1.5 Roles and Responsibilities of DHE, DSC and Facility Staff

66. The role of the DHEs is to supervise, identify problems and provide guidance to clinic staff. They do not have powers to deal with political differences of community leaders because they are civil servants, although these problems cannot affect clinic operations. The DHE can only take up such issues to the District
Steering committee (DSC), which has the power to deal with such problems because it is also constituted of politicians such as councillors. The DSC is set up and funded by the RBF project, and oversees the functioning of the program including monitoring, coordinating and advising at a local level. The DSC monitors the program and makes recommendations to the DHE about the progress of the program in the district. However, the study reveals that DSCs were not adequately empowered, having been allocated very limited resources (i.e. $100 per quarter)—not enough for them to attend more meetings, so also not enough to undertake verification processes or conflict resolution visits to individual facilities should the need arise. The DSCs gave feedback to the national steering committee (NSC also established by the RBF program), which establishes and reviews national policies to ensure proper program operations. Processes have been established to avoid direct conflicts with political leadership and to resolve issues at national level. DSC councillors can be members of HCC but not be chairpersons.

67. The NIC’s role as manager has always been to ensure good relations with all stakeholders so that the clinic operates efficiently in its environment. At five clinics NICs attended ward meetings because that is where development issues, including health issues, are discussed. Ward general assembly meetings—primary level forums to discuss general development including health—are good mechanisms for community mobilization and for disseminating information on health issues. A challenge noted by DHEs was the lack of capacity of NICs who were PCNs or inexperienced RGNs who have just completed their training in managing clinics and HCCs; their initial nurse training courses do not adequately provide skills to manage people and resources.

3.4.1.6 Role of DHE in Clinic Supervision and Factors Affecting Supervision

68. With the exception of one facility, DHEs visited health facilities once a quarter and assessed clinics using the quality supervision checklist. At DHE level a number of factors affected how clinics were supervised and mentored, including non-participation of some DHE members, including doctors, to undertake clinical care support. This was due to a shortage of doctors and lack of incentives to do the supervision.

69. District hospitals are also included in the RBF program such that members of the DHE team receive incentives at this level. However, district hospitals have large numbers of staff; one DHE team has 300 staff members who have to share about $8,000. After incentives are shared, the DHE, including doctors, get as little as $60 per quarter. They cited the system as unfair because clinic staff get five to ten times the amount the DNO (as their supervisor) gets. There were no complaints about clinics referring cases to hospitals as this was seen as a normal aspect of the health system in which hospitals should take what clinics cannot handle. What was of concern was the small amount allocated for supervisory visits and the lack of
allocations for drivers on those visits since they were not included in program design.

70. The supervisory teams were not always fully constituted with the District Environmental Health Officer (DEHO) and DMO hardly participating except in one district, resulting in a heavy workload for the DNO. The DMO participated in supervisory visits in one district because there was a good complement of four doctors at the hospital. DMOs were not always available to participate in supervisory assessment activities in other districts for various reasons that included doctor shortages. For example, one district had an establishment of four doctors, but only one was in post. That district faced a perennial shortage of doctors because it was reported that there was nothing else to do for professional and personal development at the rural growth point (a rural village or small town in Zimbabwe). One district had four doctors in post from an establishment of six but the DMO was not participating, citing difficult conditions en route to the clinic and lack of reasonable overnight facilities; another had four doctors in post out of an establishment of five, but the DMO held two positions: DMO and hospital superintendent; hence, the DMO had little time to commit to facility supervision. The DEHO’s absence in five facilities was felt in that the EHT was not acting as part of the team and not obliged to report or coordinate activities with the NIC.

71. With the exception of one district, health workers prepare for the regular DHE visits, which ensure that recommendations from previous visits are implemented before the next visit and resulting in improved structural and clinical scores that contribute to overall incentives. The quality supervision checklist the DHE used in conducting facility assessments was reported to be detailed in its emphasis on MCH issues. As such the DNOs, who mainly undertake the clinical assessments, reported that it takes them a lot of time to complete the assessment hence they would not be able to review other non-incentivized indicators adequately.

72. On the other hand health workers were of the opinion that the visits were rushed, too focused on the checklist and did not provide enough time for mentoring because the DHE aimed to cover several clinics in one day. This resulted in all clinics not getting enough mentoring, for example on administrative and financial issues. While the DHEs play an active role in identifying problems, in some cases they do not take much initiative to support the redress of these problems, particularly those related to relationships amongst various actors (with facilities and with HCCs and communities). The DHE in some cases also strongly influence how priorities are set regarding the investment of earnings, but do not consistently facilitate the involvement of HCCs and communities in the setting of local priorities.

73. In their internal review meetings the DHE discusses issues including comparing the performance of different facilities after DHE supervision. DHEs meet and are supervised quarterly by the PHE (including the Provincial Medical Director, or
PMD) and RBF issues are also included in the discussions. The PMDs meet at national level and brief the permanent secretary on RBF issues from the provinces. The PMD takes problems noted to share and address in the NSC.

74. As already discussed above one recommendation was that councillors should not chair the HCC because some councillors want to direct operations at health facilities. For example at Fc4 the local councillor wanted to run the operations of the clinic by directing who should be treated first and how resources should be spent; the perception was that it gives him personal glory to gain political mileage. However, when such cases are identified by DSC and DHE there is a delay in resolving issues due to a long timeframe from the time of DHE and PHE supervision visit and the NSC meeting, after which resolutions are taken for implementation. Problems of such major dimension should not wait for DHE quarterly visits since RBF was still in the learning process. NICs should inform their DHEs through their normal reporting structures and the DHE forward such issues through their PHEs to ensure a quick turnaround of national policy resolutions.

3.4.2 Immediate Effects and Mediating Factors
3.4.2.1 Community Participation, Ownership and Role of the HCCs
75. The HCCs in a few facilities were noted to be contributing to facility performance through their linkages with the community, particularly in the non-clinical operational aspects of the facility operations. This ensured project relevance to community members and facilitated improved responsiveness.

76. The involvement of the community through the HCC has played a key role in the improvement of the quality of primary health care. Three out of eight HCCs actively mobilized communities to access services, support the project and express their perspectives and concerns. At one low performing facility the HCC has been discussing quality scores with the facility staff with the aim of trying to find out why the scores were low. The chairman has even visited other facilities to find out why they have high earnings and are performing better.

‘I travel a lot in the district and I found that other clinics are earning as high as 12,000-

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<th>Conclusions and Program Implications</th>
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<tr>
<td>The DHE team is not fully constituted and sometimes lacks capacity to effectively deal with problems at the health facility.</td>
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<tr>
<td>The DHE shares problems at high levels but there are delays in implementation of resolutions.</td>
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<td>RBF should equate subsidies to cost incurred, or it risks contributing to further shortages at the clinic and negativity of clinic staff. Though RBF is based on use of subsidies and not cost recovery, participating clinics still receive some inputs—such as human resources and materials—from other funders.</td>
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14,000 rands yet here its 8,000 rands.’ HCC Chairperson
77. The same HCC conducts immunization campaigns for specific days in schools to mobilize mothers to come in order to improve scores. VHWs mobilize mothers to attend ANC4+ visits and the HCC chairperson who lives near the clinic at times regularly assists the clinic to analyze the register to see from where most utilizers are coming.

78. Community leaders at some facilities have demonstrated responsiveness to the clinic needs through the enforcement of regulations that aim at increasing utilization of MCH services with an underlying drive to also increase the clinics earnings. Some of the penalties have even become acceptable in the community. At three facilities penalties are used to encourage early bookings for ANC4+ and institutional deliveries. At one clinic community leaders penalize women (such as charging one goat) for home deliveries resulting in women from certain religious groups also delivering at the clinic though not staying at the MWH.

79. At one low performing clinic when the women deliver at home they are also made to pay a dollar for the baby card, a move greatly resented by the far communities where home deliveries were common due to long distances to the clinic.

80. HCCs in five facilities had challenges that included committees not being properly constituted, not elected by the communities and lacking capacity in their roles and skills for financial and administrative issues. Most of the facilities selected committee members on the basis of influence/leadership/health background or positions held in the community. At one of the low performing clinics the 15 members were not voted for by the people but were assigned into power by political leaders such as village heads and chiefs. The HCC was comprised of: VHW; Zimbabwe National Family Planning Council/Community Based Distributor (ZNFPC/CBD); TBA; /farmer; teacher; traditional healer; businessman; headmaster; councilor; village head and other members of the community. Selection of HCC members who do not represent all groups in the villages can create a lack of trust, with some members of the community feeling excluded and resulting in the community being unable to approach HCC members to ask about issues at the clinic. There were distinct conflicts of interest in some cases. For example, some of the HCC members were not working for the good of the facility since they were from the health sector and had lost out when health workers mobilized the community to seek services directly from the clinic. Health workers were mobilizing the community to seek family planning services for free at the clinic yet some community distributors provide their contraceptives for a fee.

81. As already noted, HCC guidelines recommend a political community leader i.e. a councilor to be an ex-officio member of the committee to reduce the risk of politicizing the committee. Two of the high performing clinics suffered seriously due to political interference. An HCC chairperson who was also ward councilor had
political differences with some of the committee members resulting in some postponed meetings when members could not form a quorum. This was evidenced by the HCC failing to push for progress at the clinic resulting in the failure to implement projects. At the same facility the DHE at one time had advised the HCC to select VHWs from the eight villages but a village head did not want the VHW who was selected for his village. The case ended up involving the police. At the other clinic the councilor was not elected as an HCC committee member but felt that since he was elected a ward councilor he was responsible for running the daily operations and developments at the clinic.

82. Active HCCs conducted community mobilization in support of the clinic. HCC members were not well known at far communities hence most far communities have limited knowledge of what the HCC is, membership and their roles. This was due to the multiple leadership roles they played in the community such as being a VHW and also being a member of the HCC responsible for developments at the clinic. In two facilities they acknowledged the presence of the VHW in their community and appreciated his work but were not aware of his role as a member of the HCC. The health staff, HCC and DHE lacked initiatives to improve communities’ involvement at the clinic. Far communities in most facilities were not active because they were too far from the clinic resulting in less community involvement. Two clinics did not have EHTs to reach the far communities, even though this cadre is responsible for community visits. EHTs in the other two facilities failed to reach the far communities due to fuel shortages for the bikes. In addition the DHE was not fully constituted in most cases, and with the DEHOs absent to supervise the EHTs in the facilities, the EHTs failed to properly execute their duties. At one low performing clinic the NIC complained of the EHT’s lack of coordination and teamwork.

83. HCCs in four facilities felt they should be given allowances for the work they were doing. The HCC members cited that they lacked motivation and that health workers did not respect them because they were not receiving any rewards. Some communities and the health workers regarded the RBF as a project instead of a way of working. This can be related to how RBF was introduced and the “language” used in communicating about RBF. If one talks about the RBF program, it is logical that others see it as a project. The community views RBF as temporary and not permanent. Communities are also used to the ‘donors’ who come and go. Although the understanding of RBF program among the communities has improved there is need for continued DHE supportive supervision that also targets other HCC members.
84. Some HCC members lack an understanding of their roles, responsibilities and skills in administrative and financial issues as they were either not properly trained by those who had been trained or did not receive the training at all. They lack skills in transferring the acquired knowledge in documentation, social mobilization and networking with other stakeholders. With regards to documentation, specific gaps were noted in reporting timelines for action plans. At one low performing facility, the trained vice chair did not cascade train and other members were not aware of their roles and responsibilities. This vice chair often had conflicts with the health staff as they felt that they also required a share from the RBF earnings at the facility. There are already set and established, MOHCC recommended HCC guidelines; these are being used by the RBF rollout in Zimbabwe for 794 clinics. The Working Group in Health (CWGH) spearheads the training. There is therefore need to give HCCs comprehensive training using the HCC training guidelines produced by the MOHCC and the CWGH. To complement this the DHE needs to closely supervise HCC functions and operations, ensuring that all members are capacitated with their roles and responsibilities and are aware of the RBF operational framework.

85. Ward meetings are opportunities for HCCs and health workers to participate in discussions and to gather opinions. CBOs are reaching communities far and near but not all CBOs are giving feedback to the HCCs. If one knows that he is entitled he feels empowered. At times people cannot express feelings openly in fear of victimization. One FDG participant revealed the fear that ‘you can receive an injection of water instead of drugs’ for expressing negative impressions. That was a very important statement as it shows the risks of telling the truth in terms of entitlement. In the same vein, at one facility the FGD participants confirmed long waiting times, delays in opening the clinic, bad staff attitude and favoritism in issuing drugs but no complaints were raised openly against the health staff. The HCC explained that the community does not have a culture of complaining hence they suffer in silence. This is in fact more than a ‘culture’ and about ‘complaining’ but perhaps a symptom and reflection of the state of citizenship and the sense of empowerment citizens feel (or do not feel) to claim their rights.

86. Community engagement via the HCC and the CBO client satisfaction survey is an opportunity to ensure greater, better, broader and more equitable community participation. There is need for the health facility to ensure that through the CBOs all the information from the community reaches the clinic and back to the community. The DHE should also discuss issues pertaining to the patients’ rights as part of their program and ensure on their visits that all the clinics are displaying charts on patients’ rights. At a national level the ministry is working towards a national client charter to reinforce the aspects of health care entitlement.

**Conclusions and Program Implications (Responsiveness and Representation)**
Community leaders at some facilities have demonstrated responsiveness to the clinic needs through the enforcement of regulations that aim to increase utilization of MCH services.

Most HCCs had challenges that included committees not properly constituted, not elected by the communities and which lacked capacity such as in financial and administrative skills.

Near communities are more actively involved in clinic activities than far communities who have limited knowledge of the HCC, their membership and roles, due to the long distances and the multiple roles the HCC members play.

The RBF program must capacitate and adequately finance the DSC for them to manage conflicts within the HCC. A feedback mechanism proposed in the PIM need to be strictly utilized to deal and manage conflicts by DHE and DSC.

There must be close collaboration between the DSC and the DHE and establishment of good communication channels to solve problems at the clinic.

Although the understanding of RBF program among communities has improved, there is need for continued DHE supportive supervision that also targets other HCC members.

Some communities and the health workers regarded RBF as a project instead of a way of working.

There is need to give HCCs comprehensive training using the HCC training guidelines produced by the MOHCC and the CWGH.

Community 'culture of not complaining’ is perhaps rather a symptom and reflection of the state of citizenship and the sense of empowerment citizens feel (or do not feel) to claim their rights.

The MOHCC is working towards a national level client charter to reinforce the aspects of health care entitlement.

Clinic staff should be trained to recognize and uphold patient rights from the supply side.

There is need to educate communities about their rights and responsibilities.

Health facility staff should be trained to recognize and uphold patient rights and discussions between the health facility, district and national on what should be done if the patients’ rights are violated should be done.

Community voices could better be heard through the use of VHWs, HCCs and CBOs verification surveys.

CWGH should be more visible in the community and train community members to demand their health rights.

3.4.2.2 Responsiveness to Community Needs

87. Five clinics were responsive to health issues raised by the community and presented to HCC members; the community was not comfortable presenting concerns directly to health workers. The HCC is also getting information on the needs of women who
bring children for health services. Where the HCCs were functioning, members as representatives of the community raised issues within committee meetings or individual HCC members approached health workers to present concerns raised by the community. Issues raised were mainly to do with waiting times or unavailability of medicines. These concerns were addressed by explaining to the community challenges that clinics were facing such as staff shortages and the need to start with health education before patients are attended to. However the HCC do not always present the cases well as they sometimes do not have formal processes in place to get community (especially women’s) views and communities do not speak directly to workers because they fear victimization as they are not aware of their rights. Only at two clinics were health workers making direct effort to find out and address community issues during health education sessions. Responsiveness to community needs was limited at low performing clinics where the HCC was not functioning properly. The HCC members were not calling community meeting to be briefed of community needs and therefore likely to make uninformed decisions.

88. CBO patient satisfaction surveys were carried out in all study sites and CBO researchers were known in both near and far communities. However, questions on the survey tool are too limited in nature and while they draw some basic information on patients’ perceptions of the services received in the last visit they do not adequately capture beneficiaries’ perception of care in relation to their health care needs including their rights and responsibilities. Nonetheless, the patient satisfaction surveys offer the RBF program an opportunity to start improving the process of collecting community’s views on their needs and desired quality of services.

89. MWHs may not necessarily be demand driven but are one of many health system initiatives that have been in place since the 1980s to improve maternal and perinatal morbidity and mortality in Zimbabwe. Many studies prove that MHWs reduce maternal and perinatal morbidity and mortality, leading to wider adoption of MHWs in Zimbabwe with the support of the donor community. RBF funds were used to adopt this model, which had been successful in other clinics and was supply driven with the assumption that it would improve outcomes. After MHWs were built or existing buildings were renovated, HCC members and community health workers promoted their use but contextual issues affected their use, especially among far communities. Challenges include lack of water at the clinic and the need for someone to stay at the clinic with the pregnant woman so they can assist with such chores, no one to leave children with at home, and no food or other essentials at the MHW. Food and other essentials used to be provided to make MHWs attractive but were stopped when subsidies were reduced. Consultation with communities (especially women) to develop alternatives for MWHs to improve access to institutional deliveries for women from far away communities can improve the situation. VHWs, most of whom are women, could be used to get women’s views in the community.
Conclusions and Program Implications
Health facilities lack creativity to obtain women’s perspectives on MCH issues and needs to improve their responsiveness thereby increase utilization of services. RBF should help improve clinic responsiveness by setting up mechanisms that capture women’s concerns and ideas.

DHEs should be more creative in helping health facilities critically evaluate their choices in relation to the needs of the community.

Health facilities should discuss their findings on community needs at higher level to continuously adapt the RBF program, which is a learning-by-implementing model.

3.4.2.3 Effect of RBF on Non-Incentivized Services
90. Clinics improved diagnosis of some non-incentivized conditions through purchase of equipment such as diabetes testing machines, sphygmomanometers, adult weighing scales and height measuring instruments using RBF subsidies. Some patients with chronic conditions benefitted from commodities directed for incentivized indicators, such as atenolol, nifedipine and methyldopa, although drugs were often inadequate to cater for all patients. As such patients were initiated on treatment at the clinic and referred to hospitals for continuous care since the clinic did not have enough drugs to cater for their needs. In addition not all clinic drug needs were being catered for through the RBF. The unavailability of some drugs for non-incentivized indicators was a challenge for clinics in all districts and patients had to incur costs to travel to neighboring districts or hospitals where they paid fees to access services. This was a major challenge especially for the elderly with chronic illness who needed the drugs most. Generally clinics did not also have drugs for asthma, epilepsy, eye ailments and STIs.

91. Generally RBF has helped improve the drug situation at clinics as incentives are also being used to transport drugs for non-incentivized indicators, or to finance staff to go collect drugs from the district hospital, complementing other government and donor drug distribution systems. RBF incentives were also used to transport all specimens to the district laboratory facilities, improving QoC for patients by reducing the time by which they received test results.
3.4.3 A Summary of Contextual Factors Influencing Performance of Health Facilities

92. As discussed earlier contextual factors independently, and/or concurrently influenced the performance of health facilities and had an impact on a community’s utilization of health services. These factors, which include other providers in the vicinity, health system constraints, remoteness, and cultural, social and political aspects inherent in the community, play a significant role in influencing the utilization and quality of care.

93. Only one health facility in the study had other health facilities within walking distance of less than three kilometres. Other facilities in this case were three private doctors, a faith based clinic, a dentist and the district hospital. These health facilities did not have a negative impact on OPD utilization because they charged fees higher than those in the public clinics. The district hospital had an impact on deliveries due to unavailability of this service at night and chronic diseases due to unavailability of drugs for these conditions. Four clinics had hospitals in their vicinities; the hospitals were not within walking distance but people could access them using public transport with the exception of one remote hospital where there was no public transport. These hospitals impacted the number of deliveries at clinics thereby affecting their earnings performance since deliveries are a high earning indicator. ANC service utilization improved in most clinics after the introduction of RBF but pregnant women delivered at hospitals because: hospital services are considered to be better quality, MCH services in hospitals are free, and hospitals cannot turn away a woman in labor. People bypassed the clinic to use other facilities for many reasons, including: perceived better quality services at higher levels of care (such as presence of doctors and trained midwives); anticipation that doing so would help avoid looking for transport if there are any complications; possibility of alternative payment modes such as agricultural produce; and finally that the higher level facility was easily accessible.
94. Also affecting performance was deployment of staff at RBF clinics. Deployment of staff is undertaken at district level by the DHE. RDCs may be owners of facilities but staff salaries are a government responsibility. In some districts the DHE tended to favor their own government clinics in allocation of staff and they deployed to their own government clinics at least one RGN who is a better skilled nurse compared to the PCN who was not adequately trained to manage MCH services. When PCNs were sent for up-skilling RDC clinics did not get adequate relief staff to manage clinics. In one RDC clinic there was only one nurse who was being assisted by a General Hand. This affected performance of the clinic in that in the absence of incumbent nurses relief nurses could not adequately manage some of the RBF activities due to staff shortage and lack of training in finance and management. The MOHCC’s policy on Para O women (those on their first pregnancies) had an effect on deliveries as they were all referred to hospitals in six of the health facilities. In the other two the DHE strengthened health facilities with midwives to conduct most deliveries because of the difficulties reaching hospitals in rainy or dry seasons.

95. The referral system in seven health facilities has challenges in that ambulances are based at district hospitals and called when there is a critical case requiring secondary level care. Nurses thus often face challenges to call ambulances, while community members cannot afford the cost of hiring a car.

96. Ignorance among teenage pregnant mothers affected the number of deliveries at clinics. Many young mothers failed to know their exact delivery dates resulting in home deliveries, which were reported to be occurring in all catchment areas especially in the far communities. Lack of water at facilities and other unfavorable conditions within the MWH contributed to increased numbers of home deliveries. Social factors affected ANC and deliveries at health facilities, including failure by the young mothers to get someone who can look after their children in their absence as the husbands will either be away working to earn an income or the young mothers will be single parents.

97. Other factors affecting health worker performance include women failing to attend meetings at the clinics. Traditionally women are regarded as more frequent users of the facility than men and yet men participate more on decisions at the facility than women. This means the women are not involved in decisions making concerning their MCH needs hence affecting their utilization particularly in two districts.

98. Particularly at three health facilities, ‘chisi,’ a day when the communities do not go for work in the fields, has contributed much to high workload at the health facilities as people seek health services especially non-acute conditions such as family planning or immunization when they are not busy. Another cultural factor affecting MCH issues is the lack of openness on the discussion of sexual and reproductive health issues in communities, especially among women.
4. Conclusion and Recommendations

99. While the findings and supporting details above have been presented along the lines of the conceptual framework, the conclusions below are organized to address the objectives of PME II (Section 1.2.1); the concerned objective being indicated in the italicized text.

100. The PME II study findings show that the RBF program is being generally implemented as intended and planned – with many of the intended consequences being achieved, and expectedly, some unintended changes and effects occurring. The PME II study findings show that RBF program has been able to foster many positive results through a complex web of factors, some inherent to the program, and some a function of the context in which the facilities are operating. In terms of RBF program design, the DHE quarterly supportive supervision was noted to be a driver of performance. Although the use of the new quality supervision checklist for assessment was regarded as cumbersome by both the DHE and the health facility staff it was viewed as comprehensive and very useful in not only aiding the DHE in undertaking the supervision but in guiding the health facilities to focus on areas requiring attention. This was noted to be helpful in improving performance and ultimately earnings. RBF improved communication and cooperation between the RDC and the DHE and facilitated the adoption of a shared goal of improving facility performance. This has helped to foster a localized level of stewardship for service delivery. Facilities improved data capture and recording through the regular support from Health Field Officers but also importantly due to the motivation and interest of facility staff to avoid losing earnings, as they were more aware of implications of poor quality data.

101. The PME II study found that the RBF program design and implementation processes triggered and facilitated changes in the facility staff’s performance. Staff at all the facilities used their earnings to invest and improve the quality of care through the purchase of essential equipment and drugs. The RBF program created conditions for facility staff to take the initiative in improving the quality of services. Efforts by staff were apparent and characterized by a conscious alignment to the program focus. This was clearly evidenced by the almost universal investments in availing a place for mothers to wait for delivery at the clinic. Similarly, while the MOHCC has set a standard staff establishment for clinics, some DHEs and facilities are innovatively adjusting staffing to suit workload. While the RBF program incentivized only specific services, some of the non-incentivized services also benefited to a limited extent through general facility improvements, but less so than the incentives services as more often they had to be referred for appropriate continuous care to higher level facilities. This potential collateral benefit should be viewed as an opportunity for the RBF program to serve communities better. That
said, the risk of crowding out non-incentivized services remains and needs to be constantly monitored.

102. The PME II study consistently found that many RBF program design and implementation factors played a significant role in influencing the performance of health facilities and the motivation and satisfaction of staff at these facilities, both good performance and poor performance. Staff shortages and high workloads were commonly reported in most health facilities. The nurses experience heavy workloads as they now divide their attention between supervisory, administrative and technical duties. The RBF-linked extra tasks in reporting, local procurement and organizing logistics further aggravated the shortage and workload situation leading to too few staff being available to do core clinical tasks at the clinics. This situation deserves attention; the program and the sector in general needs to fully understand the nature of tasks and workload and question whether it is the best way for the health workers to spend their time or the only solution to completing other essential but non-clinical tasks. On busy days, tasks such as temperature taking, growth monitoring and dispensing of drugs are given to the nurse aide, General Hand or VHW. Although there is an acknowledgement by the health workers and the DHE of a lack of alternative to this, there is need for a deeper reflection from a policy perspective, in view of the potential risks in safety and overall quality. Furthermore, whenever the DHE is not fully constituted, certain staff (e.g. EHT, nurses) are not adequately mentored and this affects their performance. For various reasons (e.g. competing care provision related priorities at district level, linked remuneration), the DMOs are often not actively participating in DHE supervisory visits; this presents a major constraint to performance and requires RBF program level attention.

103. PME II consistently found that contextual factors played a significant role in the performance of health facilities, both good performance and poor performance. We also realized that this disproportionate role played by the local context was insufficiently factored in the process of assessment of facility performance. Given the stage the RBF program is currently in, this is not unexpected. Looking forward, there is a need and room to better factor in local contextual factors when deciding on processes for performance assessment. Developing a more participatory, consultative and flexible facility performance assessment framework would improve the RBF program.

104. Performance in most facilities, particularly the low performing facilities, was also greatly affected by the HCCs, which were often not properly functioning. The committees were not properly constituted, not representative, had political interference and lacked capacity on many fronts. This affected community participation, especially for the communities that were far and often not represented in the committees. There were also limited feedback options for both the near and far communities as some of the communities lacked trust in the HCC and facilities
did not create or initiate opportunities to enhance the available beneficiary feedback mechanisms.

105. While community participation in the RBF program was generally found to still token at best, a beginning has definitely been made; this is thus both a gap and an opportunity for the RBF program. As a result of the RBF program, hitherto defunct HCCs have been revived; this is one area on which the RBF program needs to put greater emphasis. Efforts need to be made to gain insight into citizens’ understanding and ideas of the purpose, fairness and benefits of the RBF program. There were inconsistencies in what we heard on the role the communities play and the ways and means for them to participate and exercise ownership; HCC members, staff, DHE, community members all understood their roles differently. The RBF program can contribute to defining the roles, lines of accountability, and processes for triggering inclusiveness, representation, and genuine community participation. Doing so would help better achieve the RBF program objective of equitable access to care. The RBF program should examine the stresses in the relationships between different actors and identify opportunities to improve community participation from beyond the current mere consultation-based participation to a more developmental orientation directed at achieving genuine partnership and citizen control over local services.

4.2 Recommendations

106. Continuously examine roles and skills capacity building on RBF issues for both the health facility staff and the HCC to capacitate them in RBF administration and financial management. The HCC should be given comprehensive training using the HCC training guidelines produced by the MOHCC and the CWGH. Nurses’ review meetings should guide nurses financially and administratively every quarter. Meanwhile the accountant and administrator should spend more time to mentor staff on these tasks to improve performance.

107. Financially and technically strengthen and capacitate the DSC in order for them to effectively support HCCs, which continue to be affected by political interference and other conflict among HCC members or between HCCs and community leaders. These issues affect clinic operations. There is also need for close collaboration between the DHE and DSC and to strictly utilize the feedback mechanism proposed in the PIM to resolve conflicts between the two parties.

108. PHEs should ensure that DHE teams are fully constituted when supervising health facilities so they are able to adequately monitor all clinic sections and functions. Processes should be established to ensure that supervisory visits by DHEs achieve their supportive potential.

109. Integrate key non-incentivized services into the quality supervision checklist; the current supervision checklist emphasizes incentivized indicators.
110. **Revise the RBF facility performance assessment framework** to be more participatory, consultative and flexible. Such a framework should have room to better account for local contextual factors when making performance judgments.

111. To avoid a spiral of negativity, the government should **systematically support poor performing facilities with capital investments** so that clinics can focus on items that directly support improved clinical care, QoC and performance. This could be done through the development of a redistribution based, equity and need oriented resource allocation process, among other things.

112. **Develop a clear strategy to improve community participation** from beyond the current mere consultation-based participation, to a more developmental orientation directed at achieving genuine partnership and shared control over local services.

113. To address staff shortages and avoid handing over tasks to unqualified staff it is important for the GoZ to **further investigate current workloads** to better understand the actual versus perceived problem and to ensure that all facilities have adequate skilled staff.
Annex 1: RBF Project Design Summary
The health sector in Zimbabwe is supported in part by the multi-donor Health Results Innovations Trust Fund (HRITF) created by the World Bank in 2007 through funding from the Governments of Norway and the United Kingdom to support RBF approaches in the health sector for achievement of the health-related Millennium Development Goals (MDGs) — particularly MDGs 1c, 4 and 5. The original Health Sector Development Support (HSDS) Project grant of US$15 million from the HRITF to the Republic of Zimbabwe was approved by the World Bank Board on March 3, 2011 and signed on September 27, 2011. Based on the successful implementation of the original grant, additional financing of US$ 20 million was approved in July 2013 alongside the MOFED’s formal commitment of US$ 1 million per year domestic co-financing. Furthermore, the positive indications of progress from the implementation also led to the nationwide scale-up of the approach to cover 42 rural districts through financing from the Health Transition Fund. Under the World Bank supported districts, Cordaid serves as the Project Implementing Entity (PIE) for the HSDS Project and plays two key RBF functions in the Zimbabwe set-up: (i) purchaser of services which contracts private-not for profit, local government owned and central government owned health providers, DHEs and PHEs for defined health outputs and services; and (ii) fund holding agency. The PIE for the HTF supported districts is Crown Agents and UNICEF plays the role of the fund holder.

**HSDS Project Development Objective:** To increase coverage of key maternal and child health interventions (MCH) in targeted rural and urban districts.

**Coverage:** 3.8 million out of approximately 13 million people. The national scale-up has increased coverage of RBF in Zimbabwe to 10.4 million.

**Project Design Context:** (i) introduction of formal and informal user-fees by health providers in response to decline of public sector financing—resulting in sharply deteriorated health indicators; (ii) high incidence of poverty in both rural and urban areas; (iii) weakened public sector capacity; (iv) decline in several indicators and rankings such as the Corruption Perception Index; and (v) a complex policy environment.

**Approach:** The Zimbabwe HSDS Project aims to remove financial barriers to health care access on the demand side and to strengthen service delivery with a focus on supply side results in rural and urban pilot districts. The project supports implementation of the Government’s Results-Based Management Strategy and disburses based on quality and quality achieved by health providers. The project supports contracting of health facilities at primary and secondary levels of care for the delivery of a specified package of essential MCH services. Facilities are paid on a fee-for-service basis based on quantity and quality achieved in a given period. An internal verification process jointly undertaken by Cordaid audits self-reported quantity data by health providers. Quarterly quality audits by the District Health Executive (DHE) and Provincial Health Executives
(PHEs) verify the quality of services provided based on a standard protocol. Community Based Organizations (CBOs) undertake client tracer and satisfaction surveys using a pre-defined instrument. Client feedback and assessment of services received constitutes 20% of the overall quality score received by a health provider in a given quarter. An external verification undertaken by the University Of Zimbabwe Department Of Community Medicine independently audits the reported data. At the district level, hospitals receive performance-based contracts to improve the quality of emergency obstetric care and district health management teams are contracted to strengthen quality of supervision. Remote facilities receive higher payments for the delivery of the package of services. Main project components include: (i) performance based contracts with health facilities in urban and rural areas; (ii) management and capacity building in RBF; (iii) monitoring and documentation; and (iv) vouchers for maternal and neonatal services in low-income urban communities.

The execution of key RBF processes in Zimbabwe is guided by a Project Implementation Manual (PIM), which was developed by Cordaid, and the MOHCC and was adopted and adapted for the national scale-up. Key institutional stakeholders supporting implementation of RBF under the World Bank supported districts are reflected in Figure 1 below. The PIM stipulates that the District Steering Committee (DSC) has overall responsibility for the RBF project at the district level, overseeing project functions and facilitating buy in and inclusion of RBF activities in district health facility plans. The DSC is a multi-stakeholder committee made up of select members of the Social Services Committee, Community Health Council, Health Center Committee (HCC), DHE, an NGO working on relevant public health issues, a representative of church hospitals, a representative from Ministry of Local Government, and other members as decided jointly by DHE and the PIE.

**Figure 1: RBF Project Implementation Arrangements**
In its supervisory role, the DHE monitors the performance of the health facilities (HFs), which are responsible for direct health care service delivery to communities. The DHE provides feedback and supportive supervision to HFs to enhance their skills and improve their performance. The HCC (i) assists the HFs to manage and mobilize locally available resources from communities within an HF’s catchment area; and (iii) helps ensure the community has a platform to voice their input and perspectives on the project. CBOs are tasked with conducting quality and patient satisfaction surveys; they also conduct community verification once per month upon receipt of sampled patients from Cordaid’s field officer.

The RBF Project was rolled out in July 2011 in two districts and was scaled-up to 18 districts in March 2012. The Bank approved additional financing in July 2013, and the project is currently being scaled-up to two urban pilot districts in Harare and Bulawayo in addition to the 42 rural districts that are being supported by the HTF.

Monitoring and evaluation of project activities includes tracking the performance of incentivized quantity indicators, quality of care indicators and expenditure/payment data. While data analysis has provided useful insight into the performance of the project to date, implementing partners recognize the need to go beyond the numbers and explore the underlying processes and qualitative factors that are either enhancing or constraining execution of key RBF functions.
Annex 2: Province and District Sampling Notes

**Strata One**
Matabeleland North - 81.7%
Matabeleland South - 70.8%

*Select Matabeleland North, Exclude Binga, Implies Nkayi District*

**Strata Two**
Midlands - 67.0%
Masvingo - 63.7%
Mashonaland West - 72.4%

*Select Masvingo, Implies Chiredzi*

**Strata Three**
Mashonaland Central - 75.4%
Mashonaland East - 67.0%
Manicaland - 70.6%

*Select Mashonaland East Exclude Marondera Implies Selecting Mutoko District*

***Purposive Sampling to choose previously participating district - Kariba District***