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Report No: ICR00005586

INTERIM IMPLEMENTATION COMPLETION AND RESULTS REPORT

TF-10748; TF-15111; TF-A1598; TF-A5311; and TF-A9037

ON A SERIES OF

GRANTS

IN THE AMOUNT OF US$53 MILLION

TO THE

REPUBLIC OF ZIMBABWE

FOR THE

HEALTH SECTOR DEVELOPMENT SUPPORT PROJECT

September 29, 2021

Health, Nutrition & Population Global Practice
Africa East Region

CURRENCY EQUIVALENTS

Exchange Rate Effective September 18, 2021)

Currency Unit =	Zimbabwean Dollar (ZWL)
86.30 =	US$1

FISCAL YEAR
July 1 - June 30

Regional Vice President:	Hafez M. H. Ghanem
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ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
ANC	Antenatal Care
ARV	Antiretroviral
BCG	Bacille Calmette Guerin
BP	Bank Procedure
CBO	Community Based Organization
CHW	Community Health Worker
COVID	Coronavirus Disease
CQI	Continuous Quality Improvement
CRI	Core Results Indicator
DH	District Hospital
DHE	District Health Executive
DHIS2	District Health Information Software version 2
DHS	Demographic and Health Survey
DO	Development Objective
ESMF	Environmental and Social Management Framework
FCS	Fragile and conflict-affected situation
FY	Fiscal Year
GDP	Gross Domestic Product
GFF	Global Financing Facility
GOZ	Government of Zimbabwe
GRM	Grievance Redress Mechanism
HCC	Health Center Committee
HDF	Health Development Fund
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HNP	Health Nutrition Population
HRITF	The Health Results Innovation Trust Fund
HSDSP	Health Sector Development Support Project
IBRD	International Bank for Reconstruction and Development
ICR	Implementation Completion and Results Report
IDA	International Development Association
IFR	Interim Unaudited Financial Report
IMR	Infant Mortality Rate
IPC	Infection Prevention and Control
IPF	Investment Project Financing
IR	Intermediate Results

IRI	Intermediate Results Indicator
ISN	Interim Strategy Note
ISR	Implementation Status and Results Report
MDC	Movement for Democratic Change
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MOFED	Ministry of Finance and Economic Development
MOHCC	Ministry of Health and Child Care
MOHCW	Ministry of Health and Child Welfare
MR1	Measles and Rubella
MTCT	Mother-To-Child-Transmission
NDS1	National Development Strategy
NGO	Non-Governmental Organization
NPV	Net Present Value
OP	Operational Policy
OPV	Oral Polio Vaccine
ORT	Oral Rehydration Therapy
PCN	Project Concept Note
PCU	Project Coordination Unit
PDO	Project Development Objective
PF	Patriotic Front
PHC	Primary Health Care
PHE	Provincial Health Executive
PIE	Project Implementation Entity
PPE	Personal Protective Equipment
RBF	Results Based Financing
RF	Results Framework
RHC	Rural Health Center
RMNCAH	Reproductive Maternal Neonatal Child and Adolescent Health
SBA	Skilled Birth Attendant
SDR	Special Drawing Right
TF	Trust Fund
U5MR	Under-5 Mortality Rate
US	United States
ZANU	The Zimbabwe African National Union
ZCERP	Zimbabwe COVID-19 Emergency Response Project

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DATA SHEET

BASIC INFORMATION

Product Information

Project ID	Project Name
P125229	Health Sector Development Support Project
Country	**Financing Instrument**
Zimbabwe	Investment Project Financing
Original EA Category	**Revised EA Category**
Partial Assessment (B)	Partial Assessment (B)

Organizations

Borrower	Implementing Agency
Republic of Zimbabwe	Stichting Cordaid

Project Development Objective (PDO)

Original PDO

The Project Development Objective (PDO) is to increase coverage of key maternal and child health interventions in targeted ruraldistricts consistent with the Recipient's ongoing health initiatives.

Revised PDO

The Project Development Objective is to increase coverage and quality of an integrated package of Reproductive, Maternal, Neonatal,Child, Adolescent health and nutrition (RMNCAH-N) services, as well as strengthen COVID-19 response and institutional capacity to manage performance-based contracts consistent with the Recipients' ongoing health initiatives.

FINANCING

	Original Amount (US$)	Revised Amount (US$)	Actual Disbursed (US$)
World Bank Financing			
TF-10748	15,000,000	15,000,000	15,000,000
TF-15111	20,000,000	20,000,000	20,000,000
TF-A1598	10,000,000	10,000,000	10,000,000
TF-A5311	5,000,000	5,000,000	5,000,000
TF-A9037	3,000,000	3,000,000	3,000,000
TF-B3156	25,000,000	25,000,000	3,670,793
Total	**78,000,000**	**78,000,000**	**56,670,793**
Non-World Bank Financing			
Borrower/Recipient	11,000,000	0	0
Total	**11,000,000**	**0**	**0**
Total Project Cost	**89,000,000**	**78,000,000**	**56,670,793**

KEY DATES

Approval	Effectiveness	MTR Review	Original Closing	Actual Closing
29-Sep-2011	08-Dec-2011	22-Feb-2013	30-Apr-2023	30-Apr-2023

RESTRUCTURING AND/OR ADDITIONAL FINANCING

Date(s)	Amount Disbursed (US$M)	Key Revisions
01-Sep-2015	33.51	Change in Loan Closing Date(s) Reallocation between Disbursement Categories
21-Feb-2017	43.89	Change in Loan Closing Date(s)
27-Jun-2018	50.00	Change in Loan Closing Date(s)
20-Dec-2018	50.00	Change in Loan Closing Date(s) Reallocation between Disbursement Categories
06-Dec-2019	51.38	Change in Loan Closing Date(s) Reallocation between Disbursement Categories
25-Jun-2020	53.00	Change in Loan Closing Date(s)

KEY RATINGS

Outcome	Bank Performance	M&E Quality
Satisfactory	Satisfactory	Substantial

RATINGS OF PROJECT PERFORMANCE IN ISRs

No.	Date ISR Archived	DO Rating	IP Rating	Actual Disbursements (US$M)
01	28-Mar-2012	Satisfactory	Satisfactory	4.30
02	27-Aug-2012	Satisfactory	Satisfactory	7.10
03	30-Jan-2013	Satisfactory	Satisfactory	10.76
04	20-Aug-2013	Satisfactory	Satisfactory	15.50
05	07-Apr-2014	Satisfactory	Moderately Satisfactory	26.04
06	09-Nov-2014	Satisfactory	Satisfactory	30.42
07	14-May-2015	Satisfactory	Satisfactory	33.12
08	09-Dec-2015	Satisfactory	Satisfactory	35.40
09	23-Jun-2016	Satisfactory	Moderately Satisfactory	40.16
10	29-Dec-2016	Satisfactory	Satisfactory	44.39
11	30-Jun-2017	Satisfactory	Satisfactory	45.43

12	17-Jan-2018	Satisfactory	Satisfactory	48.43
13	19-Jul-2018	Satisfactory	Satisfactory	50.50
14	22-Dec-2018	Satisfactory	Satisfactory	50.50
15	23-Jun-2019	Satisfactory	Moderately Satisfactory	51.25
16	19-Feb-2020	Satisfactory	Moderately Satisfactory	52.77
17	18-Sep-2020	Moderately Satisfactory	Moderately Satisfactory	53.50
18	28-Mar-2021	Moderately Satisfactory	Moderately Satisfactory	57.17

SECTORS AND THEMES

Sectors

Major Sector/Sector	(%)
Health	**100**
Public Administration - Health	30
Health	70

Themes

Major Theme/ Theme (Level 2)/ Theme (Level 3)	(%)
Social Development and Protection	**20**
Social Inclusion	20
Participation and Civic Engagement	20
Human Development and Gender	**80**
Health Systems and Policies	80
Health System Strengthening	40
Reproductive and Maternal Health	40

ADM STAFF

Role	At Approval	At ICR
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I. PROJECT CONTEXT AND DEVELOPMENT OBJECTIVES

A. CONTEXT AT APPRAISAL

Context

1. This is an interim implementation completion and results report (ICR) of the Zimbabwe Health Sector Development Support Project (HSDSP). A final ICR will be produced after the closing of the project, which is currently planned for 30 April 2023. An interim ICR is required for a project that has been under implementation for a prolonged time such as this project. This project was approved by the Board on 29 September 2011 and became effective on 08 December 2011. The project has been under implementation for almost 10 years and therefore an interim ICR is triggered. The period of focus of this interim ICR is up to December 31, 2020 (which is the period of project implementation up to the fourth additional financing (AF) of the project). Implementation from the fifth AF of the project will be assessed in the final ICR because this funding became effective only on December 04, 2020. Zimbabwe was in arrears during the preparation of the project and remains in arrears to the present date. Trust Funds (TFs) have therefore been used to fund the project from the beginning of the project as this was the most feasible mechanism for funding the project given Zimbabwe's circumstances. The project introduced an innovative and relevant approach to respond to Zimbabwe's HNP challenges in the area of Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) service delivery among both the rural and urban poor, and more recently, supporting the country's health system to cope with the ongoing COVID-19 pandemic. The project was funded by TFs from the Health Results Innovation Trust Fund (HRITF) and the Global Financing Facility (GFF). The decision in the design of the project to use a project implementation entity (PIE), which ended up being Catholic Organization for Relief and Development Aid (Cordaid), was also influenced by this unique Zimbabwe context. Cordaid is an international non-governmental organization (NGO) with extensive experience in implementing results-based financing (RBF) programs and was selected on a competitive basis to serve as the PIE.

2. The socioeconomic crisis of 2000-2008 in Zimbabwe led to declines in major sectors of the economy and the deterioration of basic social services including health and education.[1] GDP declined by more than 35 percent and 500 billion percent hyperinflation was recorded in September 2008, after which a multicurrency regime was introduced. At the time of project preparation, more than half of the population was living below the food poverty line, the unemployment rate was 65 percent, and social safety net programs were significantly under-funded.

Sectoral and Institutional context

3. In the mid-1990s, Zimbabwe's health system was one of the best in Africa. There was adequate infrastructure and a functional system up to the village level. Both preventive and curative components of the health system were functioning and decentralized, and about 85 percent of Zimbabweans lived within 10 km of a health facility. However, the prolonged years of crisis severely affected the health sector. Public spending on health declined

[1] World Bank, 2011

from US$8.91 million in 2002 to US$1.85 million in 2006. There were challenges in training, financing, monitoring, and retention of health workers, many of whom left the country. Vacancy rates in 2009 were 52 percent for medical doctors, 57 percent for pharmacists, and 22 percent for senior management positions. Patients had to pay user fees for health services, making health care unaffordable for poor people. The National Health Accounts of 2007 showed that 36 percent of the population could not afford to pay user fees for hospital services.

4. Health indicators also deteriorated in response to the Zimbabwe's worsening economic situation. Life expectancy at birth declined from 58 years in 1990 to 43 years in 2008, with HIV/AIDS contributing to the decline. For the 2010 Human Development Index (HDI), Zimbabwe ranked 169th and was one of only three countries whose HDI was lower in 2010 than in 1970.

Table 1. Key Health Indicators and Coverage of Services in Zimbabwe during appraisal

a. Key health indicators (1990 and 2009)			
Indicator	**1990**	**2009**	**MDG target 2015**
Maternal mortality ratio (MMR) - per 100,000 live births	390	790	174
Infant mortality rate (IMR) – per 1,000 live births	51	60	22
Under-5 mortality rate (U-5MR) – per 1,000 live births	79	86	27
b. Coverage of maternal and child health interventions (1999 and 2009)			
Indicator	**1999**	**2009**	
Births attended by a skilled birth attendant - percentage	73	60	----------
Indicator	**2006**	**2009**	
Proportion of fully immunized children – percentage	53	49	----------
Coverage of antenatal care visits – percentage	94	93	----------

Sources: Demographic Health Surveys, World Development Indicators

5. The Government of Zimbabwe (GoZ)'s prioritization of support to the health sector was reflected in the Short-Term Emergency Recovery Plan, Government Work Programs, and the Medium-Term Plan of 2010-2015. Recovery of the primary care system was emphasized in key stabilization and recovery plans after 2009. Areas of focus included increasing health sector financing, improving productivity and retention of health workers, strengthening the supply chain for pharmaceuticals, and improving basic health facility equipment and infrastructure. The GoZ was highly committed to the project during its preparation and to reducing the MMR, reflected in the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA). As Zimbabwe was in arrears during project preparation, approval by the Executive Directors was obtained on a no-objection basis for TF grants, as proactive support to Zimbabwe during this challenging period.

Rationale for World Bank's Involvement

6. At the time of project preparation, the World Bank's Zimbabwe strategy was in transition from the second Interim Strategy Note (ISN2) (FY 08-09) to ISN3 (FY11-12). Enhancing country knowledge and improving policy dialogue with the GoZ and other stakeholders was one of the objectives of ISN2. The project was also aligned with the World Bank's 2007 Health, Nutrition and Population (HNP) Strategy, which was in effect at project preparation. The strategy, in its strategic objectives (1 and 2), had a focus on improving the level and distribution of key HNP outcomes, particularly for the poor and vulnerable and prevention of poverty due to illness. This project built on policy dialogue with the then Ministry of Health and Child Welfare (MOHCW), as well as analytical work in the health sector since February 2009. The project also focused on high impact interventions as identified by MOHCW in its Health Sector Investment Case 2010-2012 and was aligned with objectives of the GoZ's National Health Strategic Plan (2009-2013), Results Based Management Policy, and Work Program for the Social Cluster of Ministries.

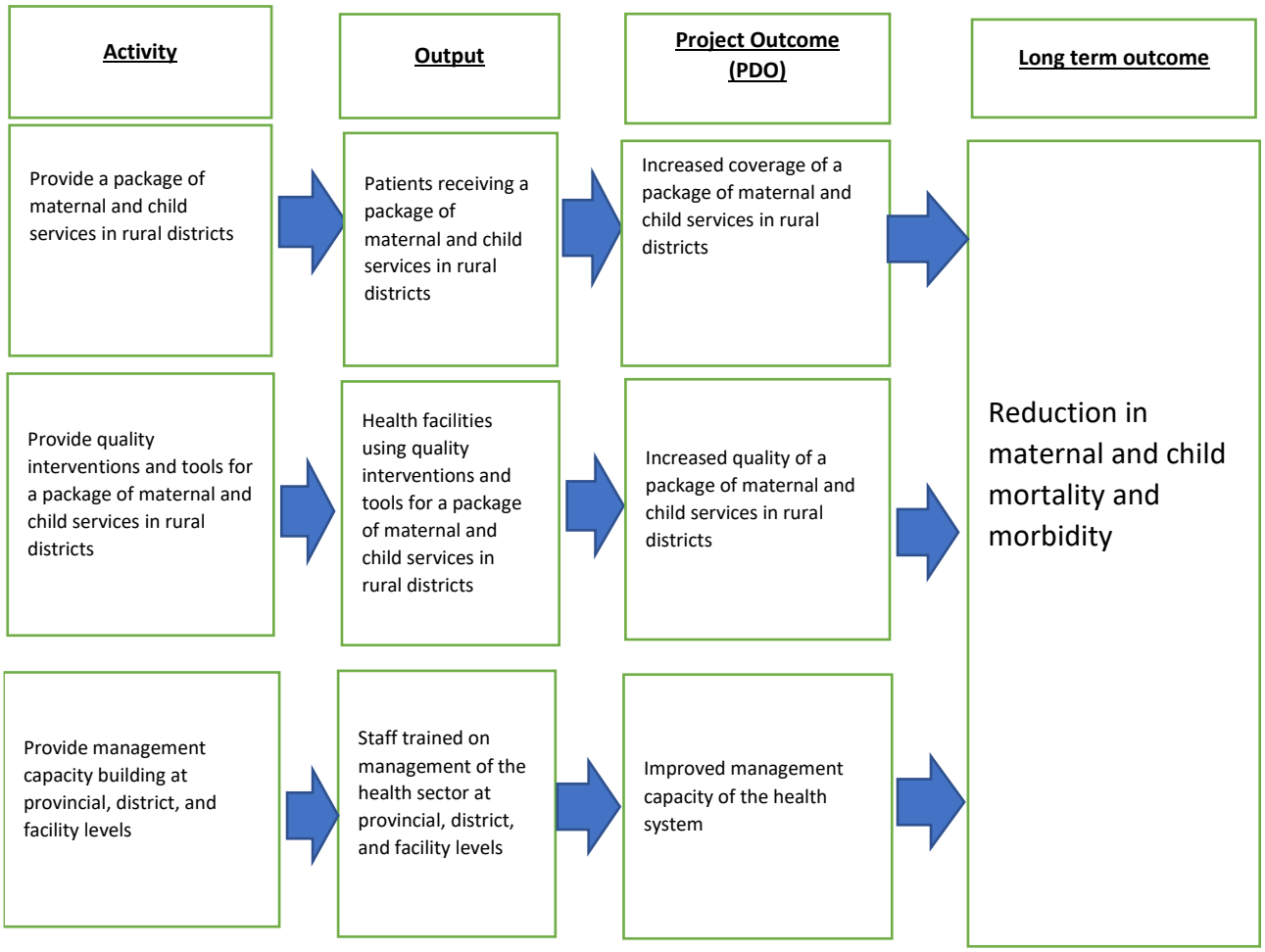
Development Partners' Engagement

7. Development partners were engaged in dialogue regarding the design of the project during project preparation and possible collaboration during the implementation of the project. Key partners in maternal and child health were engaged and these included, among others, DFID, European Commission, USAID, the Global Fund, UNICEF and UNFPA. The project planned to continue to strengthen the dialogue with development partners during the implementation of the project. In particular, the project was explicit that it did not seek to replace ongoing interventions of partners, but instead to build on what already existed in order to strengthen achievement of maternal and child health outcomes. International and Local NGOs were to collaborate closely with the PIE on various technical and implementation aspects of the project.

Theory of Change (Results Chain)

8. At project appraisal, the project did not explicitly outline its theory of change as this was not a World Bank requirement at that time. A theory of change inferred from the project description is shown in Figure 1 below. While the Project's Development Objective at appraisal only mentioned increase in coverage of key maternal and child services, the project's description clearly indicated that the project would additionally increase quality of these services and management capacity for provision of these services. The theory of change below is therefore nuanced to reflect this expanded objective of the project at appraisal, which included increase in coverage of services, increase in quality of services and capacity building of the project. Its key assumptions were that (a) the GoZ would continue to be committed to the RBF model of implementing the project beyond the lifetime of the project and (b) staff in the health sector would embrace the RBF model for service delivery.

Figure 1. Theory of change at appraisal



Project Development Objectives (PDOs)

9. The project development objective at appraisal was to increase coverage of key maternal and child health interventions in targeted rural districts consistent with the Recipient's ongoing heath initiatives.

Key Expected Outcomes and Outcome Indicators

10. Key expected outcomes and outcome indicators during appraisal are indicated in table 2 below

Table 1. Outcome and Outcome Indicators at Appraisal

Outcome	Key PDO Indicators
Increase coverage of key maternal and child interventions in targeted rural districts	PDO1: Pregnant women receiving antenatal care during a visit to a health provider in participating rural districts
	PDO 2: Percentage of births attended by skilled health personnel in a health institution in participating rural districts
	PDO 3: Pregnant women with HIV who received antiretrovirals to reduce the risk of mother-to-child transmission (MTCT)
	PDO 4: Percentage of women 15-49 years receiving during their first and repeat visits one of the modern family planning methods in participating rural districts
	PDO 5: Children immunized (Number)

Components

11. The project had the following three major components during project appraisal:

Component 1: Results-based contracts with Provincial Health Executives, District Health Executives, District Hospitals, and Rural Health Centers for the delivery of a package of key maternal and child health services. (US$33.20 million)

12. This component utilized performance-based service delivery contracts with service providers which stipulated the services to be provided (largely maternal and child health) and the level of payments for their delivery. An international NGO (Cordaid) was competitively selected to serve as PIE and was responsible for contracting service providers including rural health centers (RHC) led by Health Center Committees (HCC), district hospitals (DH), District Health Executives (DHE) and Provincial Health Executives (PHE). Performance-based payments took into consideration the quantity as well as the quality of services delivered as well as the remoteness of the health facility. Assessment of service quality included a community verification component wherein Community Based Organizations (CBOs) applied a standardized tool to verify service provision and obtain feedback from recipients. HCCs and DHs made decisions regarding their respective business plans and how funds received under the contracts were used to further improve service delivery.

Component 2: Management and Capacity Building in Results-Based Financing (US$17.40 million)

13. This component was designed to strengthen effective implementation and management of the RBF initiative. It supported training, strengthening of data quality, and reporting and financial management. An RBF training module developed to train health sector staff was implemented by the PIE, with the rollout overseen by the MOHCW. On-the-job capacity development support was to be provided to complement workshop trainings and benchmark tools were to be used to compare results and share learnings between various districts and facilities. The component was also to finance verification and counter verification of whether the facilities had provided the services they reported together with consistency and adequacy of

the verification mechanism. This process was more extensive than the community level CBO verification mentioned in component 1. Supply of some medical equipment to select facilities was also provided for under this component.

Component 3: Monitoring and Documentation (US$2.40 million)

14. Under this component, support was to be provided for monitoring, evaluation, and documentation of the project. The aggregation of results and the analysis of the data to monitor trends in coverage of services in project districts was to be supported. Learning was to be supported through a rigorous impact evaluation combined with process and qualitative reviews to capture the effect of the program on health outcomes and various aspects of the health system. The component was also to assess equity through household surveys and exit interviews during health facility assessments using an asset index.

B. SIGNIFICANT CHANGES DURING IMPLEMENTATION (IF APPLICABLE)

Revised PDOs and Outcome Targets

15. The PDO was revised three times during the life of the project. The first revision of the PDO was during the processing of the first AF for the project (approved July 2013) to include urban districts, and the PDO became 'To increase coverage of key maternal and child health interventions in targeted rural and urban districts consistent with the Recipient's ongoing health initiatives.' The second revision of the PDO was during the processing of the fourth AF for the project (approved January 2019) when the PDO was revised as 'To increase coverage and quality of key MCH services in targeted rural and urban districts and strengthen institutional capacity for results-based financing contract management, consistent with the Recipients' ongoing health initiatives.' This second revision introduced quality and institutional capacity for contract management into the PDO. The third revision of the PDO was during the processing of the fifth AF for the project (approved in September 2020). That revision led to the **current PDO** of the project which is 'to increase coverage and quality of an integrated package of Reproductive, Maternal, Neonatal, Child, Adolescent health and nutrition (RMNCAH-N) services, as well as strengthen COVID-19 response and institutional capacity to manage performance-based contracts consistent with the Recipient's ongoing health initiatives.' That revision introduced COVID-19 response into the PDO and expanded services from MCH services to wider reproductive, maternal, neonatal, child, adolescent health and nutrition (RMNCAH-N) services.

Revised PDO Indicators

16. Table 3 below shows the revised PDO indicators. It includes PDO indicators and targets during appraisal (original PDO indicators) and during AF V (current). Annex 1 of this document has a more detailed summary of the indicators and targets.

Table 2. PDO Indicators at appraisal and as of AF V (Current)

PDO Indicators during appraisal	Current PDO indicators – AF V
PDO1: Pregnant women receiving antenatal care during a visit to a health provider in participating rural districts. Baseline: 0; Target: Not specified (TBC recorded)	PDO1. Percentage of pregnant women receiving first antenatal care (ANC) before 12 weeks of gestation during a visit to a health provider in participating districts. Baseline: 10%; Target: 32%
PDO 2: Percentage of births attended by skilled health personnel in a health institution in participating rural districts. Baseline: 58%: Target: 64%	PDO2: Percentage of participating hospitals that have registered an increase in quality scores since last quarter. Baseline 25%: Target:50%
PDO 3: Pregnant women with HIV who received antiretrovirals to reduce the risk of MTCT. Baseline: 0; Target: Not specified (tbc recorded)	PDO3: Percentage of children 6-59 months receiving Vitamin A supplementation in participating rural districts. Baseline: 40%; Target:50%
PDO 4: Percentage of women 15-49 years receiving during their first and repeat visits one of the modern family planning methods in participating rural districts. Baseline: 55.7%; Target: 62%	PDO4: Percentage of identified close contacts of confirmed COVID-19 cases followed up based on national Guidelines. Baseline: 0%; Target: 80%
PDO 5: Children immunized (Number) Baseline: 0; Target: Not specified (tbc recorded)	PDO5: Percentage of health facilities managed under RBF contracts by the MOHCC Program Coordination Unit in participating rural districts Baseline: 23%; Target: 80%

17. Annex 1 includes comments under each indicator on changes that were made from the parent project to AF V.

Revised Components

18. During the September 2020 processing of AF V, project components were revised. A new component (Component 4. COVID-19 Response) was introduced to support the GoZ in preventing the spread of COVID-19, by prioritizing infection prevention and control. All the previous three components were modified based on lessons learned during implementation. Some of those modifications included: (a) expanding the RBF package of services to cover prioritized RMNCAH-N and other related services; (b) reorienting RBF to be quality focused in provincial hospitals while including central hospitals and community-mobilization; (c) scaling up the urban voucher scheme to more health facilities; and (d) strengthening institutional capacity to implement selected health financing reforms that complement RBF.

Other Changes

19. Total project financing increased during implementation through a series of five AFs accompanied by restructuring, listed in Table 4 below. The rationale for the series of the AFs was to respond to the expanding scope of the project and to accommodate the additional TFs in line with the funding cycles. This report does not cover the fifth AF as it became effective only in December 2020. Table 4 below summarizes key changes in scope and innovations during project implementation. Key changes during the series of the AFs are as follows. During

AF I, in addition to the expansion of project districts, the maternal health voucher scheme (demand side of the RBF) in selected urban areas was introduced to the project. During AF II, quality improvement innovation was introduced to the project. In the implementation of AF III, rollout of process evaluation on cost-effective approaches to verification of results was implemented. During AF IV, support to MOHCC in institutionalization of RBF was provided. Finally, during AF V, quality focused RBF in select central and provincial hospitals, a community level RBF pilot, and a last-mile commodity tracking system for COVID-19 supplies using MOHCC's Electronic Health Records System were introduced.

Table 3. Changes in Project Scope and Innovations with subsequent AFs

Zimbabwe HSDSP - Project Phases and Scope		
Financing	**Scope and Innovation***	**Population Coverage**
Original Financing (US$15 m)	RBF contracts in 2 rural districts then expanded to 16 more rural districts until July 31, 2014	3.6 million
AF I (US$20 million) approved July 2013	(i) Continue RBF contracts in 18 rural districts (ii) Introduce Urban RBF innovations* • Maternal health voucher scheme (demand-side)* • Results based contracts (supply side) Extended project until October 30, 2015	4.1 million
AF II (US$10 million) approved December 2015	(i) Continue RBF contracts in 18 rural districts (ii) Continue Urban RBF innovation • Maternal health voucher scheme (demand-side) • Results based contracts (supply-side) (iii) Introduce quality improvement innovation* Extended project until February 28, 2017 (and subsequently to January 30, 2018 through simple restructuring)	4.1 million
AF III (US$5 million) approved July 2017	(i) Continue RBF contracts in 18 rural districts (ii) Continue Urban RBF innovation • Maternal health voucher scheme (demand-side) • Results based contracts (supply-side) (iii) Roll out Quality Improvement Innovation in 5 districts* (iii) Roll out a process evaluation on cost-effective approaches to verification of results under RBF projects* Extended project until March 2019	4.1 million
AF IV (US$3 million) approved January 2019	(i) Continue results-based contracts in 18 rural districts (ii) Continue Urban RBF innovation - Maternal health voucher scheme (demand-side) - Results based contracts (supply-side) (iii) Continue with Quality Improvement Innovation in 5 districts (iv) Continue with implementing process evaluation on cost- effective approaches to verification of results under RBF projects (v) Support Ministry of Health and Child Care in institutionalizing and harmonization of the RBF program in Zimbabwe* Extended project until December 31, 2020	4.1 million

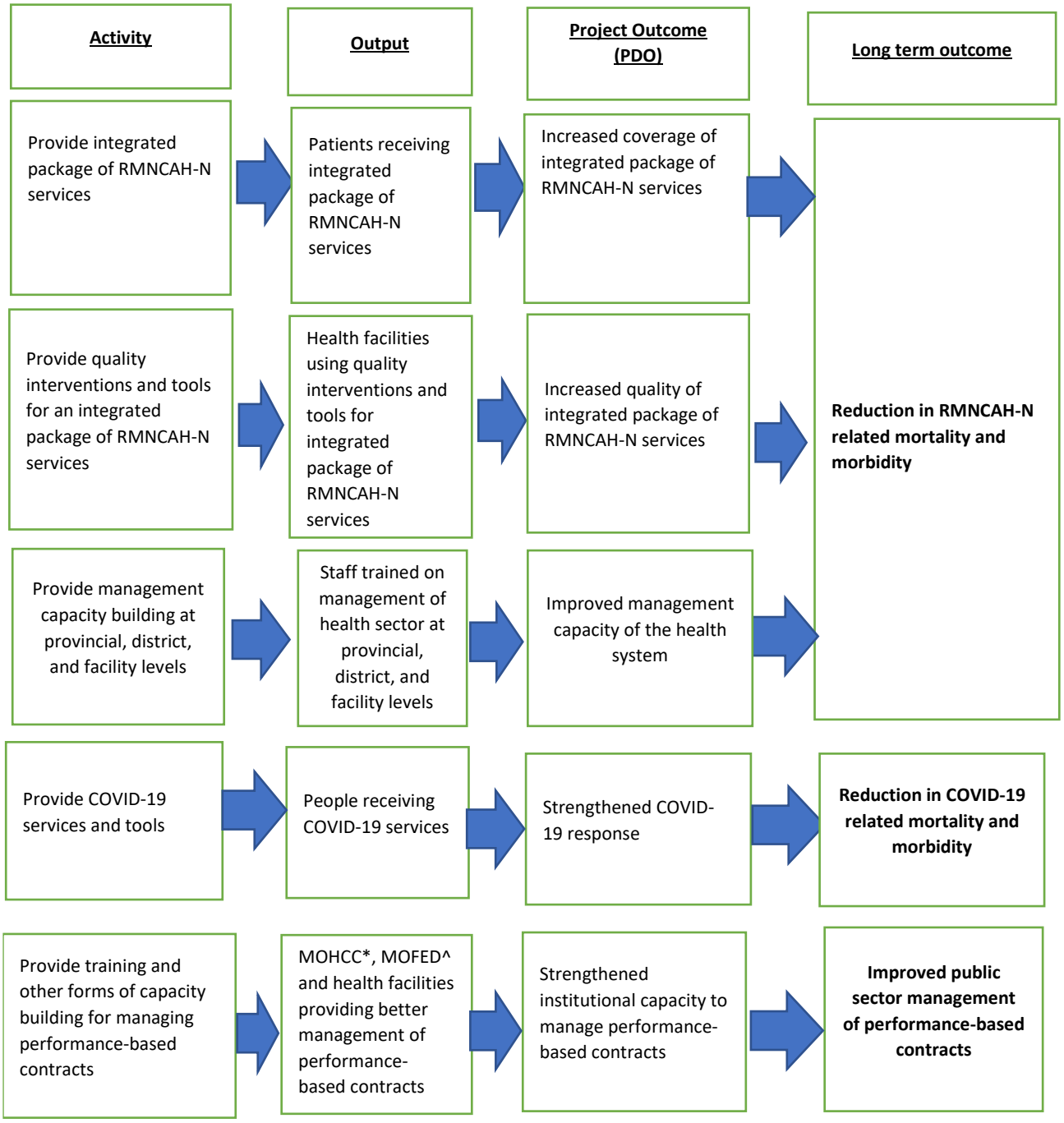
AF V (US$25 million) approved September 2020	(i) Continue with RBF in 18 rural districts in health centers and DHs. -pilot Community-based RBF and Quality based RBF in provincial and central hospitals* (ii) Continue Urban RBF innovation - Maternal health voucher scheme (demand-side) - Results based contracts (supply-side) (iii) Continue with Quality Improvement Innovation in 5 districts (iv) Last mile commodity tracking system for COVID-19 supplies using MOHCC Electronic Health Records System* (v) Blockchain feasibility assessment for RBF verification and commodity tracking (vi) Continue to support MOHCC in institutionalizing and harmonization of the RBF program in Zimbabwe* Extended project until April 2023	RMNCAH-N: 4.8 million COVID Response: 14.4 million

* Innovation

Rationale for Changes and Their Implication on the Original Theory of Change

20. The changes outlined above allowed for the project's geographical expansion from two pilot rural districts to 18 rural districts in addition to adding an urban element in Harare and Bulawayo (the country has a total of 60 rural districts). The technical scope of the project also expanded with the addition of support to management of RBF contracts and prevention of the spread of COVID-19. The project also evolved from focusing on maternal and child health to covering broader RMNCAH-N services, including those related to HIV/AIDS and non-communicable diseases. The revised theory of change is shown in Figure 2 below.

Figure 2: Theory of change based on current PDO



*MOHCC – Ministry of Health and Child Care

^MOFED – Ministry of Finance and Economic Development

II. OUTCOME

21. The following assessment of the three dimensions of the HSDSP's outcomes (Relevance, Efficacy, and Efficiency) will be limited to the period between project Approval in 2011 until December 2020, involving the funds up to AF IV, for the purposes of this interim ICR. Consequently, only parts A to C of the current version of the PDO (on coverage and quality of RMNCAH-N services, and performance-based contract management capacity) will be assessed. Part D was introduced as part of AF V in response to the current COVID-19 pandemic, which will be integrated into the complete outcome assessment to be conducted as part of the final project ICR.

22. Furthermore, this evaluation does not use a split rating methodology given the project's expanded scope[2] and increased targets. Split rating methodology is the rating of a World Bank project by segments of the implementation period.

A. RELEVANCE OF PDOs

Assessment of Relevance of PDOs and Rating

23. The relevance of the PDOs is rated **High**. The original and revised PDOs were highly relevant across all phases of implementation. The project was consistently in line with the World Bank Group's twin goals to reduce poverty and promote shared prosperity, and with the World Bank's Health, Nutrition, and Population Strategy (2007) as it supported the GoZ in promoting the equitable and efficient provision of public services, including strengthening health systems. The project, with its focus on improving RMNCAH-N outcomes, also continued to be consistent with World Bank Group priorities for the country outlined in the FY13-FY15 ISN (Report No. 74226-ZW), which includes human development within Priority 3 (Fostering an Enabling Environment for Reducing Vulnerabilities, Improving Resilience and Strengthening Human Development). Moreover, institutionalization of the RBF approach has helped foster an enabling environment for public sector management and service delivery (Priority 2).

    The project is well aligned with Zimbabwe's Transitional Stabilisation Programme (TSP) 2018-2020. In particular, it is aligned with part four of the TSP which targets human development including, in particular, investments aimed at achieving equitable coverage and enhanced quality of health service delivery. Quality of maternal health services is one of the priorities in the TSP. The project is also aligned with the National Health Strategy (NHS) 2016-2020. The NHS specifically targets reproductive, maternal, newborn, child health and adolescents as a priority area.

24. The project's original design and subsequent restructurings over its entire implementation period since approval in 2011 has also remained highly relevant in adapting to Zimbabwe's particular macroeconomic circumstances, compounded by its arrears, and resulting inability to access IDA resources to tackle challenges in the HNP sector. Consequently, in the absence of IDA financing, the project was able to utilize alternative resources from the HRITF to provide much-needed support to the HNP sector of a country in arrears. Furthermore, using the innovative RBF approach, the project's relevant design sought to respond to Zimbabwe's HNP challenges in the area of RMNCAH

[2] Increase in geographical coverage, package of services supported, and activities (inclusion of urban voucher program and continuous quality improvement initiative/CQI)

service delivery among both the rural and urban poor, and more recently, supporting the country's health system to cope with the ongoing COVID-19 pandemic. Following the success of this pioneering RBF approach in Zimbabwe, the GoZ decided to institutionalize RBF, with the MOHCC reiterating, during the MTR of the National Health Strategy (NHS) 2016-20, the GoZ's wish to "see a full-fledged national RBF program, owned and run by the MOHCC and funded by GoZ with support from partners" beyond 2020.[3]

B. ACHIEVEMENT OF PDOs (EFFICACY)

Assessment of Achievement of Each Objective/Outcome

25. For the interim ICR, the PDO of the project is being assessed against three of its four parts: (i) Part A: Increase coverage of an integrated package of RMNCAH-N services; (ii) Part B: increase quality of an integrated package of RMNCAH-N services; and (iii) Part C: Strengthen institutional capacity to manage performance-based contracts. The table in Annex 1A summarizes the combination of PDO-level and Intermediate Results indicators (IRIs) from the project results framework (RF) to support the achievement of each of the three parts of the PDO under assessment.

26. It should be noted that Part D of the PDO, i.e., strengthen COVID-19 response, was introduced as part of AF V in response to the current pandemic. It will not be assessed as part of this interim ICR and will instead be integrated into the complete outcome assessment to be conducted as part of the final project ICR. AF V extended the project's closing date until April 2023. Consequently, the project RF was significantly streamlined, with several PDO and intermediate results indicators (IRI) which had already achieved/surpassed their targets being dropped, other targets being appropriately revised, and new PDO indicators and IRIs being added with 2023 targets. Assessing the project's efficacy based on revised 2023 targets would not best reflect the ongoing project's efficacy to date. Therefore, this efficacy analysis considers the project's achievements as of the December 2020 RF and associated targets. Previously well-performing yet omitted PDO and IR indicators, as well as retained indicators, will be assessed with respect to their status as of December 2020, in relation to their associated targets.

27. **PDO Part A (increase coverage of an integrated package of RMNCAH-N services) is rated Substantial**. This rating is based on the fact that the majority of indicators linked to this part of the PDO are achieved (either partially or fully) or have surpassed their targets. This is remarkable considering that COVID-19 lockdowns and economic constraints deterred some patients from accessing services during the pandemic due to transportation bottlenecks. This PDO is measured by five PDO-level indicators (PDOs 1-5) and supported by the achievements of six IRIs (IRIs 1-6) as of the December 2020 RF, which collectively contribute towards improving coverage of key RMNCAH-N services and are thereby closely linked to the achievement of this part of the PDO. Four out of the five PDO indicators linked to this PDO (PDOs 1, 3, 4 and 5), and all six IRIs surpassed or achieved their targets. One PDO level indicator partially achieved its targets (PDO 2). These are discussed below.

a) *PDO 1 - Percentage of pregnant women who receive antenatal care during their visit to a health provider in participating rural districts.* This PDO indicator **surpassed** its AF IV target of 72%, achieving 80% as of December 2020 from a 2012 baseline of 70%. Given the 2-percentage point difference between the baseline and targets for

[3] Policy Brief on the evolution of Results-Based Financing in Zimbabwe, June 2021

this indicator when it was converted in AF IV from a numerical to percentage indicator, the target for this indicator was underestimated and it was dropped under AF V due to strong coverage.

b) *PDO 2 - Percentage of births attended by skilled health personnel in a health institution in participating rural districts.* This PDO indicator **partially achieved** its AF IV target of 88% from a 2012 baseline of 58%. It achieved 82% as of the latest available data collected during the 2019 Multiple Indicator Cluster Survey (MICS). This indicator also demonstrated strong progress when measured using the MOHCC's Health Management Information System (HMIS) collected more routinely. This indicator was dropped under AF V due to high coverage.

c) *PDO 3 - Percentage of women 15-49 years who currently use any of the modern family planning methods in participating rural districts.* This family planning indicator **achieved** its AF IV target of 70% as of December 2020 from a 2012 baseline of 56%.

d) *PDO 4 - Percentage of women who had their first ANC visit during the first sixteen weeks of pregnancy in participating rural districts.* This maternal health PHC indicator **achieved** its AF IV target of 22%, with 22% coverage as of December 2020 from a 2012 baseline of 10%.

e) *PDO 5 - Percentage of children under 5 with diarrhea receiving ORT and Zinc in participating districts.* This child health indicator **surpassed** its AF IV target of 16%, achieving 16.5% (MICS 2019), from a 2015 baseline of 13.8%.

f) *IRI 1 - Cumulative number of pregnant women living with HIV who are initiated on antiretrovirals to reduce the risk of MTCT in participating rural districts.* This maternal health and HIV related IRI **achieved** its AF IV target of 60,000, reaching 59,572 beneficiaries as of December 2020 from a 2012 baseline of 9,399.

g) *IRI 2 - Cumulative number of pregnant women receiving first antenatal care during a visit to a health provider in participating urban districts.* This maternal health indicator **surpassed** its AF IV target of 89,031, reaching 100,941 beneficiaries as of December 2020 from a 2014 baseline of 12,737.

h) *IRI 3 - Cumulative number of pregnant women receiving first antenatal care before 16 weeks of gestation period during a visit to a health provider in participating urban districts.* This maternal health indicator **surpassed** its AF IV target of 4,035 women receiving their first ANC before 16 weeks, reaching 4,989 beneficiaries as of December 2020 from a 2012 baseline of just 572.

i) *IRI 4 - Number of children immunized.* This intermediate level Corporate Results Indicator (CRI) measures utilization of a key child health-related primary health service and is defined as having completed full routine immunization with BCG, OPV 1 to 3, Penta 1 to 3, and Measles MR1. The indicator **surpassed** its AF IV target of 663,409, totaling 817,556 as of January 2021 from a 2012 baseline of 0 immunizations supported under the project.

j) *IRI 5 - Number of women and children who have received basic nutrition services.* This nutrition-related intermediate level CRI is defined as the cumulative number of children 6-59 months who were given Vitamin A supplementation in participating rural districts. The indicator **surpassed** its AF IV target of 1,544,493, reaching 2,244,678 beneficiaries as of January 2021 from a 2012 baseline of 0 supplementations provided under the project.

k) *IRI 6 - Number of deliveries attended by skilled health personnel.* This intermediate level CRI measures utilization of a key maternal health service in both rural and urban participating districts. The indicator (which is a composite of two IRIs which measure rural and urban deliveries respectively) **surpassed** its AF IV target of 762,573 deliveries, achieving 984,066 as of January 2021 from a 2012 baseline of zero. These findings are similar to findings of the impact evaluation of this project in 2014, which demonstrated that the RBF intervention package increased the rate of deliveries attended by a skilled provider by 15 percentage points and of institutional deliveries by 13 percentage points compared to control districts.

28. **PDO Part B (Increase quality of an integrated package of RMNCAH-N services) is rated High.** This PDO is measured by four PDO-level indicators (PDOs 6-9) and supported by the achievements of three IRIs (IRIs 7-9) as of the December 2020 RF, which all contribute towards improving the quality of key RMNCAH-N services and are closely linked to the achievement of this part of the PDO. Its rating is based on the fact that the PDO and IR indicators linked to this part of the PDO either surpassed (PDOs 6 and 9) or fully achieved (PDOs 7 and 8 and IRIs 8 and 9) their targets, and only one IRI 7 partially achieved its target. This is a notable achievement of the project considering that COVID-19 affected transportation of health care staff, some of whom were involved in the provision of quality services during the pandemic. The indicators for this section are discussed below.

a) *PDO 6 - Average quality scores by health facilities in participating rural and urban districts.* This key PDO indicator measures the overall quality of key RMNCAH-N services provided at the participating rural and urban facilities in the target districts of the HSDSP. It **surpassed** its AF IV target of 81%, achieving an average quality score of 83% as of December 2020, from a 2012 baseline of 68.1%.
b) *PDO 7 - Percentage of maternal deaths given audits as per protocol in participating districts.* This quality related maternal health PDO indicator **achieved** its AF IV target of 80%, achieving 76% as of December 2020, from a 2015 baseline of 0%.
c) *PDO 8 - Percentage of partographs correctly filled in participating districts.* This second quality related maternal health PDO indicator **achieved** its AF IV target of 65%, reaching 62% as of December 2020, from a 2015 baseline of 0%.
d) *PDO 9 - Percentage of children under 5 years with Pneumonia correctly managed in the participating districts.* This quality related child health PDO indicator **surpassed** its AF IV target of 87%, achieving 89.5% as of December 2020, from a 2015 baseline of 0%.
e) *IRI 7 - Percentage of health facilities implementing Continuous Quality Improvement (CQI) model in the participating rural districts.* This quality related IRI **partially achieved** its AF IV target of 23%, achieving 17% as of March 2021, from a 2015 baseline of 0%.
f) *IRI 8 - Percentage of RBF contracted facilities in Continuous Quality Improvement (CQI) districts with CQI Standard Operating Procedures.* This second quality related IRI **achieved** its AF IV target of 80%, reaching 76% as of December 2020, from a 2015 baseline of 0%.
g) *IRI 9 - Number of District Health Executives (DHEs) in participating districts using quality tool for supervision of health facilities.* This IRI impacts the quality of RMNCAH-N service provision **achieved** its AF IV target of 20, reaching all 20 DHEs as of December 2020, from a 2012 baseline of 0 DHEs.

29. **PDO Part C (Strengthen institutional capacity to manage performance-based contracts) is rated Modest.** This part of the PDO is measured by one PDO-level indicator (PDO 10) which contributes towards strengthening institutional capacity to manage performance-based contracts. Its rating is based on the fact that PDO 10 was only partially achieved, as discussed below.

30. *PDO 10 - Percentage of health facilities managed under RBF contracts by the MOHCC Program Coordination Unit in participating rural districts*. This PDO level indicator was included under AF IV, linked to the then revised PDO

statement's objective to "strengthen institutional capacity for results-based financing contract management." It **partially achieved** its AF IV target of 32%, reaching 23% as of March 2021, from a baseline of 0% in 2012.

Broader Health System Contributions to RMNCAH Services

31. The above discussed data for the PDO- and IR-level indicators from the project RF was collectively sourced from the routine MOHCC HMIS, project records, as well as from household level surveys such as the Demographic and Health Survey (DHS) and Multiple Indicator Cluster Surveys (MICS) conducted over the course of project implementation. To further triangulate and situate the above progress reported using the project's own M&E framework, the next two paragraphs will briefly discuss overall trends in key RMNCAH services, both at the country and provincial level (where available), using household data collected via the 2016 Impact Evaluation (IE) of the RBF program under the HSDSP, as well as MICSs conducted over the project lifespan.

32. The RBF Impact Evaluation was conducted by means of baseline (December 2011-February 2012) and midline (May-August 2014) surveys across 16 of the 18 districts implementing RBF, and 16 control districts, and investigated the RBF's impact over a range of RMNCAH services.[4] Results of the IE demonstrate general improvements in health service coverage across both RBF and control districts. However, coverage of key maternal health indicators such as institutional deliveries and postnatal care were both found to be 13% higher in RBF versus control districts, while child anthropometry indicators such as the percentage of children severely underweight or stunted demonstrated observable relative decreases in RBF versus control districts as well.

33. Data collected from the MICS conducted in 2009 (prior to project approval), 2014 and 2019 also demonstrate positive trends at the national and provincial levels with respect to key RMNCAH indicators, although direct attribution to the activities of the RBF under the HSDSP is not straightforward. Across all 8 provinces (Manicaland, Mashonaland East Mashonaland Central, Mashonaland West, Masvingo, Matabeleland North, Matabeleland South, and Midlands) where the HSDSP's 18 implementing districts are located, as well as nationally, the MICS found positive trends with respect to the coverage of key RMNCAH indicators. Institutional deliveries, for example, increased from 58.5% nationally (MICS 2009) to 79.6% (MICS 2014) and finally, 85.5% (MICS 2019). In addition, full immunization coverage increased from 36.8% nationally in 2009 to 69.2% in 2014, and finally, 84.5% in 2019.

Justification of Overall Efficacy Rating

34. The achievement of PDO Part A is rated on a four-point scale as Substantial, PDO Part B is rated High, and PDO Part C is rated Modest. Thus, the overall efficacy of the PDO equates to a rating of **Substantial.**

C. EFFICIENCY

[4] Rewarding Provider Performance to Improve Quality and Coverage of Maternal and Child Health Outcomes: Zimbabwe Results-Based Financing Pilot Program - Evidence to Inform Policy and Management Decisions. June 2016.

Economic Analysis

35. The economic analysis for the project shows a solid economic rationale for the investment. With a total grant disbursement of US$53 million, it has made significant progress since July 2011 in reducing maternal, infant, and under-5 mortality and stunting. The estimated impact is that over 9 years, 28,869 children's lives would have been saved, 59 fewer children under-5 would have been stunted, and 784 women's lives would be saved. The net present value of total project benefits is estimated at US$134.3 million at a 10 percent interest rate. Given project cost, this yields a cost-benefit ratio of 3.13 for every dollar invested and an overall NPV return of US$91.3 million. The internal rate of return was estimated to be 14 percent. An expanded description of the economic analysis and the assumptions used in the analysis are detailed in Annex 4.

Operational Efficiency

36. The processing time for the parent project was approximately 13 months from the concept stage in January 2011 to first disbursement in February 2012. Due to the GoZ's arrears and ineligibility for IDA resources, the Bank team is to be commended for securing the necessary trust funded resources through the HRITF to enable the project to move forward. Furthermore, the collaboration between the Bank task team, key implementing partners, Cordaid, and the GoZ in building the latter's capacity also merits recognition. This contributed to the project's overall operational efficiency and the absorptive capacity (disbursement) and delivery of the original project and five successive AFs, including responding to the ongoing COVID-19 pandemic through the existing operation. The processing time for the project and AFs were largely in line with World Bank and regional averages. Between Decision/Authorization to begin appraisal and Approval, the project was processed in 3.8 months, and the AFs I to V were processed between 1.6 and 4.5 months. The Bank's overall IPF average over the last three years between appraisal and approval was 3.4 months, and the East/Southern Africa region was 3.5 months while that for West and Central Africa was 2.6 months. The smooth transition through the AF phases were facilitated by the pre-financing arrangement among the GoZ, WB and Cordaid.

37. Five AFs were necessary across 10 years of implementation to incorporate new HRITF and GFF grants into the overall project envelope, given the country's ineligibility for longer-term IDA resources. These were accompanied by incremental project extensions up to the current April 30, 2023 closing date, to allow sufficient time for implementation, and to ensure that the project made the required course adjustments to achieve its overall objectives, including revisions to the PDO and RF, adjustment of the RBF program's geographic scope, and responding to the ongoing pandemic. The cost of verification was a necessary expense to ensure that services for which payment was claimed were actually delivered as claimed.

Assessment of Efficiency and Rating

38. Considering the above efficiency considerations, the overall efficiency of the project is rated as **Substantial.**

D. JUSTIFICATION OF OVERALL OUTCOME RATING

39. Based on High Relevance, Substantial Efficacy and Substantial Efficiency, the overall outcome rating (according to the 2020 ICR Guidelines) is **Satisfactory**. The project's relevance is considered High as the PDOs remain well aligned with Zimbabwe's national priorities and the World Bank's strategic priorities. Efficacy is considered Substantial considering the achievement of key PDO indicators and in particular those related to coverage and quality of services. Efficiency is considered Substantial particularly due to the solid internal rate of return combined with the operational efficiency findings.

E. OTHER OUTCOMES AND IMPACTS

Gender

40. The project's target beneficiaries are women of child-bearing age, pregnant women, newborns, and young children under five (including girls). While raising awareness of relevant gaps between males and females was not the focus of the project, it did contribute to the improvement of services for reproductive, maternal, newborn and child health. The project targeted women for contraceptive services, ante-natal and maternity services and in so doing, promoted women's health before pregnancy, during pregnancy, and during childbirth. For example, the percentage of births attended by skilled health personnel in a health institution in participating rural districts increased from 58% in 2012 to 82% in 2019. The project supported the purchase of necessary maternity equipment and supplies in addition to hiring more midwives to fill in vacant needed positions for provision of quality health services to women. The community workers (mostly CBOs) who were critical to linking patients to health facilities that were offering project services were mostly women and the project empowered them to assist other women to access project services.

Institutional Strengthening

41. The project is being Implemented through a PIE which has utilized decentralized structures called Local Purchasing Units. The MOHCC-Project Coordination Unit (PCU) is also managing the funds for RBF that are being contributed by the Government of Zimbabwe. Both of these entities operate in a decentralized manner. This decentralized arrangement is building capacity at both national and sub-national levels that is critical to understanding the RBF approach and its ongoing institutionalization. The project is also enhancing the functioning of the Health Center Committees (HCC) at health facilities as HCCs are key institutions in the planning and oversight of functioning of health facilities under the project. The project provided training to these HCCs in addition to training that was provided to national, provincial and district level stakeholders. World Bank staff have provided fiduciary support and training to the PIE and its decentralized staff, which is helping to build the fiduciary capacity for implementing services using the RBF approach. In particular, the project has been strengthening capacity to manage RBF contracts in the country. The National RBF Steering Committee is an institution that has been supported to help the government to coordinate RBF activities and has been instrumental in efforts to harmonize RBF activities of the project and those of other partners (the Health Development Fund - HDF). This steering committee is playing an important role in the institutionalization of RBF in the country.

Mobilizing Private Sector Financing

42. Mobilizing private sector financing was not one of the areas of focus of the project.

Poverty Reduction and Shared Prosperity

43. The project was designed to focus on the rural districts of the country which are relatively poorer than urban ones. Even with the expansion to Harare and Bulawayo cities, the project has focused on the urban poor as individuals through means-testing or as communities through targeted urban-poor communities. Project beneficiaries, who are mostly women and children, can access quality services without being hindered by their inability to pay for those services. There are also benefits for the whole community as the RBF approach allows health facilities to use RBF funds that they receive to improve the overall health system through improved overall staffing for health facilities, improved supply chain systems for drugs and supplies, and improved infrastructure through rehabilitation of existing health facilities.

Other Unintended Outcomes and Impacts

44. There were no reported unintended outcomes and impacts of the project.

III. KEY FACTORS THAT AFFECTED IMPLEMENTATION AND OUTCOME

A. KEY FACTORS DURING PREPARATION

45. During the preparation of the project, the PDO was clear and realistic as it focused on a distinct target area for intervention (maternal and child health services) which was in urgent need of support in the country. However, the PDO at appraisal addressed only coverage and did not explicitly mention quality of services although the design of the project included explicit mention of quality measurement.

46. The design of the project provided for starting RBF as a pilot in two districts that represented 'average capacity' with a plan to later roll out to other districts based on lessons learned from these two districts. The rollout was also designed to be in phases but covering all the provinces. This was a deliberate effort in the design of the project to learn lessons across districts and provinces before scaling up to more districts.

47. During preparation of the project, key development partners in maternal and child health were engaged and these included, among others, DFID, European Commission, USAID, the Global Fund, UNICEF and UNFPA. This engagement of partners during project preparation was essential to ensuring that key stakeholders in the area of maternal and child health had input into the design of the project and helped to build synergies in the area of maternal and child health in the country. It also built the foundation for further dialogue with partners in the subsequent stages of the project.

48. A key risk that was identified during project preparation was that service providers could confuse RBF with input-based financing. This risk was mitigated in the design of the project by utilizing the PIE and MOHCW

to explain the RBF approach to service providers and the PIE to provide technical support to the providers. The overall risk for implementation of the project was rated during preparation as 'Medium' which was a conservative estimate considering that RBF was a new approach in Zimbabwe at a time when the health system and the economic situation in the country were declining.

49. During preparation, women and children were clearly identified as the target beneficiaries. The districts to be targeted were also specified as rural districts, where the predominant populations are poor. Maternal and child health services were clearly identified as an area of focus for the project.

50. Lessons learned from other countries, including those on incentives, were incorporated into the design of the project. For example, piloting in two districts and then learning lessons from them before rolling out to other districts was a lesson that was implemented in the design of this project. The use of HCCs as key structures at the health facilities was also a lesson learned and which was applied in the design of the project.

B. KEY FACTORS DURING IMPLEMENTATION

Factors subject to the control of government and/or implementing entities

51. The project had clear roles and responsibilities for the key stakeholders involved in implementation, such as the HCCs, the PIE, the DHE and PHE. The National RBF Steering Committee had a national coordinating role. Training and support (e.g., exposure visits to other countries) were provided to key stakeholders on their roles and responsibilities, and facilitated ownership, empowerment, and teamwork.

52. In addition to the supply side interventions supported by the project, the urban voucher program was introduced in the project to target the urban poor. In particular, vouchers were used by poor pregnant women in urban areas to access MCH services that they would not have accessed due to user-fees that they could not have been able to pay. Participating facilities in urban areas also participated in a quality-based RBF approach. The urban voucher program was therefore a critical element for the project as it targeted poor urban women who would not have been able to access essential services without the vouchers (demand-side) in facilities that were also incentivized to provide quality services (supply side).

53. The verification process was effective in ensuring that services for which payment was claimed by the service providers were actually delivered by the service providers. This was an essential function to ensure accountability by the service providers. The process also provided a visible assurance to the communities and users of the services that there is a deliberate process that safeguards the use of project resources.

54. At the initial stages of project implementation, providers were skeptical about the value of the RBF approach. With training, support, and receipt of initial payments upon reaching performance indicators, the providers gradually appreciated the approach. The impact evaluation in 2014 also helped RBF to gain further support from authorities. There was unanimous appreciation of the value of the RBF approach among stakeholders interviewed[5] while producing this report. They particularly appreciated the

[5] As part of preparation of this interim ICR, an extensive number of stakeholders were interviewed (by phone or VC due to COVID-

empowerment that the RBF approach gave to communities to influence the services provided to them while also ensuring greater accountability by health facility staff for the outcomes of their health facilities.

55. There has been strong commitment to RBF at all levels once the approach and incentives were understood. The GoZ is currently providing its own resources to 18 rural districts as RBF subsidies and plans to increase its financing coverage to all 60 rural districts in the coming years, which demonstrates a continued commitment to RBF. The GoZ had initially planned to cover at least 30 districts by the end of 2020, but the macroeconomic situation plus the COVID-19 pandemic disrupted these plans. Other development partners have also committed resources to support the GoZ in RBF as demonstrated by the current RBF support provided to 42 districts by the HDF, which is a multi-donor fund.

56. Engagement of development partners was a key element of implementation of the project in expanding RBF to the remaining 42 districts. The Health Development Fund (HDF) has been working closely with UNICEF and UNFPA, technical partners to the Fund, and uses an RBF approach for implementing maternal and child health services in 42 districts in the country, complementing the 18 districts of this project. Since the donors for HDF include DFID, EU, SIDA, Irish Aid and GAVI, engagement of these donors, as needed, has also contributed to the implementation of this project.

57. During project implementation, this project engaged with the National RBF Steering Committee on their efforts to coordinate a common RBF approach in all 60 rural districts (18 funded by this project and 42 funded by HDF). However, some differences still remain between the two funding mechanisms for RBF in the country, namely that the HDF-funded districts (a) do not have an external counter verification system, (b) do not formally implement CQI and (c) do not contract CBOs as teams but rather as individuals.

58. Human resources challenges have persisted during implementation, particularly since 2016. The situation is currently most severe in Harare and to a lesser extent Bulawayo where there is high turnover of health staff who are leaving to work abroad. Strikes by health workers have been frequent due to dissatisfaction by workers with their working conditions and renumerations. Salaries that have not kept up with inflation and poor working conditions mainly due to inflation which escalated since mid-2019 are mentioned by stakeholders interviewed during the preparation of this report, as key factors for dissatisfaction of workers.

59. The GoZ Co-financing paid out in local currency at equivalent prevailing official exchange rates is affected on real purchase value as local currency pricing for most vendors accessible to the facilities is rated at parallel market rates. This tends to affect the successful implementation of the facility operational plans as well as the staff motivation payouts as compared to the fully USD-supported HDF districts.

60. While the expansion of direct funding of RBF activities by the GoZ is welcome and bodes well for sustainability, RBF service providers have experienced delays in getting paid for services rendered, since this increased stream of funding. Stakeholders interviewed in rural districts reported delays of two to three

19 constraints) to obtain their views about the project. The stakeholders were from national (including MOFED and MOHCC), provincial, district, and health facility levels – including HCCs and CBOs at community level. These interviews covered Midlands, Mashonaland East, Manicaland, and Matabeleland South provinces. Stakeholders from central hospitals of Mpilo and Sally Mugabe as well as stakeholders representing Harare and Bulawayo cities were also interviewed.

quarters. However, MOFED and MOHCC have indicated that recent average delays have been reduced to 3-4 months, which is still too late for timely delivery of services especially under an RBF approach.

61. The cash flow for the project between the consecutive AFs has been a challenge for service providers. Sometimes service providers lose temporary staff who are funded by RBF subsidies during these funding gaps. Quotations that are given by vendors also expire during this period leading to future purchases of the same items costing more for the service provider, due to the rapid change of exchange rates. In the Urban Voucher Program, these financing gaps led to periodic halting of project activities, which affected beneficiaries.

Factors subject to the control of the World Bank

62. The World Bank supervision team provided regular supervision for the project, which enabled the team to produce up to 18 ISRs and process five AFs for the project. The World Bank also complemented supervision with quantitative evaluations and process assessments. Supervision missions included technical staff covering key issues such as Financial Management, Procurement, Environment and Social Safeguards. The ISRs reported project implementation with candor and enabled Bank management to provide needed support to the supervision team.

Factors outside the control of government and /or implementing entities

63. Zimbabwe has been on the list of 'fragile and conflict-affected situations - FCS' for the life of this project, reflecting the challenging environment for the project from preparation through implementation. It is therefore commendable that the project has managed to overcome the challenges in this FCS environment to achieve the current levels of project service delivery.

IV. BANK PERFORMANCE, COMPLIANCE ISSUES, AND RISK TO DEVELOPMENT OUTCOME

A. QUALITY OF MONITORING AND EVALUATION (M&E)

M&E Design

64. Despite the absence of a formally documented theory of change, the results framework was clearly defined with key PDOs, PDO indicators, IRIs, baseline figures and targets, and sources of data. A few indicators were designed to be collected from surveys such as the MICS while others were to be collected from routine HMIS data. Institutional responsibility for collection of the indicators was spread across relevant departments of the MOHCW/MOHCC. The results framework continued to be refined in subsequent AF restructurings to improve measurability and consistency of data sources. For these reasons, M&E design is rated Substantial.

M&E Implementation

65. M&E data were collected through several channels to monitor both PDO and intermediate indicators. These included routine data from the HMIS/District Health Information Software (DHIS) 2 and project data including in particular the RBF checklists. There was also provision for population-based data from sources such as Demographic and Health Surveys (DHS) and MICS. Project-generated data for the purpose of RBF payments were also routinely collected by the M&E system. Data was routinely used to update the results framework and in particular to make decisions for improving services provided by the project in the project districts and facilities. M&E implementation is rated Substantial.

M&E Utilization

66. Implementation of the project was a data intensive process requiring regular collection of data from facilities that inform the payments that are made to the health facilities for provision of health services. Both quantitative and qualitative data are used for the RBF process. There was also need for verification of the data that was submitted by health facilities to ensure that services reported to the PIE were actually provided. The M&E system provided this data, which was regularly used to make decisions on payments to health facilities. The HCCs and hospital boards also utilized this data from the M&E system to make decisions on areas of improvement for their health facilities and to gauge the level of effort they would need to meet targets that they set in their operational plans. Due to this data-intensive use of M&E data during the implementation of the project, M&E utilization is rated Substantial.

Justification of Overall Rating of Quality of M&E

67. The overall quality of M&E is rated **Substantial** given the Substantial rating of M&E design, Substantial rating of M&E implementation, and Substantial rating of M&E Utilization.

B. ENVIRONMENTAL, SOCIAL, AND FIDUCIARY COMPLIANCE

Environmental compliance

68. During project preparation, the project was classified as Category B - Partial Assessment as it triggered OP/BP 4.01 for environmental assessment. This was because of the anticipated increase in health care waste generated by the health facilities. An in-country consultative process took place, and the Health Care Medical Waste Plan was subsequently updated and publicly disclosed. No major works were financed by the project. However, health centers and hospitals could use RBF funds for small repairs of existing healthcare structures. In such cases, national and local guidelines were followed. With the latest AF V an Environmental and Social Management Framework (ESMF) has been drafted. An infection prevention and waste management plan has also been prepared, particularly to take into consideration the COVID-19 project objectives that have been added. Quarterly quality assessments were carried out for health centers and hospitals to monitor their compliance with national environmental and healthcare waste management regulations and guidelines. Based on these assessments (which include issues related to incinerators, PPE, and others) performance on environment health in health centers located in project districts is regularly assessed. A quality checklist for health centers helps health centers to identify gaps and then use RBF funds to address them, including purchasing equipment and basic infrastructure to support environmental safeguards. An Environmental Specialist has also been hired recently by the project using funds from AF V.

Social Compliance

69. The project did not trigger any applicable social safeguards issues. Positive social impacts were anticipated as the project was improving accessibility and quality of health care for the poorest households. Zimbabwe has a well-established grievance redress mechanism (GRM) through which patients can express their grievances and the project has been supporting and using this mechanism. At the facility level the MOHCC utilizes suggestion boxes where patients can anonymously drop written grievances for the attention of the health facility. The facility administration including the HCCs and hospital boards take these grievances seriously and try to solve them as they are recorded in minutes of meetings by the health facility. Client satisfaction surveys are also used to identify grievances. A complementary part of the GRM works at the community level. Patients can present their grievances to their community members of the HCCs. This community approach has been incorporated into national law in Zimbabwe. The community level also has an alternative GRM approach through community outreach by CBOs. Patients can report their grievance to the CBOs in the community, who ensure that these are addressed by the relevant health care authority. With funding from AF V, the project will also provide support to a COVID-19 emergency operations committee call center, a project website, and social media accounts for citizen engagement through the project.

Financial Management Compliance

70. A financial management assessment was carried out for the project in accordance with the Financial Management Manual for World Bank-Financed Investment Operations. The conclusion was that the PIE's financial management meets the Bank's minimum requirements for project financial management as per OP/BP 10.02, when the financial management arrangements proposed by the PIE are implemented together with the Financial Management Action Plan. The overall residual risk rating after mitigation measures was Moderate. During project implementation, independent external audits of project financial statements, in accordance with the International Standards on Auditing, were carried out regularly. During project implementation, there was no reported qualified external audit of the project. The project has been compliant with the World Bank requirement of submitting quarterly interim unaudited financial reports (IFRs).

Procurement Compliance

71. Procurement of goods, services and non-consulting services for the project was to be carried out in accordance with Guidelines: Procurement under IBRD loans and IDA Credits, January 2011. Selection of consultants was to be carried out in accordance with Guidelines: Selection and Employment of Consultants by World Bank Borrowers, January 2011. The Bank's Anti-Corruption Guidelines were to apply to the procurements. Procurement of operational costs was in accordance with the PIE's Field Office Manual which was reviewed by the Bank and found to be adequate. A procurement capacity assessment of the PIE was carried out by the Bank during project appraisal. The procurement capacity of the PIE, including the organizational setup and the staff to be recruited in the field office, was considered adequate and risk was considered medium. During implementation of the project, staffing

of the PIE was found to be insufficient leading to the hiring of an additional Procurement Officer to ensure proper documentation and accuracy of documents.

C. BANK PERFORMANCE

Quality at Entry

72. Quality at entry is rated **Satisfactory**. The project has continued to be relevant to World Bank and GoZ priorities. Project design was informed by experience in other countries such as piloting in a few districts before rolling out to other districts. The project also used a PIE to facilitate implementation which was an appropriate decision for the Zimbabwe context. Assessments were carried out to ensure compliance with World Bank fiduciary, environmental and social requirements. The World Bank team conservatively assessed the risk for implementation of the project as 'medium'. The project team designed mitigation measures to reduce these risks.

Quality of Supervision

73. Quality of supervision by the World Bank is rated **Satisfactory**. Implementation support missions were carried out by the supervision team nearly once in six months, in addition to having a Health Specialist based in Harare to provide regular implementation support. Fiduciary and other subject matter technical specialists were part of the supervision missions to ensure that relevant areas of supervision were adequately supported. In addition to the 2014 impact evaluation, there were process assessments covering risk-based verification, continuous quality improvement, and the urban voucher program. The team was also able to process five AFs. The team was proactive and modified the Results Framework whenever needed and particularly with subsequent AFs. Furthermore, the World Bank team was flexible in supporting the extension of the closing dates of the project to ensure that project activities were carried out as much as possible to achieve the PDOs.

Justification of Overall Rating of Bank Performance

74. Based on the rating above of quality of entry as Satisfactory and quality of supervision as Satisfactory, the overall rating of Bank performance is rated **'Satisfactory'**.

D. RISK TO DEVELOPMENT OUTCOME

Risks associated with being a country in fragile and conflict-affected situation

75. The project has been implemented in a prolonged FCS environment. This continues to pose a risk for development outcomes of the project as existing challenges may deepen further.

Risks associated with challenges in human resources

76. Human resources challenges have been prominent from the preparation to the present date. Delivery of health services is a human resources intensive endeavor and there is a continuing risk to development outcomes of the project due to human resources constraints.

Sustainability risks

77. There has been continued commitment to the RBF approach in Zimbabwe from the national level down to the community levels. The GoZ has already been funding 18 rural districts (grant requirement for co-financing) using the RBF approach since 2019 and plans to expand to all 60 rural districts as institutionalization of RBF gains more traction and the resource envelope increases as the country's fiscal situation improves. The project is continuing to support GOZ to further strengthen institutionalization of RBF in the country given the MOHCC's expressed interest in institutionalizing the approach for the health sector in general. However, RBF is not yet formally institutionalized as the modus operandi for delivering health services in all facilities in Zimbabwe although the current HSDSP AF V is laying the groundwork to pilot community-based RBF and quality-based RBF in provincial and central hospitals. Despite the above commitment and ongoing efforts, there is still a risk that the development outcomes that have been achieved through the RBF approach may not be sustained beyond the life of the project and HDF support. The ongoing COVID-19 pandemic also poses a risk for sustainability as it has created additional challenges for GoZ and stakeholders that could potentially affect commitment and momentum for advancing development outcomes. The World Bank is supporting GoZ in responding to the COVID-19 pandemic through the current HSDSP AF V funding and additionally through the upcoming Zimbabwe COVID-19 Emergency Response Project (ZCERP), which is under preparation. This response could help to mitigate the risk due to the COVID-19 pandemic.

V. LESSONS AND RECOMMENDATIONS

Lessons

78. **Systematic learning informed project implementation.** The project has implemented a systematic learning approach across a decade of implementation, fostering innovation. Process assessments, periodic stock-taking and impact evaluations resulted in adjustments of incentives allocated to facility improvements and staff incentives and between quantity and quality indicators. The CQI initiative allowed for continuous learning from experience. Innovations such as use of risk-based verification for RBF, and inclusion of the innovative urban voucher program to target poor pregnant women in Harare and Bulawayo were based on the systematic learning fostered in the project. Both Bulawayo and Harare City Councils are interested in scaling up the urban voucher program based on systematic learning from the project. Each AF introduced innovations as shown earlier in Table 4 of this report.

79. **Piloting is necessary before rolling out.** The project started as a pilot in two pilot rural districts before being rolled out to 16 more rural districts and finally covering the current 18 rural districts. Scale-up of the RBF approach in Zimbabwe entailed building a common appreciation amongst stakeholders, which was not always easy and required investing time in nurturing partnerships and applying diplomacy over and above the technical implementation. The key lesson from this experience is that starting RBF on a pilot scale before rolling it out to other areas is still a relevant strategy in implementing an RBF project.

80. **Dialogue with development partners enhances synergy**. The World Bank team engaged with other development partners during project preparation and the dialogue continued during project implementation through the RBF National Steering Committee and Health Development Partners Group Meetings. This regular engagement enhanced synergy in terms of efforts and resources in implementing the country's RBF approach, culminating in the project supporting RBF in 18 districts while the Health Development Fund supported RBF in 42 districts.

81. **RBF approach was adopted in some urban areas.** The urban voucher program was introduced by the project to cater for the urban poor in Bulawayo and Harare. It used both demand and supply side approaches by supporting poor pregnant women to access essential maternal care services ranging from antenatal care to postnatal care without being constrained by their inability to pay for the user fees for those services. Poor pregnant women used highly subsidized vouchers to access care in facilities that participated in the RBF. Vouchers were used because urban dwellers tend to be more mobile compared to rural ones who usually access health facilities in their catchment areas. Scaling-up to other urban areas has not yet taken place.

82. **Flexible design is necessary for success.** Flexible project design was a key enabler for the strong ownership and stewardship of the project by the GoZ. RBF was customized to suit the Zimbabwe context and interest of stakeholders. For example, certain principles such as autonomy were not applied in the full context that would include hiring and termination of health staff at the local level but was modified to suit what could be practically applied in Zimbabwe. The key lesson from this is that flexible RBF project design allowed the project to fit the context of the environment in which the project was being implemented.

83. **Continuous stakeholder engagement is vital.** The increasing commitment from GOZ was in itself a product of a number of factors that include evidence sharing (from learning efforts), cooperation with and amongst partners, and buy-in of health workers, who are critical stakeholders. The engagement at implementation level (including relationship between the regulator, purchaser, the PIE, and service provider) played a very important role in sustaining interest and commitment. The key lesson from this is that consistent and effective engagement with key stakeholders during project implementation helped to sustain interest and commitment of government and other stakeholders and in bringing the country along from the initial skepticism to being committed to RBF institutionalization.

84. **Health systems strengthening is essential.** During the implementation of the project, essential health system components such as improvements in human resources and investments in key equipment were critical to the success of RBF. Facilities were, for example, able to hire additional staff on part-time basis to increase the capacity of their human resources for health and, therefore, provide better services to their patients. The key lesson from this is that health system strengthening is essential in order to successfully implement RBF.

85. **Stakeholders are empowered by RBF.** The RBF approach as implemented in this project empowered HCCs and other stakeholders to take responsibility for the planning and oversight of their respective health facilities. The RBF approach as implemented in the project increased accountability by health providers for the outcomes of their health facilities. The key lesson from this is that RBF can be a mechanism to empower health sector stakeholders and increase accountability for outcomes of health facilities.

86. **COVID-19 working environment has triggered more innovative working norms**. Due to the COVID-19 working environment, the project has adjusted to the use of virtual meetings in the conduct of project work. In particular, the National RBF Steering Committee, the verification teams and training teams have adjusted to integrating virtual meetings in the conduct of their routine duties, as well as exploring ways to use information, communication, and technology mechanisms for training, tracking, and verification. The COVID-19 working environment has encouraged the project to be even more innovative to adjust to the situation in order to ensure continuity of critical functions and project activities.

Recommendations for the remaining life of project and beyond:

87. Continue to implement a systematic learning approach in the implementation of the project in order to foster innovations based on the learning from the project. The systematic learning approach has been informing the project in the introduction of innovations.

88. Utilize the lessons learned during the current implementation of the project from its initial pilot phase, in any future expansion of the project to other districts. This allows for more lessons to be learned before RBF is rolled out on an even larger scale.

89. Maintain the flexible RBF project design to allow the project to fit the context of the environment in which the project is being implemented; for example, different approaches were used in rural and urban areas.

90. Continue to consistently and effectively engage with key stakeholders to sustain interest and commitment of government and other stakeholders to continue with RBF and other related activities. In particular, continue to engage with the HDF and other development partners to complement RBF funding and sustain the approach in Zimbabwe.

91. Address health systems components such as human resources and health financing to support implementation of RBF projects. Since RBF operates within the overall health system, strengthening health systems components creates an enabling environment for RBF.

92. Continue to implement RBF to foster empowerment of stakeholders and accountability by service providers. The payment of providers based on results rather than inputs empowers stakeholders. For example, considering beneficiary feedback on services received in determining RBF payments encourages service providers to be accountable for their outcomes.

93. Expand the coverage of the urban voucher program and explore funding support mechanisms so that it can be sustained similar to what is being done for the rural based RBF. The program is vital for the urban poor to access essential health services that they would not normally be able to pay for.

ANNEX 1. RESULTS FRAMEWORK AND KEY OUTPUTS

A. ACHIEVEMENT OF PDO-LEVEL AND INTERMEDIATE INDICATORS

Outcome	Outcome Indicator	Baseline (A)	Achieved (B)	Target 2020 (set at AF IV) (C)	Achievement 2020: (B-A/C-A)
PDO Part A: Increase coverage of an integrated package of RMNCAH-N services	PDO 1: Percentage of pregnant women who receive antenatal care during their visit to a health provider in participating rural districts*	70% (2012)	80% (Dec 2020)	72%	2020: 500.0% (Surpassed)
	PDO 2: Percentage of births attended by skilled health personnel in a health institution in participating rural districts based on survey data*	58% (2012)	82% (MICS 2019)	88%	2020: 80.0% (Partially Achieved)
	PDO 3: Percentage of women 15-49 years who currently use any of the modern family planning methods in participating rural districts*	56% (2012)	70% (2014)	70%	2020: 100.0% (Achieved)
	PDO 4: Percentage of women who had their first ANC visit during the first sixteen weeks of pregnancy in participating rural districts	10% (2012)	22% (Dec 2020)	22%	2020: 100.0% (Achieved)
	PDO 5: Percentage of children under 5 with diarrhea receiving ORT and Zinc in participating districts*	13.8% (2015)	16.5% (MICS 2019)	16%	2020: 122.73% (Surpassed)
	IRI 1: Cumulative number of pregnant women living with HIV who are initiated on antiretrovirals to reduce the risk of MTCT in participating rural districts*	9,399 (2012)	59,572 (Dec 2020)	60,000	2020: 99.2% (Achieved)
	IRI 2: Cumulative number of pregnant women receiving first antenatal care during a visit to a health provider in participating urban districts*	12,737 (2014)	100,941 (Dec 2020)	89,031	2020: 115.6% (Surpassed)
	IRI 3: Cumulative number of pregnant women receiving first antenatal care before 16 weeks of gestation period during a visit to a health provider in participating urban districts*	572 (2012)	4,989 (Dec 2020)	4,035	2020: 127.6% (Surpassed)
	IRI 4: Number of children immunized (completing primary course on immunization in participating districts: BCG, OPV 1 to 3, Penta 1 to 3, and Measles MR1) (HNP CRI)	0 (2012)	817,556 (Jan 2021)	663,409	2020: 123.2% (Surpassed)
	IRI 5: Number of women and children who have received basic nutrition services (Cumulative number of children 6-59 months who were given Vitamin A supplementation in	0 (2012)	2,244,678 (Jan 2021)	1,544,493	2020: 145.3% (Surpassed)

Outcome	Outcome Indicator	Baseline (A)	Achieved (B)	Target 2020 (set at AF IV) (C)	Achievement 2020: (B-A/C-A)
	participating rural districts) (HNP CRI)				
	IRI 6: Number of deliveries attended by skilled health personnel (in health institutions in participating rural and urban districts) (HNP CRI)	0 (2012)	984,066 (Jan 2021)	762,573	2020: 129.1% (Surpassed)
PDO Part B: Increase quality of an integrated package of RMNCAH-N services	PDO 6: Average quality scores by health facilities in participating rural and urban districts*	68.1% (2012)	83% (Dec 2020)	81%	2020: 115.5% (Surpassed)
	PDO 7: Percentage of maternal deaths given audits as per protocol in participating districts*	0% (2015)	76% (Dec 2020)	80%	2020: 95.0% (Achieved)
	PDO 8: Percentage of partographs correctly filled in participating districts*	0 (2015)	62% (Dec 2020)	65%	2020: 95.4% (Achieved)
	PDO 9: Percentage of children under 5 years with Pneumonia correctly managed in the participating districts*	0 (2015)	89.5% (Dec 2020)	87%	2020: 102.9% (Surpassed)
	IRI 7: Percentage of health facilities implementing Continuous Quality Improvement model in the participating rural districts	0% (2015)	17% (Dec 2020)	23%	2020: 73.9% (Partially achieved)
	IRI 8: Percentage of RBF contracted facilities in Continuous Quality Improvement (CQI) Districts with CQI Standard Operating Procedures*	0% (2015)	76% (Dec 2020)	80%	2020: 95% (Achieved)
	IRI 9: Number of District Health Executives (DHEs) in participating districts using quality tool for supervision of health facilities	0 (Jan 2012)	20 (Dec 2020)	20	2020: 100% (Achieved)
PDO Part C: Strengthen institutional capacity to manage performance-based contracts	PDO 10: Percentage of health facilities managed under RBF contracts by the MOHCC Program Coordination Unit in participating rural districts	0% (2012)	23% (Mar 2021)	32%	2020: 71.9% (Partially Achieved)

Achievement:
Surpassed – 100%+
Achieved/Substantially – 85%+
Partially Achieved – 65%-84%
Not Achieved – < 64%
* These indicators were dropped in AF V because of relatively high achieved coverage and to streamline/consolidate the results framework.

B. RESULTS INDICATORS

B.1 PDO Indicators

Objective/Outcome: Increase coverage of an integrated package of RMNCAH-N services

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Percentage of pregnant women who receive antenatal care during their visit to a health provider in participating rural districts	Percentage	70.00 31-Dec-2012	72.00 30-Sep-2020		80.00 31-Dec-2020

Comments (achievements against targets): Originally introduced as numerical indicator at appraisal, with wording and targets revised in subsequent AFs. Revised to percentage indicator in AF IV, before being deleted in AF V due to high coverage.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Percentage of births attended by skilled health personnel in a health institution in participating rural districts based on survey data	Percentage	58.00 31-Dec-2012	88.00 30-Sep-2020		82.00 31-Dec-2019

Comments (achievements against targets): Introduced at appraisal, with targets revised in subsequent AFs. Deleted in AF V due to high coverage, however, cumulative numerical indicator tracking institutional deliveries in participating rural and urban districts maintained at IR level.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Percentage of women 15-49 years who currently use any of the modern family planning methods in participating rural districts	Percentage	56.00 31-Dec-2012	70.00 30-Sep-2020		70.00 30-Sep-2014

Comments (achievements against targets): Introduced at appraisal as "Percentage of women 15-49 years receiving during their first and repeat visits one of the modern family planning methods in participating rural districts". Targets revised in subsequent AFs, followed by rephrasing in AF IV to the above to avoid double counting and align with Zimbabwe DHS which serves as data source. Deleted in AF V and replaced with another Family Planning indicator at IR level.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Percentage of women who had their first ANC visit during the first sixteen weeks of pregnancy in participating rural districts	Percentage	10.00 31-Dec-2012	22.00 30-Sep-2020	32.00 30-Apr-2023	22.00 31-Dec-2020

Comments (achievements against targets): Originally introduced as numerical indicator in AF I: "Number of women who had their first ANC visit during the first 16 weeks of pregnancy in participating districts." Targets refined in subsequent AFs, before being revised to percentage indicator in AF IV, and specifying "rural districts". Wording refined in AF V to 12 weeks from 16 as per new ANC protocol, and target further revised given extended closing date.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion

Percentage of children under 5 with diarrhea receiving ORT and Zinc in participating districts	Percentage	13.80 30-Sep-2015	16.00 30-Sep-2020		16.5% 31-Dec-2019

Comments (achievements against targets): Introduced originally as IRI in AF II. Target revised in AF III and reclassified to PDO level in AF IV, also specified data to be used as from "participating districts." Since very close to being achieved, deleted in AF V and replaced by another child nutrition PDO indicator.

Objective/Outcome: Increase quality of an integrated package of RMNCAH-N services

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Average quality scores by health facilities in participating rural and urban districts	Percentage	68.10 31-Dec-2012	81.00 30-Sep-2020		83.00 31-Dec-2020

Comments (achievements against targets): Introduced at appraisal originally as "Increase in average quality scores by health facilities in participating rural districts." Dropped at AF II and reintroduced as new indicator worded almost as above. Revised at AF IV to specify "rural and urban" districts and dropped at AF V to be replaced with another quality measure.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Percentage of maternal deaths given audits as per protocol in participating districts	Percentage	0.00 30-Sep-2015	80.00 30-Sep-2020		76.00 31-Dec-2020

Comments (achievements against targets): Introduced as IRI at AF II as “Percentage of maternal deaths given audits as per protocol." Target revised at AF III and then reclassified to PDO level at AF IV, and reworded to specify “participating districts.” Dropped at AF V due to high coverage.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Percentage of partographs correctly filled in participating districts	Percentage	0.00 30-Sep-2015	65.00 30-Sep-2020		62.00 31-Dec-2020

Comments (achievements against targets): Introduced in AF II as "Percentage of partographs correctly filled." Target revised in subsequent AFs and reworded at AF IV to specify “participating districts.” Dropped at AFV.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Percentage of children under 5 years with Pneumonia correctly managed in the participating districts	Percentage	0.00 30-Sep-2015	87.00 30-Sep-2020		89.50 31-Dec-2020

Comments (achievements against targets): Introduced as IRI in AF II as "Percentage of children under 5 years with pneumonia correctly managed." Target revised at AF III and then reclassified to PDO level at AF IV, and reworded to specify “participating districts.” Dropped at AF V due to high coverage.

Objective/Outcome: Strengthen institutional capacity to manage performance-based contracts

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion

Percentage of health facilities managed under RBF contracts by the MOHCC Program Coordination Unit in participating rural districts	Percentage	0.00 31-Dec-2012	32.00 30-Sep-2020	80.00 30-Apr-2023	23.00 15-Mar-2021
Comments (achievements against targets): Introduced in AF IV to reflect change in PDO to include RBF contract management. Target revised at AF V to reflect planned RBF institutionalization within the extended project closing date.					

B.2 Intermediate Results Indicators

C. KEY OUTPUTS BY COMPONENT

Objective/Outcome 1. Increase coverage of an integrated package of RMNCAH-N services	
Outcome Indicators	1. Percentage of pregnant women who receive antenatal care during their visit to a health provider in participating rural districts* 2. Percentage of births attended by skilled health personnel in a health institution in participating rural districts based on survey data* 3. Percentage of women 15-49 years who currently use any of the modern family planning methods in participating rural districts* 4. Percentage of women who had their first ANC visit during the first sixteen weeks of pregnancy in participating rural districts 5. Percentage of children under 5 with diarrhea receiving ORT and Zinc in participating districts*
Intermediate Results Indicators	1. Cumulative number of pregnant women living with HIV who are initiated on antiretrovirals to reduce the risk of MTCT in participating rural districts* 2. Cumulative number of pregnant women receiving first antenatal care during a visit to a health provider in participating urban districts* 3. Cumulative number of pregnant women receiving first antenatal care before 16 weeks of gestation period during a visit to a health provider in participating urban districts* 4. Number of children immunized (completing primary course on immunization in participating districts: BCG, OPV 1 to 3, Penta 1 to 3, and Measles MR1) (HNP CRI) 5. Number of women and children who have received basic nutrition services (Cumulative number of children 6-59 months who were given Vitamin A supplementation in participating rural districts) (HNP CRI)

	6. Number of deliveries attended by skilled health personnel (in health institutions in participating rural and urban districts)
Key Outputs by Component (linked to the achievement of the Objective/Outcome 1)	1. Patients receiving an integrated package of RBF-incentivized RMNCAH-N services
Objective/Outcome 2. Increase quality of an integrated package of RMNCAH-N services	
Outcome Indicators	1. Average quality scores by health facilities in participating rural and urban districts* 2. Percentage of maternal deaths given audits as per protocol in participating districts* 3. Percentage of partographs correctly filled in participating districts* 4. Percentage of children under 5 years with Pneumonia correctly managed in the participating districts*
Intermediate Results Indicators	1. Percentage of health facilities implementing Continuous Quality Improvement model in the participating rural districts 2. Percentage of RBF contracted facilities in Continuous Quality Improvement (CQI) Districts with CQI Standard Operating Procedures* 3. Number of District Health Executives (DHEs) in participating districts using quality tool for supervision of health facilities
Key Outputs by Component (linked to the achievement of the Objective/Outcome 2)	1. Health facilities using RBF-incentivized quality interventions and tools for an integrated package of RMNCAH-N services
Objective/Outcome 3. Strengthen institutional capacity to manage performance-based contracts	
Outcome Indicators	1. Percentage of health facilities managed under RBF contracts by the MOHCC Program Coordination Unit in participating rural districts
Intermediate Results Indicators	1. N/A

Key Outputs by Component (linked to the achievement of the Objective/Outcome 2)	1. Staff trained to implement RBF at provincial, district, and facility levels 2. MOHCC, MOFED and health facilities providing better management of performance-based contracts

* These indicators were dropped in AF V because of relatively high achieved coverage and to streamline/consolidate the results framework.

ANNEX 2. BANK LENDING AND IMPLEMENTATION SUPPORT/SUPERVISION

A. TASK TEAM MEMBERS

Name	Role
Preparation	
Supervision/ICR	
Christine Lao Pena	Task Team Leader(s)
Chitambala John Sikazwe, George Daniel	Procurement Specialist(s)
Henry Amena Amuguni	Financial Management Specialist
Tandile Gugu Zizile Msiwa	Financial Management Specialist
Rutendo Heather Nyoni	Team Member
Yvette M. Atkins	Team Member
Son Nam Nguyen	Team Member
Rahmoune Essalhi	Procurement Team
Blessing Manyanda	Procurement Team
M. Yaa Pokua Afriyie Oppong	Team Member
Laurence Elisabeth Marie-Paule Lannes	Team Member
Ronald Upenyu Mutasa	Team Member
Farai Sekeramayi Noble	Team Member
Chenjerai N. Sisimayi	Team Member
Lingson Chikoti	Team Member
Mwansa Lukwesa	Environmental Specialist
Blandine Marie Wu Chebili	Procurement Team
Erika Ella Auer	Social Specialist
Kudakwashe Dube	Social Specialist

B. STAFF TIME AND COST

Stage of Project Cycle	Staff Time and Cost	
	No. of staff weeks	US$ (including travel and consultant costs)
Preparation		
FY11	6.352	71,019.00
FY12	6.600	17,758.11
FY20	0	1,045.00
Total	**12.95**	**89,822.11**
Supervision/ICR		
FY12	48.925	278,418.32
FY13	57.637	264,652.34
FY14	32.073	280,791.57
FY15	51.288	386,875.54
FY16	42.846	313,081.87
FY17	37.753	273,946.48
FY18	23.660	223,723.50
FY19	20.684	168,211.35
FY20	22.390	277,731.55
Total	**337.26**	**2,467,432.52**

ANNEX 3. PROJECT COST BY COMPONENT

Components	Amount at Approval (US$M)	Actual as of December 2020 (US$M)	Percentage of Approved
Delivery of Packages of Key Maternal, Child and Other Related Health Services	10.9	33.20	304.59%
Management and capacity building in Results-Based Financing	3.9	17.40	446.15%
Monitoring, Documentation, and Verification of Results under Performance-based Contracts	0.2	2.40	1200.00%
Total	**15.00**	**53.00**	**353.33%**

ANNEX 4. EFFICIENCY ANALYSIS

Efficiency Analysis

1. **Project cost.** Total grant disbursements for the project up to the closing of AF IV was US$53M. The original grant and four subsequent AFs were all fully disbursed. The Net Present Value (NPV) of the total cost is US$43M.

2. **Project impact**. Following the theory of change, the estimated project impact is that over 9 years, 28,869 children's lives would have been saved, 59 fewer children under-5 would have been stunted, and 784 women's lives would be saved (see table below). The economic analysis used the total population of the 18 rural districts plus that of the cities of Bulawayo and Harare as a proxy for project beneficiaries. Assumptions taken in estimating the project impact are detailed in box 1 below.

Table 6. Estimated Project Impact

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
	Interventions' period									
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Assumed disbursement	$ 15,000,000		$ 20,000,000		$ 10,000,000		$ 5,000,000		$ 3,000,000.00	
ALL										
# of maternal deaths averted			39	46	24	216	204	199	44	11
# of newborn deaths averted			52	50	47	45	43	56	281	11
# of children <5 deaths averted			-	-	100	9,264	9,060	8,692	1,443	724
# stunted children averted (<5)			-	-	-	-	-	7	52	-
Total number of children's deaths averted (newborn to <5)			52	50	148	9,309	9,103	8,748	1,724	736
Total number of maternal deaths averted			39	46	24	216	204	199	44	11
Total number of children whose productivity is saved (<5)			-	-	-	-	-	7	52	-

Box 1: Assumptions for estimating project impact

Estimating the number of neonatal deaths averted: This number as a result of pregnant women receiving antenatal care, births attended by skilled health personnel, the average quality scores by health facilities, and the percentage of health facilities managed under RBF. Based on Tekelab et al. (2019), "Utilization of at least one antenatal care visit by a skilled provider during pregnancy reduces the risk of neonatal mortality by 39% in sub-Saharan African countries." In relation to births attended by skilled health personnel, according to Amouzou et al. (2017) also focused on sub-Saharan Africa, "After the first day of life, newborns delivered with skilled attendant at birth [SAB] were 16% less likely to die within 2–27 days than those without SAB." Furthermore, according to Chou et al. (2018), high-quality systems in low-and-middle-income countries delivering services to mothers and newborns would result in an estimated decrease of 28% in neonatal deaths compared to a situation without any improvement in the delivery of services. Using anti-corruption audit interventions as a proxy measure for institutional reforms, Nichter et al. (2020) also found reduced neonatal mortality by 8.1 percent in the non-white population, comparable to the populations that this Project served.

Estimating the number of maternal deaths averted: This number was estimated as a result of the following indicators: pregnant women receiving antenatal care, births attended by skilled health personnel, use of modern contraceptive methods among women 15-49 years old, the average quality scores by health facilities, maternal death audits, and partographs correctly filled. Jowett (2000) estimates that in low-income countries, 26% of maternal deaths are avoidable through antenatal/community-based interventions and access to quality essential obstetric care can prevent a further 48% of maternal deaths. Ahmed et al. (2012) found that the total impact of increased contraceptive use (i.e., through spacing births or reducing the number of pregnancies and thus deliveries and unsafe abortions) reduces maternal death by 44%. Chou et al. (2018) also found that high quality services in health systems would result in a 28% decrease in maternal deaths.

Estimating the impact of maternal death audits in reducing maternal deaths: Estimates were based on the study by Wilcox et al. (2020), which looked at an intervention in West Africa focused on the training of hospital obstetric team leaders. The program included one day of training about the conduct of maternal death reviews and the study estimated a 15% decrease in the odds of inpatient maternal deaths given the training on the maternal death reviews. In order to estimate the impact of correctly-filled partographs, we used a paper by Sensalire et al. (2019), which looked at strengthening health systems in Northern Uganda. The paper found that the institutional maternal mortality ratio in the intervention facilities, which included the proper use of partographs, decreased by 20%, from 138 to 109 maternal deaths per 100,000 live births between December 2014 and December 2016. However, these studies did not directly look at the impact of maternal death audits and partographs but were focused on interventions that specifically included maternal death audits and partographs.

Estimating the number of deaths averted, among children under 5: The number of deaths averted in this age group was estimated based on the effects of the following indicators: the proper management of pneumonia and diarrhea (with the use of ORT and Zinc) among children under 5, and health facilities managed under RBF. The study by Nichter et al. (2020), where we used anti-corruption audit interventions as a proxy measure for institutional reforms, found a reduction of child mortality by 9.2% among the non-white population. In relation to proper diarrhea management particularly using ORT and Zinc, Munos et al. (2010) found that oral rehydration salts prevent up to 93% of childhood diarrhea deaths. In a study of developing countries, Theodoratou et al. (2010) estimated that community case management of pneumonia could result in a 70% reduction in mortality from pneumonia among children between 0-5.

Estimating the number of cases of stunting prevented: Estimates of number of cases of stunting prevented resulting from pregnant women receiving antenatal care were based on the study by Kuhnt and Vollmer (2017). This study found that in low and middle-income countries, "At least one ANC visit is associated with a 3.26% point reduced stunting and underweight probability.

3. **Return on investment.** The NPV of total project benefits is estimated at US$134.3M at a 10 percent interest rate. Given project cost of $43 million, this yields a cost-benefit ratio of 3.13 for every dollar invested and an overall NPV return of US$91.3M. The internal rate of return was estimated to be 14 percent.

ANNEX 5. RECIPIENT, CO-FINANCIER AND OTHER PARTNER/STAKEHOLDER COMMENTS

ZIMBABWE RESULTS BASED FINANCING IMPLEMENTATION COMPLETION REPORT 2011-2020

Recipient's Perspective

Abstract

The Zimbabwe Results Based Financing Program began in 2011 in with a short pilot phase which ran for six. The program quickly scaled up to eighteen districts and later a third phase in 2014 brought on board the remaining 42 districts. The program is focused on improving maternal and child health services and has since increased the scope of services to include HIV, TB, Malaria and NCD indicators. The successful implementation of the program is attributed to its fit into the Integrated Results Based Management system of the GoZ and its peculiar nature in design where subsidies are focused on the institution to improve its capacity to deliver services. A staff incentive is a proportion of the institutional incentive. The program has brought with it innovations that need to be documented as best practice. Future aspirations of the program include RBF at all service delivery levels with a layering approach that brings equity in purchasing.

MoHCC; Cordaid

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Abbreviations

CHAI	Clinton Health Access Initiative
Cordaid	Catholic Organization for Relief and Development AID
DHIO	District Health Information Officer
DMO	District Medical Officer
DNO	District Nursing Officer
FP	Family Planning
HTF	Health Transition Fund
HPA	Health Professions Authority
ICT	Information and Communication Technology
IDP	Integrated Development Planning
IRBM	Integrated Results Based Management
MNCH	Maternal Newborn and Child Health
MIS	Management Information Systems
M&E	Monitoring and Evaluation
NCDs	Non-Communicable Diseases
NHS	National Health Strategy
NSC	National Steering Committee
ODK	Open Data Kit
PIM	Programme Implementation Manual
PNC	Post Natal Care
PMD	Provincial Medical Directorate

PNO	Provincial Nursing Officer
PFMS	Public Finance Management System
PME	Process Monitoring and Evaluation
PPS	Personnel Performance System
QAQI	Quality Assurance and Quality Improvement
QSS	Quality Support and Supervision
QV	Quantity Verifications
RBB	Results Based Budgeting
RBV	Risk Based Verification
RBM	Results Based Management
STEP	Short Term Economic Recovery Programme
TB	Tuberculosis
ToC	Theory of Change
TSP	Transitional Stabilization Programme
UV	Urban Voucher
UZ	University of Zimbabwe
VMMC	Voluntary Medical Male Circumcision
WB	World Bank
ZDHS	Zimbabwe Demographic and Health Survey
ZimASSET	Zimbabwe Agenda for Sustainable Socio-Economic Transformation

1 BACKGROUND TO RBF PROJECT IN ZIMBABWE

1.1. Country Context

Zimbabwe had the best primary health care services in Sub Saharan Africa in the 1990's but protracted years of economic challenges from 2000-2008 resulted in decline in funding to the health sector leading to brain drain, lack of resources, near collapse of health system; primary level facilities charging service fees and a significant decline in access to and utilization of services. (Ministry of Health and Child Care, 2011) This resulted also in increase in Maternal Mortality Rate (960/100 000 live births) (Ministry of Health and Child Care, 2010 - 2011) under 5 Mortality Rate (84/1000) and Infant Mortality Rate 57/1000. (Ministry of Health and Child Care, 2010 - 2011) The Government of Zimbabwe (GoZ) mobilized resources for health focusing on MNCH services and secured World Bank interest in a health investment case, which led to the Health Sector Development Support Project (HSDSP). (World Bank) At the time of negotiation on the adoption of the Results Based Financing (RBF) mechanism in 2010, the socio-economic environment had stabilized due to the adoption of the multicurrency system by the government. Health care services needed revitalization because of the long strain they had been subjected to due to the harsh economic environment that had protracted over a decade. Health worker motivation was quite low because of poor salaries across the board which were far below the poverty datum line. The introduction of the RBF mechanism in the first phase to establish how the concept would assist in revitalization of the health system hence the project was designed around an institutional incentive that would be used to revamp the health service delivery by health facilities. The second phase of the RBF project around 2012 came in when macro-economic fundamentals were improving and the subsequent response of the health system to meeting the needs of its clients. The Ministry of Health and Child Care (MoHCC) and its partners had put in place a basket fund (Health Transition Fund) focused at improving the Reproductive, maternal, child health and nutrition services as well as providing health facilities with the much need basic equipment to support RMCH&N. This fund assisted in accelerating the revitalization of the health system. It was through this fund that the third phase of the RBF project in 2014 brought on board the 42 districts which were not supported by the World Bank grant onto the RBF. The buy in by development partners to the RBF mechanism was testimony to the successful implementation of the Results Based Financing project. The project adopted the staff incentive into the second phase in 2012 and this increased staff motivation in the provision of health care services and improvement in the quality of health care as well as the enabling environment for service delivery.

The HSDSP's main design features were based on the state of health service delivery in Zimbabwe in 2010 and the design was primary care focused with a health system strengthening thrust. RBF would complement input financing, whereby additional payment for agreed upon results was made after verification. The budget aimed at adding US$2.80 per capita with a target population on 7.5 million people in the rural areas. (Ministry of Health and Child Care) This would be paid as subsidies to health facilities and hospitals based on outputs on selected quantity indicators reflecting overall disease burden.

In 2014, with World Bank funding, the Urban Voucher (UV) was designed as a sub-component of the RBF project to target low-income urban health districts. The project's objective was to provide free Maternal New-born and Child Health (MNCH) services for the poor in two pilot areas: Harare's Southern District covering Mbare and Hopley wards and Bulawayo's Nkulumane district covering five wards. The pilot areas were chosen because of their large and impoverished population groups, with the aim to improve access to and use of ANC, delivery and Post Natal Care (PNC) services. (Ministry of Health and Child Care)

1.2 Project Objectives and Link to National Health Strategy and National Development Plans

Government began rolling out initiatives to implement integrated Results Based Management (IRBM) as the management tool that will help it overcome the ineffective systems and fulfil development expectations and service delivery." (GoZ, 2005) IRBM doesn't ignore behavior or activity, but sees it as the means to the important end, that is, **results.** The link between IRBM and Results Based Financing was the interface of the two management systems as illustrated below:

Table 4: Similarities between IRBM and RBF

Integrated Results Based Management Components	**Results Based Financing Components**
• Integrated Development Planning (IDP), • Results Based Budgeting (RBB) System • Results Based Personnel Performance System (PPS). • Results Based Monitoring and Evaluation (M&E) System and Management Information System,	• Systems Analysis (Micro-economics and Health economics, public choice theory, PHC, • Social entrepreneurship • Management tools and instruments • Monitoring and contract • Operational Planning and Contract • Separation of functions • Verification • Subside and service fee • Demand and supply side focus.

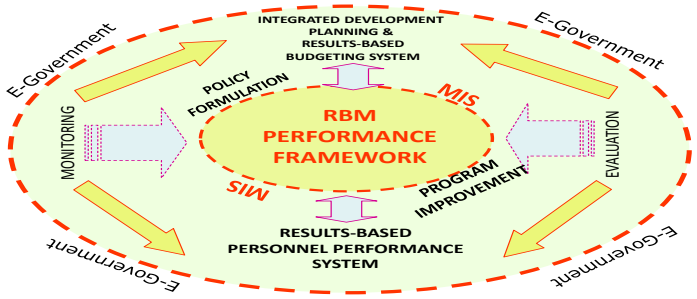

Figure 1: Components of IRBM and their linkages

The RBF project's main design features were based on the state of health service delivery in Zimbabwe in 2010, which was well documented in a range of reports. The intervention addressed a variety of demographic and public health challenges, especially pertaining to maternal and child morbidity and mortality. Moreover, it addressed various disparities, such as wealth distribution vis-à-vis health service utilization and outcome, geographical differences, disparities in functionality of the health system at primary and secondary level, ultimately translating in a range of constraints in health system performance and hence health outcomes. The objective of the RBF project is "to improve maternal and child health in Zimbabwe". The specific objective has been described as: "To improve the availability, accessibility and quality of key reproductive and child health services and their optimal utilization". The RBF project should also strengthen the Results Based Management Framework of the GoZ and hence the relationship and similarities of the management mechanisms stated above.

The project objective has remained as one of the goals of the National Health Strategies 2010 to 2015, 2016 to 2020 and beyond. The NHS is framed on meeting the National Health Outcomes as stated in the National Development Plans (STEP, ZimASSET, TSP and the NDS1).

2 PROJECT GRANTS

Table 5: WB Grants and GoZ Co-Financing (World Bank)

Date	WB Grant amount and agreement	GoZ Contribution	Comment
2011 Sept	US$15m (TF10748)*	Nil	The first financing for the implementation pilot covering initially 2 districts (Marondera and Zvishavane) and second phase scale up to 18 districts.
2013 July	AFI US$20m (TF15111)*	US$1m	n 2013 the GoZ announced that it would contribute to the RBF Project with a total amount of US$6 000 000 for which a Co-Financing Agreement was signed between the Government of Zimbabwe and Cordaid in January 2013. US$1 000 000 was received by Cordaid in October 2013.
2015 Aug	AFII US$10m (TF1598)*	US$5m	A second additional Financing Grant was approved, and it also included the urban component which came into effect in April 2016 when the urban part of the Additional Financing Grant TF15111 ended. The GoZ contributed US$5 000 000 in 2015
	Second Additional Financing Phase TFA0939* US$0,4m		This second Additional Financing Phase focused more on the quality of care and for the preparatory work to do this, the WB made available US$ 400 000 through a preparation Grant
2017 July	AFIII US$5m (TF0A5311)*	US$5m	This grant continued to include rural and urban components, quality of care and now activities for institutionalization of RBF within the Ministry of Health. Additional Financing III was extended to 31 December 2019.
2019 Jan	AFIV US$3m (TF09037)*	US$7.2m	In 2018, in line with the institutionalization roadmap, Cordaid was to capacitate the PCU in the MoHCC to take up the role of Purchasing Unit for the Rural Based RBF project. Additional resources were provided for this purpose. The fund also supported the urban voucher programme with a budget of US$1m and supported continuous quality improvement (CQI) within the 5 contracted districts.
2020 Dec	AFV US$25m (TF03511)	US$24.6m	This is funded through the Global Financing Facility (GFF) with the PDO modified to include COVID-19 response and GoZ committed a significant co-financing. US$5m of this amount was set aside for COVID-19 response support.

**These were funded through the Health Results Innovation Trust Fund (HRITF)*

3 PROJECT IMPLEMENTATION

3.1 Project implementation manual (PIM) (Ministry of Health and Child Care, 2019)

The project implementation manual is a guide to the roles and obligations of the three project stakeholders which are the regulator, the purchasing entity and the fund holder. The first PIM was more of an elaborate document that also explained what RBF theories are and how the mechanisms operate. The PIM formed basis for capacity building on RBF to all the provinces and districts. Constant reviews of the PIM were made part of the grant conditions to cater for policy changes in service provision that came out of RBF implementation and needed to be adjusted to allow the system to better respond to needs of the clients. As part of the reviews of the PIM, pricing of indicators constantly reviewed to cater for adjustment where indicators would have plateaued and were no longer changing as well as to refocus the project depending on the RMNCH project direction. Over the implementation period indicators have increased from RMNCH to include TB, HIV, malaria and NCD'S.

3.2 Theory of Change (ToC) (Ministry of Health and Child Care, 2019)

The initial PIM developed in 2011 envisaged a mechanism to be implemented through three components process and with three result effects to the health system centered on "improving the availability, accessibility and quality of key reproductive and child health services and their optimal utilization". The three results would be;

1. To strengthen the RBM framework of the government of Zimbabwe, establishing a results-based fund with specific functions of; fund holding, purchasing and regulatory functions that guarantee the realization of specific maternal and child health objectives with maximum guarantee of health system development in a (Placeholder1) broader perspective and adequate transparency.
2. DHE offices are strengthened for enhanced ability to collect health information data and supervision of rural health centers for quality primary care services; and
3. District hospitals are capacitated to provide emergency obstetric care and hence capable to serve as referral institutes. (Ministry of Health and Child Care Zimbabwe, 2011)

The moderators to the theory of change are harnessed in the important elements of RBF listed in the 2011 PIM. There was no diagrammatic outline to show the interaction between moderators and indicators and outcomes.

A quality improvement ToC was developed in 2014 after the RBF impact evaluation[6]. The ToC assumes that investments through the quality improvement model will lead to enhanced quality of care and client's satisfaction. (Ministry of Health and Child Care, 2014) .

A conceptual framework of the RBF in Zimbabwe was illustrated graphically in the 2016 Impact evaluation report. (World Bank, 2016) and was further enhanced through research by the National Institute of Health Research and its collaborating partners. The current PIM has adopted this ToC and is illustrated below:

The design is anchored on payments for results—conditional on quality for the urban RBF, and on quality and utilization for the rural RBF. Institutional arrangements are structured to uphold the principle of the separation of functions between the service provider (health facilities), purchaser (PCU and Crown

[6] Report published in 2016

Agents), and regulator (MoHCC - Head Office, PHE and DHE) (Ministry of Health and Child Care, 2019). The two RBF schemes include payment for quantity.

3.2.1. Current Theory of Change (Ministry of Health and Child Care, 2019)

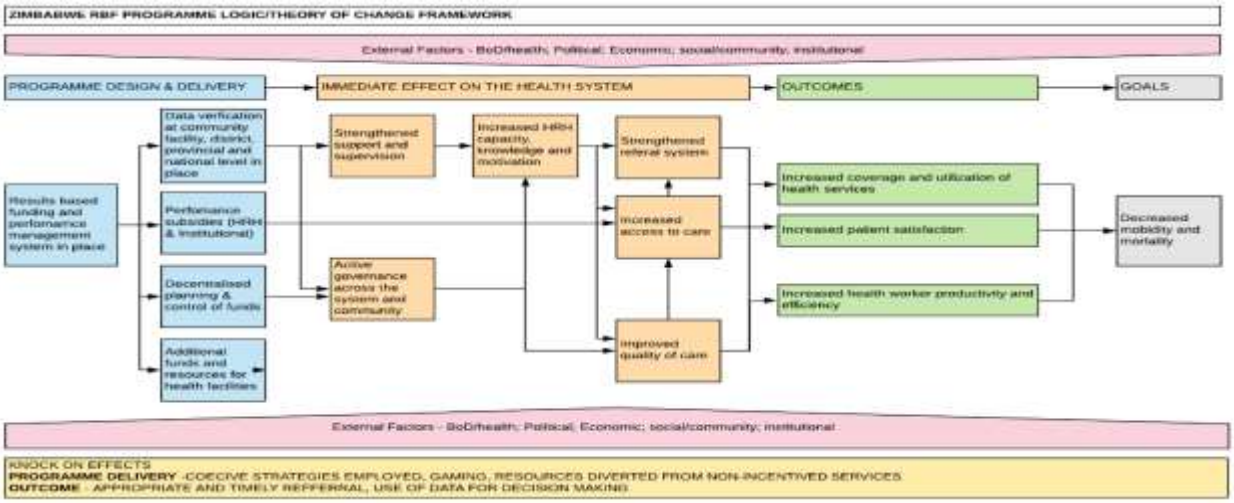

Figure 2: Theory of Change

3.3 Incentives

3.3.1 Facility Based Incentive

At the inception of the RBF programme, in the first phase, all the subsides were deliberately invested into the facility for the sole purpose of improving on service provision and the operating environment. This what differentiate the Zimbabwe RBF programme from the usual norm (focused on health care worker motivation) and it became a best practice. This was later reviewed in the second phase to consider and test the nomenclature on healthcare worker motivation by allocating a percentage of the total subsidies towards the health care workers. The concept behind the facility incentive was also to affirm that motivation is not only centered on personal monetary gain but also on other issues such as operating environment, adequacy of tools of trade including commodities, good accommodation etc. and these were addressed by the investments made through subsidies.

3.3.2 Health Care Worker Incentives / Motivation

In the second phase of programme scale up, a deliberate decision was made to bring on board a health worker incentive of 25% of the total subsidy earnings of the facility. This was meant to conform to the RBF nomenclature on healthcare worker motivation although the Zimbabwe programme then married the extrinsic and intrinsic motivation concept vis-a-vis the usual RBF designs focused on only the health care worker motivation. One development was to link the quality scoring to the health care worker incentives in such a way that health care workers will only get incentives if the facility scores is at least 60%, promoting health care workers to deliver quality care.

3.4 Key Informant Interviews: findings on programme implementation

Key informant interviews were conducted using a structured interview guide with stakeholders who included the DNOs, PNOs, CBOs, HCC Members, and former national level top managers both at PIE and Regulator level. The following is a summary of selected findings from the KII:

3.4.1 Main lessons and Significant Changes

Adapting RBF to country context was necessary. There was need for change management at senior level and need for RBF champions. Training was needed for understanding. RBF enabled autonomy and strengthened the decision making at subnational level. Increased staff motivation and performance. Increased community involvement, participation, ownership of health care services and revived Health Centre committees. Promoted performance management and operational planning. RBF improved the enabling environment / HSS for health service delivery. It improved on the quality of health information, structured support and supervision. It improved on accountability and community engagement. RBF led to improved service utilisation. Improved and timeous admission to services through availing maternity waiting homes and health seeking behaviour. Contributed to reduction in maternal and neonatal health outcomes. Gradually shifting focus from quantity to quality, which is to be considered as key to sustainable improvement. This applied to both rural and urban program. Variations in value of received subsidies due to difference in currencies used by different funding mechanisms (GoZ – ZWL vs HDF US$)

3.4.2 Key factors that affected outcomes

Program development and design was inclusive of all levels. Inadequate advocacy on PIM review at implementation level for better understanding of price changes and poor dissemination of the revised PIM. Investing money in facility development and encourage HCC members to take their role voluntarily.

3.4.3 Has the programme been successful?

By waiving user fees, RBF created the conditions for higher utilization and created a sense of community ownership for the clinics. Facility deliveries were increased due to investments like waiting maternity waiting home and better medicines availability. Improved community participation. Regular supervisory visits were very much appreciated and motivating the health care workers. Need for increased accountability for Human Resource Management to achieve better results

3.5 Institutional Arrangements for RBF in Zimbabwe

In the preparation phase there was close and structured collaboration between MoHCC, Cordaid and World Bank staff. Due to fiduciary arrangement at the time of the project inception, the GoZ could not handle WB resources directly and hence fundholding of project funds were directed to the Project Purchasing Unit Cordaid to manage on the MoFED's behalf through a subsidiary agreement. The project design catered for separation of functions between fund-holding, regulation and purchasing in which MoFED was the principal fundholder but delegated function to Cordaid through the agreement stated above. MoHCC took on the role of regulator and Cordaid the role of purchasing entity. The relationship between the purchasing unit and the service providers was also guaranteed through performance contracts meeting IRBM requirements. A project implementation manual was developed that specified the roles and responsibilities of each of the stakeholders in the project.

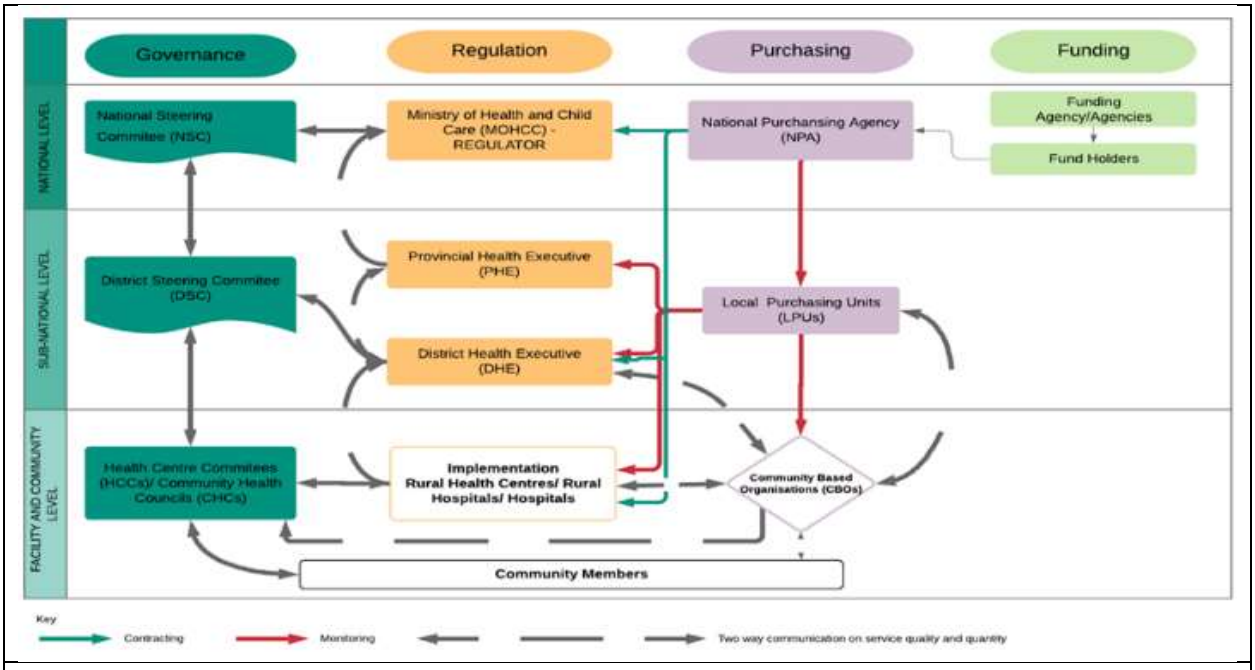

Figure 3 Institutional Arrangements

3.6 Planning and Contracting

The planning framework follows the IRBM logic. The MoHCC produces its strategic plan with clear strategies, targets, outputs and outcomes over a 5-year period. An annual implementation plan is drafted and guides operational level planning for the year. Health service providers produce their operational plans that contribute to the overall district, provincial and national plan. The plans are mandatory at facility level, and cascade the indicators to be localized with the facility responsible for setting its own progression path on how it will achieve the target output. Though informed and guided by the National level, the plans include their own strategies, autonomous processes including subsidy utilization according to their own need. These are comprehensive plans for all services provided by the health facility including the incentivized RBF indicators. subsequently supervisory levels, PHEs and DHEs, also produce operational plans that show their oversight role and stewardship over their jurisdictions. The plans are designed to apply to all the health system components and are reviewed quarterly. Performance contracts are signed between the service providers and/or PHEs or DHEs with the purchasing entity and the immediate supervising authority. The WB so far has supported contracts with 10 PHEs (8 rural, 2 urban), 20 DHEs (18 rural and 2 urban) a cumulative of 437 facilities (389 Rural Health Centers, 35 Rural Hospitals, 11 Urban clinics, and 2 Central Hospitals), and 426 Community Based Organizations (418 rural 8 urban). In the urban voucher programme contracting also includes the social workers through the Department of Housing and Community Services, Ambulance Services and community-based health workers.

The counter-verification as a process which looks at the fidelity of the whole institutional arrangements is contracted separately but not routinely.

4 PROGRAM SCALE UP AND DONOR BUY-IN

The Health Sector Development Support Project (HSDSP) started in 2011 with the introduction of Results Based Financing (RBF) in two rural districts, namely Marondera and Zvishavane, in Mashonaland East and Midlands Provinces, respectively. It was later scaled up to 16 additional rural districts in eight rural provinces in 2012 with World Bank Grant to the Government of Zimbabwe (GoZ) and the Catholic Organization for Relief and Development AID (Cordaid) as project implementing entity on behalf of GoZ and World Bank. The objective of the RBF project was to increase coverage, access, and quality of maternal, neonatal and child health care delivery supporting priorities in the National Health Strategy 2011-2013 and 2105-2020. Evidence of success from impact evaluation from the 18 districts led Government to scale-up the approach to the remaining 42 rural districts in 2014 with financial support from Health Transition Fund (HTF), now Health Development Fund (HDF).

Subsequent additional financing from the World Bank, through Additional Financing I to IV, supported the introduction of innovations in line with lessons learnt from implementation. Of note, the project-initiated pilots for an Urban Voucher Scheme in 2014 in Harare and Bulawayo cities targeting the urban poor pregnant women to improve access and quality antenatal, delivery and post-natal care. (Cordaid, 2015)

In view of the demonstrated success of introduction of RBF, other health implementing partners requested MoHCC to purchase specific indicators related to their project areas and use the RBF approach to improve the utilization and quality. MoHCC through the National Steering Committee facilitated the process for them to purchase the indicators using the RBF approach. Through this partnership, World Education managed to purchase pediatric HIV related indicator in 2016-2017 in Matabeleland South province (where HIV prevalence was high) and managed to demonstrate results. Likewise, in 2019, CHAI managed to purchase TB related indicators in Manicaland Province where TB case detection was very low as compared to other parts of the country. CHAI contracted health facilities and community health workers through Crown Agents leading to improvement in case detection. PSI is currently in consultation with MoHCC to purchase Voluntary Medical Male Circumcision (VMMC) related indicators and apply the RBF approach as part of the future sustainability plan for the VMMC.

5. INNOVATIONS

5.1. Electronic verification

The data collection for both Quality Support and Supervision and the Quantity Verification (Ministry of Health and Child Care, 2019) was being done using paper-based tools until the end of 2016. Invoicing was also done manually. The paper-based verification tools presented numerous challenges during the data collection process delaying timely submission of data and increasing risk of incompleteness of information. To improve the data collection process and its visualization, an electronic way of collecting the data from the field and computing the overall scores required for invoicing with no human intervention up to the invoice generation was developed through the support of a consultant firm called Blue square using the funding from AFIII and AFIV. It was developed using open-source system called ODK (Open Data Kit) and it is linked to MoHCC DHIS2 enabling the system to generate electronic invoicing and visualize performance data as shown in the picture below:

5.2 Electronic Partograph (e partograph)

Cordaid through Cordaid-Global office funding supported MoHCC in the development of the e partograph module within the Electronic Health Record (Ministry of Health and Child Care, 2017) (EHR). A partograph is tool used to monitor pregnancy by clinicians up to delivery. Previously the process using the paper based was difficult to monitor and provider a decision support system, with the introduction of e partograph monitoring of pregnant women can now be done on near real time with alerts to assist in timely decision making as per the set national guidelines.

5.3 Innovations within UV

Previously the data collections for identifying potential beneficiaries and the poverty assessment tool were done using paper-based tools, increasing the lead time between identification and eligibility assessment and incompleteness of information (MoHCC, 2013). Taking lessons from the electronic verifications tools develop for the Rural RBF, as of 2019, electronic tools were developed for these purposes using ODK and they were linked with the Beneficiary Voucher Repository (BVR), which Is the data base for the UV project. This has helped in reducing the lead time between identification and eligibility assessment and availing complete data in the system for invoicing and analysis.

5.4 Innovations: Continuous Quality Improvement (CQI)

In 2016, following results of the first phase of the RBF program impact evaluation, the MOHCC requested World Bank support to design and pilot a continuous quality improvement (CQI) innovation to be rolled out in selected facilities implementing the RBF program. The CQI innovation was introduced with the goal of improving overall quality of care outcomes—in particular clinical process measures-that had not been very responsive to the RBF intervention. The initiative was in line with the 2016-2020 National QA and QI strategy that outlines the need for starting CQI in selected districts, facilities, and technical areas. Through implementation of high-impact quality improvement interventions, the CQI initiative aims to decrease morbidity and mortality of pregnant women during labor and delivery and postpartum; neonates during the early neonatal period; and under-5s from common conditions (MoHCC).

As there was not enough evidence within Zimbabwe and other countries on the added value of CQI on RBF, the Ministry in collaboration with the World Bank decided to use the ‘’quasi experimental’’ design to collect enough evidence on the added value of CQI on RBF. Eighteen districts have been implementing the RBF program and constituted the study population. Stratified by province, 9 of these 18 districts were initially randomly selected to participate in the CQI pilot program. However, resource limitations further restricted the pilot to five districts. The selected five districts were Mwenezi, Centenary, Chipinge, Mangwe and Binga from Masvingo, Mashonaland Central, Manicaland, Matabeleland South and Matabeleland North Provinces, respectively. Facilities in these selected five districts received the additional quality improvement efforts through the CQI approach (MoHCC).

A process monitoring and evaluation on CQI was done by World Bank in 2018 and 2019. The PME has shown that the CQI pilot is perceived as one of the most important initiatives for improving the quality of MNCH services in Zimbabwe. There is a clear agreement among actors involved in CQI pilot about the significance of quality improvement as a fundamental tool to improve health outcomes. According to respondents, the CQI pilot was one of the first and few initiatives that ensured staff exposure to quality improvement, and which strategically and deliberately included a component of local problem analysis and planning of corrective measures (MoHCC).

While CQI may contribute to a better working environment and spur improvement in routine care practices that the staff are already well trained in, it should be seen as one tool in a broader health systems quality improvement strategy.

5.5 Risk Based Verification

One of the innovations that was made was Risk Based Verification (RBV). (MoHCC Cordaid, 2014)This approach was birthed during the 2nd Phase of the RBF in 2014 after recommendations had been made to the project since inception (Cordaid, 2014) to reduce verification costs, i.e., staff and operational costs as a whole, and in the process create sustainability for the project. The RBF project penalizes health facilities for differences of more than 5% on any indicator between the declared and the verified data (excluding waivered indicators). The RBV model is anchored on this principle and health facilities are categorized into green if they are commonly within the 5% error rate, amber if they are between 5-10% and red if the error rate is greater than 10%. The category determines the number of visits the health facility will have in the quarter. It is important to note that health facility categorization is not fixed. Re-categorizing of health facilities is done at the end of every six months and. Based on their performance health facilities can be moved either from green to red or vis-versa and will then be monitored at the frequency and intensity that is commensurate with that new category.

The adoption of the RBV was noted to indeed reduce costs without increasing the risk of over-reporting and subsequent related overpayments. The quality of data was not compromised by the change in verification model (Cordaid, 2014). The overall costs for verification declined over time and resources were channeled towards new innovations in RBF, such as the development of improved quality improvement tools and electronic data applications.

5.6 Incentive calculator

The Incentive Calculator was modified from an excel based manual to an electronic solution that provides a convenient and equitable way to calculate staff incentives of a particular health facility. (MoHCC, 2017)The health facility managers feed the required data which includes the post, number of years worked, responsibility rate, hours worked e.tc for all the facility staff. This is done on a quarterly basis. The incentive calculator will automatically generate amounts each cadre would receive using a predefined algorithm.

6. INSTITUTIONALIZATION

The implementation of the institutionalization roadmap came into effect in 2017 and the MoHCC made a deliberate decision to house the purchasing function under the Programme Coordination Unit currently doing Grant coordination for the Global Fund. This move was to ensure sustainability of RBF in Zimbabwe and has resulted in reduction of administrative costs from as high as 18% to 4.5. Cordaid's role changed from implementation support as National Purchasing Agency (NPA) to technical support to facilitate institutionalization of RBF within the GoZ. The GoZ began rolling out the initial phase of Institutionalization of RBF in the 18 rural districts formally contracted by Cordaid. This Institutionalization also aims at supporting further development of the quality assurance and quality improvement innovation project embedded within the RBF approach by focusing on process and clinical quality of care measures (a substantive change from the earlier phases of the project).

To demonstrate the full appreciation, buy in as well as recognition of RBF as a strategic purchasing mechanism the GoZ has gradually been increasing its counterpart funding. Key supporting technical staff posts were identified and the lobbying for a staff establishment on the GoZ HR support is underway.

The current arrangement is such that until positions are created within MoHCC for the RBF functions, the PIE, Cordaid has seconded staff members at PCU and Provincial Medical Directorate (PMD) office level. Concurrently, Cordaid in collaboration with the PCU, provided RBF technical assistance in capacity building areas such as organizing, developing and contributing to a variety of training activities that were undertaken during the program implementation at various levels (province, district, facility and community) associated with technical and policy issues in the area of maternal and child health. The capacity building also included support on quantity verification, where community nurses were capacitated to take up the task; invoicing where the provincial and district administrators and accountants now generate the invoices and pass them for approval to the PCU. The integration of RBF payment systems through the PFMS is underway. PCU has taken up the purchasing role, contracting and performance analysis in consultation with various departments in charge of Monitoring, Evaluation and Administration.

The second level of data verification is independent counter verification, which will assess the completeness, accuracy and validity of verified data on service delivery performance among districts and health providers participating in the RBF as well as determine the completeness and quality of health services offered to clients by the participating providers. Counter verification takes place at 2 levels: by Community Based Organizations that have been contracted to trace patients (quantity) and assess patient satisfaction (quality); and by an independent organization so as to fulfill both technical RBF needs of checks and balances. This task is appointed to reputable and independent Organizations to fulfil the technical function of conducting and managing both components of the external verification of the Zimbabwe RBF.

External counter verification was initially performed by the University of Zimbabwe, and later with institutionalization, in the Mid-Term Framework, the Health Professions Authority was identified as a suitable fit for this purpose in view of its strategic position and function as a regulator for Health Professional Councils in Zimbabwe and its independence. (MoHCC, 2016)Based on the 2016 MTR, HPA was identified as an agent to conduct CV and the UZ was then contracted to carry out an assessment of the HPA to identify its gaps and capacity needs. The outcome defined the gaps that HPA has, which cover areas of training in both RBF and Counter verification. Accordingly, capacity building was done to the HPA and its various professional councils and managed to conduct its first counter verification.

7 MONITORING AND EVALUATION

7.1 Programme evaluations and Health Systems Strengthening

Since its inception the RBF project has been regularly reviewed and evaluated, internally and externally. To mention a few:

1. Rebuild Consortium: Impact of user fees on health care seeking behavior and financial protection during the crisis period in Zimbabwe; 2016

2. Jed Friedman a.o.: Rewarding Provider Performance to Improve Quality and Coverage of Maternal and Child Health Outcomes. Zimbabwe Results-Based Financing Pilot Program Evidence to Inform Policy and Management Decision (2016)
3. Sophie Witter a.o. Assessment and redesign of the systems for RBF, Human Resources for Health and Pharmaceuticals in Zimbabwe. (2017)
4. Pemba Research team: Applying a Theory of Change in results based financing: Findings from Zimbabwe (2018)
5. Tamar Gotsadze a.o.; Reviews of the Continuous Quality improvement and urban voucher initiatives (2019)

These evaluations and underlying assessments provided valuable learnings that translated into recommendations, the majority of which were followed-up by the MoHCC. To mention a few:

- In response to **plateauing performance** in key MNCH and family planning (FP) indicators respective weighting for quantity outputs and quality was adjusted drastically. More emphasis was placed on quality performance and division of budget between primary, hybrid and referral health facilities respectively.

- **Economy and efficiency;** overhead costs were high initially and reduced over time with scope to drive these down further. For instance, Risk Based Verification (RBV) brought significant savings (50%), freeing money to initiate Continuous Quality Improvement (CQI). Data collection and processing was streamlined and made more efficient through use of phones and tablets, further developing a data portal, streamlining payment arrangements, etc.

- **Sustainability**: a need was recognized for a roadmap that would support institutionalizing RBF within the GoZ, seeking integration with the broader national RBM system. Whereas significant progress was made, domestic resource mobilization for GoZ contributions to the health RBF scheme stalled dur to an economic relapse but could be maintained at 50%.

- **Harmonization** was pursued in different ways: (i) RBF processes and procedures were harmonized between two implementing entities (Cordaid and Crown Agents); (ii) collaboration was sought with the Global Fund (adoption of indicators; harmonized HSS approaches; (iii) health service provision in poor, urban areas, with a combination supply side and demand side (vouchers) interventions, preparing for introduction of health equity cards and social health insurance.

- **Demand side RBF:** groundbreaking work for a demand-side RBF intervention was done which is expected result in complementary supply and demand side interventions.

- **Performance management:** a case was made for performance-based agreements for senior MoHCC staff, CEOs, PMDs and DMOs as the principal way of doing business in the MoHCC.

7.2. Performance of RBF indicators

7.2.1 Impact Evaluation – Key Performance Results

An impact evaluation in 2014[7] showed increase in service coverage with key indicators such as (in-service) delivery by skilled provider, and caesarean section rate improving faster in RBF districts. There were mixed but positive messages on quality with some dimensions showing significant improvement under RBF especially structural (as these health facilities invested part of their subsidies to renovate their infrastructure) biomedical waste disposal, and availability of consumables such as iron and folate tablets and equipment such as refrigerators, whilst the rest did not show significant changes. There was strong evidence suggesting no neglect on non-incentivized services and improved autonomy, decentralized decision making, strengthened facility level management and governance. (2016 impact evaluation)

7.2.2. Indicator Performance for Rural RBF

The analysis of trends in this ICR is focused mainly on those that have maintained presence on the indicator package throughout the implementation period. Indicators included are Antenatal Care before 16 weeks of Gestation; Institutional Deliveries; Long-Term Family Planning; and Vitamin A supplementation. The analysis was performed using declared data in the MoHCC HMIS (DHIS2) from facilities in the 18 districts.

7.2.2.1 Antenatal Care before 16 weeks of Gestation

As shown in the figure below, there was an overall increase in performance of the indicator from 12% in 2012 to more than 20% over the years and performance peaked between 2015 and 2018. It was however noted that the target has not been met and a decline in performance was observed in 2019 and 2020. The significant decline in 2020 could be attributed to COVID-19 related movement restrictions.

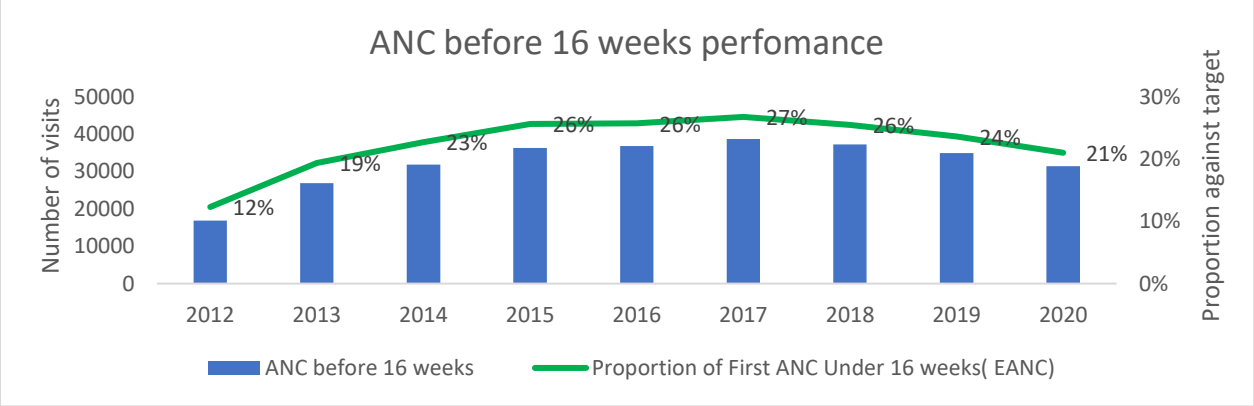

Figure 4: ANC before 16 weeks

7.2.2.2 Institutional Delivery

As shown in the figure below, there was an increment from the baseline on 77% in 2012 to above 80% over the years. A significant decline in the proportion of deliveries against the target was observed in 2020 though the performance in absolute numbers is higher in 2020 as compared to 2012. The decline in performance in 2020 could be attributed to the COVID-19 movement restrictions.

[7] Report published in 2016

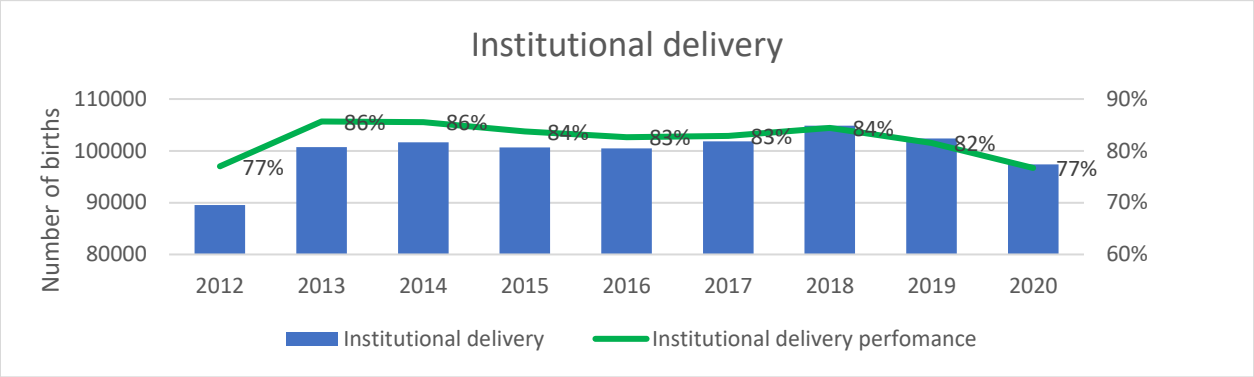

Figure 5: Institutional Delivery

7.2.2.3 Family Planning (Long Term Methods)

As shown in the figure below, generally the performance has increased as compared to the baseline. It was however noted that there has been a decline in performance from 2014 to 2017 and later increased. The decline could be attributed to reduced pricing in 2014 and shortage of FP consumables.

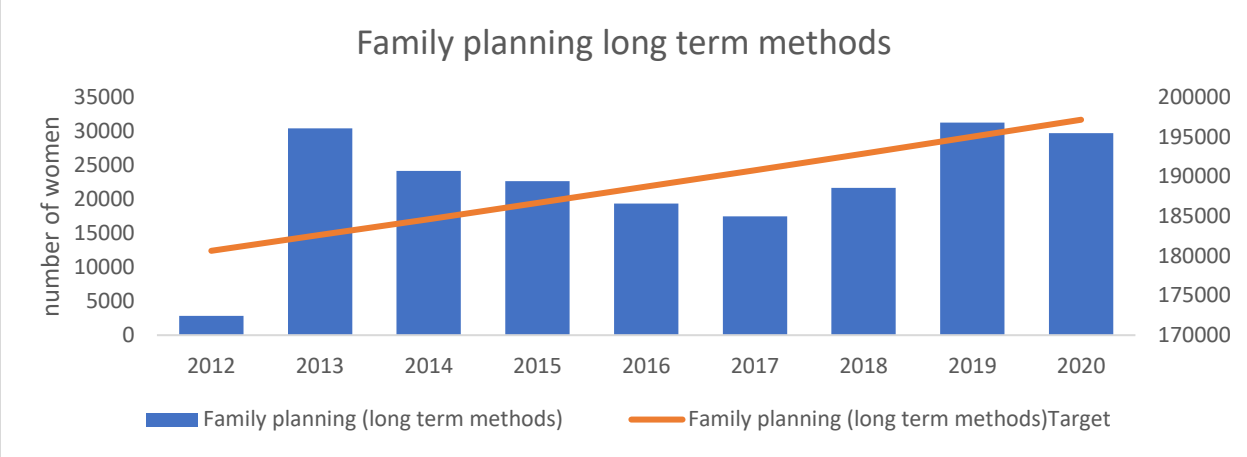

Figure 6: Family Planning (long term methods)

7.2.2.4 Vitamin A Performance against target

As shown in the figure below, there was an overall increase in performance of the indicator from 25% in 2012 to 45% in 2019 before declining to 29% in 2020 which could be attributed to COVID-19 related movement restrictions.

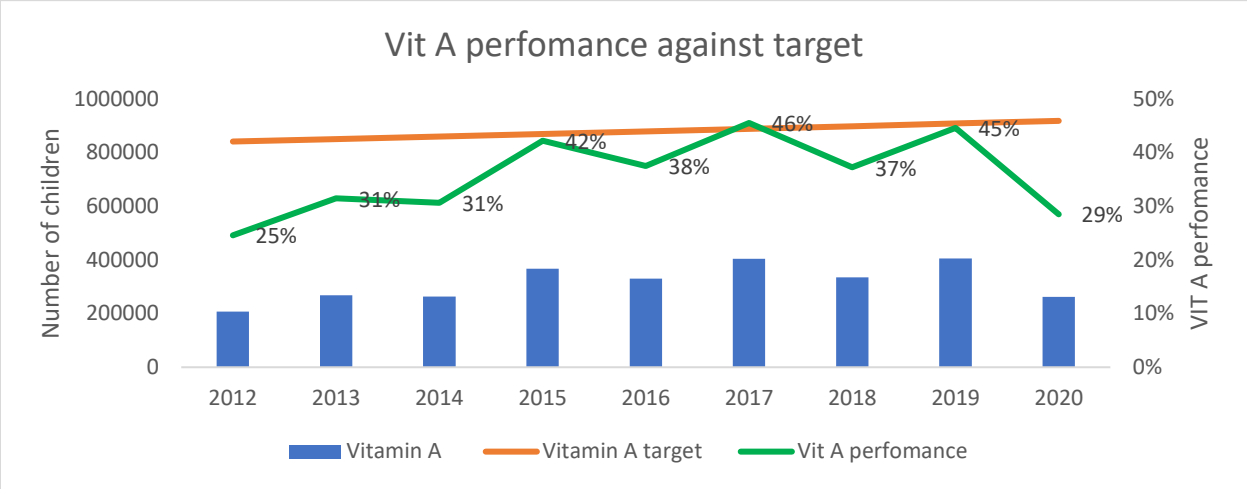

Figure 7: Vitamin A performance against target

7.2.3 Urban Voucher Programme Performance Data

Health services under the UV project were offered in 11 sites covering a population of about 300.000. (Ministry of Health and Child Care, 2016)Overall, from the start of the project through the end of 2020, 28.451 pregnant women were enrolled into the project. Out of these, 86% (24.463) of women purchased the voucher and 73% (17.755) women booked for the first ANC visit. About sixty-eight percent (16.616) of UV clients used the voucher for deliveries. Utilization rates were affected mostly by the funding gaps over the implementation period and COVID-19 affected service delivery in 2020. The project has made significant strides towards ensuring access to emergency MNCH services, including ambulance services among poor pregnant while reducing catastrophic out of pocket expenditure.

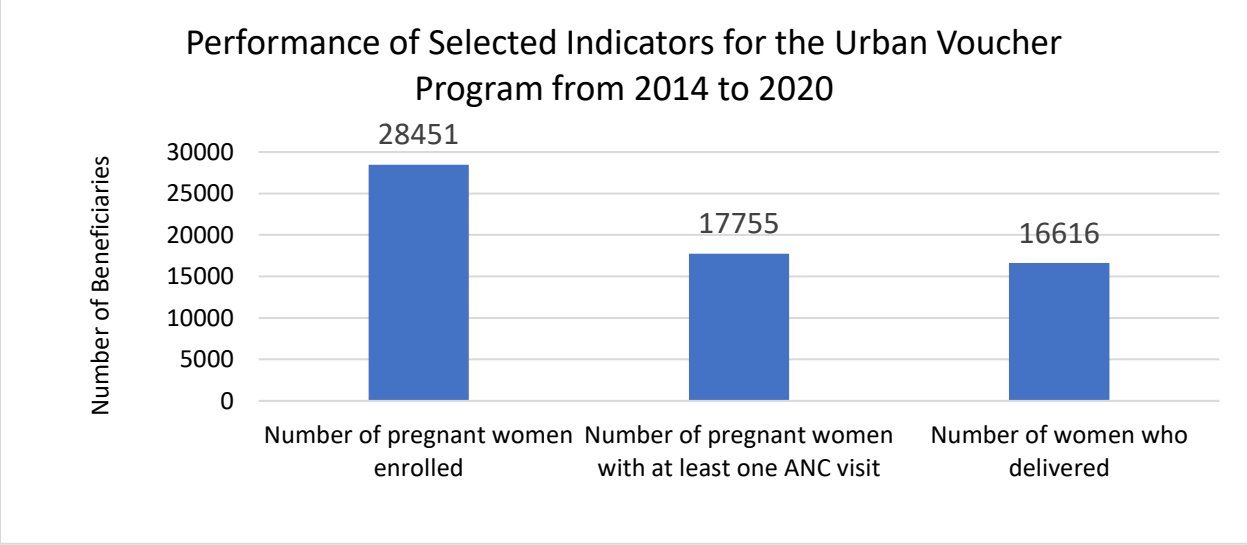

Figure 8: Performance of Selected Indicators for the Urban Voucher Program

Overall, the indicator performance has increased over the years as compared to the base line in 2012, except for the year 2020 due to the COVID-19 effect.

7.3 Support and supervision by the National Steering Committee

The NSC is a technical advisory committee to the PS that consolidates policy findings that enable or hinder effective implementation of service delivery (MoHCC, 2011, 2018, 2019 and 2020). Policy relates matters that have been noted and actioned in the NSC meetings include: The user fee policy review and the reigning in of errant service providers not adhering to the Policy and in non-conformity to the PIM. The RBF PIM reviews that were necessitated to align with the NHS to cater for moderators to facility performance on services (quality and quantity). Accordingly, the NSC recommended approval of the 2011, 2013, 2017 and 2019 PIMs. The RBF layering concept development. The NSC mandated the RBF TWG to develop further the Concept Note. Oversight and guidance to protect the motivation of service providers from shocks caused by unprecedented risks such as COVID-19 pandemic, e.g., application of retrospective performance to guide subsidy calculation in the absence of QSS scoring and Quantity Verification, late payments of subsidies etc. Providing decisions on gaming which could lead to termination of contracts e.g., as was done in the urban voucher programme where some of the community health workers claimed to have identified pregnant mothers who could not be traced for assessment or were outside the catchment area, or would also sub-contract to increase the numbers of identified mothers. Investigations were conducted and the contracts of the community health workers who were found guilty were terminated

7.4 Program management

7.4.1 Fund disbursements:

Government was able to fully disburse funds for all quarters and the payment delays gradually reduces over the periods.

On the WB side, grant processing delays led to requests to the PIE to prefinance and be reimbursed later and this helped in transitioning between grants.

7.4.2 Capacity Building

Throughout the project cycle, capacity building was provided across all stakeholders. These included refresher trainings, ICT trainings, financial management trainings and Quality assurance, staff secondments to MoHCC and quality improvement trainings.

7.4.3 Fiduciary

Quarterly Interim Financial Reports and annual audited accounts were mostly submitted on time to the World Bank with any delays communicated on time to the World Bank (MoHCC, 2012 to 2019). There were no qualified audit reports. Internal audit was conducted by an external firm. Cordaid ensured issues raised by auditors were cleared. With training and support from the World Bank team the implementing entity was generally familiar with World Bank financial and procurement guidelines. There was no ineligible expenditure and no mis procurement. No complaint case was reported against the project.

8 RBF IN THE PANDEMIC ADJUSTMENTS

Due to the COVID-19 pandemic, the following adjustments were made through the National Steering Committee meeting held in May and November 2020 to ensure safety of verifiers and adequately assess preparedness of facilities to provide care during the COVID-19 pandemic: COVID-19 addendum was

developed and pretested as the IPC component in the quality supportive supervision checklist was not adequate to assess facility readiness to continue provision of service during the COVID-19 pandemic.
Reduce the frequency of quantity verification for facilities in the amber and red category from once in two months and monthly to once in a quarter. Avoid home tracing for client satisfaction survey tools and conduct only exit interviews at facility level. Have virtual NSC meetings. Consider suspending verifications in case of COVID-19 surge.

9 ASPIRATIONS FOR THE FUTURE

The following items are being considered as part of the future of RBF. To extend the RBF beyond primary level and secondary levels to tertiary and quaternary level focused hospital, and at community level. The proposed layering approach is meant to spread the current co-financing in the 18 districts across the country as well as do the same the same with the external support to RBF. This is also intended to remove the identification of supported districts by a particular funding mechanism, facilitate harmonization of the purchasing and ensure equitable distribution of resources for balanced perception by service providers. An HRH harmonized hybrid retention scheme modelled around an RBF mechanism. Create staff establishment within the structure that caters for the purchasing unit. Ensure equity in fund purchasing pools by distributing their focus on either quality or quantity indicators across the system (layering approach). To scale up the urban voucher to all urban districts by considering financing innovations such as the health equity card / community health insurance etc. Payment of all RBF subsidies via the PFMS

10 RECOMMENDATIONS AND CONCLUSIONS

10.1 Recommendations

RBF strengthened the implementation of performance IRBM implementation and should be used to enhance understanding of IRBM principles. There is no limitation to the indicators that can be purchased and therefore the program should remain as purchasing mechanism to enhance indicator performance at all service delivery and management levels. Program logic theory is important for monitoring the effect of moderators on outputs and outcomes. A graphical illustration should be made to show the various links of the elements at the beginning of future projects. This enables easier evaluation of the program effects as well. The facility-based incentive approach achieved facility preparedness and infrastructure improvements and should be maintained as the anchor for design pf RNF programs in the system. Maintain the health worker incentive as a proportion of the facility incentive. Document and publish best practices from the program for adoption elsewhere. Program evaluations are important to affirm path towards fulfilment of program objectives. Maintain these in the program. Implement the layering approach for equity in funding mechanisms across service delivery levels. Scale up the urban voucher program. Strengthen the National steering Committee. Ensure full institutionalisation of RBF roadmap. There is a need to strengthen the program, with by extending it to the community. Regular reviews should be conducted with all stakeholders. Involving implementers from the planning stages. Capacity building on procurement for health facilities. Regular exchange visits should be conducted among facilities, districts and provinces. Ensure sustainability of RBF.

10.2 Conclusions

The RBF program has assisted the GoZ significantly reduce maternal and, child mortality over the 10 years of implementation. The program development objective was fulfilled and policy changes to improve

service delivery and access to health care have been made due to the influence of the program. The GoZ has shown commitment to ensuring that it delivers health care services to the people of Zimbabwe by also committing resources (financial, human and material) and political will to the program. The institutionalisation process will no doubt bring the much-needed continuity of the RBF a management mechanism to improve health service delivery. The program brought innovations that have improved the way of doing business and has created aspirations for future existence of the mechanisms. The Integrated Results Based Management implementation was effectively enhanced by the Results Based Financing program. It is in the interest of the Zimbabwe health system to maintain RBF as a purchasing mechanism.

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