



1. Project Data

Project ID P125229	Project Name ZW-Health Sector Development Proj (FY12)		
Country Zimbabwe	Practice Area(Lead) Health, Nutrition & Population		
L/C/TF Number(s) TF-10748,TF-15111,TF-A1598,TF-A5311,TF-A9037,TF-B3156	Closing Date (Original) 30-Apr-2023	Total Project Cost (USD) 58,210,464.93	
Bank Approval Date 29-Sep-2011	Closing Date (Actual) 30-Apr-2023		
	IBRD/IDA (USD)	Grants (USD)	
Original Commitment	78,000,000.00	78,000,000.00	
Revised Commitment	78,000,000.00	78,000,000.00	
Actual	57,462,105.27	58,210,464.93	
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2. Project Objectives and Components

a. Objectives

The objective of the project was to increase coverage of key maternal and child health interventions in targeted rural districts of the Recipient's territory, consistent with the Recipient's ongoing health initiatives (Grant Agreement, September 27, 2011, p. 8).



The PDO was revised three times with the following additions:

1. The first revision was associated with the first additional financing (AF I) of July 2013 that added two low-income urban districts. The revised PDO was “to increase coverage of key maternal and child health interventions in targeted rural and urban districts consistent with the Recipient’s ongoing health initiatives.”
2. The second revision was associated with the fourth AF (AF IV) of January 2019 that introduced quality aspects and institutional capacity for contract management with the following PDO statement: “to increase coverage and quality of key maternal and child health services in targeted rural and urban districts and strengthen institutional capacity for results-based financing contract management, consistent with the Recipients’ ongoing health initiatives” (Note: the original design included activities aiming at improving quality and institutional capacity building in support of Results-based Financing, but these were not explicitly reflected in the original PDO statement).
3. The third revision was associated with the fifth AF (AF V) of September 2020, and led to the introduction of COVID-19 response and expanded maternal and child health services under the following PDO: “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.”

This ICR Review pertains to an Interim ICR, that was required because the project was under implementation for 10 years. The Interim ICR assessment encompassed project implementation progress through December 31, 2020. The revised objective of January 2019, formulated in conjunction with AF IV, provided the basis of this ICR Review for validating the results reported by the Interim ICR under the following PDO statement: “to increase coverage and quality of key maternal and child health services in targeted rural and urban districts and strengthen institutional capacity for results-based financing contract management, consistent with the Recipient’s ongoing health initiatives.” A final ICR is to be developed after project closing, currently planned for April 30, 2023. A fifth AF became effective on December 2, 2020, and will be reviewed in the final ICR.

This ICR Review did not apply a split evaluation, as project ambition increased with expanded activities and scope, and there were no reductions in original outcome targets that were achieved and revised upward.

b. Were the project objectives/key associated outcome targets revised during implementation?

Yes

Did the Board approve the revised objectives/key associated outcome targets?

Yes

Date of Board Approval

26-Jul-2013



c. Will a split evaluation be undertaken?

No

d. Components

I. Results-based contracts for the delivery of a package of key maternal and child health services (Appraisal: US\$10.9 million; Actual: US\$33.20 million until December 2020).

This component was to support performance-based service delivery contracts with service providers stipulating the services to be delivered and the level of payments, based on the quantity and quality of services delivered. An international non-governmental organization (NGO, Cordaid), that was competitively selected, was to serve as Project Implementation Entity (PIE) and be responsible for contracting service providers, including Rural Health Centers led by Health Center Committees, District Hospitals, District Health Executives, and Provincial Health Executives. Community verification was to be undertaken by community-based organizations through the application of a standardized tool to verify service provision and obtain feedback from recipients. Health Center Committees and district hospitals were to make decisions regarding their respective business plans and how funds received under the contracts would be used to further improve service delivery.

II. Management and capacity building in Results-Based Financing (Appraisal: US\$3.9 million; Actual: US\$17.40 million until December 2020).

The component was designed to strengthen effective implementation and management of Results-based Financing (RBF). It was to support training, strengthening of data quality, reporting, and financial management. An RBF training module for health sector staff was to be implemented by the PIE, with rollout overseen by the Ministry of Health and Child Care (MOHCC). On-the-job capacity development was to complement workshop training. The component was to finance verification and counter verification of services reported by facilities. The component would also provide some medical equipment to selected facilities.

III. Monitoring and documentation (Appraisal: US\$0.2 million; Actual: US\$2.4 million until December 2020).

Under this component, support was planned for project monitoring, data aggregation, analysis, evaluation, and documentation. Learning was to be further supported through an impact evaluation and other reviews to capture the effects of the program. The component was also to assess equity through household surveys and exit interviews during health facility assessments using an asset index.

District selection: The targeted rural districts were specified as rural districts with predominantly poor populations, and women and children were identified as direct beneficiaries (ICR, p. 24). In addition, the Task Team clarified on October 29, 2021 that selection criteria included geographic accessibility/remoteness, average catchment population, staff in position, and health services utilization. The urban RBF was introduced in 2013 on a pilot basis in two low-income districts associated with the two



largest cities of Harare and Bulawayo (2013 Project Restructuring Paper, p. 12). The total population covered was 4.1 million people, out of a national population of about 15 million people.

Revised components

The first four AFs added activities within the original three components (see Section 2e).

Note: The fifth AF of September 2020 added a fourth component on COVID-19 Response to support the government in preventing the spread of infection. It also added activities to: (a) expand the RBF package to cover prioritized RMNCAH-N; (b) reorient RBF to be quality-focused in provincial and central hospitals; (c) support community mobilization; (d) scale up the urban voucher scheme to more health facilities; and (e) strengthen institutional capacity to implement selected health financing reforms that complement RBF. As stated in Section 2a, the assessment of the fifth ongoing AF is beyond the scope of the Interim ICR and this ICR Review, as it became effective only on December 2, 2020.

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

Estimated project cost at appraisal: The original cost at appraisal in 2011 was estimated at US\$15 million, covering 18 rural districts (two pilot districts initially, followed by a rollout in 16 more districts) with an estimated population coverage of 3.6 million people. RBF contracts were planned until July 31, 2014. The financial instrument was a Sector Investment Grant financed by the World Bank administered Multi-donor Trust Fund for Health Results Innovation (HRITF).

Additional financing and dates: The operation had five AF cycles funded by HRITF and the Global Financing Facility as detailed below. Zimbabwe was in arrears during the preparation of the project and at its closing date (ICR, p. 6). The project adapted to Zimbabwe's particular macroeconomic circumstances, compounded by its inability to access IDA resources, by seeking trust fund resources to deal with some of its human development challenges in maternal and child health (ICR, p. 16).

1. The first AF of US\$20 million, approved in July 2013, continued RBF contracts in the 18 rural districts and introduced urban RBF activities in Bulawayo and Harare, including a maternal health voucher, and extended the project until October 30, 2015. The estimated population coverage increased to 4.1 million people.
2. The second AF of US\$10 million, approved in December 2015, continued the above activities and introduced quality improvement innovations. It extended the project until February 28, 2017, with a subsequent extension until January 30, 2018.
3. The third AF of US\$5 million, approved in July 2017, continued the above activities, and rolled out quality improvement activities and process evaluation on cost-effective approaches to verification. It extended the project until March 2019.



4. The fourth AF of US\$3 million, approved in January 2019, continued the same activities and provided support to MOHCC for the institutionalization and harmonization of the RBF program in the country. It extended the project until December 31, 2020.
5. The fifth AF of US\$25 million (beyond the scope of this ICR Review), approved in September 2020, continued the above activities and introduced a COVID-19 response component with a "last-mile commodity tracking system" for COVID-19 supplies using the MOHCC Electronic Health Records System. Population coverage for COVID-19 activities was estimated at 14.4 million people, and 4.8 million people for expanded maternal and child health services. The AF extended the project until April 30, 2023.

Actual cost by December 31, 2020: The ICR reported an actual cost of US\$53 million by December 31, 2020, the cutoff date for the Interim ICR.

Other main dates: The project was approved on September 29, 2011 and became effective on December 8, 2011. A Mid-Term Review was carried out on February 22, 2013. The closing date is projected for April 30, 2023.

Role of Development Partners and NGOs. Development partners, United Nations agencies, and NGOs were engaged in various areas of the health sector in Zimbabwe, including maternal and child health. The main agencies were the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the World Health Organization, the UK Department for International Development (DfID), the European Commission, the United States Agency for International Development, and the Global Fund. Early dialogue was undertaken with these agencies and with NGOs, as the project did not seek to replace ongoing interventions and technical assistance, but rather sought to build on what already existed in order to strengthen potential outcomes in maternal and child health under RBF (ICR, p. 8 and PAD, p. 12).

Continued engagement with development partners during project implementation was a conducive factor to the 2014 expansion of RBF by development partners to the remaining 42 non-project districts. The expansion was financed by the Health Development Fund (HDF) supported by DfID, the European Union, the Swedish International Development Cooperation Agency, Irish Aid and GAVI (the Vaccine Alliance), working closely with UNICEF and UNFPA. Hence, all 60 rural districts were ultimately covered by RBF. But differences remain between the two RBF mechanisms (Project RBF vs. HDF RBF), as HDF-funded districts: (a) do not have an external counter-verification system; (b) do not implement a Continuous Quality Improvement Model; and (c) do not contract community-based organizations as such, but rather as individuals.



3. Relevance of Objectives

Rationale

At appraisal, the project was responsive to country needs in maternal and child health. The functioning of the sector and overall health indicators were deteriorating as a result of Zimbabwe's worsening economic situation. There were challenges in health financing and service delivery, training, monitoring, and retention of health workers, many of whom had left the country. The 2007 National Health Accounts showed that 36% of the population could not afford to pay user fees for hospital services. Life expectancy at birth declined from 58 years in 1990 to 43 years in 2008, with HIV/AIDS contributing to the decline. Zimbabwe ranked 169th on the 2010 Human Development Index. In 2009, the maternal mortality ratio was 790 maternal deaths per 100,000 live births; under-5 child mortality was 86 per 1,000 live births; attended-births were at 60%; and the proportion of fully immunized children was 49%.

Relevance of objectives was also rooted in the identified high-impact interventions in maternal and child health that were elucidated in the Health Sector Investment Case 2010-2012, developed by MOHCC with the support of the World Bank and UNICEF, and where investment needs to reach different scenarios of health outcomes were analyzed (PAD, p. 5).

Both the original and revised objectives remained relevant during the extended implementation period under consecutive AFs. Objectives were consistent with the National Health Strategies of 2011-2013 and 2105-2020, as these strategies considered reproductive, maternal, newborn, child, and adolescent health as priority areas. The objectives were also in line with the World Bank's Health, Nutrition, and Population Strategy (2007), as the latter supported the promotion of equitable and efficient provision of public health services, including strengthening health systems. The objectives were consistent with the World Bank Group priorities for the country, as outlined in the FY13-FY15 Interim Strategy Note (Report No. 74226-ZW), that included human development within Priority 3 (Fostering an Enabling Environment for Reducing Vulnerabilities, Improving Resilience and Strengthening Human Development). The project's objectives remained well aligned with Zimbabwe's Transitional Stabilization Program (TSP) 2018-2020, in particular with part 4 of the TSP that targeted human development, including investments aimed at achieving equitable coverage and enhanced quality of health service delivery. The quality of maternal health services constituted one of the priorities of TSP.

Rating

High

4. Achievement of Objectives (Efficacy)



OBJECTIVE 1

Objective

Increase coverage of key maternal and child health services in targeted rural and urban districts

Rationale

Theory of change

The ICR established the theory of change as follows: it was reasonably expected that the provision of a package of maternal and child health services would lead to patients receiving the package of services, and that this would plausibly lead to increased coverage of relevant services. It was understood from the ICR that service provision would be facilitated by activities that would support and/or improve training, staffing, technical assistance, verification of results, provision of equipment, and supply chains for drugs. Such supporting activities would concurrently contribute to health system strengthening. And, as stated in Section 2a, the original design had in-built activities aiming at improving quality and capacity building for contract management in support of overall RBF (ICR, p. 8).

Outputs

The project provided RBF contracts to 10 Provincial Health Executives (8 rural, 2 urban), 20 District Health Executives (18 rural and 2 urban), 437 facilities (389 Rural Health Centers, 35 Rural Hospitals, 11 Urban Clinics, and 2 Central Hospitals), and 426 community-based organizations, of which 418 were rural and eight were urban (Recipient's ICR, p. 59).

The project introduced the Urban Voucher Program to allow poor pregnant women to access maternal care services. In Harare and Bulawayo cities, the project focused on the urban poor as individuals through means-testing or as communities through targeted urban-poor communities (ICR, p. 23). Hence, in contrast with the rural RBF that was available to all clients (pregnant women, mothers, and children) living in the catchment area, the urban RBF was available to eligible poor beneficiaries who were identified by social services authorities.

Per Task Team clarifications (October 29, 2021), the rural RBF was based on both coverage and quality indicators, while the urban RBF focused on quality indicators. 31.6% of health facilities in Bulawayo and 12.5% in Harare participated in the urban RBF scheme.

Intermediate results



Under the project, the number of deliveries attended by skilled health personnel in both rural and urban participating districts reached 984,066 deliveries, exceeding the AF IV target of 762,573 deliveries.

The cumulative number of pregnant women receiving first antenatal care during a visit to a health provider in participating urban districts increased from a baseline of 12,737 in 2014 to 100,941 beneficiaries as of December 2020, exceeding the AF IV target of 89,031 beneficiaries.

The 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 increased from a baseline of 572 beneficiaries in 2012 to 4,989 beneficiaries as of December 2020, exceeding the AF IV target of 4,035 beneficiaries.

The number of children immunized (full routine immunization with BCG, OPV 1 to 3, Penta 1 to 3, and Measles MR1) in rural districts reached 817,556 children as of December 2020, from a baseline of zero (prior to project contributions according to Corporate Results Indicators), exceeding the AF IV target of 663,409 children.

The number of women and children 6-59 months who received Vitamin A supplementation in participating rural districts reached 2.24 million beneficiaries as of January 20121, exceeding the AF IV target of 1.54 million beneficiaries.

The cumulative number of pregnant women living with HIV who were initiated on antiretrovirals to reduce the risk of Mother-to-Child-Transmission of HIV in participating rural districts increased from a baseline of 9,399 in 2012 to 59,572 beneficiaries as of December 2020, virtually achieving the AF IV target of 60,000 beneficiaries.

The ICR (p. 23) also reported that there were general benefits accruing to the community at large, as the RBF approach allowed health facilities to use RBF funds to improve system needs such as health facilities staffing, supply chain for drugs and supplies, and infrastructure maintenance and small rehabilitation works for existing facilities.

Outcomes



The project increased coverage of mothers and children in project areas, as reflected by the above intermediate results and by the outcome indicators noted below:

The percentage of births attended by skilled health personnel in a health institution in participating rural districts increased from a baseline of 58% in 2012 to 82% in 2019, moderately short of the AF IV target of 88%. The ICR (p. 18) noted that the increase in attended deliveries was in line with earlier findings of the 2014 impact evaluation that showed that RBF increased the rate of deliveries attended by a skilled provider by 15%, and by 13% for institutional deliveries, when compared to control districts.

The percentage of pregnant women who received antenatal care during their visit to a health provider in participating rural districts increased from a baseline of 70% in 2012 to 80% as of December 2020, surpassing the AF IV target of 72%.

The percentage of women 15-49 years who currently use any of the modern family planning methods in participating rural districts increased from a baseline of 56% in 2012 to 70% as of December 2020, achieving the AF IV target.

The percentage of children under 5 with diarrhea receiving oral rehydration therapy and Zinc, in participating districts, increased from a baseline of 13.8% in 2015 to 16.5% in 2019, slightly exceeding the AF IV target of 16%.

Rating
Substantial

OBJECTIVE 2

Objective

Increase the quality of key maternal and child health services in targeted rural and urban districts

Rationale

Theory of change



The theory of change was closely associated with that of service provision under objective 1: in addition to quantitative aspects of service provision, it was reasonably expected that quality-focused activities and the use of tools that monitor and promote qualitative aspects of health services would plausibly lead to an increase in the quality of maternal and child health services.

Outputs

Main outputs consisted of utilization of quality scorecards in health facilities, quality-related tools in supervision, partographs in monitoring childbirth, maternal death audits and learning from their findings, and implementation of the Continuous Quality Improvement Model.

Explanatory Notes:

- Quality scorecards are normally used in RBF operations and include numerous structural and process quality measures, e.g., record keeping, availability of staff, availability of supplies, and hygiene. Both quantitative and qualitative aspects of delivered services were considered in quarterly performance-based payments, and adjustments to payments were made based on quality scores.
- Continuous Quality Improvement (CQI) is a continuous process of measuring, analyzing, and improving service quality. The Task Team further clarified on October 29, 2021 that the CQI model spurred health personnel to work together as a team to fulfil the CQI approach throughout its cycle: "Plan, Do, Study, and Act."
- A partograph is a graphical record of observations made during childbirth. It helps in monitoring progress with a focus on cervical dilatation, fetal head descent, uterine contraction, and fetal and maternal status. Partographs help in the early detection of maternal and fetal complications, notably in the prevention of prolonged and obstructed labor.

Intermediate results

The percentage of RBF contracted facilities in CQI districts with CQI Standard Operating Procedures reached 76% as of December 2020, almost achieving the AF IV target of 80%.

The percentage of health facilities implementing the CQI model in participating rural districts reached 17% as of March 2021, short of the AF IV target of 23%.



The number of District Health Executives in participating districts using quality tools for supervision of health facilities included all 20 executives as of December 2020, achieving the AF IV target.

Outcomes

The average quality scores by health facilities in participating rural and urban districts increased from a baseline of 68.1% in 2012 to 83% as of December 2020, slightly surpassing the AF IV target of 81%.

The percentage of maternal death audits per protocol in participating districts reached 76% as of December 2020, from a baseline of zero in 2015, slightly short of the AF IV target of 80%.

The percentage of partographs correctly filled in participating districts reached 62% as of December 2020, from a baseline of zero in 2015, almost achieving the AF IV target of 65%.

The percentage of children under 5 years of age with pneumonia correctly managed in the participating districts reached 89.5% as of December 2020, from a baseline of zero in 2015 (prior to project contributions per Corporate Results Indicators), surpassing the AF IV target of 87%.

Rating

Substantial

OBJECTIVE 3

Objective

Strengthen institutional capacity to manage results-based financing contracts

Rationale

Theory of change



It was reasonably expected that the provision of training and capacity building for managing performance-based contracts would result in strengthened abilities of MOHCC, the Ministry of Finance and Economic Development, and health facilities to manage performance-based contracts, plausibly leading to overall strengthened institutional capacity to manage performance-based contracts (in lieu of being managed by a third party, i.e., the PIE).

Outputs

Staff were trained in RBF contracting and implementation, but the ICR did not offer further information about project experience related to this objective.

Outcomes

The percentage of health facilities managed under RBF contracts by the MOHCC Program Coordination Unit in participating rural districts reached 23% as of March 2021, short of the AF IV target of 32%.

Rating

Modest

OVERALL EFFICACY

Rationale

The first and second objectives, to increase coverage of key maternal and child health services and to increase the quality of key maternal and child health services, were almost fully achieved. The third objective to strengthen institutional capacity to manage results-based by the MOHCC was partly achieved. The aggregation of achievements under the three objectives is consistent with a substantial rating for overall efficacy.

Overall Efficacy Rating



Substantial

5. Efficiency

The PAD’s economic analysis did not undertake a cost-benefit analysis, but it estimated the increase in coverage through selected interventions over a three-year period while referring to internationally-documented cost-effectiveness of such interventions. It concluded that the project would support highly cost-effective interventions known to impact positively on health outcomes, and that increased coverage under the project would provide strategic economic gains to the country (PAD, p. 18).

The ICR carried out an ex-post cost-benefit analysis. It used reasonable assumptions in estimating averted deaths in neonates, delivering mothers, and children under 5. The project impact was estimated over nine years, including an estimate of 28,869 children’s lives saved and 784 women’s lives saved. The net present value of project benefits was estimated at US\$134.3 million with a 10% discount rate yielding an internal rate of return estimated at 14%. The benefit cost ratio was estimated at 3.13 for every dollar invested.

The efficiency of implementation was adequate overall, and effective donor coordination and complementarity were contributing factors. There were moderate shortcomings that stemmed from disruptions related to human resources as a result of staff turnover and occasional strikes by health workers who were dissatisfied with their working conditions and remunerations, as salaries did not keep up with inflation. Delays in fund flows between AF transitions temporarily affected the urban voucher program. Stakeholders who were interviewed in rural districts reported payment delays of two to three quarters (ICR, p. 25). The Task Team clarified on October 29, 2021 that fund flows between AFs were dependent on the availability of grants that had their own funding cycles, beyond the control of the government or the project.

Efficiency Rating

Substantial

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 <input type="checkbox"/> Not Applicable
ICR Estimate	✓	14.00	100.00 <input type="checkbox"/> Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.



6. Outcome

Relevance of objectives is rated high, as the objectives were responsive to maternal and child health priorities and were consistent with country and Bank strategies. Efficacy is rated substantial, as development objectives were almost fully achieved. Efficiency is rated substantial in view of the cost-effectiveness of project interventions and positive estimated returns, but with moderate shortcomings in the efficiency of implementation. The overall outcome is rated satisfactory, indicative of essentially minor shortcomings in the project's overall preparation, implementation, and achievement.

a. Outcome Rating

Satisfactory

7. Risk to Development Outcome

At project closing, four main risks to development outcomes could be identified, and they raise the possibility that the realized development outcomes may not be maintained. First, the country's fragile and conflict-affected situation (FCS) may be further prolonged. Second, human resource constraints may continue to be challenging for effective delivery of health services. Third, financial sustainability remains a risk for maintaining the RBF approach. Fourth, the COVID-19 pandemic exacerbates the above risks, as it created additional challenges in various sectors.

Nevertheless, commitment to the RBF approach remains strong at all levels. Since 2019, the government has been providing its own resources to support subsidies within the RBF program in project districts. According to the ICR (p. 25), the government intends to increase its support to all 60 rural districts in the coming years with the expectation that the overall resource envelope will improve. The ongoing project continues to assist the government in further strengthening the institutionalization of RBF, given MOHCC's interest and commitment to such institutionalization. Other development partners have committed resources to support national RBF endeavors, as demonstrated by their current support to RBF in 42 districts through the multi-donor HDF (see Section 2e). The project is currently supporting the COVID-19 response under the fifth AF. A COVID-19 Emergency Response Project is also being prepared. The above efforts are expected to contribute to risk mitigation.

8. Assessment of Bank Performance

a. Quality-at-Entry

Preparation was participatory and included consultations with Development Partners, UN agencies, international and national NGOs, and national stakeholders. Project design was informed by experience in other countries, such as piloting RBF before rolling it out and promoting local ownership and involvement, including at the facility level. Preparation built on the knowledge that the Bank developed



through policy dialogue with MOHCC and other analytical work in the health sector since 2009 (PAD, p. 5). Importantly, the design built on the findings of the Health Sector Investment Case 2010-2012 that was developed by MOHCC with the support of the Bank and UNICEF (see Section 3). In view of capacity constraints, the planned use of a contracted PIE was an appropriate decision made in Zimbabwe's context.

Project preparation clearly identified roles and responsibilities of key stakeholders involved in implementation, including the PIE, Health Center Committees, District Health Executives, and Provincial Health Executives. The project planned for the coordination of RBF activities to be guided by a National RBF Steering Committee (ICR, p. 24). Arrangements for implementing activities, financial management and fiduciary compliance, and environmental aspects were adequately prepared. Risks and mitigation measures were also adequately identified. M&E arrangements were well prepared, although the original PDO statement could have included quality improvement, as related activities were already in-built in the design to determine the level of RBF payments.

Quality-at-Entry Rating

Satisfactory

b. Quality of supervision

Supervision and implementation support were intensive. Supervision missions were regularly undertaken on a six-monthly basis, and a health specialist based in Harare provided regular implementation support. Supervision missions had a variety of technical specialists, including in financial management, procurement, and safeguards. The Task Team provided added attention to verification processes, quality improvement activities, and the urban voucher program. The Implementation Status and Results Reports reported project implementation progress with candor, enabling Bank management to provide the necessary guidance (ICR, p. 26). During implementation, the Task Team closely engaged with the National RBF Steering Committee in its efforts to coordinate a common RBF approach in all 60 rural districts (18 project districts and 42 HDF-funded districts). The Team was proactive in addressing arising issues and in processing five AFs. The team was diligent in monitoring and updating the Results Framework under consecutive AFs to ensure adequate assessment of expected achievements. The ICR (p. 26) also recognized the efforts of the Task Team in providing effective supervision and implementation support in a challenging FCS environment with significant financial constraints.

Quality of Supervision Rating

Highly Satisfactory

Overall Bank Performance Rating



Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

The objectives were clearly stated and reflected by the indicators. The ICR established a generic theory of change, but it did not adequately articulate main elements of the results chains (see Section 4). The results framework was adequate, and data sources were well identified. These included the routine health management information system; RBF checklists and reports; Multiple Indicator Cluster Surveys; and impact evaluation. MOHCC departments held the responsibility to oversee M&E implementation. M&E design and arrangements were well embedded institutionally, including because the choice of indicators was consistent with the objectives of the National Health Strategic Plan 2009-2013 (PAD, p. 5).

b. M&E Implementation

M&E activities were implemented as planned, including for data collection and data verification. The results framework was updated and refined with consecutive AFs. The project carried out an impact evaluation in 2014, including a household survey undertaken through consultant experts (JIMAT Development Consultants) and a facility survey undertaken by the University of Zimbabwe. The impact evaluation was adequately carried out. It used baselines of the same surveys that were previously performed in 2011.

c. M&E Utilization

M&E findings were used to monitor project progress and were widely shared. RBF data were used to inform payments based on delivered services, with consideration to both quantitative and qualitative aspects. Health Center Committees and hospital boards utilized M&E data to make decisions for improving services at their own facilities.

Impact evaluation findings were published by the World Bank in 2016. A copy was provided by the Task Team on October 29, 2021 (Report No: 106518-ZW, titled as “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”).

The ICR (p. 60) reported that M&E findings contributed to the government decision in 2014 to scale up RBF in the remaining rural districts with financial support from the multi-donor HDF (see Section 2d). According to the ICR (pp. 24-25), M&E findings further heightened the commitment to RBF mechanism,



including for some stakeholders who were initially skeptical about its merits, as they became appreciative of visible results and enhanced accountability under RBF.

M&E Quality Rating

Substantial

10. Other Issues

a. Safeguards

The project was classified under Environmental Category B, as it triggered Environmental Assessment OP/BP 4.01 in view of health care waste that would be generated by health facilities. The risk was to be mitigated through the application of appropriate standards for medical waste management. The existing Health Care Medical Waste Plan was updated and publicly disclosed. For the ongoing fifth AF that includes COVID-19 response activities, an Environmental and Social Management Framework was also prepared, but it is beyond the scope of this ICR Review, as noted in Section 2a.

The ICR (p. 27) reported that quarterly quality assessments were carried out at health centers and hospitals to monitor their compliance with environmental and healthcare waste management guidelines, and that quality checklists were helpful for health centers to identify gaps and use RBF funds to address them. The ICR did not offer further information on the extent to which the safeguard purposes were achieved.

A moderately satisfactory rating for safeguards, based on the last ISR, was recorded in the Operations Portal. The Task Team clarified on October 29, 2021 that adherence to environmental safeguards was satisfactory for most of the project implementation period, but that in 2018 and 2019, health facilities encountered challenges in fully adhering to waste management standards due to supply issues resulting from high inflation and budgetary constraints. The project had no construction, rehabilitation, or extension works, although health centers and hospitals could use RBF funds for small works and repairs, while following national and local guidelines in such cases.

Concerning social aspects, Zimbabwe has a well-established grievance redress mechanism, and the project supported this mechanism at the facility level. Patients could also present their grievances to community members of the Health Center Committees, and to community-based organizations that followed up on eventual complaints with the relevant health care authority (ICR, p. 28).



b. Fiduciary Compliance

A financial management assessment was carried out during preparation and concluded that the PIE met the Bank’s minimum requirements for project financial management as per OP/BP 10.02. During project implementation, financial management was adequately undertaken. The project complied with the timely submission of quarterly interim financial reports. Independent external audits were carried out regularly. No qualified audits were reported (ICR, p. 28).

A procurement capacity assessment of the PIE was carried out by the Bank during project appraisal. It concluded that PIE procurement capacity, including its organizational setup and field presence, was adequate. During implementation, an additional procurement officer was also recruited. Operational costs were spent in accordance with the PIE’s Field Office Manual that was reviewed by the Bank and found to be adequate. Procurement of goods and services, and the selection and employment of consultants, were undertaken in accordance with Bank guidelines (ICR, p. 28).

c. Unintended impacts (Positive or Negative)

None reported (ICR, p. 23).

d. Other

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11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Satisfactory	
Bank Performance	Satisfactory	Satisfactory	
Quality of M&E	Substantial	Substantial	
Quality of ICR	---	Substantial	

12. Lessons

The Interim ICR (pp. 30-32) offered several lessons and recommendations, including the following lessons, partially re-stated by IEG:



Health services under RBF are improved with concurrent health system strengthening, and both RBF mechanism and health system strengthening are mutually reinforcing. The project strengthened important system components, including institutional aspects at the local level, accountability, human resource skills, key equipment and supply chains for drugs and supplies, infrastructure maintenance, and health information.

Piloting informs the full rollout of RBF operations. The project started as a pilot in two rural districts before being scaled up, in line with the good practice that learning-by-doing informs further operational expansion. Apart from technical aspects of implementation, the scale-up of RBF in Zimbabwe entailed building a common understanding, appreciation, and consensus among stakeholders. The process of reaching a common understanding was facilitated by the piloting phase.

Sustained dialogue with Development Partners enhances synergy. The Bank Team engaged with Development Partners during project preparation and continued its dialogue during implementation through the National RBF Steering Committee and through meetings held by the Health Development Partners Group. This engagement enhanced synergy in terms of activities and resources, driven by shared goals related to maternal and child health, and culminating in additional support being extended to all rural districts.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The Interim ICR was results-oriented and aligned to development objectives. It provided a detailed overview of project performance so far, and appropriately linked the narrative, the ratings, and the evidence that was of good quality. The Interim ICR offered specific lessons derived from project experience. It was reasonably concise, internally consistent, and followed guidelines. The Interim ICR had moderate shortcomings. Its reporting on Objective 3 (strengthening institutional capacity to manage results-based financing contracts) was scant. It lacked specificity in its reporting on project outputs and on compliance with environmental safeguards, and in its articulation of the results chain. Related gaps were aptly addressed by clarifications provided by the Task Team.

a. Quality of ICR Rating



Substantial