

An analysis of Results based financing as social accountability strategy in health sector. The Case study of Shamva District in Zimbabwe.

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Abstract

Zimbabwe's public health care spending per capita is one of the lowest among countries in the subregion. There is reliance on donor funding on health. Most of the people in rural areas cannot afford the health care. This study therefore examines the impact of results-based financing in improving quality health services in Shamva District. The study's beliefs were based on interpretive and critical post-modernist paradigms. Qualitative methodology was used. Data generating tools that were utilised are focus group discussions, key informant interviews and participant observation. The data generated were analysed using grounded theory. The key findings are that results-based financing (RBF) strengthened the health system and improved health service delivery in rural areas. RBF complemented traditional input-based financing at Shamva District hospital. The study concluded that cosmetic participation and transactional relationship are encouraged by conditions that are supposed to be fulfilled to get RBF earnings. The major recommendation is that government and development partners should improve provide adequate financial resources and mechanisms that complement RBF earnings that cater for health centres' administration costs in Shamva District.

Key words: Results based finance, quality health services, accountability, health centre committees, communities.

1 Introduction

The study focused on examining the impact of results-based financing strategy in Shamva District. The paper covers the back ground to the problem, statement of the problem, the purpose of the study, objectives of the study and research questions. The paper further presents the methodology, data analysis, presentation and discussion. The major findings, conclusions and recommendations are also given.

1.1 Background to the problem

An estimated 7.6% of households in Zimbabwe incurred catastrophic health expenditures (CHE) in 2015. 13.4% of the poorest households incurred CHE, while in contrast 2.8% of the richest households incurred CHE (Ministry of Health and Child Care, 2017). The Government of Zimbabwe's health sector budget is lower than many other Sub-Saharan African countries. This leads to major financial burden of health care on households in the form of out-of-pocket payments, rendering the health system inequitable and inefficient. This has been the case in Shamva District Health Sector also. There is evidence that many poor households rely on substandard care or even forgo necessary health care due to low capacity to pay (World Bank 2016). To address this the Ministry of Health and Child Care (MOHCC) developed health financing policy that targets to offer Universal Health Care (UHC) that ensure that all citizens have access to quality health services without suffering financial hardship.

Results based financing pilot program started in two districts in July 2011 and further expanded to 397 health facilities in 16 additional pilot districts in March 2012 (Vergeer and Mc Cune, 2013). The programme was funded by World Bank. In 2014 the RBF was scaled up to remaining 44 rural districts in the country with support from

Health Transition Fund that was administered by UNICEF, scaled up RBF to the (World Bank 2016). The programme reached about 3.5 million people.

In addition, most women (89 percent) and men (88 percent) do not have health insurance (Zimbabwe demographic and health survey, 2015). About 15% of the population that has health insurance is mostly covered by employers. Therefore, RBF became a strategy used to address low-performance problems, and more generally, health system reform (Meessen et al., 2011).

Zimbabwe's fiscal space analysis that was conducted in 2015 pointed to several constraints in health sector that include lack of efficient use of health sector resources, reliance on external assistance on health, weak public finance management, shortage of drugs and equipment and shortage of qualified human resources for health. To improve health outcomes and to boost the efficiency, equity and quality of their health systems, low- and middle-income countries across the globe pilot various results-based financing (RBF) approaches, such as performance-based financing (PBF) to strengthen the supply of health services (Vergeer and McCune, 2013).

1.2 Statement of the problem

Shamva District had high mobile population or internal immigrants due to illegal mining activities in the district, resulting in high levels of HIV and Sexually Transmitted Infections (STIs). Most rural communities in Shamva District are poor that they cannot afford to pay for out of pocket expenses. The Ministry of Health and Child Care (MoHCC) through the National Health Surveys acknowledges poor health services delivery in rural communities. Some of the causes of poor service delivery are shortage of drugs, lack of adequate human resources, low budget allocations to

Ministry of Health and Child Care and lack of full implementation of decentralisation. This led the Ministry of Health and Child Care to sign memorandum of understanding with development partners such as World Bank and UNICEF that supported civil society organisations to implement RBF programmes in a bid to improve quality of services delivered mostly at primary health care level.

There is lack of evidence documented on the impact of results-based financing as a social accountability strategy in Shamva District. It is not clear whether RBF encouraged deliberative dialogue between communities and health officials. It is also not clear whether communities are empowered to know their health rights and are able to demand accountability from health officials through the implementation of RBF. Therefore, it is the intention of this study to bridge the knowledge gap by analysing the impact of RBF strategy in enhancing quality service delivery in Shamva District.

1.2.1 Purpose of the Study

The purpose of this study was to analyse the impact of results-based financing as social accountability strategy in improving quality health services in Shamva District.

1.2.2 Objectives of the Study

The objectives of the study were to:

1. Determine whether the results-based financing was used as a social accountability strategy that encourages deliberative dialogue between communities and health officials.
2. Explore the implementation of RBF in Shamva District Health Sector.

3. Analyse the impact of RBF strategy in Shamva District.

1.2.3 Research Questions of the Study

The study's research questions were:

1. To what extent does RBF strategy used to initiate deliberative dialogues between the communities and health officials in Shamva District?
2. How is the RBF being implemented in Shamva District Rural Health Sector?
3. What are the benefits of RBF in Shamva District Health Sector?
4. Why there are challenges in implementing RBF in Shamva District Health Sector?

2 Review of Related Studies

RBF is “any program where the principal sets financial or other incentives for an agent to deliver predefined outputs or outcomes and rewards the achievement of these results upon verification” (Musgrove, 2011). RBF interventions can lead to improved accountability, supervision structures, and working environment (Shena, Ha Thi, Nguyen, Das, Sachingongu, Chansa, Friedmand & Qamruddinb ,2015). The model can incentivise health personnel using money (Shenat et al, 2015).

The government of Zambia, with the assistance of the World Bank, adopted RBF in April 2008 where results were linked to finances. The main aim was to increase autonomy in health facility management and planning among service providers; to be accountable to the community by involving them in managing services; to improve reporting through the usage of instruments to plan for services; and to strengthen the health services by separating the functions of policy formulation, service delivery, and regulation (Shenat et al, 2015). RBF earnings motivated the personnel encouraged the

adoption of professional behaviors, such as reporting for work on time or even early, wearing a uniform, or following all appropriate procedures when attending to patients. RBF enhanced teamwork and collaboration within its health facilities and districts. Health staff realized the importance of working together, with openness and strong communication, if they were to collectively meet RBF targets.

In addition, Rwanda's performance budget financing (PBF) program improved service delivery and utilization, especially for the country's poorest populations. Institutional deliveries among the poorest quintile increased from 12.1 percent to 42.7 percent (Vergeer & Mc Cune, 2013). In Burundi, the scaling up of PBF program improved the health equity of women and children. Operational data gathered between June 2010 and 2011 showed that institutional deliveries increased by 25 percent, and curative care consultations for pregnant women increased by 34.5 percent (Vergeer & Mc Cune, 2013).

3 Methodology

Qualitative methodology was utilised by the researcher to conduct the study. The data generating tools used were, participant observation, focus group discussion and key informant interviews. Grounded theory was used to analyse the data. In conducting the study ethical considerations were observed. The research team ensured that they got consent from participants of focus group discussions and key informants before engaging them in the study. The research team also verified their conclusions before writing a final report. The Ministry of Health Child Care and the Shamva District medical officer's permission was sought to undertake the research.

3.1 Research Methodology

Interpretive and some elements of critical postmodernist paradigms were the main assumptions and beliefs that was used by the study because of its lineage to qualitative research methodology. The current study's ontological beliefs were supported by Guba's (1990) views that, "truths exist in the form of multiple mental thoughts and beliefs that are built by local social and trial-based opinions that a person hold". The current study's epistemology involved the researcher interacting, observing, interpreting meanings from the populations being studied under the case study (Maykat & Morehouse, 1994). The study used purposive sampling for focus group participants, key informants and questionnaires' respondents. Shamva District had a population of about 130 000 and these are serviced by 16 health centres (DMO, 2018). The study generated data from five health centres that were referred to as A, B, C, D and E. Six health centres in the district had Non-Governmental Organisations (NGOs) that implemented social accountability approaches and this study sampled four of them as case studies. While one health centre B did not implement CSC strategy.

3.2 Respondents biograph

The data were generated from one to one interview with 204 community members who visited the five health centres during the data generating process. The pseudo names used for community members who visited the five health centres were QR-A, QR-B, QR-C, QR-D, and QR-E. In addition, the focus group discussions were conducted to 127 participants who were grouped as people with same interests such as Health centre committee members these were referred as HCC-A, HCC-B, HCC-C, HCC-D and HCC-E., village health workers were referred to as VHW-A, VHW-B, VHW-C, VHW-D and VHW-E. pregnant mothers referred to PM-A, parents with

children under five years referred to as PW-A and women getting contraceptives referred to WC-B. The researcher observed a district steering committee meeting in session that involved all line ministries and other stakeholders in the district and observed the patients who were in queues waiting to be attended at the district hospital.

Furthermore, 27 key informant interviews were conducted. The experts were from five local rural health centres, district hospital, Non-Governmental Organisations that are active in community health and from the national office of MoHCC. Pseudo names were used to keep the confidentiality of the participants and respondents. Table 1.1 show the pseudonyms used under key informants.

Table 1.1: Key informants' demography and pseudonyms

Facility	Profession	Pseudonyms
Health Centre A	Nurse in Charge	NIC-A
	Community Monitor	CM -A1, CM-A2
	Community Literacy Facilitator	CLF-A
Health Centre B	Nurse in Charge	NIC-B
Health Centre C	Nurse in Charge	NIC-C
	Community Literacy Facilitators	CLF-C
Health Centre D	Nurse in Charge	NIC-D
	Community Literacy Facilitator	CLF-D
	Councillor	CL
Health Centre E	Nurse in Charge	NIC-E
	Community Monitor	CM-E
	Community Literacy Facilitator	CLF-E
District Hospital	District Medical Officer	DHE-1
	District Nursing Officer	DHE-2
	Community Sister	DHE-3, DHE-4
Organisation 1	Executive Director	IP-1
Organisation 2	Provincial Coordinators	IP-2, IP-3
	Country Director	1P-4
Organisation 3	Health Economist	NO-1
Organisation 4	Social Accountability Officer	IP-5
Organisation 5	Community researcher	NO-2
MoHCC	Director of policy and planning	HQ-1

MoHCC	Director of Community health	HQ-2
Total		27

4 Findings

The findings of the study are presented in the following sub themes:

1. Overview of results-based strategy.
2. RBF implementation in Shamva District.
3. Results and challenges realised during implementation of results-based finance strategy.

4.1 Results Based Finance Strategy

Results-based finance (RBF) was identified as one of the social accountability strategies that was being used in Shamva District. The programme was led by Crown Agents, an international organisation that was getting funding from UNICEF to implement the model. IP-4 indicated that the programme had been supported by Health Development Fund (HDF) in approximately 834 rural health facilities in 42 of Zimbabwe's rural districts. All the 16 health centres in Shamva District were under RBF programme. Its aim was to increase access to maternal and child health. DHE-2 specified that the main actors at local health centre level were the HCC members who represented the communities and Nurse-In-Charge who represented the health personnel. IP-2 and IP-3 stated the main objectives of RBF strategy was to:

- a) Improve quality health service provision in the district through monitoring the way nurses delivered services to the public. The monitoring was conducted by the community sisters, district nursing officer, crown agent's provincial coordinator and the HCC.
- b) Support the user fee policy that was passed by the government as the alternate funding for the health centres that purchased specific services that were offered for

free. The services purchased were for pregnant mothers, children under five years and all neo and ante-natal services.

c) Give the community the mandate to engage with health personnel in coming up with the operational plan for the health centre and to agree on priorities to use the money earned for the quarter.

RBF earnings were the income each health centre got for the services they offered for free to the categories of people stated above. NO-1 indicated that in the medical field, they referred to RBF earnings as money that came from the purchases of the services offered at the health centres. HQ-1 highlighted that the RBF earnings were used by health centres for their day to day running costs, to improve the quality of health services provided by the facilities and for staff incentives. The funds were used in accordance to the RBF utilisation guidelines provided by MoHCC. DNO-2 said *“The guidelines included activities that were only outlined in the operational plans that were developed by the NIC and the HCCs. Drugs for maternal and child health were normally prioritised”*. HCC-D indicated that twenty-five percent (25%) of the earnings were given to the nurses as performance-based incentive or motivation. In utilising these funds, health centres were expected to comply with the MoHCC’s Financial and Procurement Guidelines which were important in ensuring accountability, transparency and value for money.

4.2 RBF implementation

RBF was implemented in Shamva District mainly by the community representatives (HCCs) and health officials through deliberative dialogues. Deliberative dialogue was a platform where the communities in Shamva District met with the health officials to

discuss the quality of health services rendered at their health centres. Deliberative dialogue in social accountability meant that all parties should discuss at the same footing and parties are expected to be frank with each other. It involved engaging mutually not confronting and blaming each other. It also involves finding solutions to the problems identified together.

4.2.1 HCC's role in facilitating deliberative dialogues between communities and health officials

The community representative cadre that were important for RBF were the health centre committee members. IP-5 indicated that, "*HCCs in Zimbabwe were established soon after independence in 1998, although they were politicised*". The representation was not based on skills or constituency bases. HQ-1 indicated that initially there were no standard guidelines governing HCCs functions which were different from RBF which outlined their mandates. The HCCs were viewed as the link between the community and health personnel. The HCCs enhanced the relationship between the citizens and health workers and brought trust between them. NO-1 pointed out that RBF assumed that HCCs carried out their mandate well, that included giving feedback to the communities. NO-1 went on to emphasise that, "*HCCs were a pre-requisite for all the health centres in order for them to be eligible to receive the earnings*". HCC-E indicated that the HCCs developed operational plan in collaboration with the Nurse-In-Charge. The operational plan was sent to the district for approval by the district nursing officer. All the five health centres had active HCCs that were carrying out RBF responsibilities for their health centres to earn income. The term of office for HCCs was three years. The HCCs at all the health centres were voted into power in July 2017.

DHE-2 indicated that all the five rural health centres' income ranged from \$2000 to \$3000 per quarter. The earnings were transferred from the implementing partner to the health centre quarterly after the earnings had been calculated. IP-1 highlighted that earnings were agreed to after the implementing partner coordinator and district community sister have verified the purchases written by the Nurse-In-Charge. IP-2 acknowledged the engagements between the HCCs and health officials that were leading them to get reasonable earnings from RBF.

Furthermore, HCC-C indicated that they had a request committee that initiated requests for purchases. The treasurer searched for three quotations for the purchases. The three quotations were submitted to the requesting team for them to select one supplier. After choosing the supplier the purchasing team bought the goods and they handed over the purchased goods to the receiving committee. The receiving committee recorded the assets in their asset register. After recording, the HCC chairperson updated all stakeholders during a quarterly meeting at the health centre on the usage of the earnings. NIC –C indicated that the clear procurement procedure enhanced trust between the community members and the health staff because there was transparency on how the purchases were done.

DHE-2 also indicated that he approved the purchases of goods that had followed the procurement chain. The procurement chain made it mandatory for the HCCs to take part in managing the RBF earnings and for them to be accountable to their constituencies. The MoHCC was proud because they had put in place a system that allowed communities to be involved in managing and monitoring their local health centres. HQ-2 said *"We are excited by this initiative because we know that every*

community member police the health centre which is important for social accountability". This tally with participatory development theory that expects the poor people to be at the centre of their own development.

In addition, HCCs played a critical role of improving communication between the communities and the health centre staff. DHE-1 indicated that the HCCs enhanced monitoring at the health centres since they met monthly with the Nurse-In-Charge and quarterly at district level. The structure and communication lines for the HCCs and health personnel were clearly spelt out. The HCCs showcased the achievements they did at their health centres using RBF earning. HCC-A indicated that they managed to use RBF funds to buy some drugs, fenced and painted their health centre. HCC-B bought some benches that were used at the patients waiting shed.

Furthermore, HCC-C renovated their labour ward and bought new beds for the labour ward. HCC-D bought new blankets for their labour rooms and painted their health centre. Last, but not least, HCC-E managed to put in place water pipes at the health centre, renovated the health centre roof and bought some drugs. All the achievements were echoed also by the DHE-2, DHE-3 and HQ1 respondents. The RBF earnings improved health centre's environment, infrastructure and availability of basic health necessities. NIC-E highlighted that the earnings had made it possible for them to perform their duties accurately and upholds their attitude. DHE-1 also said "*The RBF programme has tremendously improved the health centres if you reflect back to what was the case in 2008 and 2009 when this programme was not present*". This is also supported by NPM theory that advocates for decentralisation or contracting out to municipality for the public servants to deliver quality services.

More so, the RBF earnings also motivated nurses since they shared 25% among themselves. The HCC-C applauded the RBF by saying that, “*RBF re-energised the nurses, they were now putting more effort on treating patients properly and encouraging them to come back again*”. The nurses knew that treating patients well increased their disposable income. HQ-2 indicated that RBF approach built on the overall performance management that the government of Zimbabwe rolled out around 2009. DHE-3 pointed that the earnings were encouraging staff retention at rural health centres where there were high staff turn over records and sometimes nurses were not keen to be posted out to big towns. The availability of trained staff members resulted in high quality delivery of services and satisfaction of citizens who used to complain of unavailability of nurses at health centres. This goes hand in hand with NPM theory that points out the need to train public servants for them to perform better.

The research identified a possible loophole of staff incentive, in that the health personnel could give more priority to patients who gave them more earnings like pregnant mothers and children under five years, while neglecting patients with low or no RBF purchases. However, discussions with the NICs, DHEs and IPs indicated that they had put in place measures that mitigated the loophole, although they did not manage to explicitly tell the researcher the mitigation strategies.

Still, the researcher got some different sentiments on how RBF was run from some HCC members. Some HCCs from health centre A and D indicated that they were not on the same playing field with the Nurses-In-Charge who were the secretaries of the HCCs. The HCCs at Health Centres A and D felt that the health staff members viewed themselves as superior to them. HCC-A said “*Tinonzi imi hamungaite seni ndakaenda*

kuchikoro imi makangosarudzwa pasi pemuti” meaning “*You cannot be like me who is qualified to be a nurse because you were only chosen under a tree*”. Therefore, the Nurse-In-Charge developed the operational plan and brought it to the HCC for endorsement, and not for dialogue. This can be viewed as cosmetic participation as indicated under Participatory development theory.

The researcher verified the HCCs sentiments with NICs, members of the DHE and the IPs. They were surprised with the sentiments. IP-4 said, “*The sentiments could be the case at where the HCC members were not that literate, such that the NIC developed the operational plan on their behalf after conducting a discussion with HCCs*”. DHE-4 said “*This can be possible since there are high numbers of illiterate rates in the districts*”. This justified why the some NICs prepared the operational plans. In addition, the NICs were the secretaries of the committees that mean they had the mandate to draft the operational plans in consultation with the committee. This point did not come out in the literature review it was peculiar to Zimbabwe.

Furthermore, the HCC-A and HCC-D felt that nurses were not worried about people’s welfare, because they were not originally from Shamva area. They only focused on earnings, hence, lack of transparency on RBF income usage. CL said, “*We don’t have the final say of the usage of RBF earnings, we are told by the nurse in charge on what they agreed at the district level*”. The HCC-D indicated that if they had final say of the RBF they were going to pay the security guards from the earnings because they had two years’ arrears due to the lack the enforcement of the user fee policy.

The patients were no longer paying \$1 development fee at the health centre which was normally used to pay security guards and do other health centre maintenance. DHE-2 pointed out that the HCCs should know the guidelines of RBF before making assumptions. The researcher realised that there was lack of clarity on the use of RBF and the extent of involvement of HCCs. In addition, the MoHCC did not supplement RBF funding gap that was leading to conflicts on the usage of inadequate earnings received per quarter by the health centres. NO-2 said “*Restrictive RBF earnings could create unnecessary tensions between the communities and health officials*”. Therefore, availing adequate resources could strengthen roles of the HCCs and the health officials in improving quality health services.

In addition, the health governance structures did not pay more attention to whether engagement of the community representatives and health officials were genuine or not. The study revealed that most minutes of the engagements were mainly on financial issues and less attention was given to other community demands. NO-1 stated that constant feedback was between the health officials and the funding partners for the health centres to earn more money from RBF and attract donors to implement programmes at local level. The same sentiments were echoed by IP-5 who said, “*The emphasis is on financial accountability or financial transactional relationship than social accountability*”. Since financial relationship is more important, this meant the citizens’ rights and engagements become peripheral resulting in exclusion of important aspects that influence improvement in quality health provision. This becomes more aligned to New Public Management theory that does not pay attention to citizens’ rights but only focuses on delivering quality services while reducing

citizens to clients not as active participants as advocated by participatory development theory and human rights-based approaches.

4.6.2 Monitoring tools of RBF strategy

RBF had monitoring tools that were used at all health centres. Monitoring of the services offered at the health centres were done under RBF using four tools that are exit interviews, client satisfaction survey; counter verification exercise and suggestion boxes. Figure 1.1 depicts the monitoring tools that were mentioned by respondents especially the IP-1, IP-2, IP-3 and IP-4.

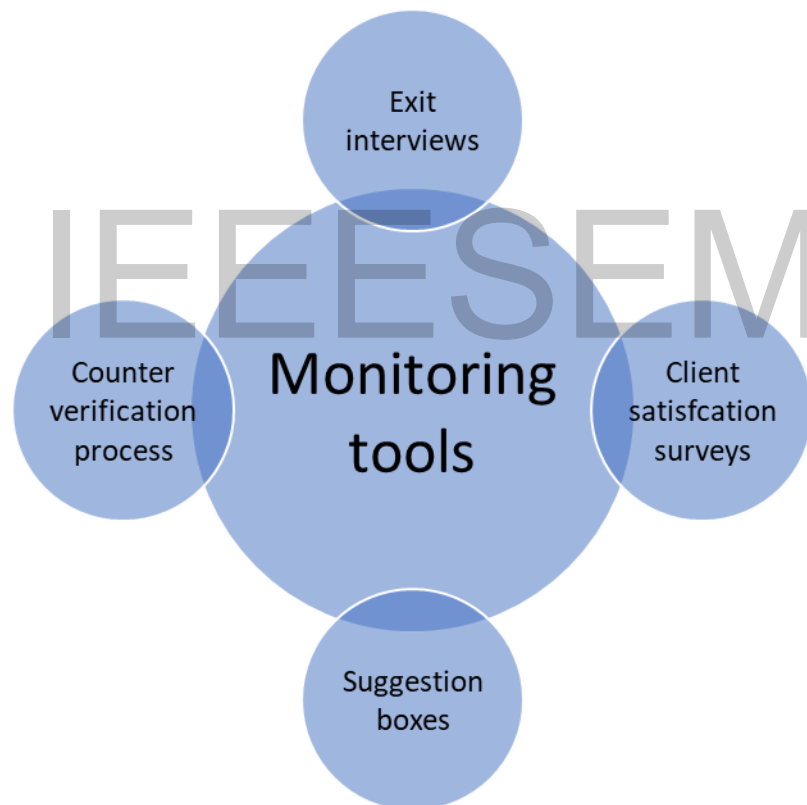


Figure 1.1: Monitoring tools used for RBF programme

4.6.2.1 Exit interviews

Exit interviews were conversations done with patients to know whether they received the expected services. DHE-1 indicated that normally, the questions that were covered included whether the patients received services for free according to the user fee policy, how long they waited before being attended to by nurses and whether they were given some drugs. Exit interviews were conducted at all five health centres and at district hospital. The exit interviews align with the empowerment theory that advocates for giving the communities the chance to rate the services they receive. At the hospital the interviews were conducted by DHEs and at the health centres the interviews were conducted by HCCs members, at health centre D the community monitors also conducted them.

DHE -4 indicated that, *“I carried out the exit interviews to patients after they have received treatment at the hospital”*. Normally, the patients complained about waiting for long and being shouted at by the nurses. DHE -1 indicated that they took seriously the complaints raised by patients. Further, DHE-2 revealed that the DHEs constantly conducted meetings with district staff members to discuss the Patients’ Charter because some nurses were trained while these rights-based issues were not part of the curriculum. It was learned that DHEs were now conducting monthly meetings with the nurses and doctors emphasising the need to respect patients’ rights.

HCC-B highlighted that exit interviews with patients enabled them to understand the views of the communities about their health centre. The main issues emerging were the shortages of drugs at the health centre. Most of them were given prescriptions to go and buy medication from the pharmacies. They had not absolutely addressed this

issue because it was beyond their control. They had referred the issue to the council for action.

The exit interviews records were examined by the implementing partners when they were verifying the calculations of the earnings. IP-3 further indicated that they carried out exit interviews randomly during their verification process. They also checked the HCC exit interviews records, to know whether the nurses were responding to communities' complaints. IP-4 said *"Usually the health centres with many complaints did not get more earnings because their marks were reduced on the quality marking"*.

4.6.2.2 Client satisfaction surveys

Another tool that was highlighted was the client satisfaction survey. The client satisfaction surveys were conducted by an independent auditor's firm employed by UNICEF. The auditors conducted the surveys biannually for them to measure the patients' satisfaction rate in the district. The patients were also given an opportunity to proffer some recommendations that were supposed to be implemented, for them to attain quality health service provisions. IP-3 said, *"The results of the surveys were presented to the district health executive for them to resolve the challenges raised and cascaded the ones they could not resolve to the provincial level"*. The report was also consolidated with other districts and was presented at the national steering committee. The auditors focused more on the patients' views and feelings.

HQ-2 pointed out that the results of client satisfaction surveys culminated into enforcement of user fee policy that allowed all patients at rural health centres to be treated for free. The government assumed that the health centres were utilising the

user fee policy since the policy was adopted soon after independence. The surveys were the ones that brought out the complaints from the patients. The client satisfaction views led the donors to increase their investments in the RBF knowing that the poor people were having access to health services for free. Action by government after getting the surveys' findings was a good sign that they were serious in addressing people's complaints.

4.6.2.3 Counter verification process

Another monitoring tool was counter verification process. The counter verification process was conducted by provincial coordinator of the implementing organisation and district community sisters. IP-3 indicated that this was a process where the provincial coordinators verified data prepared by the nurses at the health centres, that showed the number of services they offered to patients for them to receive the income for the purchases. These were done monthly in preparation for quarterly earnings disbursements. IP-1 explained the counter verification process to the researcher. The process was that nurses at the health centres recorded the number of patients they serviced, for instance, pregnant mothers. The pregnant mothers were recorded in the registers by the nurses. The provincial coordinator and District Community Nurses checked the registers to verify whether the mother's history such as their attendance for ante-natal clinic visits was correctly captured. When the nurses were satisfied with the counter verification records the figures were then compiled for earnings.

HCC-C indicated that they were aware of the counter verification process and this had led the nurses to improve the way they recorded the services they offered to patients.

RBF improved record keeping at health centres and it made it easy to determine the

disease patterns and statistics of patients. DHE-2 supported this notion, he said, *“The process made my role to become easier because NICs had statistics at their fingertips and could easily convey the statistics to the us at district level in real time”*. This also helped the MoHCC to make informed decisions using evidence. HQ-1 echoed that the process made it possible to calculate the actual cost needed to run a rural health centre. This evidence was used during the budget request period that led the MoHCC to get an increase in budget form in 2018. NIC-E agreed with the DHE-2 when she said that, *“I am now in control of my health centre because I know the statistics of my patients by heart”*. The monthly meetings that the nurses had at district level were better pronounced because all the health centres brought updated information all the time.

The health officials were on top of the situation in their districts because of RBF programme. There were no longer backlogs of requested information. IP-3 also supported this, when he said, *“The improvement in documentation were a result of good record keeping that related to better quality and increase in RBF earnings”*. The monitoring and evaluation department at national level of the MoHCC indicated that they received real time data which because of the RBF verification process. That meant all the decisions made by the ministry were backed by verifiable evidence.

However, the communities did not play a role in the verification process. It was purely done for administration purposes. Therefore, all the respondents of the questionnaire were not aware of the details of the process. The NIC-D highlighted that the process was very good, but, on the other hand, it put the nurses under pressure. They spent more time capturing data, doing administrative work at the

expense of clinical work. The DHE-2 pointed out that he was aware that nurses were filling too many registers almost 15 per health centre and had raised this issue to the national office. This could be viewed as a process that was indirectly discouraging proper dialogue between the patients and health officials. NO-1 highlighted that the implementing partners and government did not do pre-testing of the monitoring tools to find out whether the process enhanced the relationship between the patients and health officials or not before adopting them. NO-1 went on to say, “*Administration bias tools thrived at the expense of the clinical duties that were more important to patients than earnings*”. HQ-1 indicated that to counter the weakness, the Ministry was developing database software that would be easier for the nurses to input data rather than to capture the information manually. The system had been rolled out in other districts and was yet to be rolled out nationwide.

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4.6.2.4 Suggestion boxes as RBF monitoring tool

The other monitoring tools used were the suggestion boxes. The patients were encouraged to use the suggestion boxes for them to air out their grievances and to offer solutions on areas they felt needed attention. At all the five health centres and at the district hospital there were suggestion boxes close to the exit gate where patients could drop in their notes. HCC-B indicated that the boxes were normally opened monthly. At the district hospital, it was the DHE-1 that had the keys to the suggestion box. The box was opened before the DHE monthly meetings and the suggestions were discussed during these meetings.

CM- D indicated that at rural health centres, the HCC chairpersons were the ones who kept the keys and opened the box in the presence of other HCC members. The

suggestion boxes were opened just before monthly meetings between HCCs and Nurses-In-Charge. All the NICs, DHEs and HCCs indicated that there was low uptake on the usage of suggestion boxes. Therefore, they were no major issues that came from the suggestion boxes that were discussed or resolved. The researcher asked the respondents of patients' questionnaire on why they were not using the suggestion boxes. QR- A said *"Hatina zvekunyoresa uyezve unowonekwa uchikanda chipepa nanambuya zvozokunetsa mangwana box ravhurwa"* meaning *"We do not have pens to write the notes plus you can be seen by nurses putting in your note that might put you in trouble when the box is opened"*.

QR-C supported the earlier notion saying, *"The location of the suggestion boxes was very exposing that us patients are afraid of victimisation by nurses when the box was opened"*. IP-5 pointed out that victimisation was very common in the district because of dominance of one major political party that was intolerant of opposition political parties. This might be the contributing factor why the patients were afraid of victimisation.

The researcher thought that probably, writing down complaints was not a culture of rural people maybe they were used to complaining among themselves as what she observed during participant observation at the district hospital. At the district hospital the patients complained a lot while seated in long winding queues, but, they did not manage to confront the nurses with their complaints. Even when they were exiting the gate the researcher did not see any patient inserting their complaint notes in the suggestion boxes. This meant the monitoring tool did not yield results in RBF.

However, the tools used to monitor quality services at the rural health centres and at district level were familiar to key informants, but not to ordinary citizens. NO-2 pointed out that this might be the case because the tools were very formal for communities to follow through the processes. The minutes and reports compiled by the stakeholders involved in the monitoring processes were not shared with the communities. The NICs and IPs indicated that the reports were for public consumption, but, this was defeated by the fact that the communities did not even know of such processes.

The researcher managed to get hold of the reports from the NICs and IPs to prove a point that these were public documents. Formalisation of the monitoring tools that excluded communities was peculiar to Zimbabwe; this information was not mentioned explicitly in the literature review. This might be an indication that monitoring tools were developed without communities' consultation or communities in mind. NO-2 further indicated that normally, the external donors bring straight jacket approaches expecting them to work effectively everywhere. This was a good example that showed that monitoring tools were more effective in formal set ups which did not include communities, thereby, making it difficult for them to rate the services they received in an effective manner.

Furthermore, the monitoring tools were very formal and led by external people such as the independent auditors, provincial coordinators and district community sisters. NO-2 indicated that normally, communities did not give their honest opinions to external people for various reasons. Some would be thinking that false information could lead them to be included on aid list, since most donors brought aid to the poor.

Some were generally afraid of giving negative feedback to externals because they did not want to expose their internal failures.

In addition, the protocol procedures that the external people went through before undertaking a survey or a programme defeated the confidentiality element. NO-1 said, *“The DHE, chiefs and councillors were normally the ones that recommended the areas the surveys could be conducted”*. Thus, when the results came up, the leadership knew exactly where the information would be coming from. NO-1 noted that this could discourage the community members from sharing negative experiences because they did not want to be labelled as bad apples or spies by their health officials. Hence, the accuracy of the monitoring tools could be debatable.

The researcher gathered that RBF programme had improved the quality of services at health centres. The model works mainly with the health officials and HCCs as community representatives. Basing on the above arguments, this study's researcher, therefore, strongly believed that cosmetic participation of citizens could be recorded by researchers as real participation, if they failed to probe further the participants. Reports and minutes could be convincing that social accountability strategies were working while important elements of it were not being practised. The processes could be a one-sided relationship or big brother approach that only focused on outcomes of the programmes and not on all the critical processes that had to be in place to make conclusions on the outcome or impact level.

In addition, the researcher had mixed results on RBF social accountability strategy. The HCC and NIC engagements were very good in that the health centres managed to

earn more income and addressed some communities' demands using the RBF earnings. While on the other side, the deliberative dialogues between the HCCs and NICs could be viewed as cosmetic to get more RBF earnings. This might result in losing community's views. DHE-4 indicated that this might be so in the sense that, the HCC members did not understand the health systems' needs as much as the health officials did. Therefore, the Nurses-In-Charge tended to lead the decisions at the health centres as qualified persons who knew what was good for patients, which the HCCs were not qualified to do. Having frank discussions about the roles of the HCCs and health officials at the health centre was critical.

5 Results

The RBF implementation had positive impact on the quality of health services in Shamva District. The description of the results that emerged are given in the next sub sections.

5.1 Increased RBF earnings

The improvements in infrastructure culminated in increased RBF earnings. DHE-2 highlighted that since the enforcement of the user fee policy RBF brought in some income to the health centres although the earnings were not enough. All NICs during in-depth interviews acknowledged an increase in RBF earnings. The increase was associated with improved quality health service delivery because of the conditions of RBF. Therefore, the earnings were related to the quality of health services rendered at health centres. DHE-1 said, "*Quality of services offered in the district had improved. This was evidenced by more earnings received by health centres*". This clearly showed that RBF earnings were used as an indicator of quality by health officials.

Therefore, if all RBF requirements were met that meant MoHCC's outcome on offering improved quality service delivery would be met. Thus, increased RBF led to improved health services.

5.2 Health centres improved infrastructure

Another benefit of RBF was improved infrastructure. The strategy resulted in some improved infrastructure at the health centres. All the HCC FGDs indicated that the health centres used some RBF earnings and community's contributions to renovate the existing structures and building of new infrastructure. DHE-1 said, *"The construction and refurbishment of the health centres translated to clean health centres, increase in clinic deliveries since many pregnant mothers were using mother waiting shelters"*.

5.3 Better community co-ordination

There was better co-ordination between the communities and their representatives, especially the HCC members and local leaders. NIC-A pointed out that the HCC members managed to mobilise the communities to make contributions that improved Shamva District health centres. This also aligned with participatory development theory as written by Nelson and Wright (1995) who indicated that mobilising communities to contribute natural resources promote projected ownership and self-reliance.

At health centres C and E, the HCC members indicated that there was transparency on the use of RBF earnings and all the stakeholders were aware of what was happening. NIC-D said, *"The good co-ordination between the HCCs and VHWs led to*

improvements in ante natal bookings because, they mobilised pregnant mothers to register for the health centres to earn more RBF income and for pregnant mothers have safe birth deliveries”.

5.4 Provision of free health services

Provision of free health service was another improvement emerging from the study.

RBF resulted in free access to primary health care since all purchases were paid for by the programme. DHE-1 indicated that all the patients at rural health centres accessed free health services. IP-5 point out, *“That they believed the RBF led to the enforcement of user fee policy that enabled rural people to have access to free primary health care”*. WJ-B also indicated that women were getting family planning contraceptives for free. All the patients at the rural health centres got free services, although inaccessibility of drugs was still a challenge. This made this researcher to be hesitant to call this free health services.

6 Challenges

There were challenges that were identified during the implementation of RBF in Shamva District. These are given in next sub section.

6.1 Lack of feedback documentation by HCCs

The study gathered that there were minutes for the meetings that were conducted between the HCCs and health officials at local and district level that were used at provincial, national level and to donors for administration purposes. However, there was lack of evidence that showed HCCs were giving feedback to communities on the

progress made on their demands. The feedback might be happening in an uncoordinated way. However, HCCs failed to prove their feedback mechanisms. Lack of documentation hampers informed decision making.

6.2 Poor sustainable plans

Failure by government to introduce administrative budget that supplements RBF resulted in Shamva District Hospital failing to offer quality services to patients. Because of the budget gap the hospital wards were oversubscribed, the theatre was not working and there is one functional ambulance. The administration budget was not enough to supplement the RBF programme. This can contribute to failure if donors stop funding RBF.

6.3 Lack of fiscal decentralisation

The decentralised health structures were in place, but they lacked full autonomy and budget to implement their programmes. DHE-1 indicated that they relied on the centre for financial resources and authority to make some decisions. DHE-1 went on to say, *“It is very difficult to operate at district level while waiting for decisions to be made at national level”*.

6.4 Community elitism

Community elitism was another study challenge. NO-2 indicated that there was a risk of having community elites capturing communities. This was supported by about 65% of communities that participated in open-ended questionnaires interviews who highlighted that they did not have interactions with their HCCs and were not aware of their existence. This evidence was worrisome to social accountability's view. SAcc

mechanisms should involve all the socio-economic groups in the society. IP-5 added that, *“Community elitism was a potential gap that might lead elites to claim that they were representing everyone in their area while they were focusing on their interests only”*.

6.5 Conflicts between community leaders

In addition, NO-2 noted that external funding for RBF was creating conflicts to community structures. The conflicts were mainly between HCCs and councillors. IP-3 indicated that the HCC chairperson interacted most of the time with the NIC and made more decisions on RBF earnings together with health staff. While at the same time, the HCC chairperson needed permission from councillors and chiefs for them to talk during community meetings. HCC-D shared the same sentiments he said, *“If the local leaders’ views us HCC chairpersons as potential threats for their powers they simply deny us time slots to talk during community meetings that affects our visibility to community members”*. The researcher believes that this could be a reason why the HCCs were least known by communities while they were supposed to be community representatives.

6.6 Conditions from externals on implementation of induced programmes

Induced programmes were created or implemented by external actors. DHE-1 indicated that, *“RBF had specific structure that had to be followed and there were specified sanctions if the procedures were not adhered to”*. HCC-B stated that if they failed to produce or file minutes of meetings they conducted with the NIC, the health centre would lose RBF earnings and under community scorecard the programme would be negatively evaluated.

NO-2 indicated that the implementation of RBF was done with a bias of satisfying the funding partners not necessarily the communities. The health officials and community representatives concentrated more on fulfilling the donors' demands not communities. This trend could affect the motive of SAcc in the long run and strengthen cosmetic participation.

7 Discussion

Results based finance enabled the rural communities in Shamva District to access health services at rural health centres for free. The programme improved the health personnel attitude towards patients knowing that quality service delivery translates to increased income for them. The programme made it compulsory for community representatives to be involved in managing the use of health centres' earnings. The engagement platforms led to the improvements in deliberative dialogues between communities and health workers. Lack of funding sources to finance the administration costs has serious implications on the sustainability of RBF in Shamva District.

8 Conclusions

The conclusions of the study were informed by the findings of the study. There are three conclusions for the study which are:

The researcher further concluded that free services in Shamva District were not actually free because patients were supposed to buy their own drugs since there were perennial drug shortages. The patients only received consultations for free and bought drugs using their own money.

The researcher also concluded that cosmetic participation of community representatives especially the HCCs were because of fulfilling donor conditions. The researcher concluded that there was fiscal transactional relationship between the HCCs and NICs not genuine dialogues on community's needs.

The researcher further concluded that without adequate financial resources and sustainable plans RBF strategy could not yield purported results. Instead the programmes somehow created more donor dependency.

9 Recommendations

The study proffered recommendations to health sector stakeholders in Shamva District. These are given below.

9.1 Emphasis of citizenship and development in health programmes

It is recommended that health officials and implementing partners for RBF strategy in Shamva District should embrace health rights and other economic and social rights. This would give an opportunity to Shamva District citizens to express their rights and enable them to be involved in the governance of their district. Participation beyond health programmes could influence health issues to be embedded in all government sectors in the district leading to sustainability.

9.2 Importance of documentation of evidence

It is recommended that communities and their representatives be trained on gathering evidence for their proposed programmes to get support from potential funders evidence is required to make funding decisions.

9.3 Co-ordination of social accountability actors

It is recommended that co-ordination of all the actors involved in the implementation of SAcc is necessary to reduce administrative roles for nurses who are spending most of their time completing forms of both NGOs and the government for them to get more RBF earnings.

9.4 Resourcing the Social Accountability Initiatives

It is recommended that the government and donors should avail adequate resources such as financial and human resources to enhance proper implementation of RBF in Shamva District Health Sector. The financial gap necessitated by RBF and user fee policy if not managed well can result in poor quality service delivery in the long run.

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