

Results Based Financing in Zimbabwe: Any Changes in the Health Delivery System?

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Abstract

This research aims to assess the impact of the Results Based Financing programme on maternal and child health care and evaluate the challenges that are being faced in implementing Results Based Financing. Progress has been made in improving availability of healthcare to vulnerable groups however the mortality rates are not decreasing. Challenges such as bureaucratic legal frameworks, deteriorating infrastructure, lack of expertise in the health sector, poor remuneration, corruption, in accessibility of some rural health centres, religious and cultural beliefs have hampered implementation. It is recommended that political and social realities be considered as they impede implementation efforts. Accountability frameworks are important as they help curb corrupt activities. Targets set and incentives used should be appropriate and genuinely increase access to the poorest and most vulnerable, more rural health centres should be built nearer to the communities, and there is a critical need to address the issue of health staff shortages.

Key words: Result based financing, maternal health, child health, mortality

Introduction

Improving maternal and child health care has been and is still one of the key objectives of the Ministry of Health and Child Welfare (MoHCW).

In line with this, the World Bank decided to support the establishment of a Results Based Financing programme (RBF), in Zimbabwe as well as other developing countries, which seeks to accelerate the availability, accessibility and utilization of quality health services at district and health centre level. The RBF programme provides subsidies, directly linked to services delivered at primary health care level that is rural health clinics and to district hospitals. The MoHCW, World Bank and an NGO CORDAID agreed on the implementation of this Results Based Financing (RBF) programme in Zimbabwean rural health centres and district hospitals. Results Based Financing for health is a program that transfers money or goods to either patients when they take health related actions (such as having their children immunized) or to healthcare providers when they achieve performance targets (such as immunizing a certain percentage of children in a given area) Boggess and Edelstein (2006).

According to Loevinsohn (2011), the poor performance of the public health care system, including low levels of physical access in some places; poor quality of care; a lack of adequate incentive structures for health workers; weak management; and inadequate data of sufficient quality to monitor and evaluate progress has been a major deterrent to quality health care systems.

However, it is important to note that, provider institutions in developing countries typically have not been required to guarantee that services are delivered. Instead, they have either received lump sum grants or were reimbursed for expenditures by governments and donors. This system encouraged providers to devote energy to securing funds and justifying inputs rather than to improving the efficiency or the quality of health care, even when they had the intrinsic motivation to do so.

This is where Results Based Financing comes in, as it is meant to change the situation that was prevailing prior to its inception, RBF starts with the result for example more children immunized, less deaths during child birth etc as well as letting health workers and managers on the ground decide how to achieve the results.

In the 1990s, RBF initiatives were developed in Asia (Cambodia) however from 2002 onwards the ideology moved to Rwanda, Democratic Republic of Congo, Burundi, Central African Republic and Cameroon. It was then when the African states incorporated the programme in their developmental programmes nationally especially in the health sector, Soeters et al (2006). Loevinsohn (2008) says that RBF emerged from results based management; it is given the same characteristics of being results driven. Furthermore, Meessen et al (2006) argue that RBF has encouraging results compared to more traditional systems of pouring resources and assuming that results will follow.

In 2010, it was observed that 22 countries were planning for or had started some form of RBF pilot programs, Soeters and Griffiths (2003). Amongst the 22 countries, Rwanda and Burundi adopted RBF as their national policy and scaled it up successfully while the Central African Republic and Cameroon followed.

According to Basinga et al (2010), the scaling up of RBF in Rwanda has been documented through a well designed and credible impact evaluation and it found impressive results on the volume and quality of health services. Aid agencies, governments and health professionals in various developing countries adopted RBF as a new strategy to improve results so as to enable the realization of the Millennium Development Goals (MDGs) specifically MDGs 4 and 5 which aim to reduce child mortality and improve maternal health respectively by 2015. It is against this background that the World Bank and the Government of Zimbabwe through the MoHCW signed a memorandum of agreement to implement RBF projects with CORDAID as the fund holder or National Purchasing Agency.

A Brief Overview of the Zimbabwean Health System before Introduction of RBF

In Zimbabwe, the public health system is the largest provider of health care services, complemented by mission hospitals and health care delivered by nongovernmental organizations (NGOs), Bate (2005). Ushewokunze (1984) says that during the first ten years of independence (1980-1990), the government invested significant amounts of money into improving health care delivery for all Zimbabweans which was a panacea to a two tier health system of colonial regime. This colonial regime characterised discrimination in terms of health service delivery between the poor and the rich, whites and blacks, rural or urban dwellers. However, after independence, between 1980 and 1987, the government expenditure on healthcare increased by 80%, almost 3 times higher than the previous pre independence rate, Auret (1990).

The Zimbabwe government's commitment to improved healthcare paid off, and the indicators of human well being improved steadily during the early years of the new government.

Life expectancy at birth rose by nearly a decade from 54.9 years in 1980 to 63 years in 1988, Tandon (1999). The government's healthcare policies ensured that the rate of child immunisation nearly tripled between 1980 and 1988. Immunisation for diphtheria, pertussis and tetanus (DPT) increased to 75% coverage in 1986, 80% in 1994 and 81% in 1999, compared to an average of 32%, 51% and 48% respectively for Sub Saharan Africa as a whole. The improvements in primary healthcare ensured that between 1980 and 1998 infant mortality rates fell by 80% to 49 deaths per thousand by 1988, Tandon (1999).

However from the year 2000 onwards, economic decline and political instability led to a reduction in health care budgets, affecting provision of health care services at all levels, Rusa and Fritsche (2007). During this period, the country's poorest suffered the most, with a 40 % drop in healthcare coverage, they suffered from preventable diseases such as HIV and AIDS, malaria, tuberculosis and other vaccine preventable diseases, diarrhoea and health issues affecting pregnant women and lactating mothers. It must be noted that, during this period, amongst other diseases, chronic malnutrition and HIV as well as user fees limited the life prospects of more than one third of the country's children. One in every 11 children in Zimbabwe died before their fifth birthday. In other words, 35,500 Zimbabwean children under the age of five died every year, MoHCW (2012). The Maternal Mortality Ratio stood at 283 per 100 000 live births in 1994, however it increased considerably and in 2007 was recorded to be 725 per 100 000, UN in Zimbabwe (2013). This came about as a result of the reduction in health care budgets coupled with religious and cultural beliefs that prohibit people from seeking health care.

In addition to the above, the Zimbabwe Network for Health (2012) gives numerous reasons for the gross incompetence of the MoHCW in health service provision.

The country's health sector faced numerous challenges which include among others a severe shortage of skilled professionals and health care staff due to the brain drain, an eroded infrastructure with ill equipped hospitals, many lacking functional laundry machines, kitchen equipment and boilers, and a lack of essential medicines and commodities.

Definition of RBF

RBF is a strategy of financing health care delivery based on results (output, performance), which are measured through predefined indicators, Soeters and Griffiths (2003). Soeters and Griffiths (2003) further argue that results that are to be achieved and payments that are to be received are laid down in contractual relationships between the different actors in the health system and these actors include the population (patients/communities), policy makers (government, MoHCW) and health service providers (hospitals and clinics).

Results Based Financing is a cash payment or non monetary transfer made to a national or sub-national government, manager, provider, payer, or consumer of health services after pre defined results have been achieved and verified, Naimoli and Benzel (2009). RBF is one tool that can be used by governments and or donors to increase coverage of the population with high impact interventions, such as immunization of the under fives or institutional deliveries.

One can add that Results Based Financing refers to any program that transfers money or goods to either patients when they take health related actions (such as having their children immunized) or to healthcare providers, when they achieve performance targets (such as immunizing a certain percentage of children in a given area), Lindsay (2010). Since RBF is mostly used in the field of health, most theorists add the prefix "health" hence the term Health Results Based Financing (HRBF).

According to Musgrove (2010), Result Based Financing can be defined as any program that rewards the delivery of one or more outputs or outcomes by one or more incentives financially or otherwise, upon verification that the agreed upon result has actually been delivered. Pearson and Ellison (2010) argue that RBF's motive can be traced back to its roots from the Principal-Agent perspective which states that the agent must perform a certain task on behalf of the principal (funder). The agent will be motivated by incentives which will be paid upon predetermined results that have been achieved therefore this implies that chances of achieving results are increased.

Mitchell (2011) went on to cement the thrust of RBF during a workshop in the United Kingdom by saying, "We are fundamentally redesigning our aid programmes, with the focus being on outputs and outcomes rather than inputs. In these difficult economic times donors have a double duty, a responsibility to achieve maximum value for money and not just results but at the lowest possible cost".

Of course in the last decades, when most developing countries became independent, the thrust was to improve services in the health sector especially maternal and child health care, this was accelerated by fruitless donor efforts that have invested billions of funds but yielded soporific results. This was mainly because traditionally funding for health has been directed towards inputs such as salaries, construction, training and equipment among others. Improved health was assumed to follow but this has not always happened, Loevinsohn (2011).

Developing countries have the highest incidences of infant and maternal mortality, Sub Saharan Africa, for instance, has the highest rate of maternal deaths in the world with an average of about 900 deaths per 100,000 live births according to The World Bank Institute (2010).

This led Traore (2012) to make the following comment: "I cannot believe we are investing so much in health and getting back so little simply because we miss the right target, the health workers' external incentives that we neglected for so long." The RBF programme came with the aim of providing incentives to the health workers in a bid to increase their intrinsic motivation to produce best results.

Forms of RBF

Output-Based Aid (OBA) is one form of RBF which involves payment of a subsidy to cover a funding gap for the poor to access basic services. The Global Partnership on Output-Based Aid (2009) shows that OBA is used in situations where disadvantaged people such as the poor are excluded from basic services such as health because they cannot afford to pay the full cost of user fees. It can also be used for more efficient delivery of services that exhibit positive externalities. Service delivery is contracted out by the entity providing the public funds to a service provider (a private enterprise, a public utility, NGO, Community Based Organization), with payments tied to achievement of specified service performance or outputs. OBA subsidies can either buy down the capital cost of investments required to deliver the service or can cover the difference between an affordable user fee and a cost recovery user fee, for example a consumption subsidy.

According to Trémolet (2011) Cash on Delivery (COD) is a form of Result Based Aid which involves a situation where a recipient government enters a contract with a donor to receive aid only if certain pre specified results are achieved and independently verified. Actual pure COD programmes, are however very rare in the field of RBF programmes. However, Over (2011) advocates for this type of RBF by arguing that it rewards improvements in outcomes, is hands off, allows for independent verification, is transparent and complements other aid programs.

COD is more of result based aid than result based financing therefore; it involves a donor as a principal and governments as an agent, payments are made to the government by the donor in return for the achievement of certain results.

Pearson and Ellison (2010) identify Performance Based Financing (PBF) as a form of Results Based Financing, in which payments are directed to service providers only, in the provision of specific services of approved quality by the service provider (national /sub-national authority). As compared to COD which provides payments to the government, PBF instead makes payments to the service provider such as the health service centre this works as an incentive for the hospital/clinic. Meessen et al (2011) and Eichler (2006) agree that PBF will enable health service providers to improve delivery of health related services as well as enable achievement of the MDGs. PBF is the form of RBF that is used in Zimbabwe as well as other developing countries such as Rwanda, Burundi and Democratic Republic of Congo amongst other countries.

Performance Based Contracting (PBC) is another form of RBF where a contract has a fixed price set for a desired defined output, with the addition of a variable component that can reduce payment for poor performance or increase payment for good performance, Pearson and Ellison (2010). With this form of RBF, the contracted organization or party is rewarded when it achieves certain targets that have been pre agreed. If it fails to achieve these targets or if performance does not improve, the contract may not be extended or a certain part of the incentive may be withheld from the contracted health service provider. Conditional Cash Transfer (CCT) is a form of RBF in which incentives (financial and non financial) apply to the beneficiaries who agree to consume specific services, mainly in the health sector, Pearson and Ellison (2010).

An example could be that of monitoring and immunization of children who are below 5 years of age, the individual or family receives cash grants on condition that their child is immunized regularly.

Results Based Financing in Zimbabwe

In mid 2010 the World Bank issued a tender for an RBF programme in Zimbabwe. The programme was meant to support the MoHCW in its efforts to increase the availability, accessibility and utilization of quality health care to improve maternal and child health care. This was after the realization by the government of Zimbabwe that years of economic crisis had resulted in health indicators which have either stagnated or declined and are significantly off track in relation to set MDGs especially 4 and 5. During the years of economic decline, investment in public health sectors declined thereby affecting the quality and availability of health services especially in the rural areas where the majority of the population resides. In March 2011, the Ministry of Finance, CORDAID and the World Bank signed a preparatory grant to develop a detailed design of RBF programmes nationwide. This was done with the aim of developing the RBF programme in close collaboration with the MoHCW and local health authorities. The major aim of this programme was to improve the quality and the quantity of Zimbabwean health facilities and the district hospitals that are situated in the rural areas, People in Aid (2011). As compared to the previous situation where health staff were not remunerated for the job done or received medical equipment and medication that they had no use for, inception of RBF has ensured that doctors and nurses only get paid for provision of quality services and receive medical equipment that will be put to use to improve health.

The implementation of RBF in Zimbabwe started in July 2011 in two front runner districts.

The districts selected by the MoHCW are Zvishavane rural in the Midlands Province and Marondera rural in Mashonaland East Province. The experiences gained from these districts generated important operational lessons to further implement RBF in other provinces of Zimbabwe except the two metropolitan provinces that are: Harare and Bulawayo, MoHCW (2012). In each province the RBF programme started in two districts to enable mutual learning by Provincial Health Executives (PHEs) and District Health Executives (DHES). The World Bank financed the RBF programme aimed at mother and child care in rural districts, Gwinji (2012). The available amount has been estimated at an average of almost US\$2.00 per capita per year and will replace part of the user fees that are paid for mother and child services, CORDAID (2013).

The MoHCW trained Village Health Workers (VHWs) at community level to mobilise and educate the public especially the pregnant women and nursing mothers on safe pregnancy and child health care, women now give birth under medical supervision. Communities have been encouraged to form community based organizations (CBOs) for mobilizing and educating the public on health issues. The ministry has mobilized funds for training and workshops from implementing partners and NGOs such as UNICEF, Zimbabwe Expanded Program on Immunisation (ZEPI), UNIFPA and WHO amongst others. Such programmes include Zimbabwe Infant and Young Child Feeding (ZIYCF) and Baby Friendly Hospital Initiative (BFHI) among others. On health centres, the ministry provided maternal homes or waiting mothers' shelter and maternity wards to cater for pregnant women unfortunately they are inadequate. This programme has improved as well as expanded health care for Zimbabwean women and children in the 18 districts.

According to CORDAID (2013) rural clinics had an improved incentive to deliver better care and stopped referring patients to hospitals, between March and December 2012, the number of mothers who gave birth under medical supervision increased from 50 to 75 %, pregnancy checks increased from 40 to 75 % and the vaccination program increased from 35 to 50 %. Unfortunately, despite introduction of RBF in Zimbabwe and abolishing of user fees, the national maternal mortality ratio stands at 790 per 1000 live births compared with 390 in the 1990s and the under five mortality rate is 94 per 1000 live births up from 78 in the 1990s.

Challenges Faced In the Implementation of RBF

Challenges faced shall be drawn from Zimbabwe as well as some of the countries that have implemented the RBF programme successfully.

- It has been observed that during the signing of Memoranda of Understanding (MOUs) the legal framework is too bureaucratic with both national and local authorities this makes it a tedious job and can create platforms for fraud, bribery and corrupt activities among officials involved. Davidson (2009) noted that retrogressive rather than progressive policies in Uganda led to the delay of the implementation of the RBF program and later produced poor results.
- Dilapidated physical infrastructure and ill equipped hospitals due to economic hardships accelerated by hyper-inflation made the Zimbabwean government to neglect the social welfare especially the health sector which became characterized by deteriorated infrastructure and shortage of drugs among other problems. The hospitals are still poorly equipped to date.

Hansen et al (2008) noted that deteriorated infrastructure in Afghanistan and Haiti posed some serious drawbacks during the implementation of the RBF programme.

- Lack of expertise in the health sector such as midwifery personnel and doctors due to brain drain posed a serious problem in the implementation of the programme since it was one of the conditions by the funder to have adequate expertise for the release of the funds to kick start the programme. The brain drain in the public sector especially the health sector became the order of the day in Zimbabwe during the hyperinflationary era. However, currently, the situation has stabilized because junior doctors are being deployed to head district hospitals albeit the limited experience that they possess. However, despite this, Zimbabwe is not making considerable progress towards achieving MDGs 4 and 5, the Zimbabwe Network for Health (2012).
- Corruption and fraudulent activities have become rampant in developing countries such as Kenya and Uganda especially among the service providers. Some used public offices to embezzle public funds into their private pockets for personal gain at the expense of the public in form of what is called “cooking of books.”
- There has been exaggeration of results or falsifying of reports by recipients to receive more on unfinished jobs, Eldridge and Palmer (2009). In Cameroon local health officials were reported to be demanding more incentives than budgeted for and they boycotted meetings with CORDAID, the implementing entity, Harding (2009).

- Inaccessibility or remoteness of most rural areas where patients have to walk long distances to access a service such as immunization or antenatal care caused some of the patients to boycott some of the visits to their respective clinics which portrayed dismal results, Davidson (2009). Though in Zimbabwe there are mobile clinics, the visits made by the health teams in these remote areas should be increased. This inaccessibility is increasing the numbers of home deliveries as well as reducing the effectiveness of PMTCT and immunization programmes therefore maternal and infant mortality may not be abated.
- Low community participation and involvement in the RBF programme has posed a great impediment, not only lack of involvement but resistance to change was observed as one of the problems that hindered progress. This was noted in DRC and Uganda where religious beliefs in relation to certain cults and sects that are still practiced by some community members hinder achievement of results, Toonen and Jurrien (2010). However, the communities themselves including the targeted beneficiaries were sensitized of the programme to reduce resistance and stimulate a sense of ownership and responsibility towards the programme. This has made the communities accept the program readily.
- Low bonus packages also hindered progress in DRC and Uganda as service providers were not motivated to provide the best results, Toonen et al (2009).
- The unpredictable political environment in many developing countries has led to lack of political commitment in supporting RBF programme.

Politicians were not willing to mobilize people to partner and support the programme at local level due to political definitions that the programme was crafted from the West which has the hidden agenda of fulfilling political mandates. However, Basinga et al (2010) noted that political commitment in Rwanda led to the successful implementation of the RBF programme within a short period of time in the nation.

- Lack of skilled personnel has been identified as one of the challenging factors which are drawing back the effectiveness of the RBF program. The economic downturn coupled with inflation that was experienced in Zimbabwe from 2000 to 2008 led to the serious exodus of skilled personnel in all ministries especially in the health sector. In addition to the economic downturn, issues such as limited resources, low remuneration and poor working conditions have contributed to the staff shortage, Osotimehin (2012).

Skilled workforces such as medical doctors and midwives have opted to look for greener pastures mostly in Western countries. Zimbabwe is at the recovery period of gaining skilled personnel but the freezing of posts by the Zimbabwe government means that vacant posts have not been filled and to compound the dire situation resources for training and remuneration are inadequate.

Conclusion and Recommendations

Despite the challenges faced to meet the conditions for successful implementation of

RBF, it can be noted that the programme has been a success due to a number of developments which can be noticed since the implementation of the programme in Zimbabwe, in November 2011.

These developments include: building of maternity homes or waiting mother's shelters, in Binga, a district in the Matebeleland North Province in Zimbabwe, 5 waiting mothers shelters were constructed, sheds at meeting points for immunisation programmes, building of latrines, and procurement of inputs. All these developments are as a result of the RBF program the service providers (clinics) are receiving funds after predetermined results have been achieved. Unfortunately, despite introduction of RBF and the health sector recovery plan (The National Health Strategy for Zimbabwe) which was adopted after formation of the inclusive government in 2009, the Infant Mortality Rate and Maternal Mortality Rate are still a cause for concern and continue to soar despite the various interventions that have been done by the Government of Zimbabwe in conjunction with various implementing partners. Zimbabwe's health delivery system which was once ranked among the best in the Sub Saharan region, has deteriorated as service delivery continues to decline because of inadequate health staff and poor remuneration.

RBF programme designers should consider real-world factors such as political and social realities, the timeliness and quality of information systems, the ability to transfer money securely through banks, and restrictions imposed by implementing partners and governments, programmes must be flexible enough to adjust to realities on the ground.

A wide range of stakeholders should choose indicators and targets that are measurable and achievable within a contract period and measure progress against timeframes. Furthermore, it is vital that the indicators on RBF are incorporated into existing accountability frameworks in order to strengthen them and make the service providers accountable to the recipients.

This will ensure transparency in service provision. Accountability frameworks are of utmost importance as they work as foundations for RBF programmes and help curb corrupt activities. Programme designers should ensure that targets set and incentives used are those which are appropriate and will genuinely increase access to the poorest and most vulnerable populations (pregnant women and the under fives) rather than setting incentives and targets that will encourage implementers to focus on those easiest to reach and which may inadvertently increase the equity gap.

RBF schemes usually require additional resources not only to finance the incentives but also to set up the accompanying systems required for successful implementation such as management modifications and improvements to information systems. The design of RBF mechanisms, therefore, should reflect how these schemes will be sustained financially once donor support is no longer available (sustainability of service delivery). In theory, successful schemes would see recipient governments allocating some portion of their budget to support the schemes for example Uganda failed to allocate the 15% budget allocation. This requires that fundamental decisions on legal status, organizational arrangements, and governance structures be addressed early. It has been reported that a successful RBF program in Egypt stalled after donor funding began to wane because the government did not introduce legal reforms necessary to pay bonuses to civil servants.

Verifying whether targets are met, tracking results or what needs to be changed and evaluating the effects of the chosen approach are essential for any performance incentive programme and indeed, many of the potential pitfalls can be mitigated with careful monitoring and supervision.

Early engagement with stakeholders is the key to success and constant lines of communication between all players must be maintained. A willingness among programme designers and managers to adjust is required as concerns are raised and lessons are learnt. A focus on service and community linkages at the local level is essential to ensure the success of RBF therefore; the local community should be given the priority to monitor RBF initiatives to ensure that quality of services is in line with the expected outcomes.

Awareness campaign coordinators must organize public awareness campaigns for example during the World Health Organisation day, road shows and workshops at places like schools, markets, business centres and churches. This will enable them to educate all community members of all age groups about recommended maternal and child care practices.

There is need for building of more rural health centres (clinics) in areas closer to the communities, an example here is Zimbabwe where newly resettled farmers are located, to ensure convenience and safety of the pregnant women. The most a person should travel to seek medical healthcare is 5 km. In some rural areas people live far from health centres, they walk a distance of 15 to 20 km to the nearest health centre. This could put the lives of the pregnant women at risk especially when they are due for delivery. The mobile clinics must always be efficient and reliable to reach the newly resettled people especially for immunisation programmes to immunise children against the ten child killer diseases.

There is a critical need to address the issue of staff shortages in Zimbabwe, Government and local authorities should offer attractive and competitive packages to retain the skilled workforce who left the sector to look for greener pastures.

This is mainly the skilled nursing staff especially midwives who left to seek better employment opportunities during the economic downturn from 2000 to 2008. Freezing of posts by the government of Zimbabwe should be reconsidered especially for critical posts such as the health staff as health centres are being manned by student nurses and junior doctors.

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