

**MIDLANDS STATE UNIVERSITY**



**FACULTY OF SOCIAL SCIENCES**

**DEPARTMENT OF LOCAL GOVERNANCE STUDIES**

**THE EFFECTIVENESS OF RESULTS BASED FINANCING IN THE PROVISION OF  
BETTER HEALTH SERVICES .A CASE OF RUSHINGA HEALTH INSTITUTIONS.**

**BY**

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**DISSERTATION SUBMITTED TO THE MIDLANDS STATE UNIVERSITY IN  
PARTIAL FULFILLMENT OF THE REQUIREMENTS OF A BACHELOR OF  
SCIENCE HONOURS DEGREE IN LOCAL GOVERNANCE STUDIES.**

**OCTOBER 2015**

### APPROVAL FORM

The undersigned certify that they have read and recommend Midlands State University for acceptance, a research study entitled: *“The effectiveness of Results Based Financing in the provision of better health services, a case of Rushinga health institutions”* submitted by Muwanikwa Tatenda in partial fulfilment of the requirements of the Bachelor of Science Honours Degree in Local Governance Studies.

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## DECLARATION

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## **DEDICATION**

I am dedicating this research to my beloved mother, my academic sponsors, my loving sister, friends and family for enhancing the feasibility of this project.

## **ABSTRACT**

The research study focused on the effectiveness of Results Based Financing (RBF) in the provision of better services within health facilities. The main motives of this research are to examine the forms of RBF being partaken by health service providers in ensuring changes in the health sector, to identify the various challenges experienced in the implementation of RBF, to analyze the influence of RBF towards a motivated health workforce within the operating circles, to assess the extent of community participation in the implementation of RBF by health facilities, furthermore to recommend solutions to thwart the challenges experienced in rural health institutions. Methods of assessing the effectiveness of RBF were discussed in depth in the literature review phase. The study reveals the empirical evidence about the performance of RBF in an effort to curb maternal and under-fives deaths. RBF can be effectively implemented through the availability of the required resources and timely disbursement of the funds to allow early strategic planning. The results obtained from the research findings indicated that political will and commitment should be the key in ensuring the uplift of developmental reforms within rural communities. This would aid in enhancing the effectiveness of RBF in the health clinics. In this regard, related literature was critically analyzed thus different scholarly views were postulated concerning various themes identified by the researcher hence RBF was thoroughly defined, forms of RBF intended to assure changes in the health arena, issues of community participation as well as motivation of health employees to perform better were well articulated. In the research methodology section the researcher used both the qualitative and quantitative research designs. The target population of the study was 198 individuals with a sample size of 40 participants thus 18 from expecting and mothers with under-fives, 4 from the community leaders (CEO, DA and councilors), 12 from health workers and 6 from the management within the health field. Focus group discussions, questionnaires and interviews were used to acquire primary data in the research. Sampling techniques namely Stratified, Simple random sampling and purposive sampling were used to obtain information from the rightful participants. The presentation of the research findings reveals the forms of RBF used in Rushinga health facilities. The participants also unfolded the challenges that are encountered in the execution of RBF. Community participation was indicated as a critical area which need to be considered if RBF is to be effectively nailed. It was noted that employees within the health field requires motivation through motivational platforms such as early disbursement of funds and deployment of health workers in influential posts. More so it was resolved that there should effective engagement of women who are the beneficiaries of RBF in decision making on health related issues and also awareness of the health program should be fostered through awareness campaigns.

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## **ABBREVIATIONS**

CEO	:	Chief Executive Officer
COD	:	Cash on Delivery
DA	:	District Administrator
MDG	:	Millennium Development Goals
MoHCC	:	Ministry of Health and Child Care
PBC	:	Performance Based Contract
PBF	:	Performance Based Financing
RBF	:	Results Based Financing
RBM	:	Results Based Management
RRDC	:	Rushinga Rural District Council
ZIMASSET	:	Zimbabwe Agenda for Sustainable Socio-Economic Transformation



## Table of contents

APPROVAL FORM .....	ii
RELEASE FORM.....	iii
DECLARATION .....	iv
DEDICATION.....	v
ABSTRACT .....	vi
ACKNOWLEDGEMENT.....	vii
ABBREVIATIONS .....	viii
TABLE OF CONTENTS .....	ix
LIST OF TABLES AND FIGURES .....	xiii
<b>CHAPTER I.....</b>	<b>1</b>
<b>INTRODUCTION.....</b>	<b>1</b>
1.0 INTRODUCTION .....	1
1.1 BACKGROUND INFORMATION .....	1
1.2 PROBLEM STATEMENT .....	5
1.3 RESEARCH OBJECTIVES .....	5
1.4 RESEARCH QUESTIONS.....	6
1.5 SIGNIFICANCE OF THE RESEARCH /STUDY .....	6
1.6 DELIMITATIONS .....	7
1.7 LIMITATIONS OF THE RESEARCH.....	8
1.8 ASSUMPTIONS .....	9
1.9 DEFINITION OF TERMS.....	9
1.10 SUMMARY .....	9
<b>CHAPTER II.....</b>	<b>11</b>
<b>LITERATURE REVIEW .....</b>	<b>11</b>
2.0 Introduction .....	11
2.1 Definition of Literature Review .....	11
2.2 What is Results Based Financing?.....	11
2.2.1. Targets in Results Based Financing.....	13
2.2.2 Target of RBF (ZIMASSET).....	14
2.2.3. Target of RBF (MDG 4) .....	15
2.2.4. Target of RBF (MDG 5) .....	16
2.3 FORMS OF RBF THAT ENHANCE EFFECTIVE HEALTH SERVICE DELIVERY....	16
2.3.1 Output Based Aid (OBA).....	16
2.3.2. Cash on Delivery (COD).....	17
2.3.3. Conditional Cash Transfer (CCT).....	17
2.3.4. Performance Based Contract (PBC) .....	18

2.3.5. Performance Based Financing (PBF).....	18
2.4. CHALLENGES FACED IN THE IMPLEMENTATION OF RBF .....	19
2.4.1. ECONOMIC ENVIRONMENT.....	20
2.4.2. Lack of Competitive Packages .....	20
2.4.3. POLITICAL ENVIRONMENT .....	21
2.4.3.1. Lack of political commitment and will .....	21
2.4.4. SOCIAL ENVIRONMENT .....	21
2.4.4. 1 Socio cultural factors.....	21
2.4.4. 2 Lack of Community participation in the implementation of RBF.....	22
2.4.4.3 Corruption.....	22
2.4.4.4 Distance to health facilities .....	23
2.4.4. 5 Poorly Resourced Health Facilities.....	24
2.5. MOTIVATION OF HEALTH EMPLOYEES THROUGH RBF.....	24
2.5.1. Types of motivation .....	25
2.5.2. Elements of motivation. ....	26
2.5.3. Level of Staff Motivation .....	26
2.6 COMMUNITY PARTICIPATION IN RESULTS BASED FINANCING.....	27
2.6.1 Participation Platforms that fosters citizens in decision making.....	28
2.6.2 Types of Community Participation.....	28
2.6.3 Extent of Community Participation in RBF .....	29
2.7 COMPARATIVE ANALYSIS OF RESULTS BASED FINANCING .....	30
2.7.1 Results Based Financing Effectiveness in Zambia .....	30
2.7.2 Overview. ....	30
2.7.3 Results Based Effectiveness in Rwanda .....	32
2.7.4 Overview .....	32
2.7.5 Overall Observation. ....	33
2.8. ADVANTAGES OF RESULTS BASED FINANCING .....	34
2.8.1 Accountability .....	34
2.8.2 Equity .....	35
2.8.3 Transparency .....	36
2.9. Gaps Identified in the Literature Review .....	36
2.10. SUMMARY .....	37
<b>CHAPTER III .....</b>	<b>38</b>
<b>RESEARCH METHODOLOGY .....</b>	<b>38</b>
3.0 Introduction .....	38
3.1 Research Methodology .....	38
3.2 RESEARCH DESIGN .....	39
3.2.1 Qualitative Approach .....	40
3.2.1.1 Case Study.....	40

3.2.2 Quantitative approach .....	40
3.3 TARGET POPULATION FOR THE STUDY .....	41
3.4 SAMPLING TECHNIQUES .....	41
3.4.1 Stratified Random Sampling .....	42
3.4.2 Simple Random Sampling.....	42
3.4.3 Purposive sampling.....	43
3.5 SAMPLE SIZE.....	43
3.5.1 Table 1 Sample Size Composition .....	44
3.6 SOURCES OF DATA .....	44
3.6.1 Primary Data.....	44
3.6.2 Secondary Data.....	46
3.7 RESEARCH INSTRUMENTS .....	47
3.7.1 Questionnaires .....	47
3.7.1.1 Merits .....	47
3.7.1.2 Shortcomings .....	48
3.7.1.3 Resolutions to the shortcomings .....	48
3.7.2 Interviews as instruments of data collection .....	48
3.7.2.3 Resolutions to the shortcomings .....	49
3.7.3 Focus Group Discussions .....	50
3.7.3.1 Advantages of Focus Group Discussions.....	50
3.7.3.2 Disadvantages .....	51
3.7.3.3 Resolutions to the disadvantages .....	51
3.8 Ethical Issues in Data Collection.....	51
3.9 Reliability.....	52
3.10 Validity.....	52
3.11 Pre-test .....	53
3.12 Summary .....	53
<b>CHAPTER IV .....</b>	<b>54</b>
<b>DATA PRESENTATION, ANALYSIS AND INTERPRETATION.....</b>	<b>54</b>
4.0 Introduction .....	54
4.1 Response rate from Interviews, Questionnaires and focus group discussion .....	54
4.1.1 Response rate: Questionnaires.....	55
4.1.2 Response rate: Interviews.....	56
4.1.3 Response rate: Focus Group Discussions .....	56
4.2 Response of health workers by Gender .....	58
4.3 Age Group for the Participants.....	59
4.4 Level of Education.....	59
4.5 Forms of Results Based Financing .....	61
4.6 Challenges encountered at Rushinga Health Clinics in the implementation of RBF .....	63

4.7 Motivation of the employees within the Health Institutions .....	64
4.7.1 Motivation tools used within Rushinga Health facilities .....	66
4.8 Are the citizens participating in the implementation of RBF? .....	67
4.8.1 Community Participation Platforms that enhance citizens’ participation .....	68
4.8.2 Community awareness of the RBF program .....	70
4.9 Merits of Results Based Financing .....	71
4.10 Summary .....	72
<b>CHAPTER V</b> .....	<b>73</b>
<b>SUMMARY, CONCLUSIONS AND RECOMMENDATIONS</b> .....	<b>73</b>
5.0 Introduction .....	73
5.1 Summary .....	73
5.2 Conclusions .....	76
5.3 Recommendations.....	77
<b>REFERENCE LIST</b> .....	<b>79</b>
<b>APPENDICES</b> .....	<b>87</b>
APPENDIX I: Questionnaires for Health Workers.....	88
APPENDIX II: Interview Guide for the Management and Crown Agent.....	91
APPENDIX III: Interview Guide for the District Administrator, the Chief Executive .....	93
APPENDIX IV: Focus group discussion questions for expectant and mothers .....	94

### **List of tables and figures**

Table 2 Response Rate for Questionnaires.....	55
Table 3 Response Rate for Interviews .....	56
Table 4 Response rate for Focus Group Discussions.....	57
Table 5 Age Group for the Participants .....	59
Fig 4.4.1 Level of Education .....	60
Fig 4.5.1 Forms of RBF implemented in Rushinga Health Facilities .....	61
Fig 4.6.1 Challenged faced in the implementation of RBF.....	63
Fig 4.7 Motivation of employees within Health Institutions.....	65
Fig 4.7.1 Motivation Tools .....	66
Fig 4.8 Community Participation.....	67
Table 6 Community Participation Platforms .....	68
Fig 4.8.2 Community Awareness.....	70
Fig 4.9 Merits of RBF .....	71

# CHAPTER I

## INTRODUCTION

### 1.0 INTRODUCTION

The research seeks to assess the effectiveness of Results Based Financing (RBF) in the provision of better services in Rushinga local health facilities. Thus the emphasis is mainly centered on maternal and child health care and this serves for the purpose of attaining Millennium Development Goals (MDG) 4 and 5 thus to reduce child mortality and improve maternal health respectively. Moreover improved health services also spearhead development within communities when conducted in a transparent and effective manner. The research will also explore the impact of RBF for health as a tool to enhance improved health services in order to realize MDG 4 and 5 by December 2015. In this way the research study is going to unfold everything entrenched in the failure of local health clinics to deliver services and at the same time it will reveal the current position of RBF in the provision of better health services. However the section includes other crucial aspects such as the background of the problem, problem statement, objectives of the study, research questions, delimitations and limitations of the study. All in all this section seeks to introduce the reader to the research under study.

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### 1.1 BACKGROUND TO THE STUDY

Rushinga district is situated in Mashonaland Central Province, thus it is approximately 60 kilometers to the east of Mount Darwin. Thus Rushinga Rural District Council (RRDC) is 238 kilometers from Harare which is the largest city of Zimbabwe. According to ZimStat (2012) Rushinga district has an estimation population of 74040 people. In this context RRDC is a local institution which is categorized as a public sector organization thus it is non-profit making. The councils development can be traced back to the colonial era under the control of the white regime. The rural district council is a child birth of the colonial government of 1927 and it was established in 1957. It came into being after the two African councils namely Rusambo and Makusengwa African councils were amalgamated into District Councils and Rushinga remained a single district situated at Chimhanda business service Centre. The council was administered under the Rural District Councils Act Chapter 29:13 of 1988. The council offices were situated at Chimhanda Growth Point up to date. RRDC became the closest and locally accessible public

institution with a role to represent local interest and deliver locally relevant services. Thus the council emerged to meet community welfare needs and to facilitate local economic development.

Rushinga rural district council is located in natural region 4 and 5 thus it a semi-arid region which require intervention of a subsidiary body of the central government to assist the citizens by full filling their needs at a local level. Therefore the rural district council came in to picture to bridge the gap between central government and the citizens at the grass root level thus provision of services to the communities.

Results Based Financing is a health program that transfers incentives or goods either to health service providers when they achieve the predetermined outcome or to the costumers when they participate in the health programs such as giving birth at health facilities and ensuring that their under-fives are vaccinated against the child killer diseases. (Bogges and Edelstein, 2009). This research is triggered by the prevailing situation of high maternal and child death rates within Rushinga district despite the intervention by the Ministry of Health and Child care together with other partners through the introduction of RBF program.

#### 1.1.2 RBF situation at National Level

Zimbabwe's health sector of late have been experiencing high mortality rates of expecting and lactating mothers as well as children under the age of five. In this way, the prevailing situation within the health arena contrast the aims of Zimbabwe Agenda for Sustainable Socio Economic Transformation (ZIMASSET) which seeks to reverse the socio economic threats affecting people's lives in Zimbabwe particularly in rural areas. ZIMASSET is an economic blue print which was documented by the ruling government of Zimbabwe in a thrust to counter the impediments affecting the nation as a whole and these hindrances are a result of the economic sanctions posed by western countries such that Zimbabwe get stuck in poverty. Thus RBF is one of the pillars of RBM set to guide the Ministry of Health and Child Care in assisting health service institutions situated in rural areas for instance, such that they assure a decrease in the rate at which expectant women and under-fives are dying. Despite of the effort which was revealed by the government when they formulated the policy it is crucial to note that effective implementation of the document is still lacking and this have resulted in the worst performance within the health sector.

The public health service sector being one of the largest service providing ministry have been facing a series of challenges posed by the economic crisis thus it then spearheads an increase in the number of maternal and child deaths due to the inability of customers to pay user fees at health institutions. Crown Agents (2014) states that Zimbabwe's health sector is currently emerging from serious economic challenges hence making it difficult for many citizens particularly women and children to access critical health care. All these predicaments namely lack of medical drugs, dilapidated infrastructure and brain drain of skilled health personnel has made all the efforts of realizing MDG 4 and 5 fruitless. One of the major barriers to access maternal and child health services is the cost of services (Training and Research Support Centre (TARSC); 2013). According to the United Nations (2013) maternal mortality rate is 960/100 000 live births and currently Zimbabwe is ranked among the 40 countries in the world with highest maternal mortality rate. In addition to the same report by UN indicates that maternal mortality rate has increased by at least 28 % between 1990 and 2010. For instance in Zimbabwe one in every 11 child die before their fifth birthday, thus 33,500 is the figure of Zimbabwean children under the age of five who die every year (MoHCW; 2012). Such a drastic increase in the mortality rate of women and children is being catalyzed by the inability of the people especially in rural areas to pay health service fees. Therefore it is against this history that RBF for health was adopted in Zimbabwe to enhance the attainment of MDG 4 and 5. Thus the Ministry of Health and Child Care (Regulator) in conjunction with CORDAID (Purchasing agent) joined hands in the implementation of the RBF scheme in 2010.

RBF for health has revealed magnificent changes in the health sector in some of the rural districts in Zimbabwe. For instance in Marondera and Zvishavane good results have been brought about through this health program within a short period of time. The number of women who had four or more prenatal visits rose to 560 in June 2012 up to 65% from 339 a year before (World Bank ;2012). In addition in that same month the districts registered 212 deliveries at rural health clinics centers up to 83% from a year before. Also success has been scored in Marondera Rural District in places such as Chiparahwe rural clinic. RBF improved service delivery at this clinic even the rural poor can now have access to medical treatment when they are sick. According to the World Bank (2012) the clinics patient volume has skyrocketed to 883 in July 2012 from 152 a year before. The two nurses at the clinic delivered 30 babies in 2012 compared



with two in July. Moreover 162 children received the measles vaccine in July 2012 up from 142 a year before.

### 1.1.3 Regional level

According to the World Bank Institute (2010) 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 .This alone entails that a lot of work in the health sector needs to be put into practice. RBF for health emerged in the 1990s in Cambodia (Asia) and it later on spread to Sub Saharan countries in Africa from 2002 going onwards. Countries namely Rwanda, Burundi, Cameroon and Democratic of Congo among others were the pioneers of the RBF scheme. Ghana is a country situated in Africa experiencing health service challenges spearheading poor health service delivery. Ghana is slowly progressing in terms of the provision of health services despite the introduction of RBF in the health service institutions .This is so because health outcomes are not being effectively verified to ensure their validity. Hence there is no proper evidence on the effectiveness of RBF in the health sector in Ghana. Toonen et al (2012) states that maternal mortality rates remain high despite declining slowly over the past two decades from 740 per 100,000 live births in 1993 to 451 in 2008. Ghana still needs to reduce the mortality rate of the under-fives by 35 % and infant mortality by 48% to attain MDG 4(Toonen et al; 2012). Thus there is no evidence base on its success caused by limited number of evaluations of the scheme. Therefore there is need for strategic implementation of RBF to ensure that changes are achieved in health service facilities within Ghana.

### 1.1.4 Global level

Globally RBF is being implemented in low income countries with aid coming from developed countries that purchase the results hence promoting improved health services. Meessen et al (2010) states that there is an increase in the public expenditure within the health arena but health outcomes have been achieved at a slow rate. According to World Bank (2014) globally in 2010 there were 210 maternal deaths for every 100,000 live births with South Asia having the second highest burden with 220 deaths for every 100,000 live births. For instance in Bangladesh and India progress towards improved health services is being made but the pace at which the progress is being made makes it difficult for the two South Asian countries to ensure a decrease

in maternal and under five child mortality which is the core business of RBF. Challenges such as economic instability, poor governance, high illiteracy rate of women as well as ecological hardships have been impeding the acceleration of health services especially child and maternal health care within these countries. With all this information in mind the researcher therefore viewed it possible to carry out the study so as to reveal the changes brought forth by the health program as well as its effectiveness within the health service facilities.

### **1.2 PROBLEM STATEMENT**

The dilemma at hand is that there is still high child and maternal mortality rates in Rushinga health service clinics thus RBF has failed to reduce mortality rates of expecting and lactating mothers as well as children under the age of five years up to the expected levels in order to realize MDG 4 and 5 by the end of December 2015. Hence the researcher is inspired to conduct this research because of the little progress being revealed by Rushinga health service institutions. Rural health facilities are battling to ensure a decrease in the rate of child and maternal mortality thus spearheading development in even the peripheral areas where most of the rural poor resides. However it is imperative to note that under- fives, expecting as well as lactating women are still dying in large numbers despite the health intervention made through the implementation of RBF. Currently Sub Saharan African region is being ranked as one of the regions with outstanding figures of maternal and child mortality. The Government endeavor to ensure that the Ministry of Health and Child Care together with various institutions such as non-governmental organizations put extra effort so as to foster a decline in the rate at which under-fives and expecting mothers are dying. Thus ideally a low death rate for both under -fives and for expectant women is the main objective of the Government of Zimbabwe.

### **1.3 RESEARCH OBJECTIVES**

- To examine the forms of RBF being partaken by health service providers in ensuring changes in the health sector
- To identify the challenges being encountered in the implementation of RBF by health service institutions.

- To analyze the influence of RBF towards a motivated health workforce within health institutions.
- To assess the extent of community participation in the implementation of RBF by health service facilities.
- To find out the possible solutions to the prevailing challenges being encountered in the implementation of RBF.

#### **1.4 RESEARCH QUESTIONS**

- What are the different forms of RBF being implemented by health service providers to ensure changes in local health institutions?
- What are the challenges being faced in the implementation of Results Based Financing in local health institutions?
- Are the employees within the health sector motivated to produce better results by the adoption of RBF in their work place?
- Does the community participate in the implementation of RBF by health service providers?
- What are the possible solutions or recommendations that can be forwarded to address the predicaments being faced in the implementation of RBF in Rushinga Health service facilities?

#### **1.5 SIGNIFICANCE OF THE RESEARCH /STUDY**

##### 1.5.1 Merits to the Academia

Having a self-interest on the impact of RBF in local health centers as well as to the community, the researcher therefore aspire to gain wide knowledge on how RBF can be implemented within health centers to ensure improved health services to the direct clients .Moreover to be equipped with practical understanding of the changes brought forward by the program (RBF).

This proposed research is essential in the contest that it enables the researcher to gain learning experience and to broaden research skills.

##### 1.5.2 Merits to Rushinga Health Service Facilities

The research can be used as a source of information to view the essence of RBF within all the health service institution to ensure the attainment of MDGs 4 and 5 and also to assess their performance level in as far as RBF is concerned.

The researcher also hopes that health service providers in Rushinga will be able to identify the predicaments impeding proper implementation of RBF and the possible solutions they can adopt to ensure better health services to expectant women and children under the age of five years.

#### 1.5.3 Merits to the University

It can contribute to the board of knowledge thus it can be used by other university students as a secondary data source when they are conducting a research of the same nature.

In addition it can also be used as a source of information in related modules such as Results based management (RBM) because RBF is an aspect of RBM.

#### 1.5.4 Merits to other Organizations or People

The research will enhance non-governmental organizations such Crown Agents and UNICEF to better complement the efforts of CORDAID, World Bank and the Ministry of Health and Child Care in implementing RBF in an effective manner thus is to improve health service by ensuring that child and maternal mortality is reduced in local health clinics hence achieving MDG 4 and 5.

Moreover the study will give an insight to the direct clients about the RBF program in particular women who cannot afford to access medical attention for themselves as well as for their children below the age of five years due to financial challenges. This research will assist them in viewing the benefits of participating in the RBF program so as to enable a health community.

### **1.6 DELIMITATIONS**

The research under study will be carried out in Rushinga district namely at Rushinga and Chimhanda Health clinics because they have a high statistical rate of medical visits by patients who seek to attain maternal as well as child health care. Rushinga district stretches from Ruya River bordering with Mozambique on the other side Mazowe bridge borders with Mudzi which is in Mashonaland East and lastly on the western side it separates with Mount Darwin District.

The district constitutes of 25 wards and it has a capacity of 74040 people. According to Zimstats (2012) total population of Rushinga district was 74040, thus 35504 males and 38536 females.

The research will focus on maternal and child health since RBF aims at ensuring a decrease of child and maternal mortality rate. The study will not focus on the entire population but on direct clients of the RBF scheme since they will assure the availability of accurate information in the research. Employees of the two afore mentioned health service facilities and the management or senior staff members such as the District Nurses Officer (DNO) will be the targeted respondents to provide the required information. Thus these identified respondents will provide first-hand information of the impediments being faced in the implementation of RBF posing slow progress in the improvement of service provision within the health arena.

### **1.7 LIMITATIONS OF THE RESEARCH**

One of the challenges likely to be encountered in the research is lack of access to the crucial information required due to confidentiality which is one of the ethical issues to be considered by employees within any working environment. Thus the senior staff members in position of the required information might not effectively respond to the questions posed by the researcher. Therefore there is need for the researcher to effectively solicit feedback such that the research is wholly completed within the specified time.

Time-is also a constraint meant to impede the researcher in conducting the research in time .The research is being carried out in a short period of time therefore the researcher should prioritize thus applying the time management grid such that deadlines are met.

Moreover due to the distance to be travelled, the researcher finds it difficult to continuously visit the anticipated area of study thus Gweru to Rushinga a bid to obtain first-hand information pertaining the implementation of RBF this is mainly because the research is being done in a short period of time. Thus there is need for the researcher to technological means such as emails so that information is obtained from time to time.

A high cost of travelling expenses to the two clinics identified in the study situated in Rushinga as well as printing and stationery cost are some of the financial aspects which stand as stumbling

blocks in the successfulness of the study. In this way the researcher should seek parent assistance so that they sufficiently provide financial support.

### **1.8 ASSUMPTIONS**

- The assumption will be that the DNO will contribute with the required information concerning the implementation RBF to the research.
- Statistical data of RBF performance and the consumers assisted under the program will be available.
- The research will be conducted in time to meet the deadlines.
- Funds will always be available when visits to the research field are being made.

### **1.9 DEFINITION OF TERMS**

#### **Results Based Financing**

Naimoli and Benzel (2009) postulates that RBF is a cash payment or non-monetary transfer made to a nation or sub national government, manager, provider, payer or consumer of health services after predefined results have been achieved and verified.

#### **Effectiveness**

Effectiveness is the degree in which an organization realizes its goals and objectives (Rao; 2003)

#### **Millennium Development Goals**

United Nations (UN) (2009) concurs that MDGs are goals set to address extreme poverty, universal primary education, gender and equality, child mortality, maternal death, HIV/AIDS, environmental sustainability and the global partnerships for development challenges.

### **1.10 SUMMARY**

This part of the research covered the background of the research study that is the history of the health sector performance and how RBF came in to picture .The chapter also include the problem statement thus the cause of the difficulties being faced resulting in the study to be convened. It outlines the objectives to be achieved pertaining the implementation of RBF in Rushinga health service centres, research questions introduced to source answers for the objectives identified as

well as scope of the study, all these were tackled in this chapter of the research. In addition the chapter also highlights the impediments faced in the research and how the challenges standing as stumbling blocks in the successfulness of the research were addressed.

## **CHAPTER II**

### **LITERATURE REVIEW**

#### **2.0 INTRODUCTION**

The rationale of this section serves for the purpose of explaining what RBF is towards the provision of health services. The chapter will review related literature on the different forms of RBF that are tailored at enhancing effective health service delivery at the local level moreover issues of community participation in the implementation of RBF will be articulated. The paper will also tackle the challenges encountered in the implementation of RBF as well as the possible solutions that can be devised to harness the predicaments affecting local health facilities in delivering services to the consumers. The second section of this chapter will use the empirical evidence available to compare the implementation and effectiveness of RBF from different public health institutions in countries such as Zambia and Rwanda representing developing countries. Lastly the merits of RBF namely transparency, equity and accountability will be addressed and thoroughly articulated within this section as well as the gaps noted in the literature.

#### **2.1 DEFINITION OF LITERATURE REVIEW**

Tsvere (2008) is of the view that literature review is a descriptive, critical analysis and evaluation of what other authors or researchers have written. Literature review gives a short and concise interpretation and summary of information that acts as a critique to the existing literature so that contemporary data of literature is recognized (McKinney; 2008). Literature review is essential as it stimulates potential insights and views on the probable approaches for the studied research problem. Furthermore literature review refers to an evaluation and critical analysis of the already existing material thus it links the views of other authors with a unique area of research. It is an examination of the dated circulated information by other accredited scholars. This literature can be drawn from publications such as books, journals and electronic sources as well as reports.

#### **2.2 WHAT IS RESULTS BASED FINANCING?**

Results Based Financing is defined by Grittner (2013) as any program where the principal set financial or other incentives for an agent to deliver predefined outputs or outcomes and rewards the achievement of these results upon verification. According to Soeters and Griffiths (2003)



RBF is a strategy of financial health care delivery on results (output performance which are measured through predefined indicators. RBF is one of the components of Results Based Management thus it is results oriented. RBF is a health intervention funded by World Bank such that it foster better health services in particular maternal and child care and such is enhanced through payment for results attained after verification of those health outcomes. It focuses on the results to be achieved so as to enhance the realization of value for money hence improving health service quality.

Leovinsohn (2008) pinpoints that RBF evolved from Results Based Management program (RBM), as a tool for better health services in developing countries in particular Zimbabwe. RBF is a change management tool that was designed to permit a shift from concentrating on traditional funding of inputs to being results oriented. It is a program which matches finances with the expected health outcomes. Results Based Financing is not the panacea towards the achievement of effective outcomes (AIDSTAR; 2014). However health services quality and quantity is still lagging behind pertaining the achievement of MDG 4 and 5.

RBF is a health scheme meant to ensure a sustainable transition within health service institutions by funding the performed activities delivered by the healthcare providers to achieve targets as agreed upon by all parties that is both the Principal and the Agent. In this way certain targets or outcomes agreed upon should be attained for funds to be reimbursed hence improving service delivery at the grass root level. In Zimbabwe RBF is mainly concerned with improved living standards for poor pregnant and expecting mothers so that they deliver their babies under the supervision of skilled professionals within health facilities as well as to immunize an outstanding figure of under- fives thus guaranteeing a decrease in maternal and child mortality.

The World Bank concurs that RBF is any program that rewards the delivery of one or more outputs or outcomes by one or more incentives ,financial or otherwise ,after the principal has verified that the agent has delivered the agreed upon results (Musgrove ;2010). 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) to healthcare providers when they achieve performance targets (such as immunizing a certain percentage of children in a given area (Lindsay;2010). Thus RBF endeavor to resolve the principal –agent tension such that there is acceleration in the rate of health service provision within the health arena. It seeks to link the

objectives of the Principal with those of the implementing partner (Agent) through setting payments for the Agent to perform activities which enhance the realization of predefined targets. Pearson (2011) states that she will only (Principal ) release the payment if these predefined results are achieved .Therefore funds are not reimbursed by the Principal if the Agent fails to meet the agreed upon outcomes in the contract. In this way RBF was crafted in such a way that it deals away with incompetent organizations who are self-centered thus saving their personal interest.

Naimoli and Benzel (2009) alludes that RBF is a cash payment or non-monetary transfer made to a nation or sub national government, manager, provider, payer or consumer of health services after predefined results have been achieved and verified. In this regard most of the local authorities worldwide have adopted the flux of RBF in a bid to efficiently provide services in the areas of their jurisdiction. More importantly in Zimbabwe local councils are the planning authorities' .Thus the role of governmental departments and other parties in implementing public services has made RBF a viable option for local authorities especially in the provision of health services with the presence of NGO's, hospitals and its subsidiary clinics situated in the rural areas. In regards to RBF the principal is a national or sub national government body in this case the Ministry of Health or a district health authority is. The agent is an implementing partner for instance the health service providers' thus rural clinics. More to it implementing agent can be any private nonprofit making organization such as a non-governmental organization (Pearson; 2011).

Apart from this principal agent connection, organizations should play a complementary role so as to foster the effectiveness of RBF in sustaining a change within the health sector as well as ensuring a reduction in child and maternal death rate. Monitoring and evaluation of performance to both parties involved should be the order of the day such that results are obtained.

### **2.2.1. Targets in Results Based Financing**

Targeting involves the selection of direct clients thus the beneficiaries of the program (RBF).Target groups can be classified based on health status ,sex ,race ,income level as well as age .Grittner (2013) postulated that RBF scheme focus on vulnerable people within the community who are mostly social excluded from accessing basic health services, these are the

rural poor ,children who are still dependent on their parents ,girls residing in rural areas and HIV infected women situated in peripheral areas. According to Ellison et al (2010) targeting is a crucial aspect of architecture for many RBF forms since it has an implication on its effectiveness, efficiency and equity. In this green light, targeting plays a crucial role in as far as identifying the consumers of a program is of concern. It enables services providers in particular health institutions to fulfill the needs of their consumers hence improved health services.

In Zimbabwe, RBF for health was designed and agreed upon for implementation between the Ministry of Health and Child Care, World Bank and CORDAID in 2010 but it was put in to action in July 2011 with Zvishavane and Marondera districts being the pioneers later the program was then designated to other district health centres such as Rushinga district. The health scheme was mainly targeted at advancing maternal and child care hence the realization of Millennium Development Goal (MDG) 4 and 5. MDGs can be defined as targets set by United Nation in 2000 for developing countries to focus on so as to steer development within their nations thus withstanding the threats posed by poverty. Amongst the eight goals reduction of child deaths as well as maternal mortality are some of the key result areas which seriously require full attention of developing countries. In this regard RBF was devised to ensure that the health sector increases its effectiveness in the provision of services to its localities. As a result it was tailored at assuring that MDG 4 and 5 are met by the end of the year (2015). United Nations (UN) (2009) concurs that MDGs are goals set to address extreme poverty, universal primary education, gender and equality, child mortality, maternal deaths, HIV/AIDS, environmental sustainability and the global partnerships for development challenges.

### **2.2.2 Target of RBF (ZIMASSET)**

ZIMASSET is a national strategy that was crafted to thwart the socio economic impediments impacting on the operation of the various sectors including the health sector. The agenda is a results based agenda characterized into four clusters which governmental ministries and departments are advocated to dwell on for Zimbabwe to succeed in fighting the socio economic drawbacks imposed through the illegal economic sanctions by Western countries. In line with RBF social services and poverty eradication is the area of concern which cause for the attention of the Ministry of Health and Child Care in order to reduce the number of maternal and child deaths. The social service and poverty eradication cluster serves for the motive of enhancing a

change in the living standards of people within Zimbabwe. This is merely by going an extra mile in ensuring that the resources required are at hand. The dire situation prevailing in all facets of life have been causing upheavals even in the health arena such that there is an increase in maternal and child mortality rate thus threatening development which is the chief objective of any nation. On the social service field ZIMASSET targets to diminish child mortality by guaranteeing that coverage of 90 percent of children under five are immunized. Moreover a total of 85 percent of assisted deliveries is expected to be achieved as well as an increase in antenatal care visits by expectant women. Strategically the Ministry of Health as the facilitating ministry in health development processes is required to collaborate with other institutions such as Non-governmental organizations to ensure availability of adequate resources needed for the effective performance of the health sector.

Apart from all this RBF is one of the structures of RBM which is meant to guide the operations of the Ministry of Health in lessening the mortality rates of both under-fives and expecting women hence efforts revealed has proved its failure to safeguard the health interest of the country. Sachiti (2014) asserts that ZIMASSET is just a document which lacks political will on the implementation part. Although RBF also guides the concerns of ZIMASSET much have not been underpinned so as to reach the intended outcomes. Therefore expectant mothers and under-fives are still dying in large numbers.

### **2.2.3. Target of RBF (MDG 4)**

The fourth goal targets to reduce by two thirds under five mortality rate by end of 2015. The Government of Zimbabwe highlights that the country's target is to halve mortality rate of children under five from 102 per 1000 live births from 1999 up to 34 per 1000 live births by 2015. UN (2014) states that there has been a reduction in the figure of children who die before their fifth birthday hence a lot of effort is required within health organization especially in rural areas for such goals to be achieved. According to United Nations Development Program (UNDP) (2012) Zimbabwe despite interventions extended in the health arena, the country is still off track in terms of ensuring a reduction in child morbidity and mortality. Trends in line with the target reveals that progress is being achieved but at a slow pace .Over the past years deaths of children under five marked a decrease from 102 per 1000 live births to 84 per 1000 live births .This alone clarifies the fact that RBF as a health intervention as failed to guarantee the realization of MDG

4 by December 2015. Lozano et al (2011) is of the view that 31 developing countries from a total of 137 countries might met MDG 4 entailing that the rest giving a total of 106 might not realize the target.

#### **2.2.4. Target of RBF (MDG 5)**

Moon (2010) notes that Africa remains the continent facing most severe challenges in realizing MDGs progress especially in terms of improving maternal mortality. Sachiti (2011) is of the same view that Zimbabwe is unlikely to achieve MDG 5 thus a decrease in maternal mortality rate by year 2015 this is so because the capacity of health care system has deteriorated significantly. Although RBF aims to accelerate service provision by incentivizing health outcomes such efforts have been labored in vain because quantitative information indicates that there is an outstanding figure of women dying during and after birth time .UN (2014) asserts that there has been a decrease in maternal mortality but the efforts impacted on the health programs leaves a lot to be desired. In addition same views have been forwarded that progress in the health sector is achieved in the world .Comparatively, some of the developing such as Rwanda has a low mortality rate of under-fives as well as that of expecting and lactating mothers. On the same note Sub Saharan African region still has the outstanding maternal and child mortality rates thus 510 deaths per 1000 live births followed by Southern Asia countries for instance India and Bangladesh.

### **2.3 FORMS OF RBF THAT ENHANCE EFFECTIVE HEALTH SERVICE DELIVERY.**

#### **2.3.1 Output Based Aid (OBA)**

There are various and complex forms of RBF approaches that can be implemented to enhance health service provision in Zimbabwe health facilities' operating at the local level. OBA is one of the types of RBF for health that if employed on a transparent and inclusiveness platform it can yield effective results. Musgrove (2011) asserts that there are varied forms of RBF that can be applied for specific results to be achieved within the health sector. According to Savedoff (2010) Output Based Aid is a program that links finances to outcomes rather than on the processes and procedures towards results. The Global Partnerships on OBA (2009) postulates that this form of RBF is utilized where the marginalized people within the communities for instance the rural poor cannot have access to basic social services such as health services. OBA is a type of RBF in

which health care providers are rewarded for their performance in realizing the targeted outcome set by the Principal. In other words it is a payment by a national or sub national government to health service providers such that they bridge the gap between the haves and the have not such that the rural poor can also access social services. It is imperative to note that this form of RBF is not all encompassing thus some of the rural poor are still struggling to access the basic services required for them to survive thus ineffective.

### **2.3.2. Cash on Delivery (COD)**

Tremolet (2011) defines COD as a form of RBF where contracting out is done and agreed between the governments and implementing partners thus incentives are paid to the implementor when specified results agreed upon are obtained. Birdsall and Savedoff (2010) are of the same view that the health scheme is tailored at guaranteeing a complementary relationship between foreign organizations and countries. In this respect, COD is a type of RBF which strengthens the association between the principal and the agent towards the accomplishment of the desired outcome. COD is meant to deal away with sleeping partners who are not competent enough to induce and sustain change efforts within their operating environment. Sithole (2013) is of the view that pure COD schemes are rarely applied within the health arena. Over (2011) argues that COD is a conducive form of RBF that can spur effective and efficient health services because rewards are directly linked to outcomes. Apart from this donors funding health schemes seeks to pursue self-interest which contradicts the contract terms agreed on hence it deters progress intended to be achieved (The Evaluation of the Paris Declaration (2011)).

### **2.3.3. Conditional Cash Transfer (CCT)**

Musgrove (2011) is of the view that CCT is a funding or a rewarding system that is beneficial to the consumer of services such as families or even the targeted groups. Pearson and Ellison (2010) are of the same view that Conditional Cash Transfer refers to the transfer of incentives or non-monetary rewards that directly benefit the consumers if they use identified health services. In this way CCT is a form of RBF which targets the consumers (demand side) such that health quality and quantity is increased in health organizations thus development. It is meant to uphold the health status within a nation by ensuring that those in need of medical attention are paid when they participate in the program.

Asian Development Bank (2012) concurs that CCTs remains a discipline which requires full awareness of the consumers and sensitization platforms so that they better understand the effectiveness of such health interventions in improving maternal and child mortality within health institutions. A typical example of CCT by Pearson and Ellison (2010) supported by Sithole (2013) reveals that with CCT under-fives and expectant women are the beneficiaries who are paid or given vouchers that is if they consume services promoting the effectiveness of RBF. However it is equally important to note that CCT may not be a benefit to every consumer in need this is so because some of the direct clients are left out in the program. Moreover such forms of RBF have been reported to be benefitting even rich people who have the capacity to access medical attention using their own finances.

#### **2.3.4. Performance Based Contract (PBC)**

It is one of the forms of RBF that seeks to enhance RBF effectiveness towards achieving organizational objectives. PBC refers to a formal document agreed upon by health organizations that clearly spell out the activities to be done, duties to be performed by human resources responsible as well as results to be achieved (AIDSTAR-Two; 2014). Musgrove (2011) states that PBC is a program in which incentives are reimbursed to health care providers as stipulated in the formal arrangement between the parties involved. PBC is more to the supply side where payments are made to service providers considering the legal settlements made in the contract. Masango (2007) concurs that making incentives depend on certain achievements of health outcomes may foster health personnel to manipulate consumers such that they use the services for better results to be produced hence more incentives.

#### **2.3.5. Performance Based Financing (PBF)**

In Sub Saharan African region PBF has emerged to be a favorable and conducive form of RBF that is implemented by most of the developing countries in order to spearhead changes resulting in the decline of maternal and child mortality. Amongst these developing countries Zimbabwe is one the nations that is using this form of RBF to enhance its effectiveness in reducing maternal and child mortality so as to meet MDG deadline of 2015. Unlike COD, PBF ensures that incentives are directed to health service institutions thus motivating even the human resources deployed in the health field .Makoni (2014) et al defines PBF as the transfer of resources to

service providers on the basis that performance will be revealed through the achievement of the targeted outcomes.

AIDSTAR-Two (2011) is of the same phenomena that PBF is the transfer of funds to health providers for them to strategically plan and put the plans into action so as to achieve expected outcomes which are paid upon verification. Moreover this form of RBF is also confined to the principal agent correlation. Hence PBF is centered on the supply side where payments are made to health care facilities for them to deliver services for the realization of results. Grittner (2013) states that the principal and the agent usually have different opinions pertaining the achievement of results thus there is no mutual understanding and effective communication amongst organizations involved in the program. AIDSTAR-Two (2011) argues that both parties involved in the aid program should have one common goal. Apart from this it is vital to bear in mind that PBF although used in many developing countries to effectively bring about change in the health sector it has failed to reduce child and maternal deaths so as to realize MDG 4 and 5. According to Makoni et al (2014) there is no tangible information on the effectiveness of PBF in inducing improved health services.

#### **2.4. CHALLENGES FACED IN THE IMPLEMENTATION OF RBF**

There are quite a number of challenges that have been impeding effective implementation of Results Based Financing at the local level globally. These constraints have evolved from the internal as well as the external environment surrounding the health facilities meant to provide health services to the consumers. To mention political, economic, social, ecological as well as technological factors have made it difficult for RBF to yield the desired outcomes thus failing to enhance the achievement of MDG 4 and 5 by end of 2015. Leovinsohn (2008) is of the view that RBF have been affected by a multiple of factors amongst include lack of incentives to the health providers, lack of monitoring and evaluation of the results tailored at indicating that progress is being made, poor health services and distanced health facilities which are not easily accessible . To counter these challenges flexibility is therefore required thus to adapt to the dynamic environment technologically. Moreover team work will also stage significant changes if applied as one of the core values amongst partners in the implementation of RBF.



## **2.4.1. ECONOMIC ENVIRONMENT**

### **2.4.2 Lack of Skilled Human Resources**

One of the challenges being faced in the implementation of RBF is lack of human resources who have the prerequisite skills to prompt the effectiveness of RBF. RBF in Zimbabwe was adopted mainly for the purpose that it would reduce child and maternal deaths up to the expected levels but all these efforts have been rendered fruitless by lack of skilled health personnel. Sing et al (2007) asserts that even the effort of paying for results will not bring about changes if there is a shortage of qualified health workers within an organization. Mills (2009) is of the same view that lack of skilled health employees and their apposite dispersal is also a challenge in the implementation of RBF. For example in Zimbabwe the economic environment has posed serious challenges pertaining the implementation of RBF. The poorly performing economy has led to the brain drain of health expertise in the health arena in search of good living conditions in the neighboring countries. Thus these results in a shortfall of health professionals who are capable for instance to help expecting mothers to deliver safely without facing complications. Therefore RBF has failed to meet the expected targets due to lack of skilled health employees.

More the freezing of post for the trained health workers also has a hand in the failure of RBF to produce remarkable and desirable results. Vacant posts in the Ministry responsible for health have not been filled for quite some time of which the sector is already swimming in a pool branded by a short fall of health workers such as trained nurses. According to ZimStat (2010) there are multiple factors that have posed hindrances to the effectiveness of RBF amongst lack of skilled health personnel due to the freezing of post by the Central Government. In this line of thinking there is still high mortality rates for maternal as well as children under the age of five as a result of a shortage of health professionals.

#### **2.4.2.1 Lack of Competitive Packages**

Lack of competitive packages to health employees is one of the challenges encountered in the implementation of RBF for health. This situation has often acted as a restraining force towards a transition from focusing on the resources to produce results but rather on the outcomes. Toonen et al (2009) postulates that uncompetitive bonus packages have resulted in the inefficiency of RBF hence missing its intended goals. A typical example is that of Zimbabwe where staffs are not

even remunerated for their performance in a bid to elicit the achievement of better health outcomes (Meessen; 2012). In this way this incompetence can demoralize employees in ensuring that their hardworking uphold RBF efforts. In this regard it results in the failure of the health intervention.

### **2.4.3. POLITICAL ENVIRONMENT**

#### **2.4.3.1. Lack of political commitment and will**

Politicians are vital in the operations of public service institutions because they formulate policies which impede proper service delivery .On the other side their role is considered as one of the predicaments in the effective implementation of RBF programs. In Zimbabwe lack of political will is revealed in the current status of RBF programs thus it is being nailed in eighteen districts only out of a total of sixty –two districts thus politicians lack the will to foster national scaling of the RBF policy. Sithole (2013) concurs that politicians are not committed enough to influence people towards supporting RBF programs within their areas because they view the health intervention as a political threat since it is being funded by developed countries namely Norway. Canavan et al (2009) alluded that political instability is a cause of the inability of the RBF program to deliver expected services by the people. He is of the same view that even when funds are paid for results such scenario will not led to the achievement of intended goals because politics have a hand in either impeding effectiveness of such interventions or catalyzing its effectiveness. Therefore politics is one of the major challenges that can impede proper implementation of Results Based Financing.

### **2.4.4. SOCIAL ENVIRONMENT**

#### **2.4.4. 1 Socio-cultural factors**

Culture especially the notion of beliefs has greatly contributed to the ineffectiveness of RBF in reducing maternal and child mortality. Some of the people are of the idea that it is not of paramount importance to seek medical attention when the need arise but rather a waste of resources. For instance in India it was recognized that most of the women have given birth at their matrimonial homes because their husbands did not see the reason why they should seek medical attention so as to deliver their babies safely and to have their infants immunized (Gupta

et al, 2010). Ghosh (2009) indicates that socio cultural factors have a great cause to the decline of the number of people seeking assistance through RBF. Thus this hinder the attainment of valid and accurate results of what is actually taking place on the ground because the majority of the targeted groups resorts to other ways which lies contrary with the aims of RBF .

Toonen and Jurien (2010) notes that religious beliefs intertwined with certain cult practices impede the successfulness of RBF especially in Sub Saharan African countries. In Zimbabwe the apostolic sect have contributed immensely to the drastic figure of under- fives and maternal deaths due to the fact that churches such as Johani Marange do not permit its followers to seek medical attention rather they believe in spiritual healing which is sometimes unnecessary when considering the circumstances in which women give birth .This is so because they seriously need medical attention from health professionals such that they are monitored until they deliver safely. Hence it can be noted that expecting mothers and under- fives are still dying in large numbers due to religious beliefs which impede the effective implementation of the RBF program.

#### **2.4.4. 2 Lack of Community participation in the implementation of RBF**

Participation refers to the involvement of citizens in decision making on matters of concern thus it is crucial for the local people to be engaged in programs implemented in their areas because they best know what they require and the factors that can improve health services. In this regard lack of community participation in RBF programs results in interventions which does not address the needs of the people and to this organizations are doomed to fail since they will lack support from the public. The level of citizen engagement differs from institution to institution as well as nation to nation (Toonen et al; 2009). Moreover they are of the same view that most of the developing countries are still struggling to create participation platforms which effectively engage citizens in partaking action in health decision making processes. In this way lack of participation and community involvement has been a stumbling block towards the effective implementation of RBF.

#### **2.4.4.3 Corruption**

According to World Bank (2006) corruption is the misuse of public authority for personal gain, which simply confirms the notion by many scholars' that corruption is in abusive nature which then renders it as an unethical practice. In the current situation particularly in Zimbabwe

corruption is the order of the day thus there is cooking of books or results such that more incentives are paid to the health providers. To the employees within the health arena implementing RBF corrupt activities are engaged in to augment their low salary packages. Grittner (2013) states that incentives meant to promote the effectiveness of RBF are prone to fraud tendencies by both health service workers and their institutions. According to Toonen et al (2009) there is a high possibility of workers engaging in corrupt practices such that they are paid more than the reality on the ground. Thus one can note that corruption is one of the drawbacks in the implementation of RBF. The health service facilities have been producing false health outcomes in a bid to receive more bonus packages on unfinished work (Eldridge and Palmer; 2009). In this way corruption is one of the aspects which impede the effective implementation of RBF

#### **2.4.4.4 Distance to health facilities**

In rural areas most of the health service institutions are situated at a distance thus the local clinics are not easily accessed by the citizens who tend to acquire health services such as antenatal care for expecting mothers as well as immunization for the newborns. According to Ministry of Health and Child Care a local health facility such as a clinic or district hospital should be approximately 8 kilometers away from the people it serves. This is not the case in Zimbabwe typically in the furthest rural parts of the nation; women are reported to be walking a distance which exceeds 30 kilometers to access the nearest local clinic. In this respect, this challenge runs parallel to the policy by the Ministry of Health which advocates health institutions to be in a parameter of 8 kilometers away from its consumers.

Although in Zimbabwe there are mobile clinics they have not done much to reach the furthest areas where most of the disadvantaged people reside due to lack of resources such as vehicles and fuel. Davidson (2009) asserts that inaccessible health facilities which are out of clients reach have posed difficulties in as far as positive results are to be achieved. Meessen (2012) in support of the same view postulates that most of the countries in Africa still face a challenge in the implementation of RBF and this have been caused by the distance existing between the citizens and their health facilities. Therefore inaccessible health facilities by the localities is also a hindrance in the proper nailing of the RBF scheme.

#### **2.4.4. 5 Poorly Resourced Health Facilities**

Poorly resourced health institutions coupled with dilapidating infrastructure have been greatly affecting the implementation of RBF in many developing countries namely Zimbabwe. Although the scheme (RBF) pays for results no consideration have been put on the state of the infrastructure in rural local clinics. Thus most of these health institutions lack the capacity to meet the predefined targets in the implementation RBF. More to it the dilapidated infrastructures as well as obsolete equipment have hampered the efforts of RBF in attaining the desired objectives. Mills (2009) identifies lack of medical necessities such as drugs, equipment as well as infrastructure as the cause of concern pertaining the implementation of RBF. Dilapidated infrastructure in countries such as Haiti and Afghanistan has spearheaded challenges in the implementation of RBF (Hansel et al; 2008).

One of the challenges also being experience in the implementation of RBF as noted by various scholars is cherry picking (Axelson and Kraushar; 2013). Cherry picking involves putting much focus on easy targets which enhance easy achievement of results or expected outcome. Toonen et al (2009) defines cherry picking as tool by which health service providers select targets or indicators which enables them to come up with results easily. Thus they may focus on certain patients for instance those with diseases which are easy to cure or job easy to do neglecting the most complicated targets which the RBF scheme advocate them to dwell much on. In this context cherry picking is one of the challenges faced in the implementation of RBF because it does not promote the effectiveness of the health scheme but rather upholds corrupt tendencies by health workers.

#### **2.5. MOTIVATION OF HEALTH EMPLOYEES THROUGH RBF**

Guay et al (2010) defines motivation as the attributes that drives someone to take action or not. Motivation can also be the reasons fostering a certain behavior (Broussard and Garrison; 2004). According to Mathaurer and Imhoff (2006) employee's motivation is one of the key factors that reveal the successful application of RBF within the health sector. World Health Organization (2006) is of the view that motivation is one of the pillars of health institutional care structures namely quality health services, efficiency and equity. More so staff motivation has become the focal point in the provision of quality services assuming that motivated health employees can enhance positive change desired by the clients (WHO; 2006). In this green light employees

‘motivation within health service institutions is of paramount importance .This is so because motivated employees perform better hence it results in the reduction of child and maternal mortality. Barr et al (2005) asserts that skilled health workforces are the chief corner stone within the health organization thus their motivation also counts as it enhance effective and efficient service delivery. Therefore if health employees are to deliver services to the citizens’ motivation should be promoted.

In Zimbabwe for instance although funds are reimbursed to health workers they still lack the motivation to produce the desire health outcomes. Lack of motivation amongst health workforce have been posed by inherent challenges which impede workers to perform up to standard .These challenges are shortage of skilled employees which then increase the work load of the available human resources, economic crisis resulting in the freezing of post for skilled human resources. All these challenges hinder effective performance of trained health workers. Mathaurer and Imhoff (2006) postulates that lack of human resources is not only the challenge to the performance of health staff but a variety of factors also have a hand in drawing back the successfulness of RBF. Underperformance of health staffs due to lack of motivation have not only affected the operations of the health institutions but have emerged to be a setback concerning the realization of MDG 4 and 5 (United Nations; 2007)

### **2.5.1. Types of motivation**

- a) Extrinsic motivation.
- b) Intrinsic motivation.

According to Lai (2011) intrinsic motivation refers to the motivation that is derived within a person .Thus it is attached to an individual entailing that it is self-driven. Extrinsic motivation it is the ability to deliver after being paid or given external rewards, monetary and non-monetary incentives such as food. AIDSTAR -Two (2011) concurs that extrinsic motivation is intertwined with external components of motivation which drives health workers to perform or deliver services to its customers. RBF as a health intervention seeking to achieve organizational objectives of improving child and maternal health care should aim at striking a balance between intrinsic and extrinsic motivation because that play a central role in the performance of health workers

### **2.5.2. Elements of motivation.**

External elements for extrinsic motivation include incentives, food, infrastructure, protective clothing as well as good living conditions (AIDSTAR –Two; 2011). Robert et al (2004) is of the same phenomena that monetary rewards are the bedrock for inducing health workers motivation.

According to AIDSTAR-Two (2011) intrinsic motivation is linked to dynamic aspects namely moral values, challenges, enjoyment, recognition as well as respect.

### **2.5.3. Level of Staff Motivation**

Many scholars who have published literature related to the area under scrutiny are of the notion that incentives do not enhance staff motivation but rather they pose challenges to the effective implementation of RBF within health service institutions. This is so because sustainability of the RBF scheme is not guaranteed if the funding agents retrieve the aid moreover external payments undermines dynamic aspects of motivation such as recognition and respect which internally drive employees within health organizations to deliver services.

In addition underperformance of employees due to lack of motivation also results in poor service delivery. Miller and Babiarz (2013) alludes that payment for results often yields unexpected outcome this is so because health employees perform better in areas where they are not paid at all than in full filling tasks which they feel is being lowly paid. In support of the negative consequences of RBF on health workers motivation Hayman and Ariely (2004) are of the view that incentives led to a reduction in employees' effort or performance as they assume that their health targets are economic oriented rather than being social centered. In this regard RBF do not enhance employees' motivation to deliver services.

In developing countries for example it is believed that paying for the predefined results agreed upon in the partnership contract between the principal and the agent often lead to demoralization of health workers (Oxman and Fretheim; 2008). Huillery and Seban (2014) are of the view that PBF as a form of RBF that links funds to results have negative consequences on the motivation of health workers. In this line of thinking RBF does not prompt the desire of health professional to produce quality services which are needed by the consumers because in some instances in countries such as Democratic Republic of Congo employees are dissatisfied with the different incentives given to them by the donor after the accomplishment of the same predefined goals. In

this way such difference in payments to the health service providers operating under one roof is a demotivation factor which then threatens the organizations vision. Demotivation of one of the major deterrence of quality services within health service institutions (Dieleman and Harnmeje; 2006)

Axelson and Kraushar (2013) postulates that RBF program compromises intrinsic motivation by paying incentives for results obtained. Witter et al (2012) notes that in future the health sector might face a challenge of skilled workforce as paying for incentives overrides intrinsic motivation In this green light paying for results overrides intrinsic motivation thus employees will not be self-determined to perform well but rather they would be external driven by factors which are short termed. In Democratic Republic of Congo many health employees have laid complaints against RBF scheme implying that the program was straining them for they had no mechanisms that would attract more consumers hence increasing demand (Huillery and Seban; 2014).Therefore RBF leaves a lot to desired pertaining staff motivation in providing favorable atmosphere where there is a decline in child and maternal mortality thus achieving MDG 4 and5.

## **2.6 COMMUNITY PARTICIPATION IN RBF**

Mchunu and Gwele (2005) concurs that a community is a group of individuals who are bounded by a common interest or a group of people who work collectively towards achieving common concerns. More to it the authors are of the view that community participation is a shift from representative involvement to a situation where the citizens are directly involved in decision making on matters affecting their lives. Therefore community participation refers to the involvement and consultation of the public in decision on matters of concern. Participation of citizens in decision making on health related matters fosters commitment moreover it induces sense of ownership thus dealing with resistance to change by some of the community members. Citizen participation in the implementation of RBF is therefore vital because it enhances the majority or the most affected for instance women of child bearing age to identify the programs that would address their needs .The community can participate directly or indirectly .Focusing on RBF in Zimbabwe it is imperative to note that there is lack of citizen participation and consultation on matters of concern especially on health related issues. Furthermore in some of the developing countries it has been observed that the RBF structures crafted to steer progress do not provide platforms for the citizens engagement (Toonen et al; 2009). In this green light



without citizen involvement, RBF programs will be doomed to failure because the citizens will simply resist to support the health intervention hence a boom in the mortality rates of under-fives as well as expecting mothers.

### **2.6.1 Participation Platforms that foster involvement of citizens in decision making.**

There are several platforms which can enhance the community to effectively participate in decision making on matters of concern. Wachira (2013) is of the view that the main objective of citizen participation in decision making on matters of concern is for the people to influence public health services. This is so because the community can best identify and define their priorities which can result in the provision of improved health services. Amongst others the participation platforms which foster the engagement of citizens in decision making are:

- Community Based Organizations.
- Health centre committees
- Civil society in district steering committees
- Health facility committees
- Private Sectors at nation level.

### **2.6.2 Types of Community Participation**

There are various types of community participation that have been viewed as essential in primary health care. These among others include active participation, passive, interactive and functional participation.

#### **2.6.2.1 Active Participation**

This form of community participation refers to the direct involvement of citizens in all project or program phases. Processes such as monitoring and evaluation of the program as well as decision making in critical key results areas are done by the community itself. Thus there is direct engagement of the public as the beneficiaries of the program hence they directly take part in decision making to enhance the achievement of organizational effectiveness. Buss et al (2006) concurs that active participation is essential in promoting community participation moreover it fosters a sense of commitment as different individual understands the concerns and interest of

others. Active community participation also brings about the realization of realistic goals from a pool of different individuals with different interest.

#### **2.6.2.2 Passive Participation**

It describes a scenario where the community is only informed of the activities that will be taking place in the project thus there is no direct engagement of the public in decision making processes. Thus this form of participation is similar to representative democracy where the public is informed of the progress achieved in the program by their representatives. In this way this type of community participation hinders progress to be achieved within the health sector because citizens are sidelined in decision making thus the produced outcome might not meet the needs of the public.

#### **2.6.2.3 Functional Participation**

With this form of community participation the public participate in the form of groups and committees. Thus committees or groups are formulated to enhance the involvement of citizens in decision making. These committees or groups are seen as platform to realize predetermined organizational goals. In this way participation is viewed as the right way to go not as a mechanical function. The groups or committees use systematic and structured way of learning. Therefore groups take lead in deciding what's best for the community in the health arena thus the public has a hand in maintaining the structures and processes undertaken within the health program.

#### **2.6.2.4 Interactive Participation**

Recent work by various scholars reveals that people take part in decision making in a joint analysis as well in other processes namely planning and the implementation processes. The community takes charge of the decisions to be underpinned in the health facilities thus influencing change if there is a need to do so.

### **2.6.3 Extent of Community Participation in RBF**

Canavan et al (2009) is of the view that community participation varies from nation to nation and from organization to organization. Stakeholder engagement is the key element to the

successfulness of RBF schemes (Sithole; 2013). Community participation in the validation of results as well as the monitoring process of Results Based Financing is still lacking particularly in Zimbabwe. Thus this challenge in RBF initiatives has been prompting corrupt practices to prevail in health service institutions due to lack of supervision of the produced results by the direct consumers. Moreover health service institutions are providing services of low standards because they is lack of communication that is amongst the health providers and the community. Social learning platforms should be designed such that both stakeholder eligible of participating in the RBF program including the consumers can learn from each other of what is required for the initiative to be a success.

Toonen et al (2009) postulates that community participation in the implementation of RBF is still an area of concern. This is so because citizens are not effective participants in the implementation of the RBF program. Furthermore the scholars are of the view that PBF as a form of RBF partaken by most of the developing countries including Zimbabwe has proven to be a failure in enhancing citizen involvement. In Democratic Republic of Congo for instance most of the villages have a village health committee but still there is lack of citizens engagement in decision making in such committees .To add on there are no communication channels which permeate feedback to flow from both parties involved in the RBF scheme (Toonen et al; 2009). In this regard it is vital to note that there is lack of community participation in the implementation of Results Based Financing. Therefore participation structures that permeate citizen involvement in the health aid scheme should be established. Moreover through such structures transparency should be up held.

## **2.7 COMPARATIVE ANALYSIS OF RESULTS BASED FINANCING**

### **2.7.1 Results Based Financing Effectiveness in Zambia**

#### **2.7.2 Overview.**

In Zambia RBF initiatives started in 2012 covering a total of ten district (Chansa; 2014).High child and maternal mortality rates which was threatening Zambia's development in all facets of life prompted Zambia to adopt the program as a tool towards improved health. Of late Zambia

like any other developing country in Sub Saharan Africa focused on inputs assuming that better outcome would follow but with the adoption of RBF and its implementation health institutions have shifted to be results oriented. All these efforts are tailored at achieving MDG 4 and 5 by end of 2015.

Although progress is being made through the implementation of RBF it has been observed that Zambia is still performing poorly in terms of attaining the targeted health outcomes. Chiwele and Syampugani (2011) postulate that to realize MDG 4 and 5 Zambia need to put extra effort such that the overall objective is realized. They indicated that the MDG 4 target by 2015 is 63; 6% and under-fives mortality declined from 168 to 119 per 1000 live births. On the other hand maternal mortality declined from 729 to 591 per 100,000 live births. According to Chiwele and Syampugani (2011) MDG 5 target by 2015 is 162 per 100,000 live births and this entails that health institutions should go an extra mile in a bid to reach a total a target 162 per 100,000 live births thus reducing the maternal deaths by 429.

In this green light there are various challenges impeding successful implementation of RBF as well as its effectiveness in Zambia. Canavan et al (2009) noted lack of equipments as well as in adequate infrastructure as some of the challenges which results in the failure of the health aid to achieve its intended goals. More to it bureaucratic structures which delay the disbursement of funds from the national government to health providers as well as shortage of skilled employees which are competent to tackle complicated issues are some of the stumbling blocks that hinder successful implementation of RBF in Zambia (Oxman and Fretheim ;2008).

In spite of the challenges encountered in the implementation of RBF by health institutions in Zambia, the health facilities should be pro-active rather than being reactive .There is need for the national government of Zambia to commit itself to the health arena so as to save dying mothers and children under the age of five thus additional funds should be sourced such that the challenges being encountered will be neutralized. Moreover the successes made by Rwanda in reducing maternal and child mortality should be copied for implementation by developing countries such as Zambia.

### **2.7.3 Results Based Effectiveness in Rwanda**

#### **2.7.4 Overview**

Rwanda is one of the pioneers of RBF within Sub Saharan Africa. It is one of the fragile states in African that have demonstrated its ability in assuring improved health services. A decade back Rwanda have been struggling to provide basic health services to its citizens. Haub (2006) concurs that Rwanda of late have been experiencing challenges in ensuring a decrease in maternal and child mortality thus approximately 750 women per 100,000 die when giving birth more so the effort of reducing under-fives deaths were being tackled beyond the expected outcomes .In spite of the challenges that were threatening Rwanda in providing the best services to its people, Rwanda have proved to be a bedrock upon which other developing countries can rely on. Its success in improving maternal and child mortality have stood to be a motivator to other sub region countries such as Burundi to follow similar steps so as to ensure the realization of MDG 4 and 5.

In pursuit of MDGs highlighted above Rwanda initiated PBF a form of Results Based Financing in 2001 (The World Bank and GAVI Alliance; 2010). Realizing the success which was being revealed by the health institutions in districts such as Butare, PBF was than scaled up as a national policy. Eichler and Levine (2009) are of the view that the success noted as a result of the implementation of PBF between the years 2001 to 2004 led to Rwanda scaling up the program up to the national level in 2005.

Thus the coverage of the health intervention was increased in Rwanda all this pointed towards quality health services for instance the increase in coverage entails an increase as well in the number of under-fives to be immunized also an increase in institutional deliveries. The World Bank (2010) indicates that Rwanda is one of the developing countries that have displayed a desirable move pertaining the improvement of service delivery in the health sector .In other words Rwanda proved that RBF is capable of improving health services up to the required standards by focusing on outputs not on the means to an end. A typical example of RBF effectiveness in Rwanda is that for the past four years assisted deliveries increased from 12 to 23 percent more the curative rate of consumers through the health scheme recorded an increase that is from 0.22 to 0.55. The World Bank and GAVI Alliance (2010) are of the same notion that the

implementation of PBF results in the provision of better services as well as the attainment of the targeted outcome.

Moreover the institutions propounded that during 2005 to 2007 the number of women who were given contraceptive pills at health institutions increased from seven percent to twenty-eighth percent. Institutional deliveries rose from 29% to 52%. Within the same period child mortality dropped from 198 to 103 per 1000 live births and this was enhanced by an increase in the immunization coverage which rose from 83 % to approximately 100%.

It is also imperative to note the aspects that contributed to the successful implementation of PBF in Rwanda (The World Bank; 2010). Leadership commitment and political will are some of the reasons that triggered Rwanda efforts towards improved health to be fruitful. Motivated health service providers who were given competitive bonus packages for the targets met also contributed to the successful implementation of the health aid (Rusa et al; 2009). Furthermore lessons learned from developing countries in South Asia for instance Cambodia who were already using the health aid to steer development within their states significantly contributed to the successfulness of PBF to realize the intended goals.

In this way other developing countries such as Zimbabwe should draw lessons from Rwanda such that maternal and child mortality rate is deduced. Thus politicians should be committed to formulate policies which are citizens centered not self-centered thus RBF in Zimbabwe to effective it should be scaled up to be a national policy. Moreover health professionals should be internally and externally motivated such that they devote their selves to services delivery which is the core business of their organizations.

#### **2.7.5 Overall Observation.**

In regards to the above discussion RBF is an effective tool for reducing child and maternal mortality. However it is vital to note that political will and leaders' commitment is still lacking in most of the developing countries implementing RBF and this have been hindering local health institutions in such states to realize MDG 4 and 5 using the health intervention (RBF). Thus the national government in fragile states such as Zimbabwe should devote its effort and resources to the health sector so as to ensure sustainable development. Friederike (2009) notes that there are multiple factors which are hindering health institutions to achieve their intended goals and

amongst such lack of political will is one of those predicaments. This is so because politicians are policy formulators who on the other hand represent the public interest thus their action has an impact on citizens' lives. In addition their decisions can either fulfill the needs of the majority or worsen the situation at hand. To achieve MDG 4 and 5 political will and leadership commitment should be upheld.

Unlike Zambia, Rwanda is one of the developing countries that have succeeded in ensuring a decline in maternal as well as child mortality through RBF. Moreover its successful implementation of the health aid also inspired some of its neighboring countries namely Burundi to follow similar steps hence reaching the overall objective. Thus with the results drawn from Rwanda, RBF is effective in improving maternal and child mortality. For instance an increase in the figure of the immunized under-fives, completion of four antenatal care visits by expectant mothers moreover an increase in institutional deliveries.

## **2.8. ADVANTAGES OF RESULTS BASED FINANCING**

Leovinsohn and Harding (2005) states that RBF is a mechanism towards improved accountability, efficiency, quality and quantity of services delivery. RBF as a component of RBM therefore promotes good corporate governance. Accountability, equity, effectiveness, transparency and efficiency are some of the key elements encroached in this concept (Corporate Governance). Organization for Economic Co-operation and Development (OECD) (2004) postulates that corporate governance can be summarized in five terms thus shareholders rights, efficient use of resources, accountability, disclosure of vital information and transparency. In this way when implementing RBF these key factors should be put into consideration for results to be achieved. Hence one can note that there are of paramount importance in an effort to reduce maternal and child mortality.

### **2.8.1 Accountability**

Mills (2009) asserts that accountability is the chief corner towards better service delivery. Accountability refers to a process where one is answerable or responsible for his or her actions. Accountability frameworks functions as the platform for RBF programs moreover they assist in fighting corrupt practices within local health facilities (Sithole; 2013). According to Harmalin and Weisback (2007) accountability is intertwined with decision making. It enhances effective

administration operations this is so because one will be held to account for the results attained or produced at the end. Thus managers efficiency is enhanced because to achieve targeted outcomes there is need for clear roles and responsibilities for each health employee such that everyone within the organization will be aware of what is expected of them.

RBF programs enhance accountability within the operational arena because it shifts the focus on resources to produce results but rather on the actual outcome (World Bank; 2013). Moreover when accountability is ensured through RBF so does performance all heading towards improved service delivery. In this way RBF holds management accountable for their performance thus a tool to reduce high child and maternal mortality.

### **2.8.2 Equity**

Equity refers to the equal opportunities ensured amongst for instance men and women or between the poor and the rich. They are various ways in which equity within health institutions can be assured (The World Bank; 2013). A typical example is that of Burundi where the health scheme (RBF) enhanced equity through funding the health providers with bonuses especially those located in the remote parts. Hence bridging the gap between well-equipped health facilities and the poorly resourced health clinics. The poor are the most affected within the rural communities because they cannot easily access health services due to the fact that they are financially incapacitated therefore many die at home without assistance from health service providers. This is because they will be lacking the resources to seek medical attention in health facilities. In this regard RBF as a health intervention promotes equity in the sense that it bridges the gap between the poor and the rich more over health institutions in rural areas are not restricted on what to use their incentives but they can utilize their payments on whatever they deem necessary. In this respect they can use the funds to purchase health equipment or motivate their health staffs thus improved health facilities.

On the demand side user charges are reduced in most of the developing countries. Toonen et al (2009) notes that the decrease in the consultation fee of expectant women entails an increase in the inclusion of the disadvantaged within the rural areas. Therefore equity is one of the merits of implementing RBF in rural local clinics.



### **2.8.3 Transparency**

Transparency is one of the merits of RBF which promotes the improvement of health services to its consumers. It is one of the pillars of corporate governance thus corporate governance is anchored on transparency. Borgia (2005) alludes that corporate governance should foster accurate disclosure of financial statements as well as the performance of employees in relation to the organizations vision. Transparency can be defined as the free flow of information pertaining an organizations operations. It is the provision accurate and accessible information to the relevant people. This information can be organizations financial statements, audit reports, vision as well as the mission statement. Transparency builds trust among organizations and its stakeholders therefore it is required if an organization is to succeed thus reducing maternal and child mortality up to the expected levels. Sithole (2013) is of the view that transparency is essential within an institution because it assist in curbing corruption tendencies by health service providers.

According to AIDSTAR-Two (2011) transparency ensure the existence of clear lines in data reporting, verification as well the validation of the results at all levels. In this way transparency is one of the benefits of RBF tailored at improving health service outcomes.

### **2.9. GAPS IDENTIFIED IN THE LITERATURE REVIEW**

Community Awareness of the RBF program requires more attention especially on the merits of the health aid. Although this was not well discussed by accredited scholars specializing in the RBF arena it is imperative to bear in mind that direct consumers lack an insight of how the program functions and the advantages of participating in the scheme. Therefore there is need for effective awareness campaigns in the communities with traditional leaders being one of the facilitators in educating and encouraging people under the area of their jurisdiction to take part in health related programs.

Moreover another gap noted is that of ways to sustain the RBF scheme in case the donors withdraw their assistance in developing countries. It is of paramount importance for Sub Saharan African countries to have a foresight on what the future will be when the funding agencies withdraw their assistance. In this regard contingency planning is needed so as to assure sustainability of the health program.

Effective communication networks between various key players in the RBF program is also a gap that requires attention because it results in poor service provision to the citizens. This is so because when there is lack of communication this entails that there will be contrasting visions thus different perspectives. In this way the actor implementing the health aid will undertake duties that satisfy their own interest hence affecting the third part. Therefore there should be effective communication between the Ministry of Health and rural health clinics so as to achieve the common goal and this is only achievable through conducting meetings and educational workshops.

Moreover the issue feedback on the services provided was not addressed in the literature. Thus health service providers should conduct client satisfaction surveys such that they know if the costumers of the health service are satisfied and also for them to priorities on the activities to undertake.

## **2.10. SUMMARY**

This section unfolded literature by various scholars in relation to RBF within public health facilities worldwide. The theoretical background and the possible solutions to counter the challenges impeding effective application of RBF were also articulated in this chapter especially with reference from developing countries which are still lagging behind in terms of achieving MDG 4 and 5 by the end of this year (2015). In this chapter different scholarly views pertaining forms of RBF as well as its definition were also discussed at length. Moreover a comparative analysis on the implementation as well as the effectiveness of RBF between countries was also done to provide an insight on the best practices to be employed within health service institutions in order to realize the achievement of MDG 4 and 5. Lastly merits of RBF were addressed and these include transparency and accountability.

## **CHAPTER III**

### **RESEARCH METHODOLOGY**

#### **3.0 INTRODUCTION**

This chapter aims at enhancing a detailed examination of the research instruments employed to assist the researcher in coming up with factual information relating to the effectiveness of RBF in improving health services. The section highlights the various mechanisms that will be considered to acquire relevant data needed in the research. The research design will be articulated together with the sampling techniques appropriate for the effectiveness of the research. In this chapter data collection instruments will be presented. Moreover the data collection tools will not only be scrutinized but for the effectiveness of the research its validity and reliability will also be maintained. Finally the section is enveloped with a chapter summary.

#### **3.1 RESEARCH METHODOLOGY**

According to Denscombe (2007) research methodology refers to an examination of the processes and procedures implemented in a bid to achieve results within a specified area of study. A research is an organized search of enquiry that enables one to have an insight of the situation avail therefore coming up with appropriate recommendations (Redmen and Mary ;2009). Research methodology is a systematic enquiry of relevant data pertaining a certain subject. It defines the processes and procedures to be underpinned and measures progress achieved .Williams (2010) is of the view that research methodology is a systematic way towards attaining the prerequisite information aligned to a particular research problem. More specifically research methodology simply refers to the various data collection techniques that the researcher intends to use in obtaining information required in the study. These tools are namely focus group discussions, questionnaires and interviews to mention but a few. In this respect there are various research mechanisms that can be devised to resolve the research problem. Industrial Research Institute (2010) concurs that methodology are the processes set to harness the existing research problem or find answers to the problem at hand.

A research is not confined to the social field alone but is also hitched around other disciplines which require a search of enquiry to be done. Research methods refer to the various systems and

processes applied to the area of study. Apart from this, research methods advocates for an examination of information grounded on factual evidence and observations. Therefore research method is a systematic process of finding possible answers to the problem statement. In this regard it is imperative to note that a well strategized research methodology enhances the successfulness of the overall research. This is so because proper mechanisms of data collection enable better analysis of the produced outputs.

### **3.2 RESEARCH DESIGN**

A research design is viewed as the structure of a research. It is the glue which cements all the elements of the research together. Kumar (2010) defines research design as the framework that allows the researcher to generate answers in line with the research topic. Research design is the conceptual structure within which the study is undertaken. It is the skim outline that describes when, how and where information is to be gathered and examined. Basically it is a strategy which outlines the steps to consider when collecting data. According to Wegner (2005) research design is the logical framework in which the required information is obtained to address the research hypothesis in line with its objectives in a more efficient manner. Research design is usually based on the nature of the problem and of course how this problem is conceptualized. It saves time and increases research flexibility by stimulating the researcher to anticipate possible challenges in carrying out the research. Thus the motive behind this concept research design is to find the appropriate ways in undertaking a detailed research. More over the focus should be centered on the validity, reliability as well as on the accuracy of the information to be collected. Therefore the research design has three ideal objectives and these are

- To provide answers to the question being studied
- To provide possible resolutions to the problems being encountered
- to sustain variations

For the purpose of the study, the researcher will focus on both qualitative and quantitative techniques. According to Cresswell (2007) the researcher can use both techniques thus qualitative and quantitative for data analysis through an application of varied method matrix to examine various techniques pertaining data collection in the study.

### **3.2.1 Qualitative Approach**

Denzin and Lincoln (2004) postulates that qualitative research design involves narrative description of phenomena namely life experiences, observations, historical events, case studies and interviews. Qualitative approach is based on a research that is interactive. It analyses the culture and behavior of humans from the starting point up to the end of those being studied. Qualitative approach enhances a detailed explanation of any given phenomenon. Thus it encompasses the use of research instruments such as observations, focus group discussions and questionnaires. Qualitative research design unlike quantitative approach is more conducive and less rigorous (Lyingberg and Douglas; 2008).Tewksbury (2009) alludes that there are several merits of undertaking qualitative research unlike in quantitative research .A typical example pertaining the conducive environment displayed by qualitative research is that using qualitative approach enhances a detailed description of the effectiveness of RBF within health service institutions thus ensuring a reduction of child and maternal mortality. Punch (2014) postulates that qualitative approach is a broad concept embracing various aspects that analyses data in non-numeric ways.

#### **3.2.1.1 Case Study**

A Case study is one of the qualitative research designs used within the research. David and Sutton (2011) notes that a case study is more focused on a detailed single arena especially were much pertaining the area under investigation is not known. Furthermore they are of the view that a case can be that of an institution, individual as well as of a geographical field. In this respect Rushinga case study was used in the research .The research conceptualized on what is transpiring in Rushinga health service centers namely Chimhanda and Rushinga were RBF program is being implemented .Thus this will assist the researcher to come up with a comprehensive paper of the current position of RBF.

### **3.2.2 Quantitative approach**

Quantitative approach uses quantities to evaluate a phenomena thus measuring or quantifying them. The approach is generally conducted using research strategies such as questionnaires, measurements and any other techniques that may result in the quantification of data. Quantitative research design statistically analyses data and presents the information in numeric form. Figures,

numbers as well as formulas are normally used to ensure that the required data is at hand in a bid to achieve the objectives of the research. In quantitative approach a group of respondents is examined to produce the required information (Anderson; 2006). In some instances formulas are used to assure a manageable sample size within a particular population. According to Tewksbury (2009) purports that quantitative approach is more of a scientific method where the gathered data is quantified. In this respect quantitative approach is more concerned with specific definitions which are aimed at realizing intended objectives.

### **3.3 TARGET POPULATION FOR THE STUDY**

Target population is the entire aggregation of individuals that suits the designated criteria established. Degu and Yigzaw (2006) alludes that target population is the total number of people which the research is entitled to draw a conclusion on. The targeted population of this research is mainly the residents of Rushinga district located in Mashonaland central province. According to ZimStat (2012) the entire population of Rushinga district constitutes to a total of 74040. However this research targeted 198 respondents inclusive of management officials, employees of the two clinics thus Rushinga and Chimhanda. The population coverage also includes direct clients in particular women who will be seeking medical attention from the two earlier mentioned clinics in concern of the RBF program. For reliability and validity of the research it is therefore important to note that the researcher focused mostly on the two wards in Rushinga district. Moreover it is vital to have an insight of the target population to be used in the research for the realization of organizational.

### **3.4 SAMPLING TECHNIQUES**

Techniques of sampling are characterized in two ideal groups namely non-probability and probability sampling methods. With probability sampling technique every individual has an equal opportunity of being selected to represent a well-defined populace. It is the bed rock from which the sample is depicted. David and Sutton (2011) purports that probability sampling methods deduce the inaccuracies thus the variance amid of the population findings as well as the sample data findings. Typologies of probability sampling include stratified sampling and simple random sampling. On the other side non-probability sampling is another broad sampling technique that can be employed to decide who will participate in the study for instance purposive sampling. According to David and Sutton (2011) non-probability as a sampling

technique is implied when the targeted respondents are not easily identified or accessed. In line with the research three sampling techniques entrenched under both probability and non-probability sampling methods were used in the study and these are stratified sampling, simple random sampling and purposive sampling

#### **3.4.1 Stratified Random Sampling**

Stratified random sampling involves the classification of the target population into smaller sectors known as the strata. Furthermore in stratified random sampling, the strata are formed based on members shared attributes or characteristics. With this method of sampling the researcher stratifies the population in a way that the target population within a stratum is homogeneous. A stratum can be organized on certain characteristics such as income level. To add on the sampling technique subdivides the specified population into strata basing on the characteristics such as location. Focusing on the research problem the population would be stratified into stratum grounding on the rank of the employees of Rushinga health clinics mainly to those having a hand in the implementation of the RBF program. Age of women is another characteristic that shall be implied in the study this is so because women are key players in the research thus women between the age of 18 -35 shall be sampled using stratified random sampling technique. Hence out of a target population of 157 women only 18 will be nominated using the stratified random method. According to the Ministry of Health and Child care the above age rank is encouraged to bear children because the women are said not to be on risk. This technique when applied in the research reduces sampling errors this is so because the sample differentiates the population under study.

#### **3.4.2 Simple Random Sampling**

After applying stratified random sample, simple random sampling was then applied to select the required number of elements from each stratum. It is assumed that in simple random sampling each element of the population is given an equal and interdependent chance of selection. Therefore simple random sampling is the most convenient method of sampling which enhances accuracy in regard to the sample size required. Castillo (2009) is of the view that simple random sampling is a fair way of selecting a sample from a given population since every member is given equal chance of being selected. There are several strategies that can be used in this form of sampling .However the researcher shall apply the hat system to select the respondents who were

required in the study. Papers will be placed in the hat and the respondents blindly picked papers written yes or no. Those who will pick small pieces of paper written yes will participate in the research. Thus simple random sampling shall be applied in the study to select 12 respondents of from a group of 20 employees of Rushinga health facilities. Furthermore implying the same sampling technique 6 out of 10 councilors shall be choose to represent the district as well as their areas of jurisdiction. The main aim of the research is to draw a conclusion concerning the population from the outcome attained from a sample. There is no bias in the selection of the respondents when using this sampling technique because there is an equal platform of participation in the research.

### **3.4.3 Purposive sampling**

Purposive or judgmental sampling is a method of data sample which fall under non-probability category. The primary consideration in purposive sampling is the judgment of the researcher as to who can provide the appropriate information to achieve the objectives of the study. In purposive sampling the researcher only goes to those people who in her or his view are likely to have the required information and will also be willing to share it. This type of sampling is regarded as the best when one wants to construct the historical reality thus to describe a phenomena or develop something about which only a little will be known. Purposive sampling therefore has merits which make it more favorable when conducting a study. The sampling method will be used to select management officials who are assumed to have factual evidence on what is transpiring at the local level in line with the RBF program. Purposive sampling method has varied merits when applied thus there is no wastage of time due to the fact that the relevant information is attained from the right person from time to time. In this green light purposive sampling shall be used in the research so as to center the research on the rightful candidates who are assumed of having the required information in the study.

### **3.5 SAMPLE SIZE**

Thakur (2009) is of the view that sample size is the ration of the entire given population within a particular geographical area. Given the numerical figure of 198 respondents within Rushinga district it is therefore not feasible for the research to focus on such a drastic figure due to the fact that the whole procedure will be time consuming. In spite of this, the feasible sample size viable to reveal the effectiveness of RBF in improving health services within rural clinics is 40



individuals. Aaker (2005) states that a sample size is a fraction of the entire targeted population within a given area. Sample size enhances the researcher to acquire information needed in the study despite using a fraction of the total targeted population. Beneath is a table which shows the sample size composition:

**3.5.1 Table 1 Sample Size Composition**

Category	Population	Sample Size	Sampling Techniques
Management officials	6	6	Purposive Sampling
Employees of the Rural Clinics	25	12	Simple Random Sampling
Women(direct Clients	157	18	Stratified Sampling
Councilors, D.A and C.E.O	10	4	Purposive Sampling
Total	198	40	

**3.6 SOURCES OF DATA**

The research shall consist of information collected from both primary and secondary sources. Thus it will assist in shaping the research such that the objectives intended to be achieved are realized.

**3.6.1 Primary Data**

It is the first hand information obtained from the research field and it has limited bias. Bryn and Bell (2000) argued that primary sources of data collection are sources in which the data is collected in its original form. Primary data refers to the information extracted from the research

field in its raw state. It is the raw information on the effectiveness of the RBF program in assuring a decrease in the rate under-five children as well as expectant mothers are dying. Interviews, focus group discussions and questionnaires are some of the primary data sources that will be administered to solicit data from the management, health service workers, women of the child bearing age and councilors.

#### 3.6.1.1 Merits of Primary Data

- It enables the researcher to draw conclusions of the identified problem thus coming up with appropriate recommendations
- There is no bias of information since there is interaction between the researcher and the respondents who will be participating in the study.
- It enhance the availability of factual evidence of what will be taking place on the operating arena thus the availability of first- hand information

#### 3.6.1.2. Demerits of Primary Data

- Language can be a barrier when one wants to gather information. Some of the people intended to provide first- hand information especially the public residing in peripheral places are illiterate thus some of them are not able to read or write so as to respond to the questions asked. Therefore they are not reliable in providing primary data.
- Primary data sources such as questionnaires does not provide an opportunity for the researcher to clarify. In this respect irrelevant information is sometimes obtained at the end.

#### 3.6.1.3. Solutions to the demerits

- There is need for the researcher to clearly craft questions which are simple and understandable such that the respondents will find no challenges in responding to the probed questions hence primary data.
- Clarification on some of the questions such as open ended questions is required .Thus closed ended questions can also be utilized to ensure a balance in the research hence effectively obtaining the required information.

### **3.6.2 Secondary Data**

According to Francis (2004) secondary data is data which already exists and which was originally collected for the same purpose thus the problem at hand. Secondary sources provides information that have already been published by other accredited scholars (Saunders et al; 2009) It can also be viewed as information documented or published by other writers thus it readily exist. This includes electronic sources namely journals, archival material, press cutting, books, and government reports. More so these sources also forms the base upon which the research relies on.

#### 3.6.2.1 Merits of Secondary Data

- ❖ Secondary data gives the researcher an insight of what will be taking place globally concerning the research problem due to the availability of publications by other scholars.
- ❖ It enables the researcher to critically examine the available literature hence producing a comprehensive paper which meets the intended objectives of the research.
- ❖ It is easily accessed for instance online material such as books, journals and government reports.

#### 3.6.2.2 Demerits of Secondary Data

- ❖ Plagiarism can be a threatening factor when soliciting secondary data. Thus the researcher may fail to acknowledge the sources used in the study hence plagiarizing someone's work.
- ❖ Some of the secondary data can be relevant but outdated thus invalid in the research.
- ❖ Secondary data is sometimes not easily accessed, some of the data may be archived in secured placed thus with unknown passwords especially on line information.

#### 3.6.2.3. Solutions to the demerits

- ❖ The research should authenticate the work produced by acknowledging the use of secondary data in the study
- ❖ The researcher can alternatively use current data available even on the internet
- ❖ There is need for one to seek assistance to technology expertise so as to access the data required in the study

### **3.7 RESEARCH INSTRUMENTS**

The researcher used both qualitative and quantitative data collection tools thus questionnaires, observations and Interviews

#### **3.7.1 Questionnaires**

A questionnaire is one of the quantified method of data collection (quantitative). This research tool encompasses inherent questions which prompts for the mission of obtaining data from the respondents. Panneerselvam (2004:23) is of the view that a questionnaire consist of a set of well formulated questions to probe and obtain responses from respondents. The researcher is going to make use of questionnaires as data collection instruments because they are easy to administer moreover they can be dropped or given to the respondent and collect them later but within the data gathering period. The questionnaires were distributed to the management of Rushinga health service institutions, employees as well as to the councilor representing the public at large. Both closed and open ended questions were used by the researcher to attain information about the changes probed by RBF program in Rushinga as well as its effectiveness within the health sector focusing on maternal and child care. In addition closed ended questions enabled data by the researcher to be easily gathered. The closed ended questions enabled data tabulation and analysis of the responses to be easy therefore the research is going to focus on both structured and unstructured questions in the collection of the required information.

##### **3.7.1.1 Merits**

- Questionnaires are easy to analyze. For instance data entry and tabulation for nearly all survey techniques can be easily done with many computer software packages.
- It ensure privacy and confidentiality of the respondents due to the fact that names are not revealed thus also they is no bias of information due to the fact that every respondent is free enough to air their views what will be taking place on the ground.
- Questionnaires are easy to administer since they can be dropped or posted to the respondent for collection on a later date.
- Questionnaires are cost effective thus they can be distributed to multiple respondents at the same time also within a short period of time.

### **3.7.1.2 Shortcomings**

- Questionnaires can provide irrelevant information to the research from the respondents as they misinterpret the probed questions by the researcher
- Language can be a barrier especially to most of the citizens residing in rural areas. Thus due to lack of clarity they may fail to understand what the question requires them to do.
- Questionnaires do not provide room for elaboration of the answers especially when using closed ended questionnaires.
- Questionnaires do not usually provide checks and balances on the level of honesty of the respondents in particular when they are responding to questions.

### **3.7.1.3 Resolutions to the shortcomings**

- Clarity of the questions is therefore required from the researcher such that the respondents provide accurate information relevantly required.
- The researcher should use both open ended as well as closed ended questionnaires such that one will respond to questions he or she feels comfortable in responding.
- On the issue of language the researcher can craft the questions in simple terms such that every respondent will be able to understand what will be expected of him or her.

### **3.7.2 Interviews as instruments of data collection**

It consist a set of questions that one asks the respondent .Interviews usual has a guide called an interview guide. Chaturvedi (2010) postulates that interviews are a direct conversational interface between the information seeker and the information bearer. Due to the issue of confidentiality within the health clinics the researcher therefore made use of interviews so as to build mutual understanding between the interviewer and interviewee. In an interview the researcher can use an interview guide which consist of a set of questions intended to solicit ate answers from the respondents .With an interview guide questions may be structured or unstructured hence the researcher can make use of both. The researcher intends to interview health workers who are implementing the RBF program within the rural clinics as well the management facilitating the whole process within the rural health facilities for instance some of the senior management verifies and validates the produced results .Thus they will be having

detailed information on the effectiveness part of the RBF program. In addition interviews will also be conducted to obtain information from the District Administrator (D.A), Chief Executive Officer (C.E.O) and the Crown Agents facilitator representing the purchasing agency in Rushinga district.

#### **3.7.2.1 Merits**

- ❖ Interviews facilitate feedback amongst the communicating individuals .Thus even the interviewee also have the opportunity to ask the interviewer questions hence a two way communication channel
- ❖ It allows the researcher to get first -hand information thus relevant information is obtained from the research field
- ❖ An interview enhances the researcher to come up with requisite recommendations pertaining the research problem.
- ❖ It gives a chance for clarification of the questions which may be unclear to the respondents thus achieving the main objective of the research. The interviewer can simplify the ambiguous questions hence enhancing a common understanding.

#### **3.7.2.2 Shortcomings**

- ❖ The respondent can misinterpret the questions asked resulting in information which is not accurate.
- ❖ Language also hinders the effectiveness of data collection in the research field .This is so because most of the people in rural areas are not well educated thus they may fail to respond to the questions by the interviewer due to the issue of language (failing to understand English).
- ❖ A lot of information may surface during the interviews hence it may be difficult for the interviewer to grasp the required answers which enhances effective data collection.

#### **3.7.2.3 Resolutions to the shortcomings**

- ❖ There is need for the researcher to specify the time to be taken by the interviewee in responding to the questions presented at hand hence time management.

- ❖ The researcher should avoid ambiguous and sensitive questions which might confuse respondents especially to the less educated.
- ❖ There is need for the researcher to carefully pay attention so that crucial points are noted as the respondents provide answers.

### **3.7.3 Focus Group Discussions**

Focus group discussions involves an explanation of a particular phenomenon .It is an exploratory research instrument where individuals express thoughts regarding the attainment of detailed data on a particular subject where little information is known(Sherraden;2001). To achieve effective results focus groups should be minimized to a set of seven –eight individuals such that participation of the respondents is fostered. Thus large group of respondents may inhibit some of the participants to effectively forward their views regarding the discussed issues. Focus group discussions are normally conducted in the research study when the researcher intends to have an insight of the topic under scrutiny. Therefore there are varied as to why focus group discussions can be underpinned and these motives amongst others include:

- When the researcher wants to generate qualitative data
- Broaden the research arena
- When one wants to identify key themes underlining the main idea of the research
- Develop emergent themes
- Also when the researcher develop interview schedules

However the researcher shall make use of focus group discussions to solicit information regards to the topic under examination. In this respect the researcher will facilitate the discussions and on the other hand women as beneficiaries of the RBF program will be the targeted respondents thus they will be engaged as the participants of this research instrument. However is of paramount importance to note that there are various advantages of using focus group discussion as a research tool to effectively gather the required information in the study.

#### **3.7.3.1 Advantages of Focus Group Discussions**

- ✚ It is flexible thus it is not time consuming .Pertinent issues concerning the research issues can be gathered from a large group of people within a short period of time.

- ✚ With focus group discussions individuals are free to participate and share experiences moreover they can be motivated to reveal the realities being faced on the ground hence ensuring the availability of factual information.
- ✚ It is simple to undertake
- ✚ There is room for clarification of the research issues from both the facilitator as well as the participants of the research study
- ✚ Fewer expenses are incurred in when gathering data using this research tool because the facilitator can distribute few research questions to a large group of people.

### 3.7.3.2 Disadvantages

- ✚ It can be difficult for the researcher to assemble a group of targeted participants since there are to be pursued and convinced such that they are motivated to take part in the research study.
- ✚ Data gathered can be difficult to evaluate
- ✚ Participants may not feel comfortable to disclose information in the presents of other people hence biased information will be attained as a consequence of such actions

### 3.7.3.3 Resolutions to the disadvantages

- ✚ The researcher can collect the required data on gatherings such as at any district function or meetings for instance at the Ward development committee meetings, roadshows and when expectant mothers come for their antenatal visits at local health clinics.
- ✚ Listening skills are required from the researcher such that only vital information is jotted down and recorded for analysis
- ✚ There is need for the researcher to build teams whereby individuals within groups are motivated to participate towards the realization of a common goal

## 3.8 ETHICAL ISSUES IN DATA COLLECTION

Cascio (2010) defines ethics as the study of morality. Thus the study of what is morally good or bad, right or wrong. In a research there are various ethical issues that must be put into consideration for the research to attain its targeted objectives. For instance confidentiality is one of the vital aspects which the research must take note of when seeking for information in the research field. Thus the researcher must maintain confidentiality at all times. Participation of all



the stakeholders must be fostered moreover the participants must be willing to take part in the whole process. In line with the acceptable ethical values the researcher must be open enough when dealing with other researchers and research subjects. Moreover equity should be assured amongst social groups such that all individuals be it men or women have an equal opportunity in providing the required data. In this regard ethical issues are essential to take note of in data collection because they enable the researcher to choose the best implementable practices that motivates the respondents to effectively participate in the research. In this regard the researcher will strictly adhere to the rules which uphold good ethics within an organization or district. Thus the researcher will ensure that ethical principles such as confidentiality are maintained, participation of the direct clients is also sustained through the engagement platforms which foster citizens involvement in decision making moreover the researcher will provide equal opportunities between men and women as the targeted respondents in the research.

### **3.9 RELIABILITY**

Reliability refers to the exactness and correctness of a research instrument .For instance a reliable research tools should be free from errors. McLeod (2013) postulates that reliability is the uniformity of the collected data .It is therefore imperative to note that reliability of a research instrument is also affected by ethical issues. A typical example is that of an interview as a research tool thus the reliability can be threatened by sensitive issues which might be asked by the interviewer thus in the end result will not be accurate because the respondents can choose not to respond to issues which are sensitive. Therefore it is essential to ensure the reliability of the research tools in the study because it brings out the accurateness of the research instrument in obtaining data in the research arena.

### **3.10 VALIDITY**

Validity refers to the capacity of a research tool to measure what it is anticipated to quantify. The research tool should clearly indicate what is intended to be measured. For example in line with the research topic the main objective of the research is to find out the effectiveness of RBF within the rural health clinics. Hence instruments such as questionnaires should measure what it is intended to observe thus the effectiveness of RBF in improving rural health services hence validity. However there are various types of validity that can be applied in research but in this

study the researcher focused on content validity which is one of the forms of validity. This is so because it is easy to use.

### **3.11 PRE-TEST**

Pre-testing is a trial done before one conducts the actual research thus to view the reliability and validity of the research tools. In the research pre- test for research instruments such as questionnaires and interviews was conducted to ensure the effectiveness of the study in soliciting the relevant information. Moore et al (2004) states that experiments can be used to test the versions of the research tools such as questionnaires and interviews. The main idea behind pretesting was to deduce errors before the actual study was conducted. Pre testing enhances various benefits within the study .This is so because it fortifies the research hypothesis and aims, enables the existence of the sample size and the estimates, lastly it assist in collecting preliminary information (Rajaseker et al, 2006). The researcher intends to conduct the pretest at Midlands State University where RBF is being theoretically studied as a component of Results Based Management. The researcher mainly centers the focus on students in the local Governance department mostly level 2:2s who have detailed information pertaining the effectiveness of RBF in reducing maternal and child mortality. Thus this will enable the researcher to view whether the research instrument suggested are suitable for the realization of effective results in the study. In this line of thinking pre testing is vital within a research because it enables a research to produce effective outcomes by examining the reliability and validity of the research instruments.

### **3.12 SUMMARY**

The section unfolded the research mechanisms that were implied to obtain information from the research field. Research methods such as the research designs, target population, sample size, sources of data were also considered in this chapter. Merits and demerits of the research instruments used in the study are also revealed. Moreover the reliability and validity of the research tools were also discussed. A pretest was also carried out to ensure the effectiveness of the research tools in data collection. Finally this chapter ended with a chapter summary, hence paving way for chapter 4 which is data presentation and analysis.

## **CHAPTER IV**

### **DATA PRESENTATION, ANALYSIS AND INTERPRETATION**

#### **4.0 INTRODUCTION**

In this chapter presentation of the information which was extracted in the research field using research tools namely focus group discussions, interviews and questionnaires in accessing the effectiveness of RBF in improving health services in Rushinga district will be revealed. The data gathered from different groupings of participants and sort shall be presented in the form of tables and percentage rates so as to reveal the total responses per group or sort. In this regard the collected data will be explored in the form of tables, bar graphs as well as pie charts. Moreover data analysis will be done in line with the presentations that will be conducted. Thus data analysis simplifies the presentations hence making the information gathered in the research more easy to understand. Thus this chapter is vital in the sense that it enhances a vivid research summary to be drawn from the research findings of the previous chapter through graphical presentation

#### **4.1 Response Rate from Interviews, Questionnaire and Focus group discussion**

A total of 14 questionnaires were distributed to Rushinga health clinics of Chimhanda and Rushinga mainly focusing on the health workers. The researcher also scheduled 10 interviews to solicit information from senior health managers, councilors, the D.A and the C.E.O. Moreover 2 focus group discussions were formulated targeting pregnant women and mothers with under the fives as the rightful respondents in concern of the research topic.

#### 4.1.1 Response rate: Questionnaires

**Table 2 Response Rate for Questionnaires**

Respondents	Questionnaires distributed	Questionnaires received	Questionnaires not received	Respondents rate %
Top Management	3	2	1	67 %
Middle Management	4	3	1	75%
General Employees	5	3	2	60%
Total	12	8	4	67%

Source: Research Data (2015)

Middle management within the health sector responded fairly well to the probed questions by the researcher because out of the four distributed questionnaires a total of three questionnaires were answered giving a respondents rate of 75%. The top management and general health employees had the same range of respondents' rates thus 67% and 60% respectively and this revealed a fair conduct of participants responding to the questions which were distributed to them by the researcher. Over all the response rate of the 12 questionnaires which were distributed is 67% thus a total of 8 questionnaires were responded to out of 12 distributed questionnaires. The respondents who failed to respond to the questions expressed their apology in pretext citing that

they had attended other work businesses in the neighboring districts thus a non-respondents rate of 33% due to the fact that the respondents had other work commitments.

#### 4.1.2 Response rate: Interviews

**Table 3 Response Rate for Interviews**

Participants	Total number of Interviews	Number of those interviewed	Number of those not interviewed	Response rate as a %
Top Management	4	3	1	75%
Middle Management	4	3	1	75 %
Councilors	2	2	0	100 %
Total number of participants	10	8	2	80 %

Source: Research Data (2015)

In line with interviews which were convened in the research field councilors responded well to the articulated questions which were presented in the interviews guide thus they had a response rate of 100%. Secondly top management and middle management fairly responded to the interviews thus they both scored a response rate of 75%. A total of 8 interviews were successful convened in the research study out of 10 interviews which were scheduled to obtain valid information concerning the topic under scrutiny. Thus the overall response rate of the interviews conducted was 80%. In this respect the researcher managed to attain primary information through interviews thus bias of information within the study was reduced. Apart from this the researcher could not conduct 2 interviews which scored a total of 20% non-response rate. The respondents which were targeted were not able to attend interview sessions due to other work commitments which kept them busy when the interviews were being convened.

#### 4.1.3 Response rate: Focus Group Discussions

**Table 4 Response rate for Focus Group Discussions**

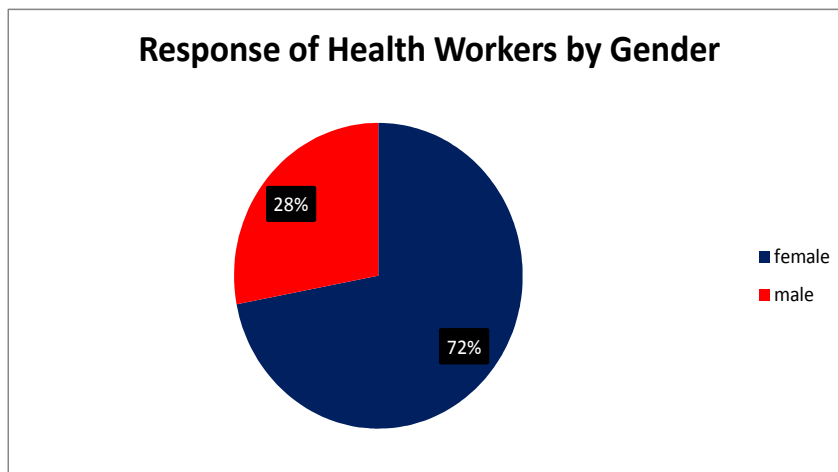
Sample Group	Participants intended to participate	Respondents who participated	Non-participants	Response rate %
Focus Group Discussion A	9	8	1	89%
Focus Group Discussion B	9	7	2	78%
Total number of participants	18	16	2	89%

Source: Research Data (2015)

In view of the data presented above out of the two focus group discussions which were formulated by the researcher with a total of 9 respondents from each group. Thus 16 individuals altogether participated in the research out of the 18 participants who were targeted. These focus group discussions were used to solicit information in regards to the effectiveness of RBF in the health sector. Pregnant as well as mothers with under-fives were the targeted respondents. Focus group discussion A had 8 respondents who thoroughly discussed the questions that were introduced by the researcher scoring a total of 89% response rate. Secondly focus group discussion B yielded a response rate of 78 %. Therefore this diminished the notion of bias information to be gathered because targeted participants discussed issues hitched around RBF. However focus group discussion A had a non-response rate of 11% and focus group discussion had 22 %. The response rate failed to equalize the targeted percentage due to the fact that the key informants in particular women did not effectively participate in the study because they had no idea of the program thus there was lack of awareness to the public about RBF. Hence other key informants could not discuss together with others about the health program which they had no knowledge of what it really does. Lack of community participation greatly deterred the effectiveness of RBF in reducing maternal and under-fives deaths (Toonen et al; 2009). In this way lack of awareness and community participation hinders the progress intended to be realized

in the health field because women cannot have an insight or idea if they are not informed moreover if they are not participating hence they should take part in decision making when the overall outcome affects them.

#### 4.2 RESPONSE OF HEALTH WORKERS BY GENDER



Source: Research Data (2015)

**Fig 4.2.1 Response of Health Workers by Gender**

From the data which was extracted from the research instruments females tend to be active participants in the research study constituting a percentage of 72% on the other hand 28% of the respondents were males .Thus the gender imbalance was brought about by unequal recruitment and selection of the employees within the health sector. Moreover due to the job requirements and expectations females prefer to work in the health sector as compared to their male counterparts because the work requires personnel to be caring, patient and understanding .In this way the respondents rate had great influence from the females . Apart from this the research topic seeks to scrutinize the effectiveness of RBF in the improvement of health services with expectant mothers and women with children under the age of five being the direct clients of the

health program .Hence the researcher also targeted women of such category to be participants in the research study. Thus the respondents would assist in providing a detailed document of what is transpiring in Rushinga health institutions underpinning the RBF program.

### 4.3 AGE GROUP FOR THE PARTICIPANTS.

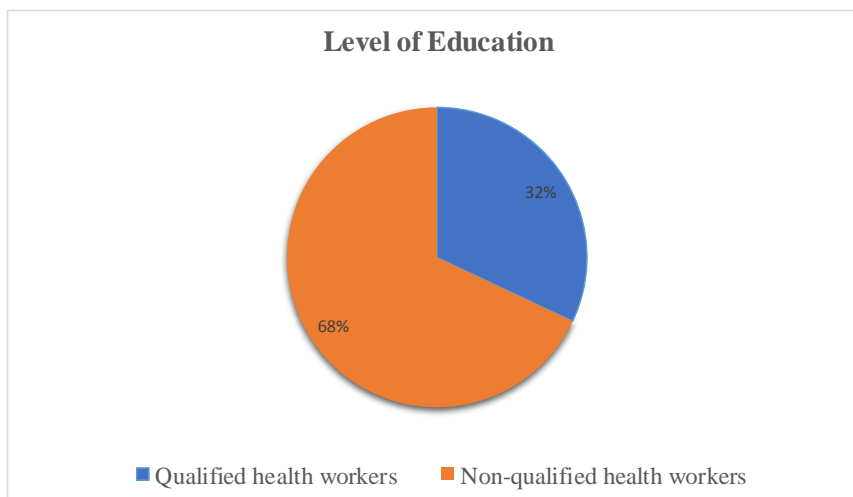
**Table 5 Age Group for the Participants**

Age Group	21-29	30-39	40-49	Above 50	
Frequency	2	12	3	1	

Source: Research Data (2015)

According to the research instruments that were administered it was noted that 11% of the participants are between the age of 21-29, 67% of the health employees are in the age group of 30-39 years moreover 17% of the respondents fall under the age category of 40-49 and only 6% is above the age of 50 years .Thus the age category entails that the health workforce within Rushinga health facilities know what they are expected to do in their institutions .In this way the health employees should perform better to enhance the effectiveness of RBF in improving health services

### 4:4 LEVEL OF EDUCATION





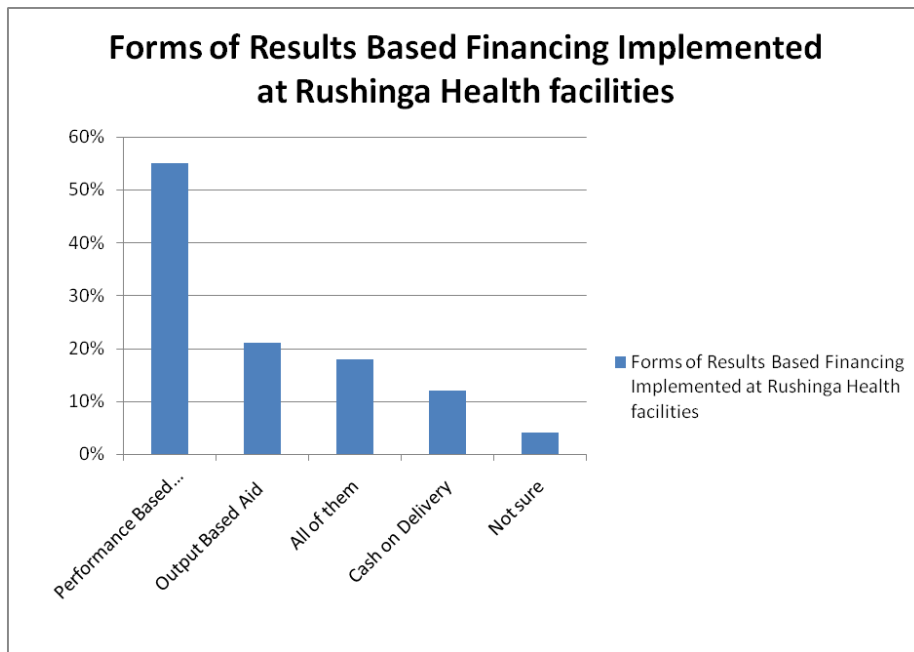
Source: Research Data (2015)

#### **Fig 4.4.1 Level of Education**

The data presented reveals that 68% of Rushinga health clinics have trained health personnels but still there is lack of skilled health workforce so as to enhance the effectiveness of RBF in health service provision. Especially general health employees who are involved in the implementation RBF have national certificates entailing that they are beholders of 'O' Level certificates. This therefore stands as a challenge in the health sector because lack of skills negatively affects service provision (Research Data; 2015). For example from the research findings the health employees employed at Rushinga health clinics revealed that they were not well versed with the RBF program hence it clearly shows that they might be presentation of bias results

On the other hand the data extracted and viewed from the presentations above reflects that only 32% of the health workers are qualified thus they have at least a diploma, degree and some have upgraded their skills by doing health related courses for instance training to be a midwife. However it can be noted that although there is a 32% of the total percentage of skilled employees there is still understaffing of skilled labor thus it also hinders effective application of the RBF program to save dying pregnant mothers and children under the age of five. Moreover the majority of health employees are general employees thus nurse aids and general hands .In this respect there is need for recruitment of skilled labor thus more management officials such as doctors and also there is need for skill upgrade especially to the health employees who lack the prerequisite skills to perform well within health organizations

#### 4:5 FORMS OF RESULTS BASED FINANCING.



■ Forms of RBF implemented at Rushinga Health facilities

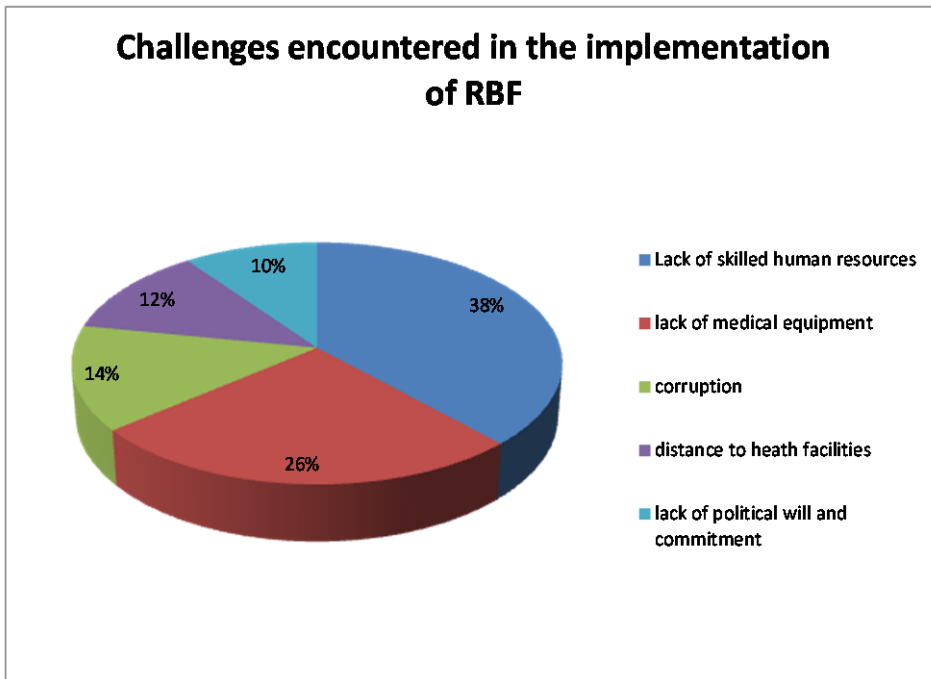
Source: Research Data (2015)

**Fig 4.5.1 Forms of RBF implemented in Rushinga Health Facilities**

The Global Partnerships on Output Based Aid (2009) postulates that Output Based Aid is a form of RBF meant to bridge the gap that exist between the poor and the rich and it also enhance the most disadvantage within communities to have access to proper medical attention. Performance Based Financing is also another form of RBF which links resources to the predetermined health outcomes .This type of RBF proved to be the most popular and implementable form within Rushinga health institutions. Apart from this it is also a common form of RBF that is viewed as appropriate in reducing maternal and child mortality in Sub Saharan Africa thus it is underpinned in most of the developing counties. Finally Cash on Delivery was also noted in the research findings as a component of RBF.

In this way 55% of the health employees identified Performance Based Financing as the most appropriate and convenient to achieve the intended results within rural health institutions in Rushinga thus it is the most common form of RBF that is used in the district, followed by 21% for the Output Based Aid, thirdly 12 % of the health workers indicated that Cash on Delivery is also another form of RBF being undertaken within health institutions. 18% cited all the mentioned types of RBF as being used in Rushinga health clinics.4% remaining were not sure of the most applied form of RBF in the health facilities in Rushinga. In this view only one form of RBF which is Performance Based financing is being effectively undertaken in Rushinga health facilities .Therefore it is vital to note that all the forms of RBF are vital in assuring the realization of the intended goals and objectives. Moreover these types of RBF are somehow interlinked thus they should be effectively implemented for better health outcomes. In particular Zimbabwe as one of the developing countries underpinning the health aid it uses Performance Based Financing.

#### 4.6 CHALLENGES ENCOUNTERED IN THE IMPLEMENTATION OF RBF



Source: Research Data (2015)

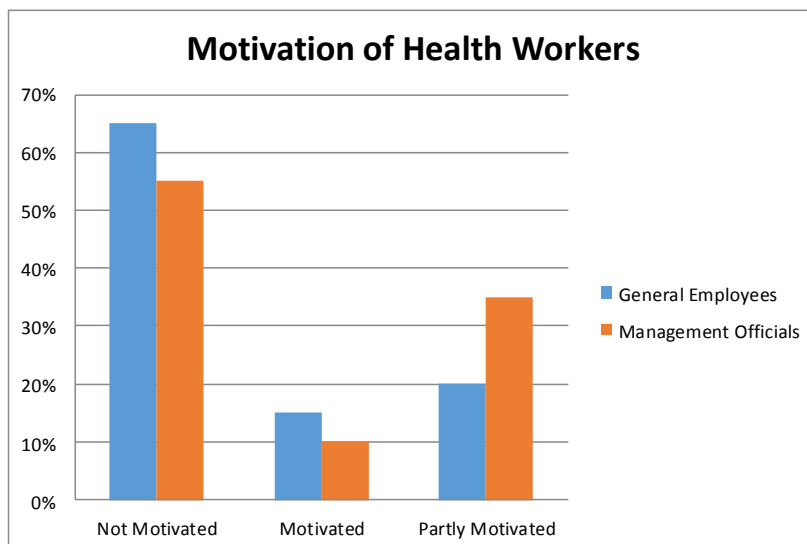
**Fig 4.6.1 Challenged faced in the implementation of RBF**

Leovinsohn (2008) alludes that RBF is affected by various factors which impede its effective performance within the health arena. In line with the research findings lack of skilled human resources is the major hindrance in the successful implementation of RBF scoring 38% noted by health personnel's. This alone entails that local health clinics are understaffed hence it increases even the health providers workload to the few employees undertaking health responsibilities. 26 % of the health employees responded that lack of medical equipment for instance medicines is also a serious health threat affecting progress realization within the health sector. Corruption was also cited as one of the challenges with 14 % impact rate. Moreover distance to health facilities with 12% is also a barrier hindering direct clients of RBF to access medical health provision from health facilities. Thus most of the clinics are not located in an accessible area which

permeate citizens to regularly seek medical attention if need arises. Lastly 10% of the health workforce indicated that lack of political will and commitment is another challenge encountered in the implementation of the health program.

However there are various challenges which are encountered in the implementation of RBF mostly in Sub Saharan African countries. Health institutions therefore should work hand in hand with development partners such as NGOs so that they assist in constructing many clinics which are situated within a short distance in this way client will be able to seek medical attention hence improved quantity. Employment of qualified health workers should be the call of concern in the Ministry of Health and Child Care so as to counter the shortfall faced in terms of human resource availability. In addition one of the challenges is that there is a weak reporting system between the planning authority and the Ministry of Health pertaining RBF (Research Data; 2015).

#### 4.7 MOTIVATION OF THE EMPLOYEES WITHIN THE HEALTH INSTITUTIONS



Source: Research Data (2015)

#### **Fig 4.7 Motivation of employees within Health Institutions**

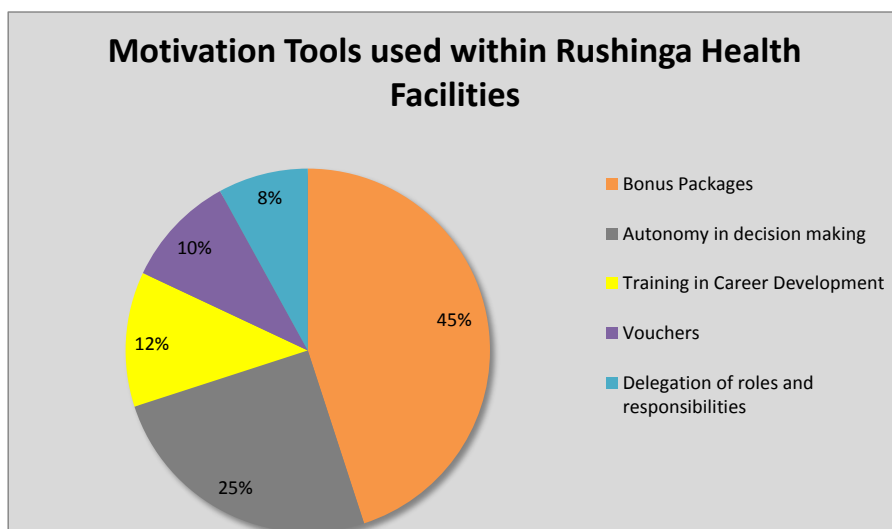
According to the presentations 65% of the general employees revealed that they were not motivated with the implementation of RBF in their working environment. In support of the research findings Barr et al (2005) is of the view that human resources are the pillar for effective operation of any institution thus their motivation is of paramount importance if positive results are to be achieved. RBF have negative consequences on the performance of health service providers because employees better perform where they are not given incentives for the work done thus the implementation of RBF have caused more harm than good in as far as quality services provision is of concern (Hayman and Ariely;2004). On the other hand 55% of the management thus top and middle staffs were of the same view that the RBF program does not motivate them to perform better but it has stood to be a burden to them since they are intended to meet the predetermined results surrounded by a pool of unavoidable hindrances which impede them to perform better. The health workers are demotivated by the working conditions within their health institutions which leave a lot to be desired. For instance health employees cited that dilapidated infrastructure ,lack of skilled health force and lack of medical equipment among other things have been demotivating them to perform up to standard (Research Data ;2015). Moreover late disbursement of bonus packages due to bureaucratic structures and processes also affects the operation of the health employees within the health sector hence they perform poorly resulting in poor services as well.

Some of the health workers were partly motivated by the RBF program entailing that they are not 100% satisfied that health scheme motivates them so as to perform up to the expected standards. Thus 20% of the general health workers indicated that they are partly motivated with the implementation of RBF and 35% of the management officials stressed out that RBF implementation has also partly motivated them to perform better hence improved health care. Thus the employees stated that they were now given incentives for the work done at the same time improving the quality and quantity of the services (Research Data; 2015).

In line with the above presentation 15% of the general health employees revealed that they were motivated with the implementation of the RBF program. In addition 10% of the management supported the view that RBF was a motivation tool which has enhanced positive impacts within Rushinga health institutions. Thus health workers now have the autonomy to decide how to

improve their services so as to meet the targets hence it entails the improvement of health care .Employees now have bonus packages to augment their salaries which are low and unsatisfactory to them moreover the health services are improving hence a reduction in the rate at which children under five and expecting mothers are dying.

#### 4.7.1 Motivation tools used within Rushinga Health facilities



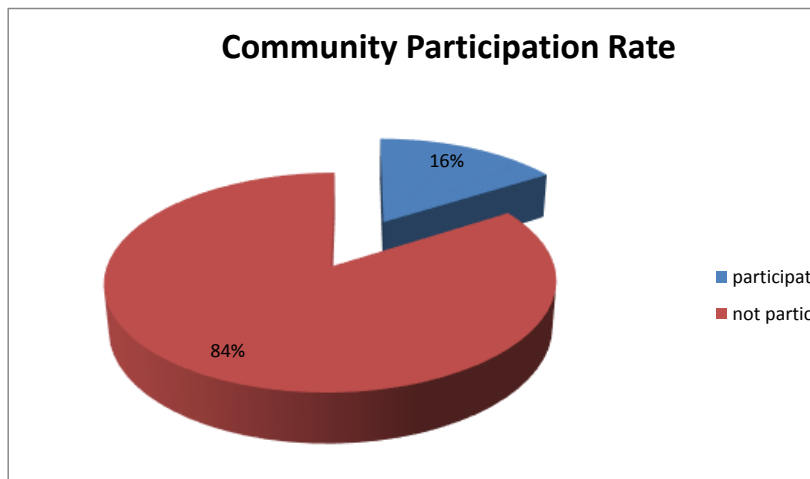
Source: Research Data (2015)

**Fig 4.7.1 Motivation Tools**

45% responses of the health employees showed that bonus packages are one of the motivation strategies that have been devised through RBF to motivate the health workforce to obtain the specified health targets within their operating environment. 25% of the health staffs viewed autonomy in decision making as one of the crucial aspects that have been prompted through the implementation of RBF. This is so because it enables health providers to priorities the need to provide to their targeted consumers thus focusing more on the provision of health services. Training and career development had 12% support as a motivational tool used in the health sector for the employees to be persuade to produce the intended outcome. Thus there is skill

upgrade to those who lacked the prerequisite skills to undertake their roles and responsibilities hence in most health institutions especially nurses are given the opportunity to do the Midwifery course so as to have detailed information of how to assist expecting mothers during their delivering time. To health workers vouchers are also ideal as a motivation tool giving a response rate of 10% and lastly 8% recognized delegation of roles and responsibilities as a vital move enhanced through the implementation of RBF. Thus the employees have the power to manage their activities so as to provide the expected outputs.

#### 4.8 COMMUNITY PARTICIPATION IN RBF



Source: Research Data (2015)

**Fig 4.8 Community Participation**

84 % of the women who are the targeted respondents of the health aid clearly indicated that citizens are not participating in decision making mostly due to lack of awareness of the RBF program. This research finding is supported by the views forwarded by Toonen et al (2009) that community participation is critical in development spheres moreover it is still lagging behind in terms of effectively involving the community to air its views pertaining the health subject. From the research findings women who had discussed the topic under study had no idea on what RBF is and the benefits it has to the targeted clients. Moreover health workers in support of lack of



community involvement in RBF cited that women who are the targeted customers are not aware of the implementation of RBF within the district thus there is lack of communication among citizens and the health committees which represent them. Only 16% responded that the citizens are engaged in decision making mainly through representative participation and a few through Community Based Organizations which are formed by the citizens. In this way community participation should be fostered firstly by assuring that there is a space for communissty involvement in decision making on matters of concern more to it awareness campaigns should be convened effectively such that women are kept abreast of the health programs underpinned in their communities.

According to the above presentations responses revealed that the community is not actively involved in the implementation of RBF. Participation involves the engagement of citizens in decision making on matters of concern such that they identify their needs and how to achieve them (Wachira; 2013). Thus it is of paramount importance for the community to be engaged in decision making especially in health issues because it fosters a sense of ownership of the program which will be undertaken moreover it enhances citizens commitment hence it will result in better service provision. In this regard there is need for community involvement in health matters because citizens can best identify what they require.

**4.8.1 Community Participation Platforms that enhance citizens’ participation**

**Table 6 Community Participation Platforms**

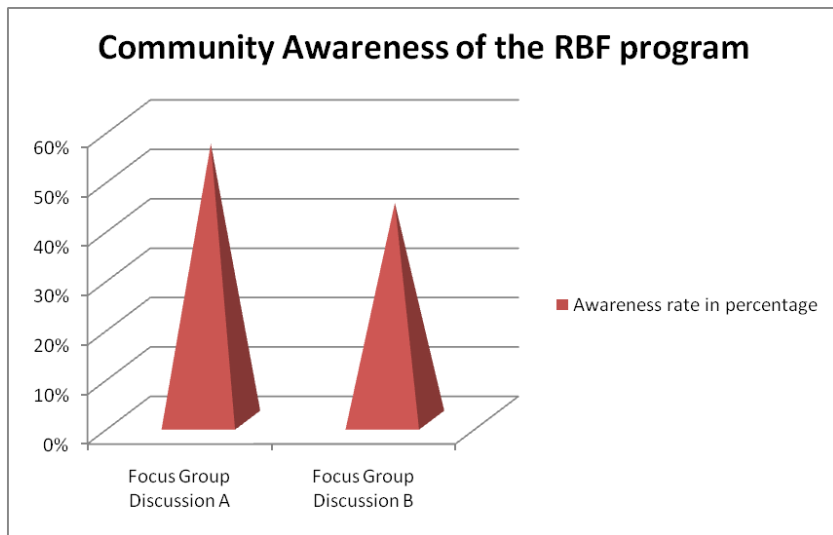
<b>Community Participation Platforms</b>	<b>Response Rate</b>
Community Based Organizations	8%
Health Centre Committee	4%
Civil Society in District steering Committee	3%
Private sector at national level	1%
Total participation rate	16%

Source: Research Data (2015)

Out of the 16 percent of women who supported the notion that the community is engaged in decision making in the implementation of RBF, 8% indicated that the community is mainly engaged through the Community Based Organizations which are crafted directly by the citizens so as to create space in which the public is directly engaged in decision making processes. 5% responded that health center committee is one of the participation platforms that have been created to increase community involvement in health issues. 3% identified civil society in the district steering committee as another community participation platform that have enhanced engagement of the majority especially women in decision matter pertaining matters of concern. Finally 1% responded that private sectors operating at national level also foster community involvement in decision making in health related issues

In this regard it is imperative to note that community participation in view of RBF effectiveness is still an area of concern which requires consideration from both partners in development if maternal and under-fives death rates are to be reduced up to the expected targets. Therefore there is need for creation of community participation platforms which assure active engagement of the community in matters of concern because such move results in realistic ideas which ensure that citizens receive quality health care hence a developed community through reduced death rates for the targeted consumers.

#### 4.8.2 Community awareness of the RBF program



Source: Research Data (2015)

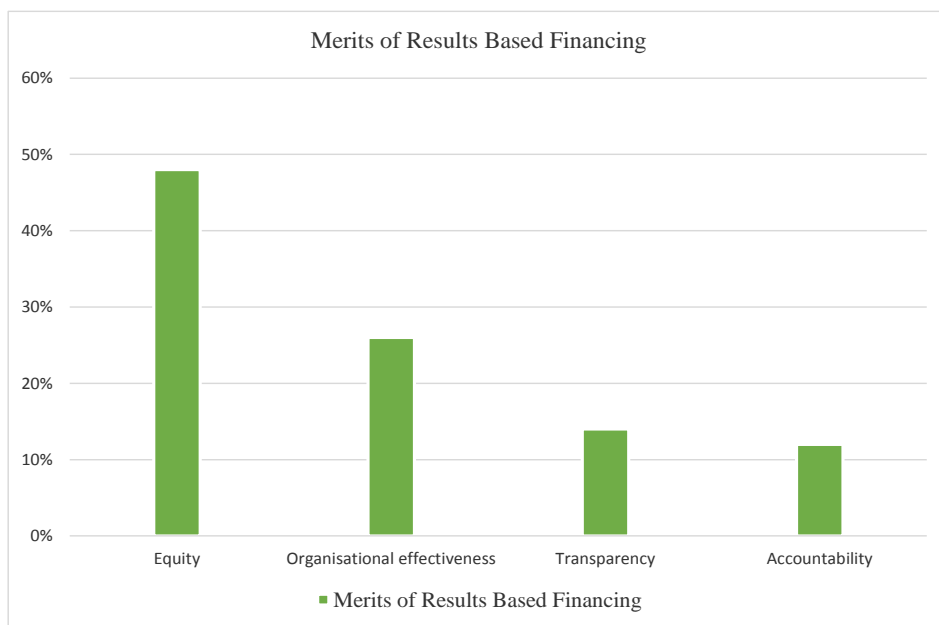
**Fig 4.8.2 Community Awareness**

From the research findings community awareness of the RBF program remains a critical issue which has hindered the progress which was intended to be achieved within Rushinga health facilities health. 56% was obtained from the first focus group discussion which was formed by the researcher. Secondly 44% was obtained from the second focus group discussion which was crafted by the researcher. The presentations paved way for a conclusion to be drawn highlighting lack of community awareness of the RBF program as well as its benefits if one takes part in the health programs. The women who were the targeted participants in the research lacked knowledge on what RBF is, what it intends to achieve and its beneficiaries.

Thus they were not aware of the health program which was being implemented in their health clinics by the Ministry of health, service providers together with Crown agency an NGO which purchase the specified health outcomes in Rushinga health facilities. Moreover lack of citizen awareness impedes participation of citizens' decision making because citizens cannot participate in decision making on issues which they don't even have an insight of what it is really about.

Therefore there is need for awareness campaigns within Rushinga communities such that citizens have a green light of what RBF is ,its beneficiaries ,the benefits of giving birth at health facilities and having under-fives immunized against child killer diseases. In this way citizens will participate in the program hence improve service quality and quantity.

#### 4.9 MERITS OF RESULTS BASED FINANCING



Source: Research Data (2015)

**Fig 4.9 Merits of RBF**

The targeted participants thus both expectant mothers and health workers, 48% identified equity as a benefit of RBF. Thus Equity was selected as the major benefit of RBF simply because it allows for equal opportunities that is among the most disadvantaged and the rich ones .With RBF those termed as the rural poor now have access to quality health services hence equity is viable in promoting good corporate governance thus a merit of RBF. 26% indicated that institutional effectiveness is also a merit of RBF, 14% agreed that transparency is an end product of Results Based Financing and lastly 12% viewed accountability as one of the advantages of RBF .Thus

checks and balances are regularly done such that results obtained are verified and validated in this way one will have to account for such results be it good or bad. All in all one can note that RBF is not only beneficial to health institutions but to the community at large and to other various key players such as civil societies.

In regards to the above data presentations effective RBF implementation upholds corporate governance principles namely accountability, transparency ,equity and organizational effectiveness .For instance transparency builds trust amongst stakeholders because it fosters clear lines of organizational operations and conduct (International Institute for Environment and Development(IIED);2010).

#### **4.10 SUMMARY**

In this chapter presentation of the information extracted from the interviews, questionnaires and focus group discussion were well articulated. Thus the information was presented in the form of bar charts, pie charts and tables. The chapter included the analysis part of the same data which was gathered in the research study. All the discussed information was aligned to the research objectives and the research questions so as to bring about a coherent flow of the research. It was noted that Chimhanda and Rushinga are the two clinics which receive many medical visits of the targeted clients. In a bid to improve the health care in the district health institutions uses PBF as the common form of RBF particularly undertaken in Zimbabwe at large. Lack of skilled labor was noted in the research as a deficit in the health sector spearheading slippages in service provision moreover lack of community participation was noted in the research and it was indicated that lack of awareness have greatly affected community participation. Apart from this the next chapter is going to round up the research thus a summary of the whole study shall be drawn .More so recommendations of the research study shall be provided for resolution of the research problem identified

## **CHAPTER V**

### **SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

#### **5.0 INTRODUCTION**

The chapter shall summarize the entire research study as the final section of the research. The main theme behind the research was to assess the effectiveness of Results Based Financing in improving rural health services particularly at Rushinga health facilities. In this regard this episode serves for the motive of rounding all the paper work which was prepared by the researcher in the study in line with the area of research. Conclusions shall be drawn from the data gathered in the research field more so recommendations will also be provided to ensure effective implementation of RBF within health institutions hence reduced under-fives and maternal deaths.

#### **5.1 SUMMARY**

The main motive of the research was to examine the effectiveness of RBF as a results oriented tool in improving health care for under-fives and expectant mothers. RBF within the health sector is the key to effective and efficient use of resources, it enhances effective performance of health employees' thus good corporate governance. Chapter I unveils the historical background of Rushinga District as a case study of the research topic under analysis. This section also examined the health changes that have been brought about through the implementation of RBF within Rushinga health facilities. The types of RBF that can assure changes within the health field were also addressed at length. The researcher also noted that community participation and motivation of employees are key priorities within the study hence they were considered in this chapter. This introduction chapter also looked at other critical components of this chapter namely the significance of the study, delimitations, limitations as well as the assumptions of the research.

The idea for conducting this research was to achieve the research objectives namely

To examine the forms of Results Based Financing being implemented by health service providers in ensuring improved health care.

To identify the challenges being encountered in the implementation of RBF in health service institutions

To analyze the influence of RBF towards a motivated health workforce within the operating environment

To assess the extent of community participation in the implementation of RBF by health service facilities.

To find out the possible solutions to the challenges being experienced in the implementation of the RBF by health institutions

Chapter II of the study critically analysed relevant literature which is aligned to the topic under scrutiny thus addressing research questions provided for in Chapter I. In this chapter a critical review of the already existing literature by other scholars was thoroughly convened concerning the implementation of the health program (RBF) in a bid to diminish the rate at which the targeted clients thus expecting, lactating mothers and under-fives are dying. Thus various themes under this section were discussed to come up with a comprehensive paper for instance several definitions of RBF were articulated as postulated by various accredited scholars, targets of RBF types of RBF, motivation issues and community participation were also considered in this second phase of this research. Moreover a comparative analysis on the implementation of RBF as a results based tool tailored at reducing maternal and under five deaths was also done between two developing countries where RBF is being implemented amongst Rwanda proved to be a bed rock upon which other Sub Saharan Countries can refer to when the need arise hence achievement of development. Despite of this the reviewed literature was gathered from varied secondary sources especially online material thus e-books, e-journals, government reports, the ZIMASSET document and newspapers among other things.

The research methodology was underpinned under chapter three thus qualitative and quantitative approaches to research were addressed. The targeted population in the study was 198 respondents but this figure was reduced to a sample size of 40 individuals which permeates the study to be feasible due to the fact that this sample frame allows the researcher to obtain the required information which address the research objectives as the chief aim of the entire study. Out of this target 32 individuals participated in the research and the remaining 8 individuals failed to participate in the research because the health employees had other work commitments

which required urgent attention on the other side expecting mothers and those with under-fives as targeted respondents within the research also failed to assure a response rate of 100% due to lack of knowledge concerning the implementation of RBF and this was posed by lack of awareness of the health program from the health service department within Rushinga District.

In soliciting for reliable information the researcher used stratified random sampling and simple random sampling as sampling techniques to select expectant mothers and those with under-fives as the beneficiaries of RBF and health employees respectively. In contrast to this under non-probability sampling the researcher purposively sampled the management officials as key informants pertaining the topic under research. Focus group discussions, interviews and questionnaires were used in this chapter as research instruments and this enhanced the availability of primary data on the performance of RBF within the health facilities in Rushinga District

Apart from this chapter, in Chapter IV tables, bar charts and graphs were utilized in the presentation of data extracted from the research findings. According to the research findings 32% of the overall respondents were males and 68% of the responses were from females mainly because RBF is a health program entitled to ensure that pregnant women and children under the age of five especially those residing in the rural areas receive proper health care hence a decrease in the death rate . In this way women are assumed to be aware of the health scheme as compared to males hence giving a higher respondents rate. More so the job description and the requirements naturally limits men to work in the health sector thus women had a higher respondent's rate pertaining the RBF topic as compared to their male counterparts. The health employees identified various challenges as stumbling blocks in the implementation of RBF. In spite of this lack of skilled human resources within health facilities was stated to be the major challenge encountered by health service providers in promoting the objectives of RBF.

In addition there is lack of motivation amongst health employees due to the fact that there is a shortfall of health intellectuals hence the workload affects health workforce operations and activities. The bonus packages attained when the health results are achieved are not disbursed in time thus employees tend to be demotivated when it comes to the notion of performing well in the health arena. Performance Based Financing was identified as the commonly used form of



RBF and this alone pinpointed that other types of RBF such as Cash on Delivery and Output Based Aid are not effectively underpinned to enhance the provision of better health services.

## **5.2 CONCLUSION**

Performance Based Financing (PBF) is the common form of RBF used in Zimbabwe at large hence it is also implemented within Rushinga health institutions. Although it is the most used and identified form of RBF it has failed to impact positive changes in the provision of health services hence the health results provided do not augur well with the anticipated targets .Therefore other forms of RBF should complement PBF to ensure that changes are brought forth hence a health community.

Various challenges were noted to be impeding effective application of RBF within rural health facilities. However the major challenge faced is lack of skilled labor and this have threatened all the progress that have been achieved. Lack of skilled health force have been posed by the freezing of posts within the health field, moreover the economic hardships also paved a way for brain drain thus the exodus of health workers to the neighboring states as they seek for good living and working conditions. To resolve the challenge employee recruitment and selection as well as retention of skilled health workers should be the key priority within the health arena.

From the research findings it can be concluded that motivation is an essential aspect to consider if health institutions are to progress. In this respect employees are key players within the organizations because they can drive the organizations towards its goals hence they need to be motivated. Apart from this there is lack of employee motivation in Rushinga health facilities due to the working conditions moreover the incentives which are given to the health employees are not disbursed in time therefore the employees lack the zeal to better perform resulting in poor service delivery. If employees are to go an extra mile so as to produce expected results motivation issues should be addressed through disbursement of competitive bonus packages.

Community participation was cited as the chief cornerstone for a developed community. In spite of this lack of community engagement in decision making have been drawing back the gains of RBF.This so because if the public does not participate in decision on matters of concern they resist to support the programs which they feel that they do not own moreover there will be lack of commitment has the public neglect such change efforts. It is imperative to note that this issue

have been spearheaded by lack awareness of the health program .Thus participation of citizens should be enhanced through participation platforms which assure effective engagement of the public. Moreover RBF is critical component that can negatively impact on development if not well handled at the grass root level.

### **5.3 RECOMMENDATIONS**

To Rushinga Health Facilities implementing RBF

Retention of skilled employees as well as deployment of qualified health personnel in essential places is required within the health institutions so as to maintain an equilibrium between the human resources available and the quality and quantity of services expected.

Motivation of health service providers should be enhanced through autonomy in decision making on how to use the funds disbursed to them more so employees should be given competitive salaries not incentives because the bonus packages are not permanently fixed thus there should be an increase in their fixed salaries such that they are incited to work even in the absents of additional incentives.

Additional funds should be channeled to the health facilities because they are currently experiencing a shortage of resources to purchase drugs and purchase caesarean tools which are utilized when expectant mothers are giving birth.

Moreover there should be early disbursement of the funds such that health providers plan their activities well on time thus enhancing effectiveness in the provision of health care

There should be participation of various stakeholders in decision making especially expecting and women with under-fives because they are the targeted beneficiaries of the health program. Hence they assist in problem identification as well as problem solving thus assuring quality services which tally with the expected health results.

There is need for awareness campaigns to foster awareness of the public of the RBF scheme. Thus community leaders such as traditional leaders, community nurses and the District Administrator should take advantage of meetings or gatherings for instance village development committee meetings, road shows, health related meetings and churches convened in their areas

so as to steer awareness and educate the majority on what RBF is, as well as the benefits of RBF to the development of a community.

The health service providers should seek feedback from service users so as to note key results areas.

Monitoring and evaluation of the program should be strengthened by ensuring checks and the balances in the results produced versus the performance of the employees. Therefore accountability on the effectiveness of the RBF should be a responsibility of every employee involved but mostly to the management as the overseers of the entire program.

Lastly there should be a cordial relationship between the local authority and the health department .This is so because the local council is the planning authority hence it creates the environment in which the health facilities operates. Thus the health service providers should consider the political and social environment which can deter or influence health changes.

In Rushinga District more health facilities should be constructed within the advocated distance such that distance issues are mitigated. The health clinics should be in a parameter of 5-8 kilometres as alluded by the Ministry of Health and Child Care. Moreover every clinic should have a waiting mothers shelter so as to avoid cases were mothers give birth at home due to the fact that they had nowhere to stay during their expecting the period.

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### APPENDICES



## APPENDIX I: Questionnaires for Health Workers

Muwanikwa Tatenda is my name. I am a student at Midlands State University doing Local Governance Studies. In partial fulfilment of this Bachelor of Science Honours Degree. I am therefore conducting a research by the title **The Effectiveness of Results Based Financing in the provision of better health services. A Case of Rushinga Health Institutions** .Thus your views and comments are highly acceptable and appreciated in the research study.

### General Instructions

- 1) Put ticks where necessary and provide details where the options are provided.
- 2) Respondents are advised to complete the questionnaires on their own
- 3) No disclosure of names of the participants to the public

Information gathered will continue to be private and confidential moreover the information will only be used to achieve the objectives of the study.

1) Gender                      Male                                            Female                     

2) Age Category

25-30                                            30-39                                            40-49                                            50+                     

3) State in full the working experience in the rural health clinics?

10years and below                                            11-15 years                                            16-20years                                            21+                     

4) What is your level of education? Tick where appropriate

National Certificate                                            Diploma                       Degree                     

5) What is meant by the term Results Based Financing? Tick where appropriate.

A health program that links incentives to the expected health outcomes                      [   ]

A result oriented scheme meant to improve health care                      [   ]

RBF refers to monetary or non-monetary transfer made to health providers when specified health results are achieved. [ ]

All of them [ ]

None of them [ ]

Not sure [ ]

6) Are there any changes revealed pertaining improved health services thus to the targeted consumers?

YES [ ] NO [ ] NOT SURE [ ]

7) Identify the different forms of RBF being implemented in local health facilities? Tick where suitable

Conditional Cash Transfer [ ] Cash on Delivery [ ]

Output Based Aid [ ] Performance Based Contract [ ]

Performance Based Financing [ ] Not sure [ ]

All of them [ ] None of them [ ]

8a) Are you motivated to improve service provision through the implementation of RBF? Tick where appropriate?

Yes [ ] No [ ] Partly [ ]

b) What are the strategies employed to motivate health employees?

Bonus packages [ ] Vouchers [ ]

Autonomy on how to use the incentives [ ]

Delegation of roles and responsibilities in the health sector [ ]

Training and career development of employees [ ]

Not sure [ ] All of them [ ]

9) Are the citizens involved in decision making in the implementation processes of RBF?

Yes [ ] No [ ] Not sure [ ]

10) Are the direct clients of the RBF program aware of the health scheme as well as the benefits of participating in the health intervention?

Yes [ ] No [ ] Not sure [ ]

11) Is RBF a panacea to the health problems encountered in the health institutions? Tick where suitable

Agree [ ] Disagree [ ] Not Sure [ ]

b) Justify the answer

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.....  
.....

12) What are the challenges being faced in the implementation of the RBF program? Tick where suitable

Lack of human resources [ ] Lack of political commitment and will [ ]

Corruption [ ] Distance to health facilities [ ]

Culture impeding clients to seek medical attention [ ] Not sure [ ]

All of them [ ] None of them all [ ]

13) What are the main reasons for the failure of health services institutions to improve health services with the implementation of RBF?

Lack of resources [ ] Dilapidated Infrastructure and obsolete equipments [ ]

Corruption [ ] Bureaucratic structures delaying the disbursement of funds [ ]

Resistance faced from the direct consumers [ ]

Not sure [ ] All of them [ ]

14) What are the possible solutions that can be employed to counter the threats impeding effective implementation of RBF?

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**Thank you for your time**

**APPENDIX II: Interview Guide for the Management and Crown Agent Facilitator**

Muwanikwa Tatenda is my name. I am a student at Midlands State University doing Local Governance Studies. In partial fulfilment of this Bachelor of Science Honours Degree. I am



therefore conducting a research by the title **The Effectiveness of Results Based Financing in the provision of better health services. A Case of Rushinga Health Institutions** .Therefore I kindly request for your co-operation and assistance by responding to the questions within the interview guide. You are assured that your responses to the questions probed will remain private and confidential.

A total of eighty health workers shall be interviewed by the researcher in the study.

Date of interview .....

- 1) What is Results Based Financing? Elaborate more on the health program
- 2) What are the different forms of RBF being implemented within health service facilities?
- 3) What is your opinion in regards to the performance of the RBF program in improving maternal and child care, are there any changes achieved?
- 4) Are all the stakeholders involved in the health program given the opportunity to take part in decision making in issues affecting their lives?
- 5) Does the RBF program motivates you to perform better within the health service institutions?
- 6) What are the motivation strategies that are being introduced through the RBF program within the rural health clinics?
- 7) What are the exit strategies devised to ensure the sustainability of the health program?
- 8) What are the challenges being encountered in the implementation of the RBF program?
- 9) How can RBF be effectively implemented to reduce child and maternal deaths?

**Thank you!!!!**



**APPENDIX III: Interview Guide for the District Administrator, the Chief Executive Officer and Councillors**

Muwanikwa Tatenda is my name. I am a student at Midlands State University doing Local Governance Studies. In partial fulfilment of this Bachelor of Science Honours Degree. I am therefore conducting a research by the title **The Effectiveness of Results Based Financing in the provision of better health services. A Case of Rushinga Health Institutions** .Therefore I kindly request for your co-operation and assistance by responding to the questions within the interview guide. You are assured that your responses to the questions probed will remain private and confidential.

Date of interview

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- 1) What do you understand by the term Results Based Financing?
- 2) What is your overview pertaining the Results Based Financing?
- 3) Are the citizens participating in the implementation of Results Based Financing?
- 4) Are the citizens aware of the RBF program being implemented in the rural health facilities under your jurisdiction?
- 5) As a leader within the district of Rushinga what are the challenges being faced in the health service facilities?
- 6) What are the possible solutions that you can recommend to the health service facilities implementing the RBF program?

**Thank you**



**APPENDIX IV: Focus group discussion questions for expectant and mothers**

**With under fives**

A total of eighteen expecting and mothers with under-fives are intended to discuss issues pertaining RBF together with the researcher who will probe the research questions.

Muwanikwa Tatenda is my name. I am a student at Midlands State University doing Local Governance Studies. In partial fulfilment of this Bachelor of Science Honours Degree. I am therefore conducting a research by the title **The Effectiveness of Results Based Financing in the provision of better health services. A Case of Rushinga Health Institutions** .Therefore I kindly request for your co-operation and assistance by responding to the questions within the interview guide. You are assured that your responses to the questions probed will remain private and confidential.

Date of interview

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- 1) What do you understand by the term Results Based Financing?
- 2) What is your opinion in line with the performance of health institutions implementing the RBF program?
- 3) Is RBF effective in reducing child and maternal mortality?
- 4) Are you participating in the implementation of the RBF program?
- 5) What are the participation platforms that foster your engagement in decision making on matters of concern?
- 6) What are the benefits of participating in the health program?
- 7) Are you aware of the implementation of the health aid program as well as its benefits?
- 8) What are the impediments being faced in the implementation of the RBF program?

9) How can health institutions improve the provision of health care for the reduction of child and maternal mortality?

**Thank you for your time.**