

# Extending Results-Based Financing to Community Demand

## **A Case Study from Jonasi Clinic**

## Decentralizing Demand Creation and Introducing More Sustainable Incentives

Results-Based Financing (RBF) is a strategic financing approach where health facilities are rewarded for delivering high-quality services and meeting specific performance targets. In Zimbabwe, the government is implementing a National RBF system, financed by both domestic funds and international partners. This system, overseen by the Ministry of Health and Child Care (MoHCC), incentivizes facilities to conduct Voluntary Medical Male Circumcision (VMMC) procedures. Payments are contingent upon the quantity of services provided and adherence to set quality standards.

The National RBF system focuses on facility-level service delivery outputs, with community-level demand creation activities managed and financed by implementing partners. Implementing partners directly incentivize community health workers (CHWs) to conduct demand creation activities, which creates a sustainability issue: demand creation is led and funded by external partners rather than by the facilities themselves. This poses the risk that demand creation efforts may cease if the implementing

partners' funding ends. To mitigate these risks, ownership of demand creation needs to shift away from implementing partners to a more centralized system under the MoHCC. Integrating demand creation activities into the National RBF system could support sustainability and increase effectiveness.

In response, the INTEGRATE project adapted Zimbabwe's National RBF system to fund VMMC demand creation incentives at the community level. This adaptation, termed Community RBF (cRBF), expanded the national RBF's scope to include community-level demand creation outputs alongside facility service delivery outputs. Its objective was to decentralize ownership of demand creation by providing shared incentives to both facility staff and CHWs, fostering and incentivizing ownership among facility leaders. Demand creation for VMMC was incorporated into facility operational plans, embedding these activities into the daily operations of local health facilities.



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## The Key Challenges That RBF Aimed to Address Included

### **Localizing demand creation approaches**

VMMC promotion is challenged by weak coordination between health facilities and CHWs, with some CHWs not residing within the facility catchment area. cRBF addressed this by recruiting CHWs locally, fostering stronger partnerships and a unified approach between facilities and CHWs for VMMC promotion.

### **Increasing sustainability of incentives**

By integrating demand creation activities for VMMC into the National RBF mechanism, cRBF aimed to establish a more sustainable incentive structure, reducing the risk of demand creation activities halting abruptly when external funding ends. The idea was that MoHCC would fundraise for cRBF indicators in the same way it mobilizes resources for indicators under the National RBF system.

### **Moving away from individual Incentives**

VMMC demand creation incentives are typically paid directly to individual CHWs. However, under the cRBF model, incentives are split between the CHWs and the facility, fostering joint ownership while still rewarding and motivating CHWs and facilities for their efforts. Under cRBF, incentives are split to incentivize facilities to take charge of demand creation, which was previously led by implementing partners.

### **Providing facilities with an additional source of funds**

cRBF incentivized facilities by allocating them funds and subsidies for investment in broader community health initiatives.

### **Integrating VMMC demand creation into facility operational plans**

As demand creation was historically led by implementing partners, VMMC demand creation activities are not included in facility operational plans, which can impact the sustainability and effectiveness of interventions. cRBF integrates these activities into the facilities' operational plans, supported by active support and supervision from the Health Centre Committee (HCC).

## Location of Pilot

The cRBF pilot was conducted at Jonasi Clinic, located in Seke district of Mashonaland East province, which was selected due to its functional service and demand footprint catering to rural and peri-urban communities. Selecting a clinic with the infrastructure, staff, and resources already in place minimized learning curve and provided an enabling environment for introducing the cRBF model.

## Operationalizing the cRBF Model

### **1. Community and stakeholder engagement**

To garner buy-in and support for the cRBF model, a series of district stakeholder meetings was held to explain the new approach. Community stakeholders—including health facility leadership, staff, community leaders, CHWs, community-based organizations, local schools, and school health masters—were informed about the benefits of cRBF, particularly how it supports activities aimed at increasing interest and participation in the VMMC program. Facilities and CHWs were informed about the financial incentives they could receive for promoting VMMC services.

### **2. Adapting and distributing incentives**

The cRBF model re-allocated incentives compared to the vertical implementing partner model, with a greater proportion directed towards community engagement. Specifically, out of a total subsidy of three dollars, two dollars were allocated to CHWs, and one dollar was allocated to the health facility. It was intended that health facilities would use the funds they receive from the cRBF to develop and implement strategies that foster community engagement. This could include using funds for broader health initiatives, administrative costs, and media-related activities to disseminate health information.

Incentives were closely monitored through a designated form used to track the number of clients each team mobilized. Facility nurses verified the form data, ensuring that client counts and services rendered were accurately recorded. Based on these verified records, financial disbursements to CHWs and facilities were made on a quarterly basis, following a detailed verification process.

### 3. Integrating cRBF into existing financing structures

HCCs supported monitoring of cRBF by regularly checking how the model was implemented, tracking payments made to CHWs, and helping plan activities at health facilities, as part of their existing responsibilities under the National RBF. The HCC members were motivated by the increased facility earnings, enabling their facility to implement quality assured services.

### 4. Decentralizing responsibility

The cRBF model shifted coordination and ownership of VMMC demand creation activities directly to facilities, enabling facilities to tailor activities to the specific needs of their community and manage resources more effectively. At each facility, staff collaborated with the HCC to develop annual and quarterly work plans. These plans outlined the facility's goals and how they intended to meet them based on local needs. They also set budgets for VMMC demand creation activities and regularly reviewed their progress against targets. With incentives paid directly to facilities, there was increased motivation to actively participate in the VMMC program.

### 5. Promoting local ownership and sustainability

In the past, HCCs had a limited role in the VMMC due to the program's top-down approach. With the introduction of cRBF, HCCs took on greater oversight and ownership, motivated by the potential of additional earnings for their facility. In collaboration with districts, the INTEGRATE team conducted training sessions aimed at improving HCCs' understanding of national and community-based financing models tailored specifically to VMMC. Topics included the evaluation and funding of VMMC programs, generating demand for VMMC services, and VMMC service delivery models. As a result, HCCs became more involved in facility operational planning and decision-making about how to use funds and mobilize additional community resources. Furthermore, HCCs ensured VMMC demand creation activities were integrated into the health facilities' operational plans and budgets. They regularly reported to the district steering committee, supporting coordination and strengthening the overall effectiveness and sustainability of the VMMC program.



KLKMB Campaign, Digital Health Program. Zimbabwe, 2016

## Successes and Challenges

The cRBF pilot supported the decentralization of demand creation by providing incentives to facilities and activating HCCs. This helped foster local ownership and led to more organized and effective operational planning at health facilities, including the integration of demand creation activities into their operational plans.

The cRBF model's contributions to Jonasi Clinic's overall funding were modest but impactful. From July to September 2022, the model contributed 9% of the clinic's total RBF earnings, followed by 6% from October to December 2022, and 5% from January to March 2023. These funds were reinvested by the clinic to support community-based demand creation initiatives, including a community health expo.

However, despite these achievements, the cRBF model faced significant challenges with its payment structure. While cRBF payments were sourced from the INTEGRATE project, the model was designed to align with the national RBF's quarterly payment cycle for consistency and to leverage existing verification and invoicing processes. The project was unable to modify the quarterly payment schedule while maintaining integration with the National RBF system, creating an insurmountable barrier to its implementation. The widely spaced payment schedule failed to meet the needs of CHWs who require regular and timely financial incentives to remain motivated. This lack of timely rewards led to considerable demotivation, prompting some CHWs to leave the program.

After evaluating the outcomes, the stakeholders involved in the INTEGRATE project—including district representatives and community leaders—concluded that the cRBF model implemented at Jonasi Clinic was not suitable for continuation or expansion to other districts. This decision stemmed from significant challenges related to the payment structure, which adversely affected CHW's motivation and overall program sustainability.

## Key Lessons and Future Directions

The cRBF pilot offers valuable insights for the broader community of practice involved in health system financing and service delivery. It demonstrates the benefits of decentralizing demand creation and empowering facilities to lead these efforts within their communities. By transferring ownership and management of demand creation to local facilities, the model fosters a stronger sense of responsibility and commitment among facility leaders and HCCs and supports demand creation strategies that are specifically tailored to meet the unique needs of each community, increasing overall sustainability.

At the same time, the cRBF model highlights the importance of aligning payment structures with the operational and motivational needs of CHWs. The quarterly payment cycle under the national RBF framework, although structured to maintain systematic disbursements, was not effective in meeting the immediate financial needs of CHWs. This misalignment caused significant challenges, including demotivation and attrition among CHWs and key stakeholders, undermining the overall goal of increasing demand, service uptake, and maintaining program stability.



Digital Health Program. Zimbabwe, 2021

## Key Takeaways

- Effective demand creation is crucial for disease prevention programs, especially those targeting groups like men and boys, who typically exhibit low health-seeking behaviors. These programs require a responsive incentive system to stimulate interest and demand for services.
- Integrating service and demand creation into national output financing mechanisms can support sustainability given the uncertainty in future VMMC funding. However, payment structures must align with the operational and motivational needs of CHWs. Quarterly payment structures will not motivate or engage CHWs, who prefer daily, if not weekly payments.
- Decentralizing ownership and coordination of demand creation to the facility-level fosters a stronger sense of responsibility and commitment among facilities and HCCs. Decentralization can increase sustainability, foster local ownership, and support demand creation strategies that are tailored to unique community needs.
- The INTEGRATE cRBF system was integrated into the National RBF system and tied to its quarterly payment structure. There may be potential in other settings to establish a community RBF system with more frequent payment cycle, addressing the challenge of healthcare worker motivation observed during the pilot. In Zimbabwe, stakeholders could consider adapting or realigning verification processes in the future. Although this was not feasible during the pilot phase, future opportunities might allow for adaptations that align cRBF payments with the frequency needed to keep community health workers motivated.



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