Health Development Fund

Supporting the National Health Strategy to improve access to quality health care in Zimbabwe

CROWN AGENTS
ACCELERATING SELF-SUFFICIENCY & PROSPERITY

GENDER AT THE CORE

Women and the RBF Programme in Zimbabwe

MARCH 2019

Approximately
800
women die daily 'due to complications of **pregnancy** and child birth.

3.7 billion
females in the world today, yet women remain underrepresented in the **Global Developmental Discourses**

stunting prevalence at national level has dropped from **33% in 2010 to 26% in 2018**. However, it remains above the acceptable global threshold of **20%.**

70%
of **Women** constitute the world's poor, make up **70%** of the world's working hours and earn only **10%** of the world's income, half of what men earn.

2012
the first female chairperson, **Irene Silikombola**, was appointed.

Muonwe Clinic and community has undergone significant improvement since the appointment of its first female Health Centre Committee (HCC) chairperson.

2012-2014
facilitated the drilling of a **borehole** thus improving access to **potable water**.

the second female chairperson
Maud Adam
2014-18
purchased **$300.00** worth of bricks and half a ton of cement in her own capacity.

FOREWORD /

Our mission as the Ministry of Health and Child Care (MoHCC), is to 'administer, coordinate, promote and advocate for the provision of equitable, appropriate, accessible, affordable and acceptable quality health services and care to Zimbabweans.' Every citizen in Zimbabwe should enjoy their inalienable right to health, as to deny it, is to deny the right to life itself. Our mission is therefore critical, but not easy; infrastructure must be developed, staff trained and deployed, medicines supplied and communities mobilised. To achieve this we need partners. This is why we are grateful for the support we receive through Crown Agents under the Results-Based Financing Programme (RBF).

Through RBF a number of health facilities in several districts have already made good strides. We have seen buildings repaired, new maternity wings built and more medicines procured. In addition to this, the support we receive though RBF which goes towards paying staff allowances has kept morale high and improved service levels.

These developments are in line with the government's Transitional Stabilisation Programme (TSP), which is informed by the Sustainable Development Goals (SDGs) and the African Union's Agenda 2063. Among other goals, the TSP seeks to address the following critical challenges in the heath sector:

- Sub-standard quality of maternal health services, such as ante-natal care, delivery, and post-natal care, including the prevention of mother-to-child transmission of HIV and sexually transmitted infections
- Medicine shortages and the provision family planning products
- Inadequacy of emergency transport and communication systems, which have a bearing on mortality rates
- Strengthening the Health and Management Information System at facility level

We continue to cherish and nurture the invaluable partnerships which help us to reach these goals.

This publication presents real life stories describing the impact of our partners' interventions on real people and their communities. The Ministry is proud to be partnering with them in helping to create these success stories.

Major General (Dr) G. Gwinji (Rtd)
Secretary for Health and Child Care

WHAT'S IN THIS ISSUE?

LIST OF ACRONYMS /

ANC	Ante-Natal Care
CBO	Community Based Organizer
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CSS	Client Satisfaction Survey
DHE	District Health Executive
DSC	District Steering Committee
EU	European Union
FP	Family Planning
GAP	Gender Action Plan
HCC	Health Centre Committee
HDF	Health Development Fund
HFO	Health Field Officer
HIV	Human Immuno-Deficiency Virus
GEWE	Gender Equality and Women's Empowerment (A Programme of the EU)
MoHCC	Ministry of Health and Child Care
MP	Member of Parliament
NCDs	Non-Communicable Diseases
OPD	Out Patient Department
PMD	Provincial Medical Director
PMTCT	Prevention of Mother to Child Transmission (for HIV)
PNC	Post-Natal Care
PPH	Post-Partum Haemorrhage
RBF	Results-Based Financing
RHC	Rural Health Clinic
RMNCH	Reproductive, Maternal, Newborn and Child Health
SADC	Southern Africa Development Community
SDGs	Sustainable Development Goals
TB	Tuberculosis
TBA	Traditional Birth Attendants
UNICEF	United Nations International Children's Emergency Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

FROM THE EDITOR /

This issue is a ‘shout out’ to women! As Crown Agents together with all of our stakeholders in the RBF programme we want to celebrate women and raise greater awareness of women’s issues, which are not getting the recognition they deserve.

Dedicated commemorative days such as Women’s Month, International Women’s Day, International Day of the Girl Child and the 16 Days of Activism Against Gender are wonderful women’s initiatives, but they are few and far between. This edition seeks to shine a light on what women are doing every day in the health sector all over Zimbabwe. We want to talk about these women now and to keep talking.

This publication aims to highlight how women have influenced and impacted, not only their personal spheres, but the health sector and human development discourses at large. We will present success stories and case studies and we hope to provoke serious reflection on the crucial role these women are playing towards the betterment of our country.

The situation for women today, not only in Zimbabwe but globally, is poor. The average reader will probably need a full day to read this edition cover-to-cover. As horrific as it sounds, in that very same space of time an average of 830 women would have died across the world from causes related to pregnancy and childbirth. Several more hundred would have lost their new born children, particularly those living in developing countries.

Yet the causes of this tolerated ‘femicide’ are preventable. Only minimal investments are needed to make a difference as well as the recruitment of more women in finding the solutions to this inequity. Women are capable of taking on and delivering inordinate amounts of work and responsibility, yet few women in Zimbabwe play a role in decision-making and even fewer are acknowledged for their contribution.

1 the number of days it will take you to finish reading this booklet. By that time, globally, approximately **830 WOMEN** would have died owing to pregnancy and childbirth related causes.

Together with the Ministry of Health and Child Care, UNICEF and the Health Development Fund, the RBF programme is striving to achieve both measures; it is financing interventions to reduce maternal and neonatal deaths and making strides to empower women to participate in sustainable solutions for Zimbabwe.

It is not our intention for this issue to leave you in despair, but rather to raise awareness of the challenges women face, and to celebrate the champions and the heroines of women’s health.

We hope that this edition will inspire you to see women not as victims, but as heroes of their own and our collective struggles.

On behalf of Crown Agents and the editorial team, I would like to wish you a very prosperous 2019!

Marie-Jeanne Offosse
HDF/RBF Team Leader at Crown Agents Zimbabwe

FROM LEFT:
Caroline Mubaira, HDF-RBF Deputy team leader; Sister Matimba, Matron at Bikita Rural Hospital;
Marie-Jeannne Offosse, HDF RBF Team leader and Muchaneta Mwonzora, Crown Agents Country Director.

ABOUT THE PUBLICATION /

Millions in public funds are being channeled towards development aid every year. The need to demonstrate that these resources are achieving their targets has given rise to results frameworks which can prove that they are being put to good use. Very often however, these frameworks make our work too technical and scientific for an ordinary person to follow. Reports based on log frames, for example, will fall short of telling the full human story. The tangible grass-roots impact of our work is sometimes lost as real people become data and statistics. Somebody has to tell the story differently and this is why we conceived this publication – to simplify development discourse by telling the real life stories behind our work.

This is the third edition by Crown Agents. The first edition was titled, Results-Based Financing: The Story of Hope and Caring in Zimbabwe, followed by a second edition named Results-Based Financing: Strengthening the Health Delivery System in Zimbabwe. In this edition we describe how the RBF programme impacts women’s health and we celebrate a diversity of women who are driving the programme.

FROM LEFT:
Ian Malcomson, Crown Agents Chief Finance Officer; Dr Obadiah Moyo, Minister of Health and Child Care; Muchaneta Mwonzora, Crown Agents Zimbabwe Director and Marie-Jeanne Offosse, HDF/RBF Team Leader at Crown Agents Zimbabwe.

NEW MINISTER OF HEALTH APPOINTED, PLEDGES SUPPORT FOR RBF /

The President's Cabinet has been described as an action team of technocrats with a record of delivery – a team carefully curated to halt and begin to reverse the decline in many sectors of the country's development, particularly in healthcare. Towards this goal, President Emmerson Mnangagwa has recently appointed a new minister, Dr. Obadiah Moyo, to turn around the fortunes of the health sector.

With a track record in delivering successful results we are delighted at Dr. Moyo's appointment. Among many achievements he led the Chitungwiza Central Hospital with excellency throughout Zimbabwe's crisis years and the hospital has described him as 'a visionary and creative leader' who adopts a 'professional hands on approach and is skilled in problem solving'.

Dr. Moyo acted swiftly in the midst of Zimbabwe's cholera crisis and wasted little time in containing the outbreak. He also raised awareness that the outbreak itself was just one symptom of a health sector in need of urgent resuscitation.

Under his charge the Chitungwiza Central Hospital was also chosen as a venue to celebrate the United Nations 2013 Safe Motherhood Initiative. The hospital was recognised for its outstanding model in implementing systemic solutions and building strategic partnerships to successfully deliver public health services to disadvantaged communities.

In alignment with the RBF programme Dr. Moyo's priorities include; ensuring the availability of drugs, improving staff welfare and addressing the cost barrier for access to services with respect to women's health.

If the zeal and commitment with which he has acted in previous assignments is anything to go by, then Zimbabwe's health sector, and by extension the RBF programme, has a very bright future.

CHAPTER ONE /

WHAT IS THE RESULTS-BASED IN HEALTH FINANCING STRATEGY?

Introduction /

Results-Based Financing in Health is the transfer of resources to health providers on the condition that measurable action will/has been taken to achieve predefined health system performance targets. RBF is increasingly being promoted by leading global actors as a way to efficiently and effectively increase performance in terms of service quality, service utilisation, as well as improving staff motivation in a way that will ensure Universal Health Coverage (UHC). As a model, RBF in health rewards health facilities based in their performance and achievements.

WOMEN AND THE RBF PROGRAMME

There are not enough resources in the world to fund all the existing priorities for human development. In 2015 a total of 17 priorities were identified in the United Nation's Sustainable Development Goals (SDGs). But what if there was only one priority which made the biggest impact on all the rest?

SDG number 5: to achieve gender equality and empower all women and girls, is arguably the most important, given that nearly every other priority is significantly impacted by gender.

THE SDGS: LOCATING WOMEN IN THE CONTEMPORARY DEVELOPMENT AGENDA

Women represent around half of the world's population, yet they remain under represented in global development discourses, most of which affect them to a far greater proportion. Women constitute 70 per cent of the world's poor, make up 70 per cent of the world's working hours and yet earn only 10 per cent of the world's income.

The Global Poverty Project observes that; 'We live in a world in which women living in poverty face gross inequalities and injustice from birth to death. From poor education to poor nutrition to vulnerable and low pay employment, the sequence of discrimination that a woman may suffer during her entire life is unacceptable but all too common.'

According to the World Health Organisation, approximately 800 women die daily 'due to complications of pregnancy and child birth, including severe bleeding after childbirth, infections, hypertensive disorders, and unsafe abortions. Out of these 99 per cent are in developing countries and over half occur in sub-Saharan Africa to which Zimbabwe belongs.'

This is just a small part of the picture in relation to a handful of development goals. The bigger picture is even more disturbing and makes for very sad reading. But while women are still living in cultures and societies which disfavour them, more and more are rising to claim equal opportunities. It is incumbent upon every global citizen and institution to support them. Perhaps then the catastrophe of 'man-made' poverty and under-development might be overcome.

HDF AND RBF IN ZIMBABWE

The foregoing analysis of the global development agenda instructs the funding model for Zimbabwe's health sector – the Results-Based Financing programme under the Health Development Fund (HDF).

About the HDF

The HDF is a multi-donor fund to the Zimbabwean health sector, with a focus on Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH-A). Women take an active role in the steering committee of the HDF hence providing leadership in the RBF programme as well.

ABOVE:
Smashing the glass ceiling: Women providing leadership in the HDF National Steering Committee. From Left: Redah Manga (MoHCC), Jane Mudyara (MoHCC), Martina Dhliwayo (DFID), Angelica Broman (SIDA), Amina Mohammed Unicef and Dr N. Zvongobani (ZNFP)

The In Zimbabwe maternal mortality rates remain at an unsustainable 443 mothers out of 100 000 live births. In response to this, the RBF programme puts a premium on investments that seek to reverse this tide.

In Zimbabwe about 80 percent of all primary health workers are women yet they remain under-represented in decision-making. They are entitled by both by demographic and democratic imperatives to play a role in finding solutions to contemporary world challenges. As such RBF pursues gender equality in its processes, particularly with respect to decision-making when it comes to how resources are allocated and utilised.

SNAPSHOT: WOMEN IN THE RBF PROGRAMME

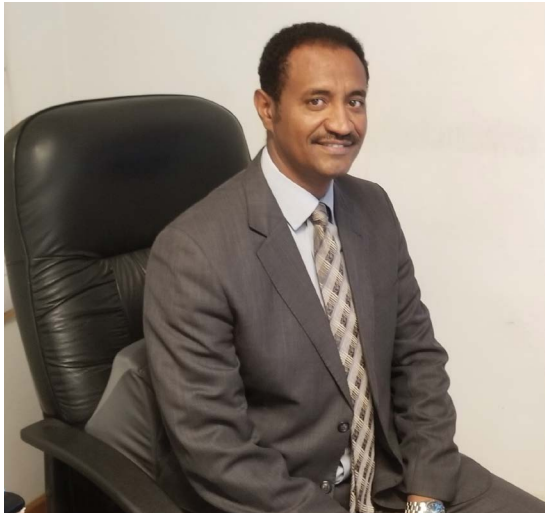
- Key targets of the RBF programme are aimed towards improving women's health
- Women are active at various levels in the implementation of the programme from the local community level to the national policy making and coordination functions
- 20 percent of Provincial Medical Directors (PMDs) who coordinate the implementation of the RBF programme are women
- Evidence at community level is showing that women-led Health Centre Committees are doing well in promoting women's health under the RBF programme

1.2 Women's empowerment goals in the strategies of RBF's partner organisations /

There are several key actors in the RBF programme, ranging from funding partners and coordinating agencies to those involved in its implementation. Each of these organisations have their own goals, yet they all converge with respect to women's empowerment and gender equality. Through RBF they are able to advance their own agenda towards women's empowerment. In this section, we review the strategic goals of RBF partners with respect to women.

1.2.1 UNICEF: Saving Children through Empowering Women /

An interview with UNICEF's Dr Nejmudin Kedir Bilal
by Tayson Mudarikiri



ABOVE:
Dr Nejmudin Kedir Bilal, the UNICEF Chief of Health and Nutrition

afternoon to fulfil an appointment which I have been trying to secure for weeks – an interview with Dr Nejmudin Kedir Bilal, UNICEF's Chief of Health and Nutrition.

Dr Bilal is a busy person and so I hadn't thought twice about sparing my time to accommodate the slot. In truth however, it wasn't so much my time as my family's. My seven year-old daughter, whom I had just picked from school, and my father, who had just seen her perform in an end-of-term show, had been abruptly dumped in the car park while I conducted our interview.

'You shouldn't have left your daughter in the car park, feel free to go fetch her and bring her along –we are a child protection organisation and won't allow children to be treated like that.' Having been chastised by Dr. Bilal, I found myself sheepishly defending my fathering skills by explaining that the car was very warm and that she was accompanied by her grandfather, who could call me anytime if they needed me.

I might have expected it really, given his reputation for genuinely caring about children. For Dr. Bilal working for UNICEF is a vocation rather than just a profession, and both the UNICEF office and the person behind the officer have a lot in common when it comes to protecting children. Another thing I learnt that day, is that protecting children starts with caring for and supporting the mother - UNICEF's entry point into the RBF programme.

THE ROLE OF UNICEF IN THE RBF PROGRAMME

'UNICEF's general goal is to make sure that children survive, thrive and achieve the best in their lives,' said Dr Bilal, before explaining that the organisation came to coordinate the RBF programme for women because 'caring for children begins during pregnancy.'

He afforded a sobering example through the problem of stunting –a condition affecting human development caused by malnutrition which begins in pregnancy. 'Those affected don't just bear the socio-economic impacts of a shorter stature, but they are also affected by cognitive impairment and are at greater risk of developing other illnesses, as well as premature death' he said.

In Zimbabwe today the prevalence of stunting has dropped from 33% in 2010 to 26% in 2018, but it remains above the 'acceptable' global threshold of 20%.

If stunting and other conditions affecting children are to be addressed, then mothers are a crucial entry point into the health and survival of children. This, he explains, is why the RBF programme operates at the nexus between women and children's health through interventions that seek to reduce maternal deaths, as well as loss of newborns.

Whether supporting initiatives through the health sector, in agriculture, or though water, sanitation and hygiene programmes, UNICEF acts to safeguard

children by also helping to lighten their mothers' burden of raising them. And in describing the importance of delivering antenatal and postnatal care, he stressed that these services 'save both the lives of mothers as well as their children'.

Together with RBF, UNICEF recognises the gendered nature of Zimbabwe's pressing health priorities.

EVIDENCE-BASED PROGRAMMING IN WOMEN'S HEALTHCARE

UNICEF manages the HDF through seven pillars, one of which is the RBF programme. It's role is to ensure that the fund is prioritised for the sake of mothers and children of Zimbabwe and they do this through programme and finance monitoring to ensure accountability and delivery of programme outcomes. In keeping with evidence-based prioritisation, the organisation advises donors on how best to utilise the resources available and also provides technical advisory services.

Dr Bilal also explained that UNICEF uses a broad evidence base to shape programmes such as the RBF owing to the fact that that indicators can be contradictory. To provide an example, health indicators such as coverage might appear to be adequate, yet child and maternal mortality rates remain high. To uncover this disparity the organisation undertook a bottleneck analysis, which revealed that many women would remain in delivering facilities for up to three days after giving birth in order to receive specialised care, yet only 10 percent of these women actually received this care.

ABOVE:
Nurse at Jari Clinic orienting community members on early booking

The lessons learnt from this analysis have helped to instruct the RBF programme whereby equal premiums are placed on both the quantity and the quality of services provided. Through the introduction of client satisfaction surveys health facilities are now increasingly inclined to listen to their clients and measure the quality of their services since the facilities are no longer financed solely on the basis of the number of women they treat, but also on their ability to meet their expectations. 'This has saved a lot of women's lives', remarks Dr.Bilal

1.2.2 Women's health and the European Union /

Gender equality and the empowerment of women and girls are fundamental human rights which are among the founding values of the Treaty on European Union (EU) and the Charter of Fundamental Rights of the EU. Equality between men and women is a principle objective for the EU as well as a prerequisite for long term democratic, equitable and sustainable global development. As such, the European Union works towards the removal of obstacles to gender equality, such as discriminatory legislation and policy, social norms, cultural attitudes, gender stereotypes and the distribution of power.

In 2007 the European Commission adopted the Communication on Gender Equality and Women's Empowerment (GEWE) in its Development Cooperation Policy. Subsequently the EU Council called on the Commission services, the European External Action Service and member states to promote clear objectives and indicators on gender equality in all sectors.

In 2010 the EU adopted two successive external action plans on GEWE: Gender Action Plan I (GAP I) and Gender Action Plan II (Gap II).

In 2016 the EU commissioned a gender analysis which informed specific objectives from the following three thematic priorities for GAP II (2016-2020) in Zimbabwe.

- **Priority 1: Ensuring girls' and women's physical and psychological integrity**
  OBJECTIVES
  1. Girls and women are free from all forms of violence against them (VAWG) both in the public and in the private sphere.
  2. Promoted, protected and fulfilled right of every individual to have full control over, and decide freely and responsibly on matters related to their sexuality and sexual and reproductive health, free from discrimination, coercion and violence

- **Priority 2: Promoting the economic and social rights/empowerment of girls and women**
  OBJECTIVE
  1. Equal access by women to financial services, productive resources including land, trade and entrepreneurship.

- **Priority 3: Strengthening girls' and women's voice and participation**
  OBJECTIVES
  1. Challenged and changed discriminatory social norms and gender stereotypes
  2. Equal rights enjoyed by women to participate in and influence decision-making processes on climate and environmental issues.

These priorities are currently being implemented through programmes including the Health Development Fund, of which RBF is one initiative which helps the EU to achieve the above objectives.

1.3 Women at the Core of Primary Health Care /

1.3.1 Women as primary healthcare service providers /

Female nurses constitute around 80 per cent of healthcare personnel in rural areas, which puts them at the frontline of the RBF programme. Often working long hours with limited resources and equipment, the RBF programme helps to ensure that they are rewarded for their work and that their healthcare facilities are well-equipped.

ANurses today are far more than just traditional healthcare staff who administer medicine. Their role within the health sector is evolving to meet the ever-changing health needs of communities, particularly in the field of sexual and reproductive health and rights. With improvements in the provision of healthcare services to include family planning, RBF subsidies are being used to dispatch specially trained nurses to family planning centres.

This is one of many examples in which the RBF programme is empowering women as primary health care service providers.

ABOVE:
Health workers at Mutorashanga Hospital, mostly women, pictured with family planning commodities

1.3.2 Community Based Organisation (CBOs): New roles for women in the provision of health services at community level /

For many people the words ‘women’ and ‘healthcare’ suggests nursing. Nurses are at the core of our work but the RBF programme has also introduced other roles for women in the delivery of health services. One emerging and crucial role is that of the community based organiser, or CBO, who is responsible for giving feedback to facilities on their findings, as well as conducting feedback meetings with the Health Centre

WE TALK TO NEW CBO MEMBERS /

The majority (54%) of CBO members across all the districts in which Crown Agents and partners are rolling out the RBF programme are women. As this edition celebrates the role of women in the RBF programme, the Crown Agents HFO and regular contributor to this publication, Shungurudza Mudereri (SM) caught up with newly appointed CBO members, Selina Hausi (SH) and Christine Huni (CH) at the side-lines of the CBO members training and orientation to discuss their role and aspirations for the RBF programme, particularly in improving the health of women. Below are excerpts of the conversations:

SM: How are you Selina? How are you Christine? Thank you for making it to the CBO members training and congratulations on your appointment. How do you feel about the appointment?

SH: Truly speaking, I feel humbled by the appointment. I am passionate about working for my community. My desire has always been to see positive developments within our communities, especially in our health facilities. I feel confident that through this role I will be contributing to improvements

CH: I am equally excited to be appointed a CBO representative. Despite this being a voluntary assignment I feel very encouraged to work hard towards improving our health facilities.

SM: How do you think your work as a CBO member will help women and the nation at large?

SH: From my understanding the RBF programme is more inclined towards mothers and children under five. I believe that the satisfaction surveys we will undertake will improve issues to do with maternity homes, the availability of medicines and the quality of maternity healthcare. I see this as a result of the feedback that we will receive.

CH: I I think that there will be efforts to make use of the honest feedback to improve health care services. I have also heard that this feedback will be shared with district health executives, district steering committees and health field officers to help make decisions which improve access to services.

ABOVE: Crown Agents staff with CBOs

1.3.3 HCCs: Opportunities for Effective Female Leadership at Grassroots Level /

One One of RBF's key successes so far has been to support the decentralisation of decision-making to communities and to allow citizens to play an active role in running their own health facilities through Health Centre Committees (HCCs). HCCs were established under the Primary Health Care Act which stipulates that each clinic should have one. Although still few HCCs are led by women, those that exist perform extremely well. Muonwe clinic in Mashonaland District is one such facility which has been successively led by women. Below is their story.

ABOVE:
Genia Jaka, Nyaure clinic HCC leader with community nurses, facility staff and Crown Agents. (Goromonzi district in Mashonaland East Province)

MUONWE CLINIC /

SUCCESSFUL FEMALE LEADERSHIP IN HCCS

By Sarah Nyengerai

ABOVE:
Ms Adam, The HCC Chairperson for Muonwe Clinic

2014-18
the second female chairperson, **Maud Adam** purchased **$300.00** worth of bricks and half a ton of cement in her own capacity.

One of 13 rural health facilities in the Mashonaland Central province, the Muonwe Clinic and its community has significantly improved since the 2012 appointment of its first female HCC chairperson, Irene Silikombola.

On assuming her appointment her first step was to action the drilling of a borehole to improve access to portable water. In Zimbabwe the sourcing of water is largely the responsibility of women and girls, who often have to walk long distances. This one development had a major impact on reducing the workload of women and girls in the community by freeing them to be productive in many other ways, including giving them an opportunity to attend school. Access to clean water is also a prerequisite in preventing waterborne diseases such as cholera, typhoid, and dysentery.

Following her appointment in 2014 the current chairperson, Maud Adam took over. She first served the HCC as a committee member and was later elected as chairperson. The main source of funding for the committee is the government's annual Constituency Development Fund. Prior to her appointment a large percentage of this fund went to the development of schools and roads, neglecting the community's health needs. As chairperson she successfully lobbied for more funds to be allocated for the clinic.

Ms Adam also works to ensure the day-to-day smooth running of the clinic and since her involvement stocks of essential drugs such as paracetamol has improved notably. But keeping the clinic operational isn't her only focus. Ms Adam's is also striving to put in place long term transformations and has advised local leaders on the necessity of doing more than just equipping a community with immediate products. For her, there is a need to increase the community's capacity to take control of future developments.

Currently she is mobilising the community to build a maternity waiting home with seven rooms and the capacity to accommodate three women at a time. In most rural areas such as hers, pregnant women face numerous challenges when it comes to accessing health care services, often walking long distances on poor roads to reach hospitals which don't have ambulances.The construction of this waiting-home will reduce maternal and neonatal mortality often caused by poor health services and other risks associated with born before arrivals. Expectant mothers that live in remote areas will check-in approximately two weeks prior to their due date for access to skilled birth attendants and specialised emergency care. The community will be responsible for providing free labour and cheap building materials such as river sand to make bricks. For additional materials such as molds, cement and door frames, funds will be raised through various projects spearheaded by Ms Adam. To date she has purchased $300 worth of bricks and half a ton of cement.

The building of the waiting-home began in 2018 and her hope is that it will offer a complete package of care from pregnancy to infant care, delivery wards and postnatal wards.

For Ms Adam the sustainable delivery of health services to communities is only possible with the involvement of women. 'Women need to be proactive in shaping their destinies and in correcting the patriarchal injustices that have for so long neglected maternal care,' she says.

'Projects such as shelters for expectant mothers can only really be understood by the women who have had to walk to a clinic while in labour.'

It is this understanding that spurs Ms Adam to commit to making sure that these women are close to health facilities. She also wants to disprove prevalent stereotyping which dictates that women cannot lead but notes that over the years these perceptions are changing as communities are bearing the fruits of female leadership.

The story of Muonwe Clinic is by no means an exception. In Gokwe North, Midlands province, health facilities with HCCs led by women are also making improvements in maternal health. For example, facilities with the highest deliveries in the Zumba Simuchembo and Chireya districts both have HCCs led by women who are using their role in planning to prioritise maternal care.

DETE CLINIC /

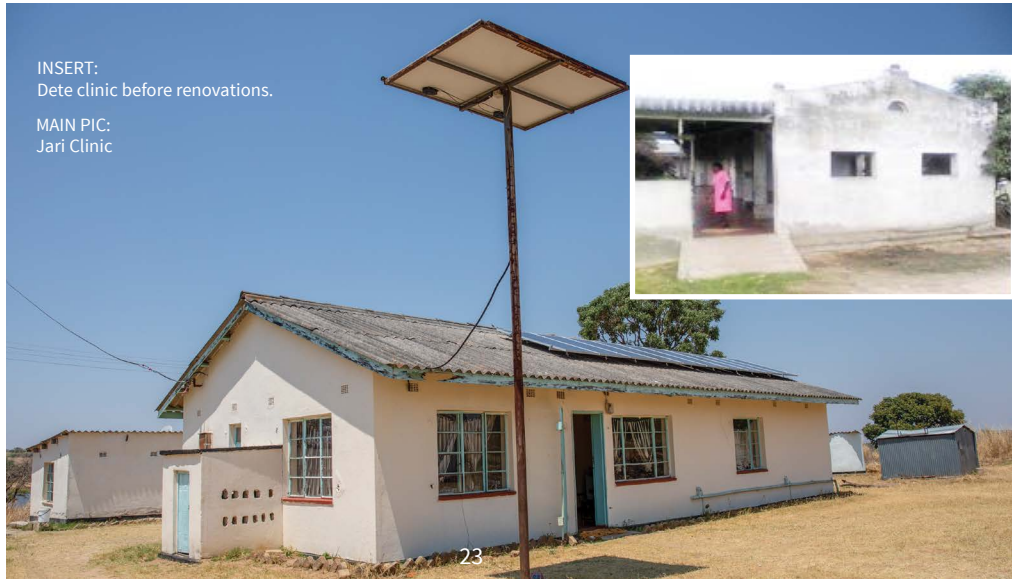
ANOTHER FEMALE HCC CHAIR

Dete clinic is one of the facilities contracted under the RBF programme in Hurungwe district, Mashonaland West province. The clinic is about 90 km away from the district hospital in the remote mountainous Hurungwe communal lands.

The clinic's HCC consists of seven members and a female chairperson, Tsitsi Kamutepa, appointed in 2014 when the RBF programme was introduced in Hurungwe district.

Under her leadership she has renovated the clinic as well as its maternity centre and staff homes, and has procured new linen and medical supplies. She has also encouraged her team to prioritise expectant women, newborns and children under five. As one of the few women who are occupying a position usually held by men in Hurungwe, she attributes her success to a very supportive community. Dete clinic is one of the best performing facilities with high antenatal care bookings as well as high institutional deliveries compared to the national average.

ABOVE:
Mrs. Kamutepa, Dete Clinic HCC chairperson

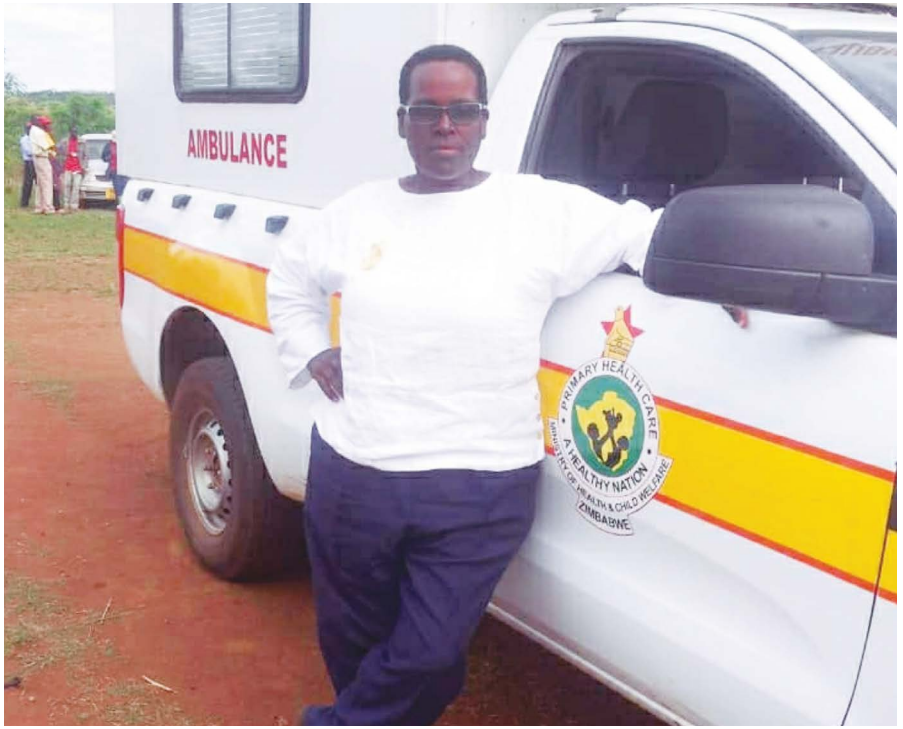


INSERT:
Dete clinic before renovations.

MAIN PIC:
Jari Clinic

WOMEN DRIVERS /

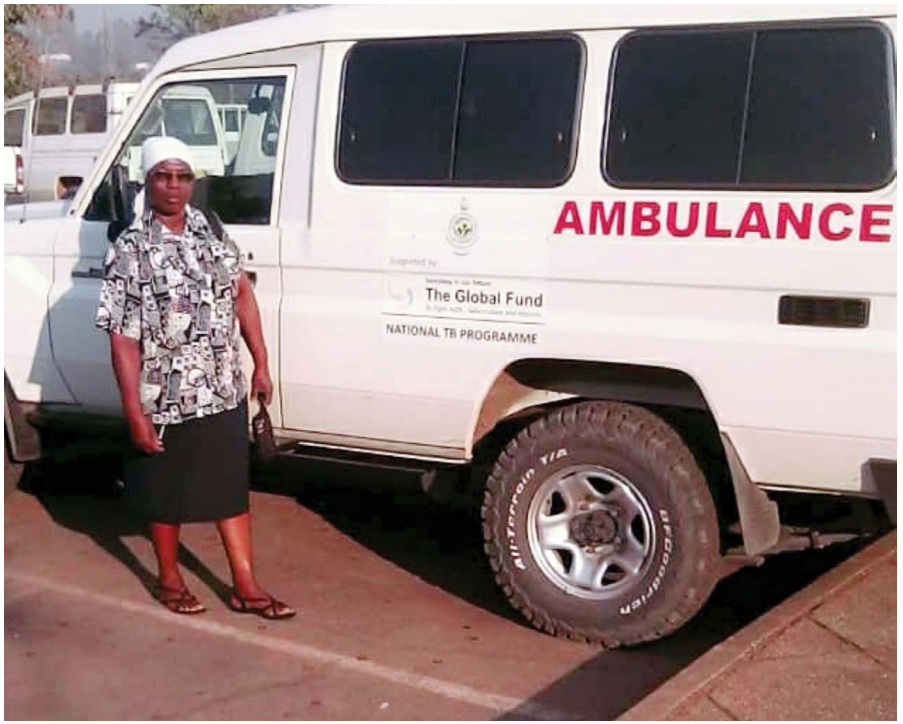
WOMEN DRIVERS CHALLENGING GENDER NORMS



ABOVE:
Laina Mageza, Ambulance Driver

Mashonland West Province
Hurungwe District
Laina Mageza

As road traffic increases daily in Zimbabwe one of the most frustrating jobs in the delivery of health services is that of an ambulance driver, for whom very few drivers seem to want to give way. These drivers are taking responsibility for fragile lives, aggressively meandering through traffic and driving at speed and so in most people's minds they are assumed to be males. Not so in Hurungwe or Makonde districts in Mashonaland Province, where the role is being handled by Ms Laina Mageza and Ms Mavis Chipata.



ABOVE:
Mavis Chapata, Ambulance driver

'I got my driver's licence in 2000. When I joined the transport department there was a lack of trust from some people who doubted if a woman would be able to withstand the pressure associated with driving. It's a profession seen by many as the domain of men,' says Ms Chipata.

Ms Mageza agreed; 'In the workplace, men feel challenged by my position and work as an ambulance driver. Usually they look down upon women, though now things are improving.'

Asked what motivates them to claim their space in a 'man's world' they say it is mostly the thought of saving fellow women's lives. 'Most of the emergency calls we get are maternity cases. I always feel privileged when I get a maternity referral and to be able to bring the mother to the hospital in time for her delivery. Being a woman myself, I feel for these women,' says Ms Chipata.

WOMEN ANCHORING COMMUNITY /

PARTICIPATION IN THE RBF PROGRAMME

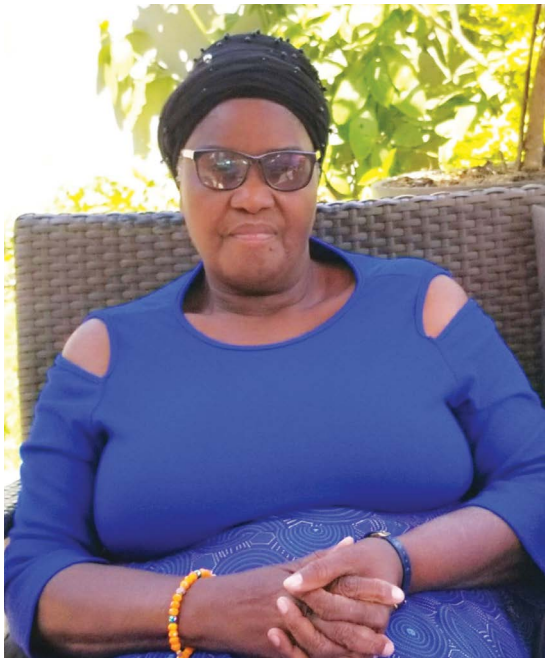
In Zimbabwe the culture of working together for the common good is a central tenet of life, especially in rural areas. Zimbabweans are far more than just passive recipients of aid, rather they come together to build their own infrastructure and to give whatever they can to see their communities develop.

This culture of community participation is in-built into the architecture of the RBF programme. RBF provides financial resources to complement community initiatives in building and maintaining health infrastructure so it's a cost-effective symbiosis. And although women are under-represented in influential positions in the heath sector, under RBF they are becoming more and more involved in community initiatives to build and renovate health facilities. While unheralded, these women are anchoring the RBF programme at community level through their manual labour, which includes tasks like fetching water during construction projects.

ABOVE:
Community members, mainly women helped fetching water for the building of a maternity block at Mketi clinic, in Zvishavane district funded by the HTF-RBF programme. Women are keen to participate because the intervention impacts them. Before the construction of the maternity wing the nearest delivery facility was about 20 km away.

CHAPTER TWO /

GENDER EQUALITY IN DECISION MAKING: WOMEN IN HEALTH POLICY MAKING



ABOVE:
Dr. Ruth Labode

2.1 Introduction /

Under the RBF programme, new structures and roles such as HCCs and CBOs are extending the role of women in primary healthcare beyond nursing. These remarkable women have defied the odds to become important influencers in the health sector and particularly within the RBF programme. Below we hear from other female leaders on how they intend to use their influence to advance the cause of women, children and the nation at large.

2.1.1 Dr. Labode: Using a Rich History of Leadership to Shape the Future of RBF[1] /

Dr Ruth Labode stands at the intersection of the past and the future in healthcare. In spite of having a rich background in influencing Zimbabwe's health policy, she won't rest on her laurels until more doors open for the meaningful participation of women in the health sector and until women's health improves.

MAKING HISTORY

Having graduated as a medical doctor in 1984 Dr Labode made history when she became Zimbabwe's first female provincial medical director (PMD).

Her working life began at Mpilo Central Hospital where she undertook her pre-qualification, after which she moved to Kadoma General Hospital before successfully becoming the superintendent for the United Bulawayo Hospital. She held this position until taking on a role with Bulawayo's City Council where she remained until 1992 when the government appointed her as the first woman PMD.

From there, as they say, the rest is history. She later served as the board chair for Mpilo Hospital before becoming a Member of Parliament under the women's quota, a befitting tribute to her unparalleled contribution to her country. In recognition of her role in the health sector she has

1 This article was prepared during the 2013-2018 parliamentary tenure when Dr Labode was a Member of Parliament and Chair of the Portfolio Committee on Health and Child Care.

also been serving in the Parliamentary Portfoliio Committee on Health and Child Care.

TENURE AS POLICYMAKER AND PORTFOLIO COMMITTEE CHAIR

When Dr Labode stopped being a medical doctor she thought she was retiring to rest. As fate would have it she was in fact marking a new beginning as a policy maker who has remained steadfast in her determination to finish what she started as a PMD.

'I have grown to realise that my role as a policymaker is simply a continuation of what I started as a medical practitioner. When I was appointed PMD, my core business then was maternal mortality and children's rights,' recollects Dr Labode. 'While I played my role in that capacity, a lot remained to be done and my current role allows me to finish what I started,' she says.

In a country where people still need to restore faith in their elected leaders, Dr Labode explains the role she and her colleagues play in driving the national health agenda. 'The mandate of MPs is to develop laws which the portfolio committee follows up on. As an MP, you meet the community and play an advocacy role at all levels through inputs of the constituencies you represent,' she says.

'I have been an advocate pushing for free maternal health care. I have also advocated for the reduction in the cost of blood used for blood transfusions so that institutions can afford to buy their own blood. As the chair of the health portfolio, I have also managed to get the Public Health Act reviewed, which was last reviewed in 1974. This review process empowered health personnel, especially nurses and doctors, to speak out with their issues. We also advocated for sexual reproductive health and rights, including comprehensive sexuality education for adolescents.'

Dr Labode's role in championing women's health doesn't end there. She has also been an advocate for safe abortion and notes that many girls are forced into unsafe abortions after being denied access to contraceptives and family planning services. She is also working towards the repeal of the law criminalising the transmission of HIV. 'This law is unfairly affecting women because in most cases women are the first in a relationship to know about being HIV positive and so end up being accused of bringing the virus into relationships.'

VIEWS ON WOMEN'S PARTICIPATION IN DECISION-MAKING WITHIN HEALTHCARE

For Dr Labode the involvement of women in the health sector is an imperative which is founded on fundamental human rights. 'It is women who get pregnant, women's hearts are softer, and as the Shona saying goes, 'musha mukadzi' –a home is because of a woman. Without women, children and families suffer. In our health services women constitute almost 90 per cent of the personnel and they disproportionately carry the burden of our daily life. Women are so crucial to the well being of our society yet we do not have enough women in important positions in the health sector. Women remain underrepresented as PMDs or as principal directors among other key positions in the Ministry of Health and Child Care. Where are they?' she asks.

In spite of the inequity Dr Labode remains solution-oriented. 'Mentorship can be conducted to improve the representation of women. Those who have excelled in public health should visit universities and show other women that they can still lead and be in positions of authority whilst also being a wife and mother,' she advises.

ABOVE:
Innovations are at the heart of delivering RBF in Zimbabwe. Women have been leading in designing the innovations and training of people

ABOVE:
Smilling patient at Rutope Clinic, Bindura District, Mashonaland Central

ON THE RBF AND WOMEN

In support of the RBF programme Dr Labode feels that 'it in itself it is there to protect women'. Looking at evidence she says that programme's results are a testimony that RBF is the best model for financing the health sector, particularly in rural clinics which are now well-stocked with essential medicines and whose workers are well motivated.

PERSPECTIVES ON THE FUTURE OF THE RBF

During her time as a PMD she remembers how the public health sector was served well by mobile clinics. 'Nurses would go and stay in remote parts of the country, some for days, to conduct follow-up maternal services. The biggest challenge today is the distances that women have to travel leaving many unable to access services.' For pregnant women, part of RBF's contribution has been to construct shelters for expectant mothers in health facilities ensuring that they don't need to travel long journeys at the onset of labour.

Several shelters have already been built, renovated or equipped since the introduction of the RBF programme. In the first edition of this publication we reported a marked decrease in maternal and newborn deaths owing to these shelters.

This aside, Dr Labode would like to see more local funding in the health sector with a focus on expanding access to services for marginalised and remote communities. To achieve this, she feels that RBF will need to start supporting mobile clinics –a tradition that is proven to work. This will be a stop-gap measure she says, as the government and its partners continue to support the construction of health facilities in marginalised rural areas.

2.2 What the doctor ordered: A female PMD tackles women's health and defies gender norms /

Since Dr Labode became Zimbabwe's first woman PMD (see 2.1.1) there has been no return for women working at high level in Zimbabwe's health sector.

Although still a long way towards achieving gender parity in decision-making, the world of PMDs has far improved since Dr Labode broke the glass ceiling. Today, two out of ten PMDs in the country are women, and while they wait for more women to join them, their performance in implementing the RBF programme is proving their critics wrong. We talked to Dr Mafaune, the PMD for the Manicaland province, about her personal journey and her secret to success. through the RBF under her leadership.

"I feel **WOMEN'S** participation is **IMPORTANT** yet we do not have enough women in the important positions in the health sector"
DR LABODE

AN INTERVIEW /

WITH DR PATRON MAFAUNE, PMD MANICALAND PROVINCE

ABOVE:
Patron Mafaune

Q: What role does a PMD play in the implementation of the RBF programme?

A: The PMD is responsible for translating government policy into action. With the government using the Results-Based Management (RBM) approach, the PMD provides oversight in the implementation of the RBF programme across various management functions including execution, coordination, planning, organisation, monitoring and evaluation, as well as the sharing of lessons learnt and best practices. The PMD also undertakes advocacy at provincial level, particularly with provincial heads and the provincial minister, among other stakeholders.

Q: What are some of your success stories of the RBF programme in Manicaland province?

A: As PMD I have worked with many stakeholders to ensure that we meet the targets of the RBF, especially in reproductive, maternal, newborn and child health (RMNCH). During my tenure and under the RBF programme the province of Manicaland has witnessed a decrease in maternal and perinatal deaths with the exception of 2017, which was an outlier year. We have seen facilities such as the Hauna clinic refurbish their maternity waiting homes and significantly reduce the referral of simple deliveries to Hauna District Hospital. Such initiatives have decongested the district hospital and improved efficiency in the health delivery system. We have also seen the Sakupwanya RHC build a maternity wing which accommodates a labour ward and antenatal and prenatal care

Q: In your view what are the pressing women's issues with regards to health and how is the RBF helping to address them?

A: The RBF programme focuses mainly on RMNCH, HIV, TB and some noncommunicable diseases (NCDs). These mainly affect women and children who are classified as vulnerable populations. Through RBF, financial access to such services has been addressed and by focusing on quality of care, client satisfaction has improved and health facilities are now more responsive to their clients' needs, especially with the issue of prompt care. This is reducing the opportunity cost for mothers. Women can now go about their daily lives with the comfort of knowing they can seek help when necessary. Now they are giving birth in clinics and thereby avoiding unnecessary deaths. As such, the health issues affecting our vulnerable populations are being addressed and the burden is being lifted.

However, there are still challenges among these successes. Cancer screening and treatment is only at secondary level and not at the entry level for health care. In addition, it is important to ensure that when a rural health centre refers a client to secondary level facilities, there is a follow-up as some patients may be lost without systematic care. Most importantly there is a great need for outreach programmes to cater for those in remote areas where facilities do not exist.

Q: Should Should we have more women in positions of power in order to address women's health concerns?

A: It's the way to go if we are to allow women to take action from their own experience and their empathy for fellow women. Women in leadership will add value to health systems as they bring with them their rich professional and personal experiences. To achieve this though, there is a need to nurture and mentor women and to prepare them for this role since many are raised to be submissive. Again, there is no better teacher than experience. Considering that many women have experienced the different layers of the health system, I believe they will make good leaders and decision makers

Q: What needs to change in the structure and process of the RBF programme if it is to fully address women's health issues?

A: Although the RBF programme is already doing well, the programme still needs to look at the demand side and reach out to remote pockets with services. I would also recommend that the Minister of Health and Child Care shares this innovation with other ministries in order to ensure that social determinants of health are addressed adequately. For improved population health, the health system can only do so much, it will take a cross-sector approach to ensure that full potential is realised. Education for example is crucial. As the saying goes, 'if you educate a woman, you have educated the whole nation'. The nation will be healthier if women are empowered through knowledge.

SAKUPWANYA RURAL HEALTH CENTRE /

A STORY OF RBF SUCCESS IN MANICALAND PROVINCE

SAKUPWANYA RURAL HEALTH CENTRE:
A STATISTICAL OVERVIEW, 2017

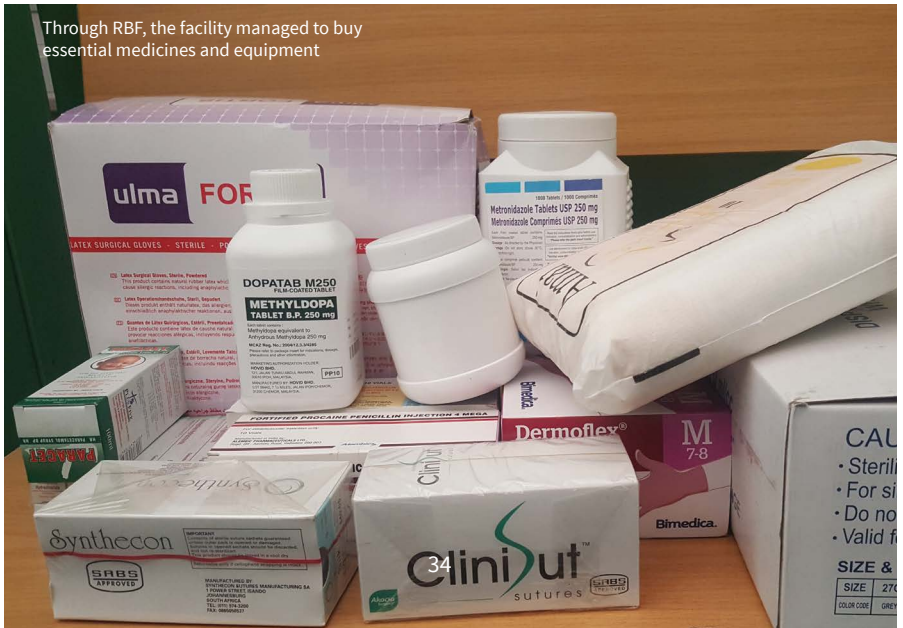
Catchment population	0, 1%	5213
Under 1	(3, 3%)	172
1-4 years	11, 8%	615
Under 5years	27, 2%	1 418
15years and over	57, 5%	2 997
15-29years	26, 99%	568
Women of Child Bearing Age 23	67%	234
Expected pregnant	8,8%	241
Expected births	33,4 / 1000	174
Females	52,6%	2 742
Males	47,4%	2 471

Through **RBF** staff incentives **Sakupwanya clinic** has been **renovated** and managed to procure **essential medicines**

SAKUPWANYA RHC: RBF SUCCESSES

Prior to receiving RBF's support the Sakupwanya clinic only had one wing from which they provided general outpatient services as well as immunisation, antenatal care, family planning, HIV counselling and testing, PMTCT, disease surveillance and growth monitoring. There was no privacy at the clinic and the 70's building was in a shambles – a leaking roof, hanging ceiling, broken windows and cracked walls were some of features of this facility which is intended to promote wellness. What's more it was badly equipped and lacked sufficient stocks of essential medicines. Today, though RBF subsidies and staff incentives, it's a very different story.

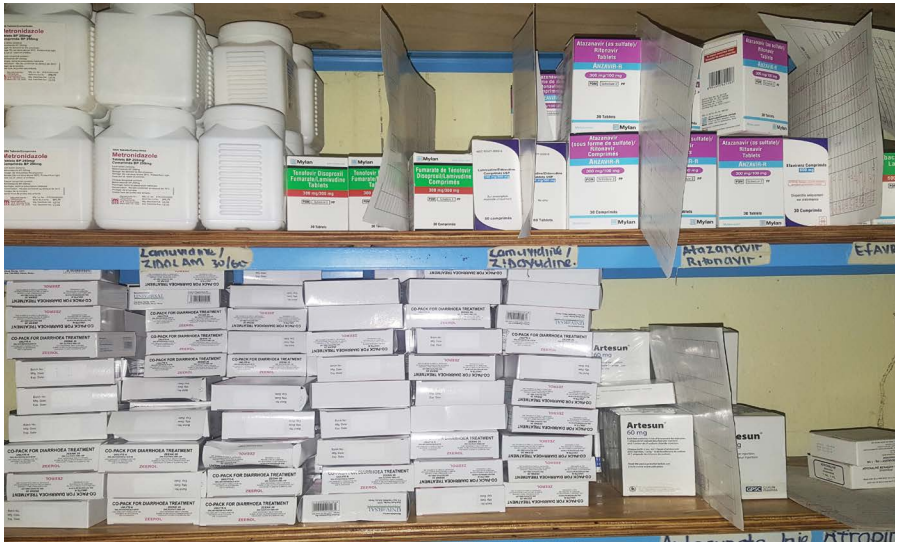
Among many other improvements, including repairs to the building's infrastructure, the facility has managed to procure essential medicines, linen and equipment.



Through RBF, the facility managed to buy essential medicines and equipment

Community Sensitization Improves Institutional Deliveries

Health Education including sensitization was done with the community, the HCC and the headman on the importance of institutional deliveries and dangers of home deliveries. The facility was able to identify TBA and gave them health education on the complications which might rise due to home deliveries like PPH, hypothermia, meconium aspiration leading to the loss of the mother and the baby. Now institutional deliveries have improved and in case of complicated cases during delivery, we have fuel coupons to refer these mothers to the hospital.



ABOVE:
The facility managed to assemble own PPH Kit and the eclampsia kit. The kits are replenished regularly.

IF YOU SET YOUR MIND ON IT,

YOU CAN ACHIEVE IT

ABOVE:
Sister Matimba: Matron at Bikita Rural Hospital

In spite of the many limitations to the pursuit of female leadership roles, few are greater than lack of self-belief. Having been raised by societies that still diminish women, many struggle to find the inspiration to aim high. For these women, Sister Matimba, the matron of Bikita rural hospital, has the following message: 'If you set your mind on it, you can achieve it!'

Here's what she had to say when she spoke to our editorial team:

What inspires your work?
I love the work that I do. What inspired me was a desire to change and improve the way hospitals operate. I wanted to give our hospital a 'feel-at-home' environment for our patients. I am also glad to say that the funds we have been receiving from RBF have been very motivating. For example, I often end up using my own car to carry out the hospital's immunization outreach programme whenever hospital vehicles are down.

To motivate staff I give them an extra day off for the hard work that they do during outreaches. It's heartwarming to see the community happy when we are doing these outreaches. We even take advantage of them to provide other services such as antenatal care, family planning, as well as male circumcision.

What has Bikita Rural Hospital achieved?
Before RBF we were operating under very difficult conditions. We did not have enough working space and we had no outpatient department or treatment room or consultation room. This has all changed since receiving RBF funds. We have also decorated the postnatal ward and the labour ward and have managed to erect an electronic hospital signpost.

Any parting words for women in the health sector?
My word of encouragement to other women is that you can achieve all that you want if you set your mind to it. I know this to be true based on my experience.

CHAPTER THREE /

RBF AND WOMEN: THE HUMAN FACE STORIES

3.1 Introduction /

So far in this periodical we have celebrated a range of women at various levels in the health system, each of whom play a seminal role in the RBF programme, and each of whom are motivated by their desire to help make the burden lighter for other women. In this chapter we speak to the patients who have benefitted from their work – the women who have needed life-saving services from our health system.

3.2 There is Life in Darkness: Apostolic Faith Mothers Seek Maternity Services at Night /

The Seke rural community is a hive of activity during the day with people defying the scorching sun as they go about their daily chores. Yet when the sun goes down, for many, the darkness can also invite fear.

Among the few exceptions punctuating this darkness are the small fires in the huts scattered across the plain with mothers busy making supper for their families before retiring to bed. The darkness is nature's decree that the day has ended and there can no more be activity outside the house. Superstitious children will rarely loiter outside for fear they might disturb the ghosts of their grandparents, though a handful of habitual drinkers, emboldened by their lost senses, might be heard singing as they stagger from their drinking holes after quenching their hot summer thirst with home-brews. But this is not a city, there are no evening pubs to gossip about the day or live shows to dance the night away.

Families will eat supper over stories of the day, huddled over a fire, while the cloudless nights allow the heat of the day to escape, as if to spite the locals who would have spent it complaining about the burning sun.

But not all families are going to sleep after the meal. Esther's family is braving the darkness to venture out. She is a mother of three and as soon as she puts the children to bed, she and her husband set out to visit the clinic for antenatal care. It's not a very long walk but a frightening one in darkness. It's a fear which, if unconquered, could mean the difference between life and death, as Esther well knows after two of her five previous pregnancies. Her apostolic faith does not allow her to use health facilities or to take medicines. On three occasions she managed to successfully give birth at home without any help, on the other two she was unlucky, though lucky enough to still have her own life.

When local health staff sensitised them to the risks of home births, she and her husband refused to relive the harrowing experiences of losing their children. But although they are seeking to access health services, they don't want to leave their church either –for them the apostolic tradition is more than just a faith, it is a social foundation to which they are

completely bound. For Esther and her husband it is welcome relief that the clinic's nurses will allow them to access services at night, without the prying eyes of their neighbours and fellow congregants.

Apostolic churches are known for their religious beliefs against seeking modern healthcare, but health professionals are increasingly finding innovative ways to attract these populations towards improving maternal and new born indicators in line with the RBF goals.

At Kunaka Rural Hospital in Seke the nurses have gone an extra mile to educate the women of the Johanne Masowe and Johanne Marange churches. There they opened a secret register offering family planning, antenatal services and immunisations. The women of these faiths know that they are welcome to access these services after hours to avoid discrimination by their communities, while the nurses treating them will often work longer hours to help save their lives and that of their children.

DID YOU KNOW?
Apostolic religious doctrines and socio-cultural norms continue to influence the behavior of apostolic women and female adolescents. Their doctrine inhibits women and young girls from using modern services, including sexual reproductive health services. As such, apostolic believers would be a prime beneficiary of targeted RMNCH communication strategies.

ABOVE:
Some apostolic faith believers in Zimbabwe do not believe in accessing services offered by hospitals

3.3 No more lives lost unnecessarily /

For all the desire we have to remain alive sometimes our fate is not in our own hands. What if the conditions for life weren't right? In spite of many expectant mothers successfully reaching health facilities, many still lose their lives if the facility is ill-equipped, as Pearson's story tragically illustrates.

PEARSON'S STORY: BRINGING BACK SMILES INTO THE COMMUNITY.

On 15th of May 2011 my sister gave birth to a bouncing baby boy at one of the public hospitals. However, what should have been a happy day for us turned into tragedy after she lost a lot of blood during labour and kept losing it for the next one and half days. She died from excessive bleeding.

My sister may have been neglected, as I recall some of the nursing staff may have been harsh on her at a time when she needed care.

Sadly, the cause of my sister's death is not something that should be killing women in labour or during child birth –if hospitals are fully equipped and health personnel are motivated and happy to do their job, many lives, including my sister's, could be saved.

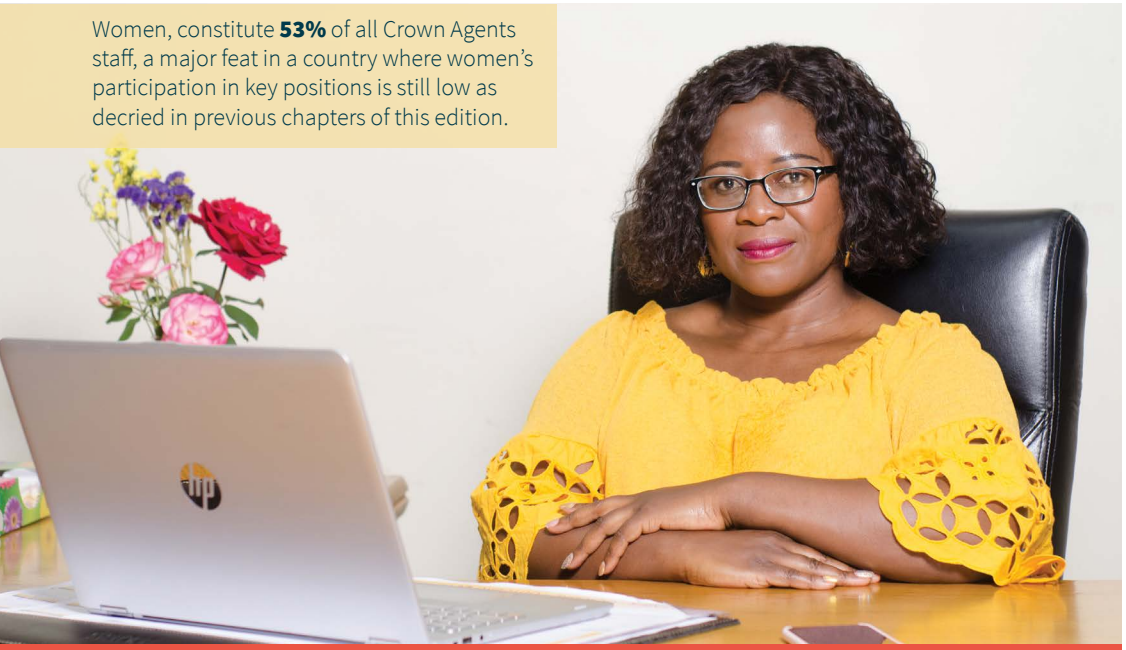
Although I am sad that my sister is no longer with us, I take heart in noticing that the same facility where she lost her life has improved and that essential medical supplies are always in stock while nurses appear to be motivated and happier.

I would like to thank MoHCC and Partners for the RBF programme which has contributed to the healthcare system. Many families will not needlessly lose their loved ones.

CHAPTER FOUR /

CROWN AGENTS EAGER TO DELIVER

Women, constitute **53%** of all Crown Agents staff, a major feat in a country where women's participation in key positions is still low as decried in previous chapters of this edition.



4.1 Introduction /

Over the years Crown Agents Zimbabwe has played a significant role in the management and implementation of the RBF programme. The women in Crown Agents Zimbabwe have also played a major role in its success owing to the female leadership team – the director Mrs Muchaneta Mwonzora and the RBF team leader, Marie-Jeanne Offosse.

Women constitute 53 percent of all Crown Agents Zimbabwe staff which is a major feat in a country where female participation in key positions is still far too low. Our contributor, Nakita De Barros, sat down with Mrs Mwonzora to explore the role women have played in advancing the RBF programme at Crown Agents.

4.2 Genesis: RBF and Women in Crown Agents Zimbabwe /

Mrs Mwonzora recalls the excitement she felt in April 2014 when asked to roll out RBF across 42 districts in Zimbabwe. 'This was an exciting proposition for us given the objective of reducing maternal and infant mortality. This spoke strongly to the grandmothers, mothers and young women in the organisation, many of whom have roots in rural areas and have grown up

understanding the challenges of accessing affordable health care. The programme would fulfill government policy to provide free primary health care and this energised and motivated us all. Each of us can recall a sad story about women and child birth, but here was an opportunity to write a happy ending.

At the beginning of the programme two incredible women stood out. They are Caroline Mubaira, Crown Agents Zimbabwe operation manager and the former scale-up manager, Bernadette Sobuthana, who both worked tirelessly to train health field and nursing staff on RBF. But within the development sector there were many other women who took up the baton in rolling out the programme. Among them were Cynthia Kamtengeni, UNICEF's project manager and Jane Muita, UNICEF's deputy country representative. Their efforts to keep the programme afloat and promote more understanding of RBF in the sector were reinforced by Wendy Banda at DFID and Joyce Mdlauzi at Irish Aid.

A special mention also goes to HDF-RBF Programme Coordinator Patricia Darikwa at UNICEF, who played a huge role in ensuring that reporting was done to requirements and that the RBF progress reports for the HDF Steering Committee were completed.

IN HER OWN WORDS UNICEF'S PATRICIA DARIKWA SHARES HER VIEWS ON RBF

Since the start of the programme my main role has been in advocacy. I have been there to listen to all sides, those for and as well as those hesitant about the programme, and to address their concerns. On the technical side I tried to tailor the implementation of the programme from the perspective of mothers and children as this was the entry point for the RBF in Zimbabwe. I had to be an advocate and an articulator, contributing to decision-making within the RBF programme. After the Health and Development Fund introduced RBF at clinic level, I continued to advocate for equity in access to health services so that in 2018 RBF was introduced at hospital level.

4.3 Women and the RBF Programme today and in the future /

By Muchaneta Mwonzora

Currently RBF has strong women at the helm with the team leader, Marie-Jeanne Offosse, a dedicated RBF health economist. She is also being assisted by deputy team leader, Caroline Mubaira, and her staff of which 16 members are women. This significant representation of women also extends to many partner institutions involved in RBF's implementation. Ensuring the smooth running of the programme and financial reporting in the MoHCC is Mrs H. Machamire, the finance director. Her leadership and grasp of the RBF mechanism has helped streamline the process of approving of RBF invoices, thereby making the system more efficient in line with MoHCC and Crown Agents procedures.

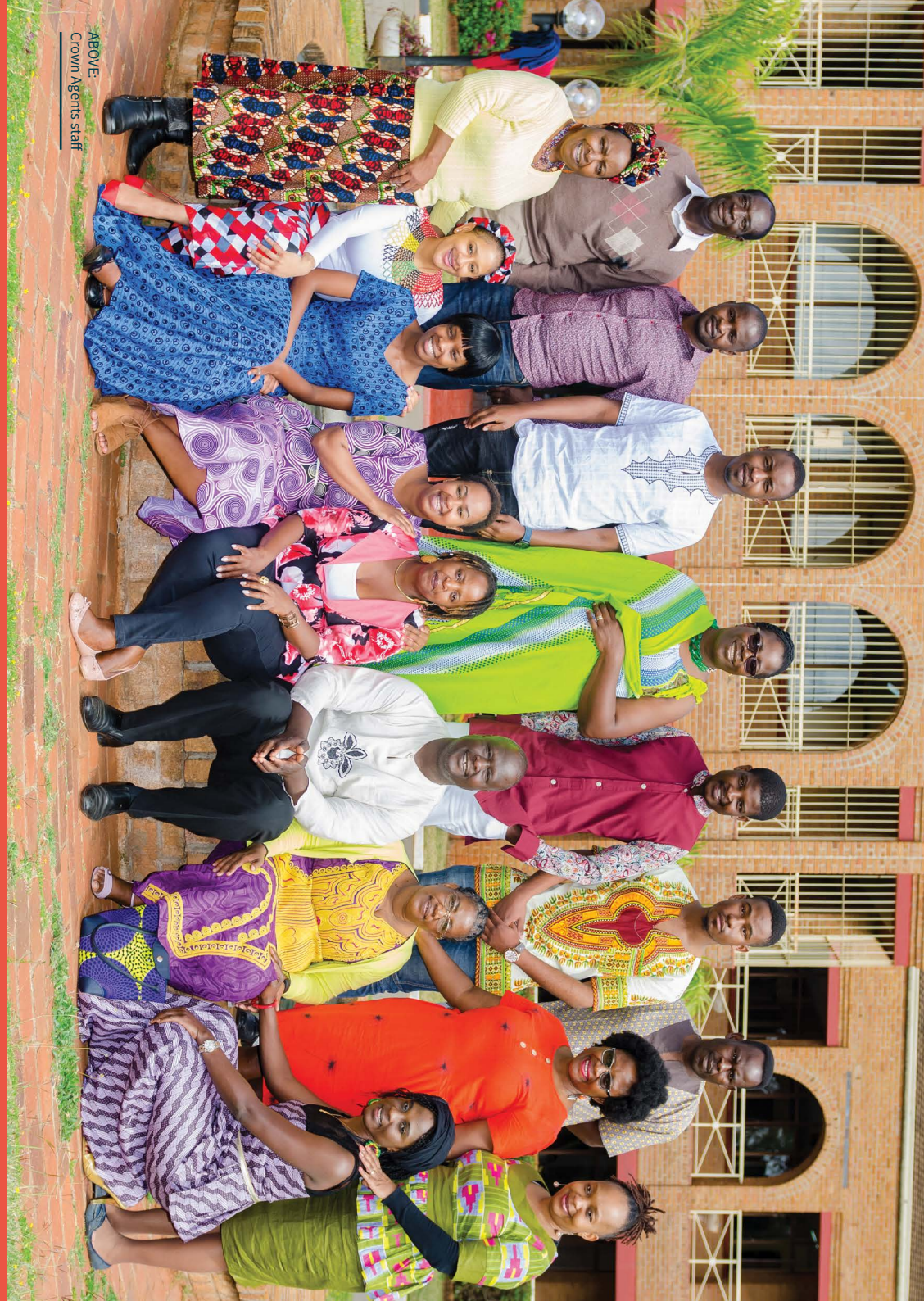
THE FUTURE OF THE RBF IN ZIMBABWE

When we began RBF I had been involved in the input-based financing model for health financing. At first I wondered why we did not just give facilities the money they needed. It was only after six months that my eyes were truly opened to the practical benefits of RBF on the ground. I witnessed huge strides in the improvement of data capture and reporting by health facilities and saw visible returns on investment of RBF funds. The facilities could account for funds which had been disbursed to them and they had results to show over a much shorter period than expected. The government, having embarked on Results Based Management (RBM), was eager to roll out RBF throughout the country as a way of institutionalising RBM. Like myself, at first the donors were a little hesitant since they were used to input-based financing. They didn't have a good understanding of the RBF programme and were unsure of what results would be obtained for women in Zimbabwe.

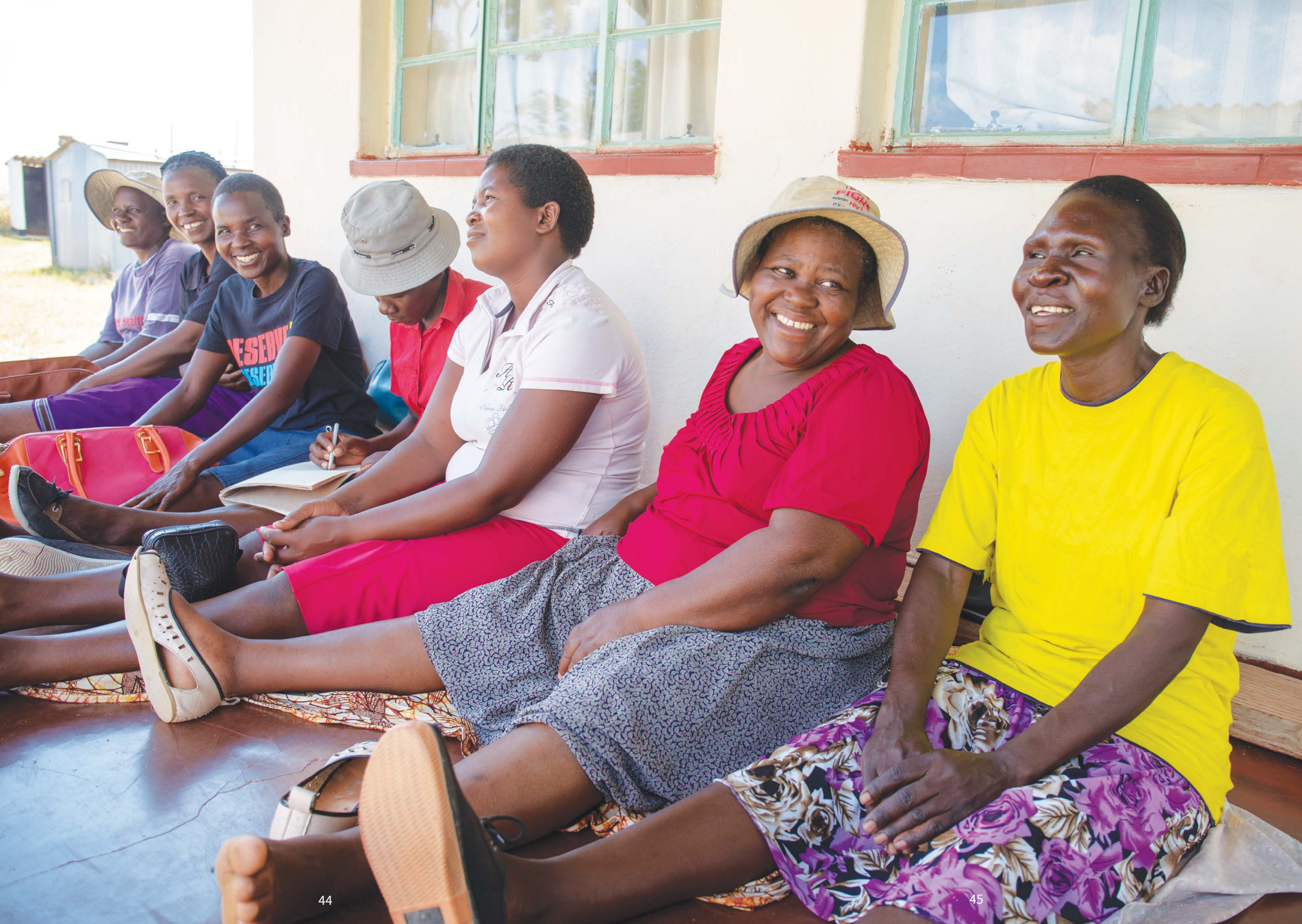
I am happy to report that RBF has successfully complimented mechanisms that MoHCC and its partners have put in place to reduce maternal and infant mortality. Community participation and ownership have been improved at all rural health facilities in Zimbabwe through the active participation of HCCs.

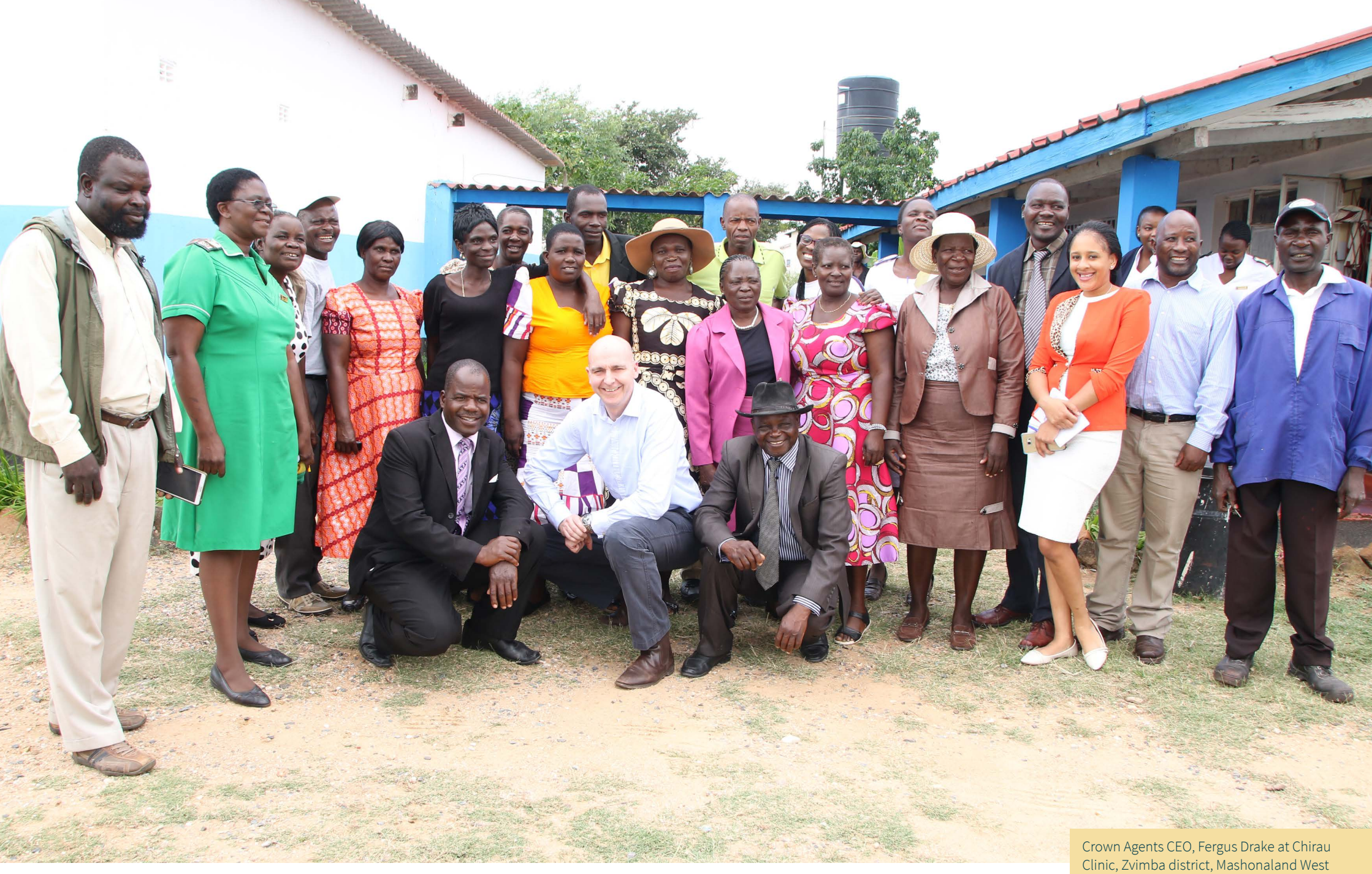
Going forward, several issues have emerged including the need to continuously reassess RBF indicators as some are very responsive to RBF mechanisms while others aren't. It is important to sustain what works, while continuously seeking ways to ensure that all other indicators work as well.

Finally, owing to the economic situation in Zimbabwe, there is an over reliance on RBF funds because government grants are minimal and inadequate to cover the running costs of the facilities. Resultantly RBF funds have become overstretched. These funds are being used to procure medicines and other products which means that any break in the RBF payment cycle will adversely affect health facilities and therefore the health of women.



ABOVE:
Crown Agents staff





Crown Agents CEO, Fergus Drake at Chirau Clinic, Zvimba district, Mashonaland West Province.

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