

## POLICY BRIEF

### GOVERNANCE: INSTITUTIONALIZATION OF RESULTS-BASED FINANCING IN ZIMBABWE

This brief discusses the evolution of RBF governance mechanisms that resulted in institutionalization of RBF in the Ministry of Health and Child Care and Government of Zimbabwe structures. The brief discusses the (i) evolution of governance institutional arrangements; (ii) implications of RBF governance institutionalization on pre-existing institutional arrangements, roles, and responsibilities at centralized and decentralized levels and stakeholder engagement; (iii) the challenges that were faced during the RBF governance institutionalization and strategies that were devised to overcome the challenges; and (iv) how RBF governance institutionalization can be further strengthened.

#### BACKGROUND

Results based financing (RBF) in Zimbabwe is a government-initiated approach focused on improving poor populations' access to health services, including reducing financial barriers, strengthening health services quality through improving health facility performance and management, and promoting results orientation, thus contributing to sustainability in health service provision. The present RBF program started in 2011 in two front-runner districts, was scaled up to 18 districts, and eventually to the remaining 42 rural districts. An urban component pilot was also introduced in 2014.

In response to identified challenges related to i) the limited role of the government in executing key RBF functions from national to district level (governance, fundholding, management, purchasing, and verification of services), ii) the accounting system that lay outside the Public Finance Management system, and iii) declining development partner funding, the Ministry of Health and Child Care (MOHCC) and the Ministry of Finance and Economic Development (MOFED) initiated the development of the Medium-Term Strategic Framework (MTF) in 2016-2020, which spelled out the institutional, technical, and financial set-up for the RBF program in Zimbabwe.

There was general consensus that the institutionalization of RBF would take time. According to the consultations, the transition period would take 2-5 years or longer. Critical path analysis guided the timing of activities and phasing of the program.

The participatory preparation of a phased plan took into account the following:

- i. As a first step, RBF knowledge and lessons learned were shared with MOFED and other key institutes like the Ministry of Public Service, Labor and Social Welfare, and the Ministry of Primary and Secondary Education.
- ii. Assessments and strengthening of essential support systems of RBF to reach a critical operational level were conducted. Capacity was built to sufficiently strengthen the M&E/Health Information System through use of information communication technologies (ICTs) thereby reducing the administrative

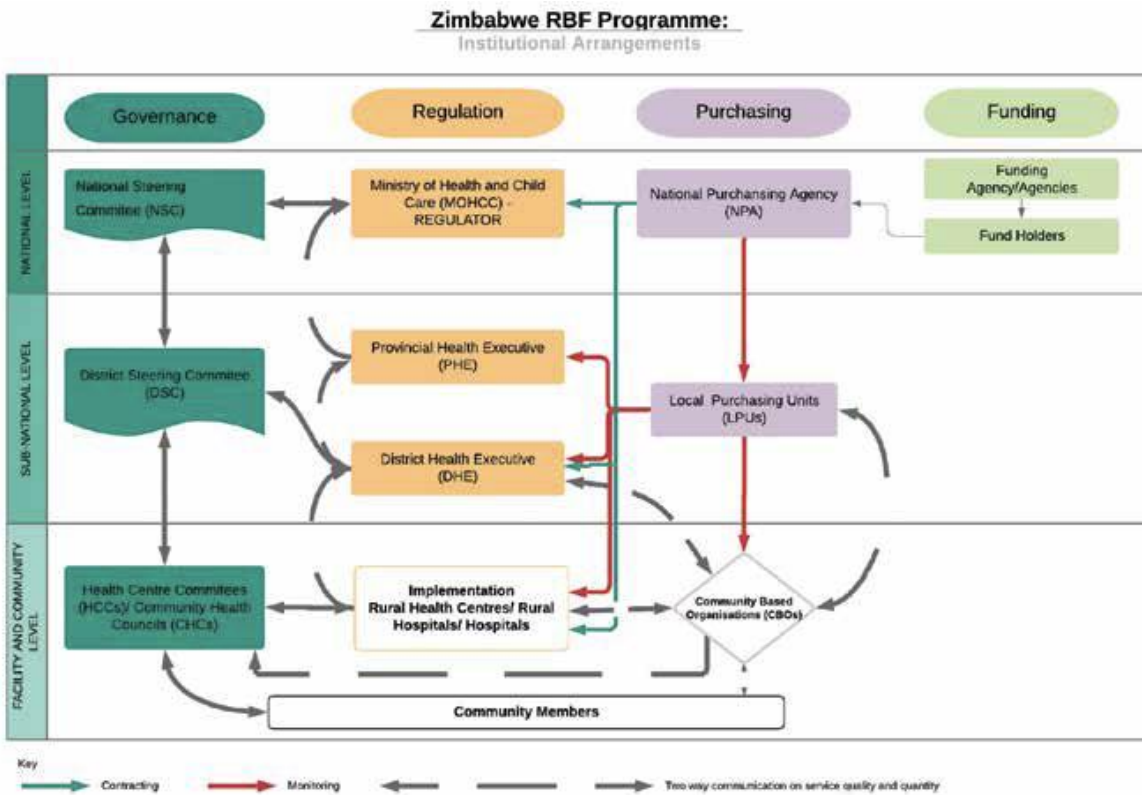
- burden at the health facility, improving the analytic capacity at district level-human resources, and strengthening the pharmaceutical supply chain capacity.
- iii. Based on assessments, capacity strengthening plans for the institutionalized RBF in the MOHCC Program Coordination Unit (PCU) and departments (HR, Finance, others), decentralized structures, verification entities, etc.) were conducted paying ample attention to the nature and capacities of decentralized structures. This approach builds on lessons from the national scale up in Rwanda which demonstrated a return to a more centralized management in the absence of such capacities at local level.
  - iv. The PCU was strengthened through creation of five posts for a Health Specialist, Data Analyst, District Health Information System 2 programmer, Data Manager, and Finance office who were all trained in RBF.

## **EVOLUTION OF RBF GOVERNANCE INSTITUTIONAL ARRANGEMENTS**

The governance structures for RBF evolved from existing GoZ governance structures in the MOHCC and MOFED. The MOHCC had initially resisted generic RBF for four years, arguing for full contextualization of the mechanism to Zimbabwe given that RBF had been implemented in countries whose health systems were not comparable. Zimbabwe adopted the Primary Health Care approach at independence in 1980, resulting in a decentralized health system with delegation of functions to provincial, district, and ward level as opposed to the autonomy advocated for by Results Based Financing. The Provincial Health Executive (PHE) chaired by the Provincial Medical Director (PMD) provides policy, technical, and administrative oversight to health districts that are managed by the District Medical Officers (DMOs) who chair the District Health Executive (DHE). Health Centers are managed by a Nurse-in-Charge with oversight from the Health Center Committee (HCC) comprising community members.

The MOHCC and partners are currently using the fourth RBF Program Implementation Manual (PIM) as evidence of the evolution, responsiveness, and adaptive nature of the RBF program in Zimbabwe. The updating and development of PIMs is solidly anchored on evidence generated within the program and inputs from the governance structures of the MOHCC/MOFED/RBF program. Institutional arrangements are structured to uphold the principle of the separation of functions between the National Steering Committee and District Steering Committees (stewardship and oversight), service provider (health facilities), purchaser Programme Coordination Unit (PCU) and Crown Agents (CA), regulator (MOHCC-Head Office, PHE and DHE), verifiers (community nurses) , and counter-verifier (initially the University of Zimbabwe Department of Community Medicine and now the Health Professions Authority). This set up increases checks and balances, reduces corruption, creates more integrated management systems, improves quality control, and increases transparency.

**Figure 1.** Results Based Financing Governance structures in MOHCC



Source: National Results Based Financing Program Implementation Manual Revised December 2019

## 1. The Multi-level Steering Committees:

**1.1. The stewardship and oversight role for RBF is the responsibility of the National Steering Committee (NSC) since the inception of RBF.** The RBF National Steering Committee (NSC) was appointed by the MOHCC to oversee planning and implementation and to ensure good governance of RBF in Zimbabwe. The Permanent Secretary constituted the NSC by purposefully selecting important stakeholders in consultation with other GoZ ministries, civil society, and health development partners. The NSC includes relevant representatives of the MOHCC and other line ministries, Provincial Medical Directors, National Purchasing Agencies (NPAs), and national and international donors and NGOs, as well as Civil Society Organizations (CSOs). The RBF NSC is chaired by either the Chief Director Preventive Services or the Chief Director Policy Planning Performance Monitoring and Evaluation. The NSC consists of 31 members in accordance with the terms of reference provided by the MOHCC/MOFED and meets quarterly. The committee reports to the MOHCC Permanent Secretary. The RBF National Steering Committee makes its decisions based on the technical work conducted by Technical Working Groups that are formed to address technical issues per rising need. For the Urban Voucher Scheme, there is a specific Voucher Management Team (VMT) with specific terms of reference that provides technical advice to the NSC. The RBF National

Steering Committee shares its decisions and recommendations with the Health Development Fund partners for consensus. The NSC has been strong and effective since the beginning of RBF. Responsibilities of the NSC include ensuring the overall coordination of all stakeholders, the validation of budgets, management of conflicts, and supporting the National RBF PCU in its advocacy for the RBF initiatives. The Community Working Group on Health (CWGH) is part of the NSC and is a powerful organization widely representative of community members at grassroots level and ensures that the voice of the community is heard. The resuscitation of HCCs is significantly credited to the pressure and leadership from CWGH.

**1.2 The District Steering Committee (DSC) is a multi-stakeholder oversight and advisory structure for a given RBF district.** The DSC falls under the existing GOZ structure and consists of an equally balanced number of government ministry and department officials and community members. The PHE and the DHE together steer the process of constituting DSCs. The DSC is part of the Social Services Committee and reports to the District Development Committee (DDC). Communication and information flow up through to Provincial Development Committee (PDC) and the NSC so that decentralized actions harmonize with overall national strategy. The DSC is constituted by selected members of the Social Services Committee, Community Health Council, Health Centre Committees (maximum of two HCCs- on rotational basis), District Health Executive (maximum of two DHEs), an NGO working on relevant public health issues, a representative of church hospitals, a representative from Ministry of Local Government, other members as decided jointly by DHE and NPA. The District Steering Committee decides on a chairman by voting, but the DMO was the chair in the first phase. Members of the committee who are not be able to participate in a scheduled Steering Committee meeting inform the Chair and Secretary about their absence and nominate a representative to stand in for them. Members or officially designated alternate members are not be allowed to miss two Steering Committee meetings.

The DSC is yet to play a much stronger stewardship role when the selection and pricing of RBF indicators for health facilities at the district level will become a management instrument for the DSC in collaboration with the DHE and PHE. Findings from the RBF MTF 2016 -2020 showed that before the DSC could assume this role, there was need to build DSC technical capacity and to review and change the composition of the committees. As strategic purchasing is broadened in view of the varied disease burden, DSCs shall be at the center of recommending indicators that speak to their unique settings. It has also begun to provide better aligned support to HCCs and works with DHEs to resolve RBF related conflicts at district level. The DSC-DHE-PHE linkage is providing a channel for community feedback to filter to the local government authorities.

**1.3 The Health Centre Committees (HCCs) are the governance structures for Health Centers and have been in existence since Independence in 1980.** Initially HCCs were established as committees that were part of the Ward Development Committees (WADCs) but were recently made a statutory requirement in the revised Public Health Act that was passed in parliament in 2018. These HCCs are constituted by a Chairman, Treasurer, and two committee members from the community and the Nurse-in-Charge and the Environmental Health Technician working at the HC who are ex-officio or non-voting members. The majority of HCCs were neither in place, nor functional when RBF was introduced in 2011. The 2013 PIM had a strong NSC and DSC and weak to non-existent HCCs. Governance was weakest at health facility level. Presence of a

functional HCC at a health center was a pre-requisite for a Health Centre to be eligible for RBF hence these HCCs were revived.

The broader responsibilities of the HCC are outlined in the Public Health Act and have been enhanced for the purposes of RBF.

The PIM 2017 replaced the RBF National Management Team (NMT) with the MOHCC PCU. The NMT had been originally envisaged as a means of providing management oversight bringing together the three government ministries involved in RBF namely MOHCC, MOFED, and MOPLSW. The NMT was meant to ensure continued alignment of implementation of RBF to government policy. However, there was some confusion as some within government considered the NMT as the precursor to the institutionalized implementing entity which became the PCU. There is need for clarity on the separation of roles and functions of the PCU and the Policy and Planning Directorate to date.

The PIM also introduced the University of Zimbabwe for counter verifying the performance verified by DHEs and PHEs. The HCCs were strengthened through this PIM by making sure that all RBF facilities had HCCs that were trained on RBF and functional. However, the functionality and effectiveness of the HCCs has not been without question or controversies because of conflict of interests in a very polarized socio-political context and this will be elaborated on in sections below.

#### **1.4 CBOs/NGOs are contracted to collect feedback from communities through client satisfaction surveys and exit interviews as a means of strengthening governance, transparency, and accountability.**

RBF requires household level verification of the extent that subsidized services take place and to assess client satisfaction and perceived quality of care. This information is shared with the health facility and the community through the HCC. Participating CBOs/NGOs should be registered through the Department of Social Welfare and working within the catchment area of the health facility.

CBOs/NGOs have the following roles and responsibilities:

- Receive a sampled list of patients from the Community Sister.
- Validate the existence of the patient and cross check whether the patient was satisfied with the services using a standard checklist.

The CBO/NGO received training to undertake the above tasks. The feedback loop from CBOs to DSC and DHE remains weak as evidenced by recurrent findings by CBOs in majority of cases that remain unaddressed. While issues of bad staff attitudes have been addressed to the satisfaction of communities, an example of an issue that remains unaddressed is removal of users' fees in Rural District Council and Mission facilities where these fees are used to pay for security guards etc. Communities became drivers of the RBF agenda through their involvement at HCC level. Structural and institutional changes required to address some of the feedback however lagged due to lack of a clear feedback loop to the DHE. The latest PIM version has addressed this issue by putting in a requirement for each CBO result to be shared with the DHE

for monitoring changes and for addressing higher level issues. The results from these changes are yet to be documented.

## REGULATION AND TECHNICAL STANDARDS

In terms of regulating the health sector, several institutions and laws exist that regulate the provision of health services in Zimbabwe. The overarching law is the Public Health Act that defines the regulatory bodies and their functions and the Health Services Act that regulates the recruitment, retention, promotion, retirement, disciplinary and firing measures. Because of these laws, Health Facilities do not have the autonomy to hire and fire staff.

## COMMUNITY OWNERSHIP AND FEEDBACK MECHANISMS

The functionality and effectiveness of HCCs has been experiencing some challenges varying from attrition to conflict of interest among members. The current RBF implementation resulting in the MOHCC and MOFED allowing primary care health centers to open sub-bank accounts to district hospital accounts, develop their operational plans and budgets, procure commodities, and use the indices tools for paying personal incentives, provisions that are not permissible according to the Public Finance Management Act (PFMA). The decision to allow this to happen was facilitated by the deep understanding of the benefits of RBF by MOHCC and MOFED leadership and the championing of RBF by implementers. The HCCs however operate on a semi-autonomous basis in the sense that their plans, budgets, and procurement processes are subject to approval by the DHEs and PHEs, and they cannot hire and fire staff as they see fit. The capacity and composition of HCCs requires evaluation and review to enhance their contribution to community and health facility including mandatory training for new members and regular on-the-job refresher training for members.

## EXTERNAL VERIFICATION: FROM THE UNIVERSITY OF ZIMBABWE (UZ) TO THE HEALTH PROFESSIONS AUTHORITY (HPA)

**The counter verifier is an agency that provides an independent verification of all services provided and paid for under RBF.** Initially the counter verifier was the University of Zimbabwe and institutionalization discussions in 2015 suggested the Health Profession Authority (HPA), the National AIDS Council (NAC) and the Health Services Board (HSB) as potential counter verifiers within MOHCC governance structures. In the Mid-Term Framework, the Health Professions Authority (HPA) was identified as a suitable fit for this purpose in view of its strategic position and function as a regulator for Health in Zimbabwe and its independence. CORDAID contracted the UZ to carry out an assessment of the HPA to identify its capacity and capacity needs. The outcome defined the gaps that HPA has, which covered areas of training in both RBF and counter-verification. The HPA has received, within its councils and its members, the skill-set necessary to carry out the counter-verification. As part of the RBF institutionalization process, the HPA was delegated by the MOHCC to take over counter Verification and have conducted one round of counter-verification in 18 districts thus far. They will scale up to the 60 RBF districts once they prove proficiency. The technical role of counter-verification

is aligned to the mandate of HPA of inspecting and accrediting Health Facilities. The HPA draws from a large pool of health professionals and will be able to constitute multiple teams that can cover the country. Mainstreaming the functions presents a natural fit in view of regulatory mandate of HPA and its councils.

## **IMPLICATIONS OF RBF GOVERNANCE INSTITUTIONAL ARRANGEMENTS ON THE TRADITIONAL GOVERNMENT OF ZIMBABWE GOVERNANCE STRUCTURES**

**The governance structures in the MOHCC are defined in the Public Health Act, a law that guides all operations of the public health sector. The RBF governance institutional arrangements did not pose a major threat to the governance status quo because they were spawned out of existing structures within MOHCC.** However, these governance structures remain vulnerable to changes in view of the anticipated devolution and formation of Provincial Health Councils and District Health Councils.

The Government of Zimbabwe adopted Integrated Results Based Management (IRBM) in 2005 but did not have resources to implement the concept effectively. Results Based Financing presented a resourced opportunity to operationalize IRBM. A Mid-Term Framework for the Institutionalization of RBF was developed in a participatory approach in 2016, to guide the process. Key Informant Interviews were conducted with important stakeholders and their views guided the selection or re-purposing of governance structures to align to RBF functions. The transparent process of RBF governance institutionalization removed any anxieties and fears associated with such changes especially in government bureaucracies. The most important players, namely Sisters-In-Charge of health centers/HCCs, District Medical Officers (DMOs)/DHEs, PMDs/PHEs and PS office were highly in favor of institutionalization of RBF governance such that the process was not difficult in MOHCC even though RBF was still under criticism by other development partners at that point. The RBF National Steering Committee did not pose any threats to the then Health Transition Fund (HTF) as evidenced by representation of the then HTF and now Health Development Fund (HDF)<sup>1</sup> in the NSC. The DSC incorporated members from existing management and governance structures in MOHCC and Ministry of Local Government. Health Center Committees whose existence is a statutory requirement were revived.

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<sup>1</sup> The Health Transition Fund (HTF) was a basket of donor funds from the EU, Irish Aid, DFID, and Swedish Embassy managed by UNICEF from 2009 to 2013 when it was re-named to the Health Development Fund (HDF). The HDF pays RBF subsidies to 42 districts in Zimbabwe.

## CHALLENGES WITH RBF GOVERNANCE INSTITUTIONALIZATION AND STRATEGIC INTERVENTIONS

**There were challenges with effectiveness of the RBF National Management Team in managing the RBF program** within the MOHCC at head office. At the initial scale up of RBF in 2012, an RBF National Management Team was set up that was responsible for overall monitoring of RBF implementation. It was led by a team composed of staff from the Donor Coordination Unit and the Family Health Department due to RBF's focus toward maternal and child health at that time. When the Mid-Term Framework for the Institutionalization of RBF was developed in 2016, it was one of the structures considered for possible establishment of a purchasing unit within the MOHCC together with the PCU. Eventually the PCU was considered as the best fit for assuming purchasing function due to its independent structure and institutional capacity as it already handled funds from the Global Fund. This was resolved by the appointment of the PCU to overall manage the RBF program with sub-national PCUs providing technical support to DSC, PHEs, and DHEs.

**There were challenges with the technical capacity of the DSC and conflicts of interest of members.** Re-selection of members based on the level of i) technical merit rather than political engagement and on ii) community representation was suggested in the MTF 2016-2020. The DSC now reports to the District Development Committee (DDC) that has a wider representation and salient issues that are crosscutting may be brought to the attention of the DDC. The feedback loop from the CBOs to the DSC and DHEs remains weak as evidenced by the majority of recurrent issues that remain unaddressed.

**There were challenges in the regulatory function of the PHE which included:**

- According to RBM principles, the PMD is mandated to conduct quarterly personnel performance appraisals for all District Medical Officers and Provincial Health Executive Members. However, due to lack of resources and objective performance data, this responsibility currently remains a ritualistic exercise done once at the end of the year without objectivity. Nonetheless, there was a general consensus that RBF was/is a vehicle for operationalization of RBM going forward. The current NHS 2021-2025 that is yet to be launched has a robust Monitoring and Evaluation Framework with indicators that will be used for personnel performance appraisals.
- Although the PHE does not directly provide services, they belong to the same institution as the institutions that they regulate, and this was viewed as a potential source of conflict of interest according to the principles of RBF of separation of functions. However, from the evaluations that have been done, there is no evidence to substantiate that, and this arrangement has continued in the scale up of RBF.
- Another challenge was the capacity of the some PHEs in public health and program management. This challenge has mainly been addressed by having PHE members with a Public Health qualification, although program management remains a challenge in some PHEs. There have been training programs for PHE members in management, but there is need for refresher courses and a training program for new members joining the PHE.



There has also been conflict associated with the influence of interests in vertical disease control programs that constrain integrated support and supervision and strict criteria on the composition of the PHE that performs quality supportive supervision have resolved the issue to a certain extent and this should be maintained.

**There were challenges in the regulatory function of the DHE which included:**

- *Weak capacity of some DHEs in public health and program management.* This challenge has been mainly addressed by training programs for DHEs, but there is need for refresher courses and resuscitation of training programs in management in public institutions for new members before deployment.
- *Conflict associated with the influence of interests in vertical disease control programs that constrain integrated support and supervision are constrained due to the influence of conflicting interests in vertical disease control programs.* To a certain extent this has been mitigated by introducing strict criteria on the composition of the DHE that performs the quality supportive supervision.

**STRENGTHENING RBF GOVERNANCE INSTITUTIONALIZATION-DEFRAGMENTING AND STRENGTHENING TECHNICAL CAPACITY ACROSS ENTITIES**

The recommendations for strengthening RBF governance institutionalized are outlined below according to those that can be implemented in the short term (-year) medium term (1-3years) and long term (3-5years).

**Short term recommendations**

- Ensure that the NHS 2021-2025 Monitoring and Evaluation plan under development has an integrated HRH performance appraisal system that is feasible.
- Ensure that feedback from CBOs is discussed in the DSC and NSC meetings as an agenda item and DHEs and PHEs follow up with actions to resolve issues raised - a tracking register/tool can be developed for this.
- Strengthen technical capacity of HCCs in RBF and management of health facilities - a training calendar for new training and refresher courses can be developed for this.

**Medium Term Recommendations**

- Capacitate the PCU to manage larger pools of funds.
- Capacitate DSC to play a more technical role in RBF e.g., analysis of epidemiological profiles and indicator selection.

**Long Term Recommendations**

- Improve efficiency by having a single fundholder for RBF- moving away from Ministry of Health and Child Care (holds MOFED funds), UNICEF (holds funds for the Health Development Fund) and Cordaid (holds funds for the World Bank) as separate fundholders. This could initially be a virtual fund until Zimbabwe settles its obligations with the World Bank.

- Improve efficiency by having a single purchaser-work on the Zimbabwe National Health Insurance should include RBF as a mechanism for strategic purchasing as outlined in the National Health Financing Strategy and Policy.