ZIMBABWE

# NATIONAL RESULTS BASED FINANCING PROGRAMME

## Programme Implementation Manual

**REVISED December 2019**

The Ministry of Health and Child Care

The Ministry of Health and Child Care


# National Results Based Financing Programme: Programme Implementation Manual

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## 1. Foreword

I am pleased to introduce Zimbabwe's fourth Results Based Financing (RBF) Program Implementation Manual (PIM). This version comes at a time when the Government of Zimbabwe is strengthening its Results Based Management (RBM) through the Whole of Government Program Management. The Ministry of Health an Child Care (MoHCC) is implementing and leading the Institutionalization of Results Based Financing road map. This manual was developed by the MoHCC through its RBF National Steering Committee (NSC) and its Working Groups, building on lessons that have been learnt since the inception of RBF and with sustainability and adaptation to government systems in mind. It reflects the Ministry's aspirations to connect local best practices to well grounded theoretical frameworks on performance based approaches to financing for health.

While acknowledging the challenges that the health system faces in delivering its mandate, the PIM provides a pathway for improved domestic financing for health and a sustainability framework for RBF. It is envisaged that this document will guide the MoHCC, its donors and implementing partners in improving the health system while achieving results for the most vulnerable members of society.

**Air Commodore (Dr) J Chimedza**
Permanent Secretary for Heath and Child Care

## 2.Contents

## 2. Acknowledgements

The development of Zimbabwe's Results Based Financing Programme Implementation Manual was successfully conducted due to the commitment, cooperation and collaboration of several actors and stakeholders. I would like to mention especially the World Bank, HDF, UNICEF, CORDAID and CROWN AGENTS who provided financial, technical and logistics support for the revision of the manual.

Much appreciation goes to the PIM technical working group, led by the Policy and Planning directorate from the MOHCC Head Office who ensured that all key stakeholders were consulted and involved in this process. The RBF National Steering Committee, chaired by the Chief Director, Preventive Division, Dr G Mhlanga reviewed and approved all key processes and steps during this revision. The various directorates including desease programme directors for Epidemiology and Disease Control (EDC), Family and Child Health (FCH), AIDS and TB (ATP) provided key inputs especially for the revision of indicators. The directorates of finance and administration (DFA) , Human Resources and Policy guided the team in formulating the Management Indicators for Provincial Health Executives (PHEs) and District Health Executives (DHEs)

Appreciation is send to the PHEs and DHEs from Manicaland, Mashonaland East, Midlands, Mat south and Mat North provided key insights into the management indicators and sub-national institutional arrangements. District Steering Committees (DSCs) and Health Centre Committees (HCC) from selected districts and primary health facilities in the same provinces provided key insights in the stricture and function of those entities.

The enthusiasm and active participation, views and contribution of other Ministries especially the Ministry of Public Labor and Social Welfare, Local Government was critical in highlighting the importance of the multi-sectoral approach that makes RBF successful. Last but not least the consultant and his team for facilitating the development of the PIM.

**Dr G Mhlanga**
RBF National Steering Committee Chairperson.

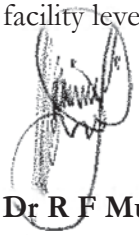
## 3.Preface

The PIM is revised bi-annually when the need arises in order to make changes based on the lessons learnt and new International and National developments. This is done under the leadership and guidance of the National Steering Committee. Accordingly, the first PIM i.e., 2011/2012 version was revised in 2013/2014. During this revision process, the indicators were not changed; rather the price of some of the indicators, notably those related to Family Planning (FP) services were decreased. This was due to the decline in the available envelope for RBF. A second revision was initiated in 2016 and finalized in 2017 to align the RBF program with the changes in the new National Health Strategy 2016-2020, which gives more emphasis to quality than quantity. In the current revised PIM 2017 version, indicators related to HIV and AIDS, TB, Malaria and NCDs were included, in addition to Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition (RMNCAHN) indicators. This is in line with the MoHCC plan to expand the program to include other priority focus areas as part of RBF institutionalization.

The revised PIM has been in use as of Quarter 2, 2017 in the 18 PCU/Cordaid districts and Quarter 1, 2018 in the 42 Crown Agents supported districts. Preliminary findings, based on analysis from the 18 PCU/Cordaid supported districts, have shown that the gap in the earnings between low volume and high volume clinics and hospitals is narrowing and low volume facilities' earnings are steadily increasing while earnings of high volume clinics and hospitals have shown a relatively significant decline. It was also observed that for the first time hospitals in the 42 Crown Agents supported districts have also started to benefit from the RBF program. This was made possible by the restructured pricing for the RBF envelope which made it possible for the HDF to allocate resources for RBF in the hospitals found in the 42 HDF supported districts. It was, however, noted that due to the overall decline in the subsidy earnings of high volume facilities, the staff incentives reaching the pocket of each health care worker have become almost negligible especially at high volume hospitals.

This Programme Implementation Manual (PIM) describes the key features of the RBF programme and presents the basket of priority indicators recommended for RBF implementation by GOZ and its partners. This basket has been expanded to include indicators related to HIV and AIDS, TB, and Malaria, in addition to Reproductive, Maternal, Neonatal, Child, and Adolescent Health and Nutrition (RMNCAHN) indicators. The PIM is reviewed biannually and as needed. It also describes how the RBF programme is supposed to be implemented unformly in Zimbabwe including all processes, systems, and monitoring mechanisms.

This is the fourth PIM revision and was necessitated by the need to align RBF implementation guidance with the GOZ's Institutionalization drive. Additionally a number of the indicators were either obsolete or no longer aligned to the MOHCC, performance monitoring plan and evolving disease burden. This PIM verson also reflects the increased and evolving responsibility matrix for RBF management from national to facility level. Every implementer of RBF is required to use this document as a guide.



**Dr R F Mudyiradima**
Chief Director Policy Planing and M&E

## 4. Acronyms

CA ..... Crown Agents
CBO ..... Community-Based Organisation
CDPPME..... Chief Director Policy, Planning and Monitoring and Evaluation
CMAM ..... Community Management of Acute Malnutrition
CORDAID..... Catholic Organization for Relief and Development Aid
CSO ..... Civil Society Organisation
DDC ..... District Development Committee
CHN ..... Community Health Nurse
CQI ..... Continuous Quality Improvement
DFCH..... Director of Family and Child Health
DH ..... District Hospital
DHE..... District Health Executive
DHIS ..... District Health Information System
DIPA ..... District Integrated Performance Agreements
DMO ..... District Medical Officer
EMA ..... Environmental Management Authority
EMNOC..... Emergency Obstetric and Newborn Care
GFATM ..... Global Fund to Fight AIDS, Tuberculosis and Malaria
HCWMP..... Health care Waste Management Plan
HCC..... Health Centre Committee
HDF..... Health Development Fund
HF ..... Health Facility
HFO..... Health Field Officer
HFP..... Health Financing Policy
HQ..... Head Quarters
HIMS..... Health Information Management System
HTF..... Health Transition Fund
HPA..... Health Professions Authority
IRBM..... Integrated Results Based Management
LPU ..... Local Purchasing Unit
M&E ..... Monitoring & Evaluation
MDG ..... Millennium Development goals
MSC ..... Most Significant Change
MICS..... Multiple Indicator Cluster Survey
MNCH ..... Maternal Neonatal and Child Health
MOFED..... Ministry of Finance and Economic Development
MOHCC ..... Ministry of Health and Child Care
MOU..... Memorandum of Understanding
MOLGPWNH ..... Ministry of Local Government, Public Works and National Housing
NATPHARM..... National Pharmaceutical Company of Zimbabwe
NGO..... Non-Governmental Organisation
NPA..... National Purchasing Agency
NSC ..... National Steering Committee
NIC ..... Nurse in Charge
OOPE ..... Out–of–Pocket Expenditure
OVC ..... Orphans and Vulnerable Children

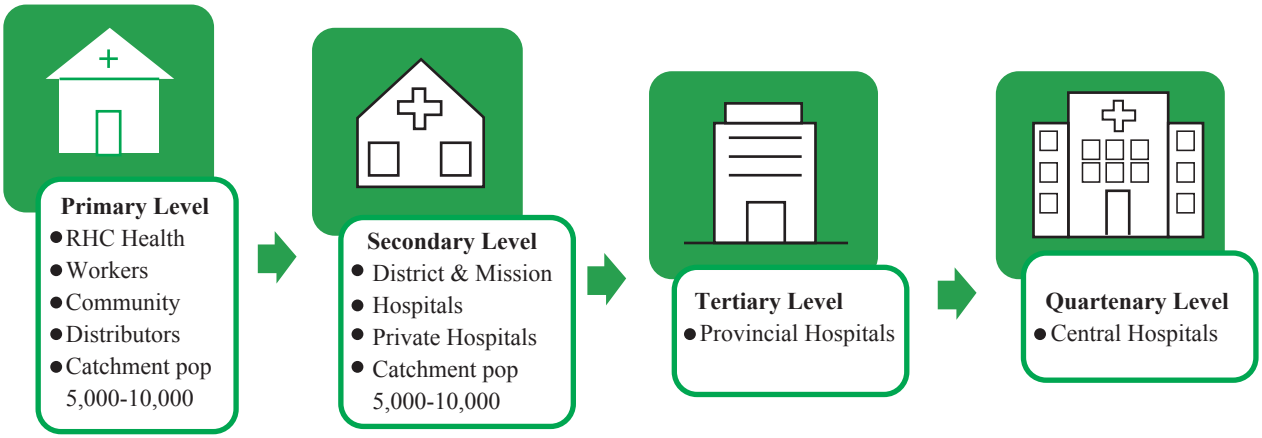
PCR..... Polymerase Chain Reaction
PDC ..... Provincial Development Committee
PH..... Public Health
PHFO ..... Provincial Health Field Officer
PFMS..... Public Finance Management System
PHE..... Provincial Health Executive
PIE..... Project Implementation Entity
PMD..... Provincial Medical Directorate
PMTCT..... Prevention of Mother to Child Transmission
PPA ..... Private Purchasing Agency
PPME..... Planning, Monitoring and Evaluation
RBF..... Results Based Financing
RHC..... Rural Health Centres
RHCP..... Reproductive Health Care Program
RMNCAHN ..... Reproductive Maternal Neonatal Child Adolescent Health& Nutrition
SDG..... Sustainable Development Goal
SICC..... Sister-In-Charge Community
STAG..... Scientific Technical Advisory Group
TB..... Tuberculosis
TMT..... Top Management Team
TWG..... Technical Working Group
TDA..... Temporary Deposit Account
UNICEF..... United Nations Children's Fund
VHW..... Village Health Worker
VIAC..... Visual Inspection with Acetic Acid and Cervicography
VMMC ..... Voluntary Medical Male Circumcision
WB..... World Bank
WE..... World Education
ZNHSP..... Zimbabwe National Health Strategic Plan
ZSARA ..... Zimbabwe Service Availability and Readiness Survey

## 5. Introduction and Background

### 5.1. The Zimbabwe Health System

Zimbabwe assumed a Primary Health Care approach in 1980 and structured its health systemaccordingly. The country's health services delivery platforms include primary, secondary, tertiary (provincial), and quaternary (central) facilities as seen below in Figure 1.

**Fig. 1: Zimbabwe Health System**




MostZimbabwe's health facilities are primary care facilities, which refer complicated cases to the next levels of care. The referral pathway goes from primary to secondary then tertiary and quartenary. These health facilities include at the first and second level, government, mission, council and private owned. Urban areas have council owned and run primary and secondary facilities which then refer to central hospitals. In addition to this, there are private facilities which include doctor and nurse run general practice and referral/specialist hospitals mostly in urban areas. Zimbabwe's four levels of health service delivery can be distinguished by facility type, the numbers of which can be found below in Table 1.

**Table 1: Health Facilities by Type**

| Facility level/ Managing Authority | All facilities | Hospitals | Primary Health Facilities |
|---|---|---|---|
| Central Hospitals | 6 | 6 | |
| Provincial hospitals | 8 | 8 | |
| District Hospitals | 44 | 44 | 0 |
| Mission Hospitals | 62 | 62 | 0 |
| Rural Hospitals | 62 | 62 | 0 |
| Private Hospitals | 32 | 32 | 0 |
| Clinics | 1122 | 0 | 1122 |
| Polyclinics | 15 | 0 | 15 |
| Private clinics | 69 | 0 | 69 |
| Mission clinics | 25 | 0 | 25 |
| Council/Municipal Clinics/FHS | 96 | 0 | 96 |
| Rural Health Centre | 307 | 0 | 307 |
| Totals | 1,848 | 214 | 1,634 |

Source: ZSARA, 2015

**Primary Care Level**

At primary level,aVillage Health Worker (VHW) serves approximately 100 households with health promotion, education, and preventative measures, , and supply households with basic medicines. The proportion of households with access to VHWs has increased from 46% in 2009 to 75.6% in 2017 with support from Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Health Development Fund (HDF) .

Zimbabwe is in the process of finalizing a Community Health Strategy and a Community Essential Health Package to guide community-level healthcare delivery.Zimbabwe is also improving access to care through the establishment of 1,600 health posts, which will serve as the first point of clinical care for the community.Health posts are envisioned to be the fist level of care within communities bridging village health workers with Rural Health Centres (RHC). They provide basic medical, maternal and child health services. They are manned by a primary care nurse whose scope of practice determines the kind of services that are offered.

According to the WHO standards, patients should have access to a health centre within an 8-kilometre radius from where they live. A totalof 1,634primary care facilities provide basic health promotion, prevention, curative and rehabilitation services to their catchment population. Primary care facilitiesalso provide reproductive, maternal, newborn, child, and adolescent health services.Community based distributors—under the Zimbabwe National Family Planning Programme—assistPrimary Care Facilities to provide family planning services. In addition, mobile clinics and outreach points provide long term family planning methods and treatment of minor ailments to communities in rural areas. Outreach teams also go to designated places offering primary care services to those in hard to reach areas especially for child health services. Primarycare facilities are also responsible for environmental sanitation, water supplies, hygiene, waste disposal systems, control of communicable diseases, nutrition, and services for people mental health disorders and disabilities.

Primary care facilitiesare the point of reference for VHWs and are staffed with at least two nurses—one of whom should be a skilled midwife. The staff complementalso includes an Environmental Health Technician.

**Secondary Level**

At thesecondary level, each district should have a district hospital with a catchment population of >140,000. At this level, there are 60district hospitals covering the 60 districts, with some being government and others church-related hospitals.District hospitals offer more complex medical interventions than the primary care level. These include caesarean sections, minor surgery and blood transfusions.

**Tertiary level**

The tertiary level refers to provincial hospitals, which provide specialized services. There are eight provincial hospitals in Zimbabwe and seven of them are owned and run by the government. Only St. Luke's Mission Hospital in Matabeleland North is church-run and owned. Provincial hospitals provide health services to patients referred from district hospitals.

**Quaternary level**

The quaternary level offers highly specialized hospital services. This level of service is only available in Harare, Chitungwiza and Bulawayo. Normallyreferred to as central hospitals, these facilities provide services to patients with complications as referred from the provincial hospitals.

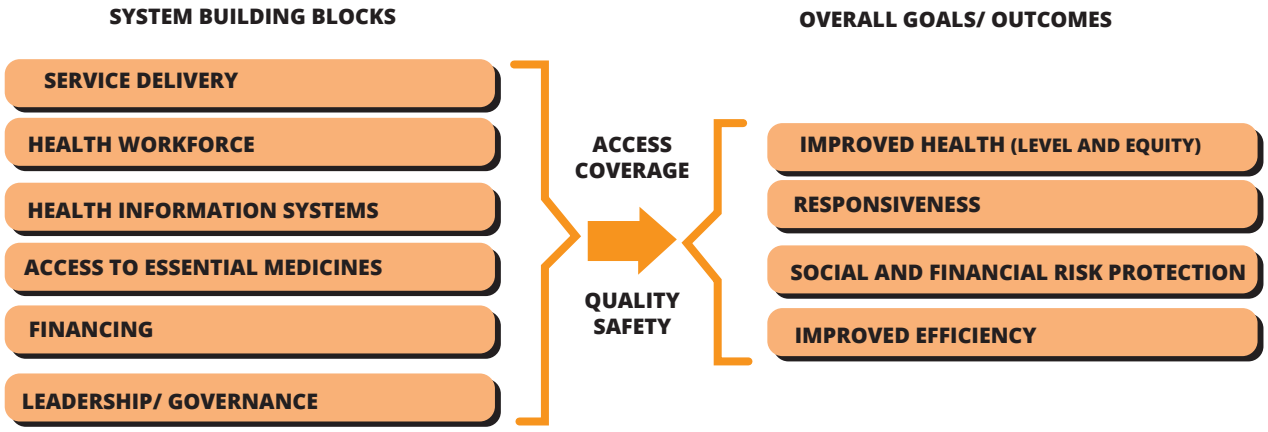
Health facilities have different governance and ownership arrangements, such as via the MOHCC, Local Government, and churches. In addition, there are many private clinics, mainly in urban areas. The RBF

program focuses on the public-service-oriented private not-for-profit facilities in eight rural provinces and private for-profit providers in the voucher system for the two urban provinces.

## 5.2. Alignment to the WHO Health Systems Framework

The WHO has defined the following health systems framework, whichwas considered in the design of Zimbabwe`s health system.

**Figure 2: The WHO Health Systems Framework**




### Health Workforce

There are gaps in human resources for health at all levels of Zimbabwe's health system, particularly in rural areas, which havemany vacant posts. In the last few years,the MOHCC introduced Primary Care Nurses (PCNs) at rural health centres, which improved availability of nursing care. This cadre, however,lacked midwifery skills,so the MOHCC rolled out an upskilling exercise that trained most PCNs in basic midwifery. In addition, the MOHCC has providedin-service training Emergency Obstetric and Newborn Care (EmNOC) to nurses and their supervisors. The government also unfroze a significant number of posts, which resulted inregistered general nurses (RGNs) being recruited for RHCs, even though they are not trained in midwifery. In the midterm, the PCNs will move to health posts.

To address the "brain drain"of human resources for health in Zimbabwe,the HDF and the Global Fundhave been payingretention allowancesto all staff from Grade C5 and above, in addition to staff allowances for midwives, doctors, and those in managerial roles.

### Procurement and Supply of Medicines and Other Essential Items

Through various funding mechanisms, the MOHCC has received support from partners in the UN system, GFTAM, HDF, the United States Government (USG), other donors, to procure and distribute essential medicines, consumables (including blood and related blood products), and other items such as Basic Emergency Obstetric and Neonatal Care(BEmONC) kits for health centres. The government has further strengthened the financing of medicines and commodities through an airtime Health Levy. The National Pharmaceutical Company of Zimbabwe (NATPHARM) is responsible for the supply chain of medicines and commodities, including those procured by partners, but has met challenges maintaining the supply system, resulting in periodic ruptures in the supply of essential items.

**National Health Information Management System (HIMS)**

A fully functional Health Management InformationSystem (HMIS) is in place with on-going national initiatives further strengthening it such as Electronic Health Records (EHR). Currently the HMIS uses paper based data collecting and reporting tools such as programme registers, tally sheets (T3, T5, T6 and HS 3/5 forms);which feed into the District Health Information System (DHIS2). The system allows data to be collected at the primarycarefacility level and transmitted to head office through district and provincial health offices.Data is collatted on T5 and other programme-specific forms at clinic and hospital level and HS 3/5 forms at hospital level.

All quantity indicators for the RBF program are based on the T5, HS 3/5, and programme-specific forms and the 99 indicators mentioned in the National Perfomance Monitoring Framework. The 2018 revision of the NHIS incorporated the development and deployment of the Electronic Health Records (EHR), which has made the system more efficient.Innovative electronic tools for MCH—such as Electronic Death Notification and e-Partograph—have further linked DHIS2 to quality of care. It is important to note that the current version of DHIS2on which the NHIS is operating requires an upgrade to allow more functionality within and easy interaction with other systems, such as the DHIS2 instance that RBF is operating on.

**Financing**

Although GOZ spending on health has been increasing over the years and is comparable to similar income countries in the region, overall per capita spending is below the WHO-recommended $60 per personminimum required to provide an essential package of health services and to achieve Sustainable Development Goals (SDGs).Many externally-funded programs partly compensate for this, including the GOZ co-financed RBF programme.Over the years, the GOZ has increased its contribution towards RBF including wholly assuming purchasing responsibility for the 18 districts formally supported by the World Bank.

A GOZ policy has removed user fees at PHC level.At secondary care level, patients receiving RMNCH, TB, malaria and HIVservices, and those over 65 years of age,are not supposed to pay for services. Many communities support their rural health centresthrough periodic development levies that are collected from every householdto cater for community health initiatives. In areas where majority of the people are poor, any charges will impact uptake of services. Care is not supposed to be denied due to lack of fees/levies, though actual practice by health facilities is not uniform. The MOHCC has engaged stakeholders at Rural and Urban Development Committee level to ensure adherence to the government policy.

**Leadership and Governance**

**The Head Office**

The MOHCC's National Head Office develops policy and provides overall guidance to the national health system. This office is responsible for functions such as the determination of funding allocation, policy, and administrative guidance, and approvals of staff hires at the district and provincial levels.

**Sub-national governance**

A Provincial Health Executive (PHE) provides direct oversight on policy implementation and adherence for all health services in the province including provincial hospitals. The Provincial Medical Director (PMD) isalso responsible for overseeing the utilization of government of Zimbabwe (GOZ) funds to the provincial hospitals and district health officers (DHOs). Atdistrict level, DHOs play a more direct role in administering and managing rural health clinics (the lowest level of primary carefacilities), as rural health

facilities may only have a nurse on staff to provide primary care services and noadministrative staff. District health services are overseen by a District Health Executive (DHE). A community health council (CHC)provides oversight to the district hospital while a health centre committee (HCC) provides oversight to the primary health facility.

## 5.3. Ministry of Health and Child Care Priorities

The MOHCC has set priorities in the Strategic Plan 2016-2020, bearing in mind the current socio-economic hardships of limited financial and human resources. After developing the strategic plan, a "Two Year Rolling Plan" was developed. This rolling plan covers priority performance areas to maintain critical activities that keep the health sector moving forward. This year, a Mid-Term Review (MTR) of the NHS was done and its results are being used to prepare for the next NHS and also inform the Health Sector Investment Case (HSIC) development.

**Focus on Primary Health Care**

Primary health care (PHC)is a priority area for Zimbabwe. In 2018, Zimbabwe joined the rest of the world in re-committing itself to strengthening primary health care by signing the Declaration of Astana.The Declaration of Astana reaffirms the historic 1978 Declaration of Alma-Ata, the first-time world leaders committed to primary health care. It is anticipated that the Primary Health Care Approach will assist the Ministry in not only addressing the health needs of this nation, but also steer the country towards attainment of the Sustainable Development Goals. In 2015, Zimbabwe officially adopted SDGs as the nation's 2030 development vision and is working towards meeting SDG targets. Based on diseases and conditions prevailing in Zimbabwe, the following priority areas will be strengthened or scaled up through an integrated approach:

- HIV and AIDS, STIs, and TB
- Nutrition
- Environmental Health and Hygiene
- Reproductive and Child Health
- Malaria Control
- Non-Communicable Diseases
- Epidemic Preparedness and Response
- Mental Health
- Oral Health
- Eye Care
- Health Promotion, including the School Health Program

Revitalizing the healthcare delivery system based on primary health care—including an effective, efficient referral system and emergency services—is a major priority. In order to successfully strengthen or scale up aforementioned areas, the MOHCC requires resources and an appropriate enabling environment. The MOHCC identified the critical success factors for the successful scaling up of health care as:

1. Provision of adequate, skilled, and well-remunerated Human Resources for Health as a retention strategy
2. Continuous supply of medicines and medical supplies
3. Provision of functional equipment (fixed and movable) and infrastructure
4. Provision of transport and community systems to improve referrals
5. Addressing the issues of leadership and governance at all levels, disease surveillance, and health information for decision-making, as well as strengthening coordination of health sector players

Achieving these goals requires a robust financing mechanism to implement activities to deliver expected results. GOZ designed strategies to address these health financing issues, including:

*(1) Strengthen the financial management system at all levels*

- Improve implementation of the Public Finance Management System (PFMS) at all levels of care
- Strengthen financial management and accounting skills for all levels of health care
- Monitor and evaluate resource utilization

*(2) Improve use of existing resources*

- Institutionalise implementation of Integrated Results Based Management (IRBM)
- Institutionalise RBF

RBF has been implemented in all rural districts and two urban districts in the last seven years and has produced impressive results.

### 5.4. Key Coverage and Impact Indicators

Zimbabwe's 2015 Demographic Health Survey (DHS) showed a significant increase in coverage of key MCH indicators. However, high coveragewas not commensurate with the impact indicators, which still showed high maternal and perinatal mortality. The report showed:

- 93% of women receive ANC, but only 39% receive ANC during the first trimester
- 76% of women receive 4+ ANC visits, an increase from 65% in 2010-11
- 77% of births are delivered in health facilities, up from 65% in 2010-11
- 78% of births are delivered by a skilled attendant, most commonly nurses or nurse-midwives
- 57% of mothers and 73% of newborns receive a postnatal care visit within 2 days of delivery
- In the seven-year period before the survey:7.6 women died for every 1,000 women per year and 7.5 men died for every 1,000 men per year
- Maternal mortality ratio (MMR) for the 7-year period before the survey =651 deaths per 100,000 live births(Confidence Interval: 473829)
- 76% of children 12-23 months old have received all basic vaccinations, up from 53% in 2005-06
- 78% of children with diarrhoea received ORT, as recommended
- 58% of newborns are breastfed within the first hour of life, and 93% within the first day
- 13% of newborns are given food or liquid other than breastmilk (prelacteal feed), although this is not recommended
- 98% of infants are ever breastfed
- 27% of children under 5 are stunted, or too short for their age; 6% are overweight
- 37% of children, 27% of women, and 15% of men are anaemic

## 6. Zimbabwe RBF Programme

### 6.1. Background of the RBF Programme

The 2014 impact evaluation results of the HSDSP and subsequent progress reports have shown that the project has contributed to improving the coverage and quality of care of some priority MCH services. For example, the impact evaluation found that the RBF intervention package increased the rate of deliveries attended by a skilled provider by 15 percentage points and of institutional deliveries by 13 percentage points compared with control districts.

Since mid-2019, however, achievements of some indicators such as percentage of antenatal care and

institutional deliveries have remained stagnant or marginally decreased. For example, the percentage of pregnant women receiving first antenatal care (ANC) before 16 weeks of gestation during a visit to a health provider in participating rural districts decreased from 25 percent in 2018 to 24 percent in 2019. The draft HSIC and NHS 2016-2020 MTR identified gaps in community level interventions as a major cause of slow progress of ANC and child health indicators. Despite challenges posed by the macroeconomic situation, the average quality score (82 percent) for all participating district hospitals and health centers was slightly higher than the end of project target of 81 percent.

## 6.2. The Strategic Direction of RBF

The RBF programme in Zimbabwe is designed to improve both supply- and demand-side performance of health systems to achieve Universal Health Coverage as outlined in the NHS 2016-2020. This PIM is being written at a time when the GOZ has adopted and begun to rollout RBF institutionalisation. As such, most of the processes are being reviewed to fit in with a programme that reflects all the key elements of the Government's RBM approach.

The NHS 2016-2020 reflects the MOHCC's decision to adopt a High Impact Interventions Costing Scenario, with the objective of reducing mortality associated with the 20 established leading causes of death in Zimbabwe. This will particularly focus on scale up of RMNCH-N, malaria, TB-HIV, and NCDs interventions with emphasis on lower levels of care.

In its national health sector strategy, the MOHCC is positioning the RBF as the mechanism to align with these priorities and to ensure efficient utilization of GOZ funding and other global health financing, such as support from the GFF, Global Fund, HDF, and GAVI. RBF is also going to become the MOHCC's main platform for the incorporation of previously vertically funded disease control programmes into a health systems approach for scale-up and sustainability. Within the context of IRBM and building on RBF structures and processes, institutionalized RBF will support a health system that is: equitable, sustainable in terms of financing and operations, cost effective, robust in accountability and transparency, and supportive of Zimbabwe'sprogress towards Universal Health Coverage.The MOHCC`s overall health strategy—and related sub-components, from Health Financing to Essential Packages—significantly inform the strategic direction RBF is taking.

## 6.3. Objectives

### 6.3.1. Main Objective

To improve the availability, accessibility, and quality of health services with a focus on integrated key reproductive, maternal, new born, child adolescent health and nutrition (RMNCAHN), and an expanded scope including NCDs, TB, HIV and malaria services and their optimal utilization.

### 6.3.2. Specific Objectives of the RBF Programme:

1. To contract health care facilities to implement innovative strategies that increase access and utilization of quality priority health services.
2. To improve quality of care through an integrated national quality assurance and quality improvement (QA/QI) framework.
3. To foster community participation and ownership in the delivery of health care services through increased involvement of Health Centre Committees (HCCs), Community Based Organization (CBOs) and other services.

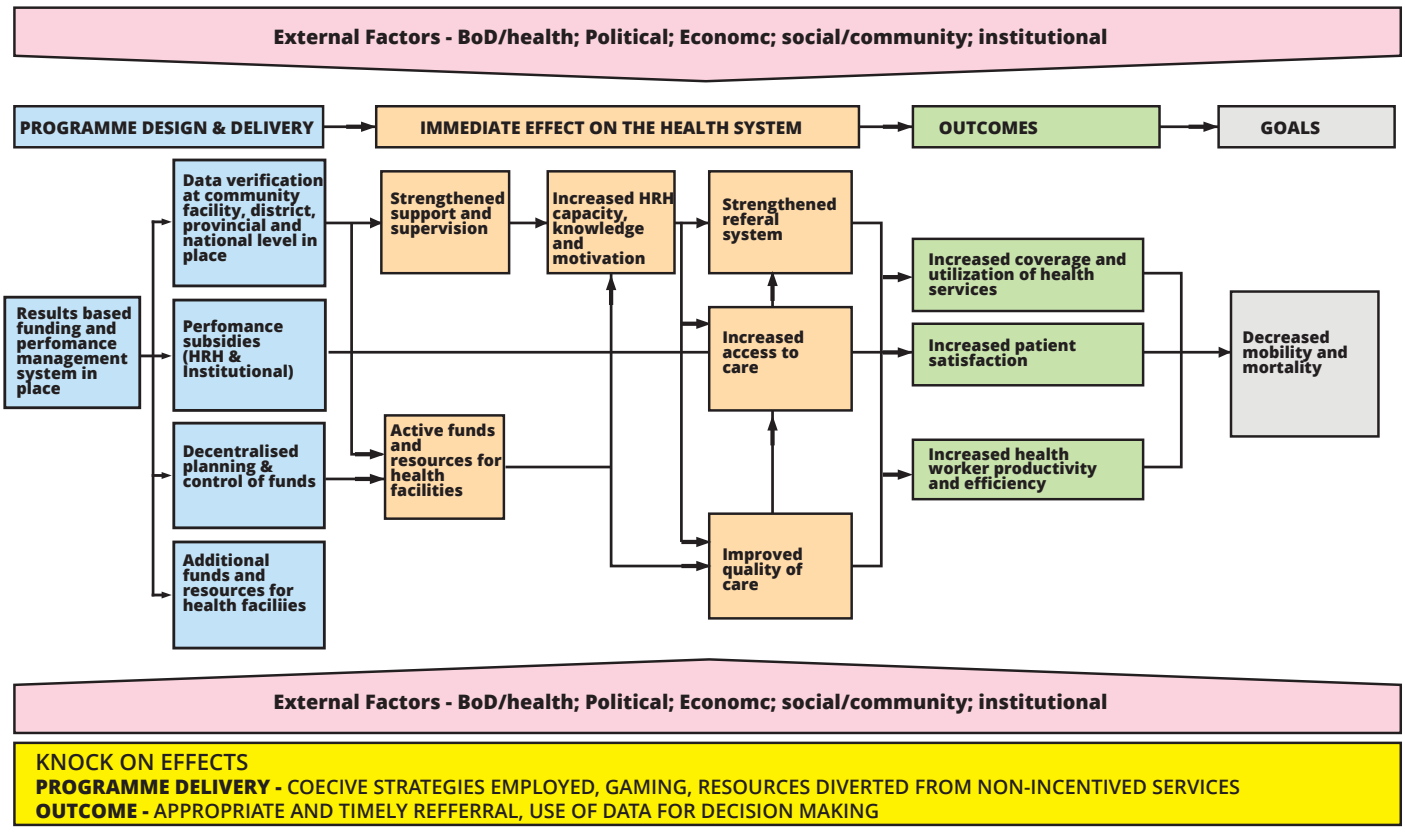
4. To strengthen the National Health Information System (NHIS) through improving data quality, reporting and utilization.
5. To motivate and retain qualified Health Care Workers (HCWs) through incentivizing performance and creating a conducive environment.
6. To strengthen managerial capacity at national and subnational levels for effective service delivery.
7. To strengthen accountability and ownership across all levels through enhanced monitoring and evaluation.

## 6.4. Theory of Change

The design and implementation of RBF in Zimbabwe reflects the essential elements of an RBF mechanism as shown below in Figure 5. The design is anchored on payments for results—conditional on qualityfor the urban RBF,and on quality and utilization for the rural RBF. Institutional arrangements are structured to uphold the principle of the separation of functions between the service provider (health facilities), purchaser [Programme Coordination Unit (PCU)] and Crown Agents (CA)), and regulator (MOHCC - Head Office, PHE and DHE).

The system exhibits some autonomy through decentralized planning and decision-making at facility level, whilst recognizing the importance of facility-level governance through revitalized HCCs. Efforts to address equity are apparent in the user fee policy and remoteness bonuses for hard-to-reach facilities. Accountability at the community level is guaranteed through the involvement of HCCs in the governance of health facilities, and through the engagement of CBOs, who conduct periodic patient tracer and satisfaction surveys that provide a platform for client feedback.

**ZIMBABWE RBF PROGRAMME LOGIC/THEORY OF CHANGE FRAMEWORK**



### 6.4.1 : Explanations of the Framework Components

| RBF TOC Component | Key Component Considerations |
|---|---|
| **Programme/ intervention delivery** | – **Linking payments to results, rather than payment for inputs**, generates more accountable and efficient health programs and outcomes.<br>– **Separation of functions between purchaser, regulator, and provider** increases checks and balances, reduces corruption, creates more integrated management systems, improves quality control, and increases transparency.<br>– **Contracting** helps to link payment to results, thus minimizing waste, creating value for money, improved quality control mechanisms, and demarked responsibilities and obligations.<br>– **Decentralization** increases local control, management, and responsiveness to local needs.<br>– **Equity provisions** are increased via remoteness bonuses and the removal of user/out-of-pocket fees.<br>– **Community involvement and feedback in decision-making** processes and operational planning fosters: community buy-in, greater policy legitimacy, better representation of local health needs, reduced corruption, increased accountability, and social entrepreneurship. |
| **Immediate effects of the intervention on the health system (system impacts)** | – More motivated and knowledgeable health workers and an increased sense of staff pride in conjunction with facility improvements, which enhance staff retention and reduce absenteeism, increase productivity and efficiency, and improve facility readiness to provide services.<br>– Improved provider-patient interactionsclient engagement,and perceptions of quality associated with improved facilities, and confidence in services.<br>– Strengthened governance. |
| **Mediating processes** | – Improved funds, funds for direct medicine purchasing by health facility, increased equipment and supplies purchased directly by involved facilities.<br>– Additional personnel recruited, receiving regular bonuses, with greater interest in making services attractive to beneficiary communities through pricing, responsiveness, and facility and quality improvements.<br>– Contracting sets explicit performance payments, with improved service availability; and improved data quality and use. |

| | |
|---|---|
| **Quality outcomes** | **In terms of quality:** Improved service quality, including improved technical and perceived service quality in (i) incentivised tracer (indicators) service; (ii) non-incentivized tracer service. |
| **Coverage outcomes** | **In terms of quantity:** Improved health service utilisation(disaggregated); and improved health seeking behaviour (disaggregated by service type vs.burden of disease). |

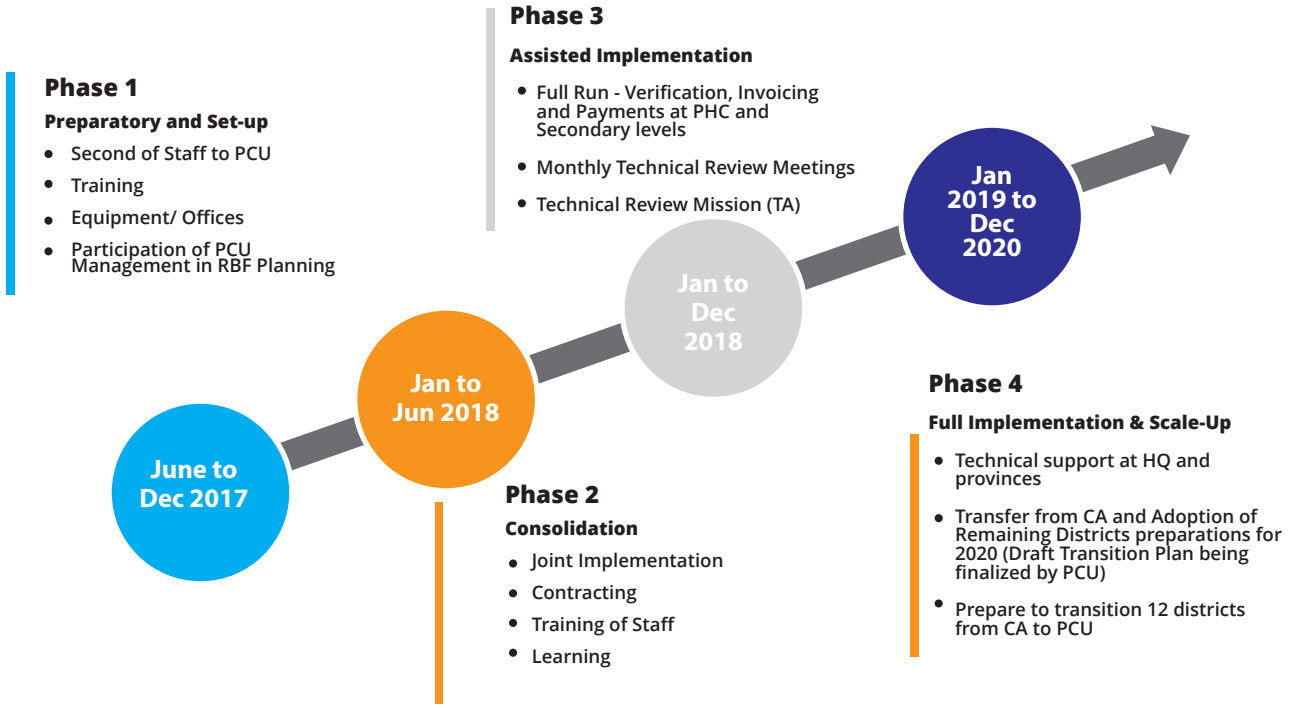
### 6.4.2 Assumptions

1. Health workers are directly affected by financial incentives, which will increase their motivation to exert effort, thereby delivering more services to the population and improving the quality of services delivered where quality is explicitly incentivised (e.g. delivery of specific drugs/tests during services where highlighted in the clinical protocol).
2. Health workers are also expected to change the way they deliver services to make services more attractive to patients and increase patient demand (in order to deliver more services). Strategies that may be adopted to increase demand include:
   - Making services more affordable (e.g., reducing or eliminating formal and informal charges at primary care level); and
   - Becoming more responsive to community and patient needs (e.g., improved client-provider interactions and greater community engagement in service delivery through governing committees).
3. Performance data verification by supervisors strengthens relations between providers and their managers, enhancing system governance through more frequent and focused supportive supervision, and facilitating resource prioritisation to meet targets. Incentives provided to managers (via bonuses, payment penalties, or managerial invoice verification processes before payment release) for monitoring performance and/or supervision performance further strengthen links and governance capacities between health system levels.
4. Investing financial rewards for meeting targets in improving facility infrastructure and drug supply impacts both facility resource levels and readiness to deliver services. This in turn improves the work environment by enhancing worker motivation and increasing patient demand and perceptions of quality.
5. Incentives may also result in unintended consequences, such as a displacement of effort away from unincentivised services,or positive spill-over effects.

## 6.5. RBF Medium Term Framework (MTF)-Evidence for Institutionalisation

TheMedium-Term Framework(MTF) was carried out in 2016 with the aim of guiding the GOZ toward institutionalisation of RBF for sustainability. The MTF defined institutional arrangements for RBF implementation, funds flow and accountability arrangements, and the care package of services reflecting burden of disease. Within the context of RBM and building on RBF structures and processes developed so far; the strategy of the RBF MTF was to further strengthen the checks and balances within the health sector, and to build a more equitable and sustainable (in terms of finance and operations) health system. In addition to those defined issues, the MTF also developed a roadmap and identified conditions needed to institutionalise RBF as shown in Figure 5 below.

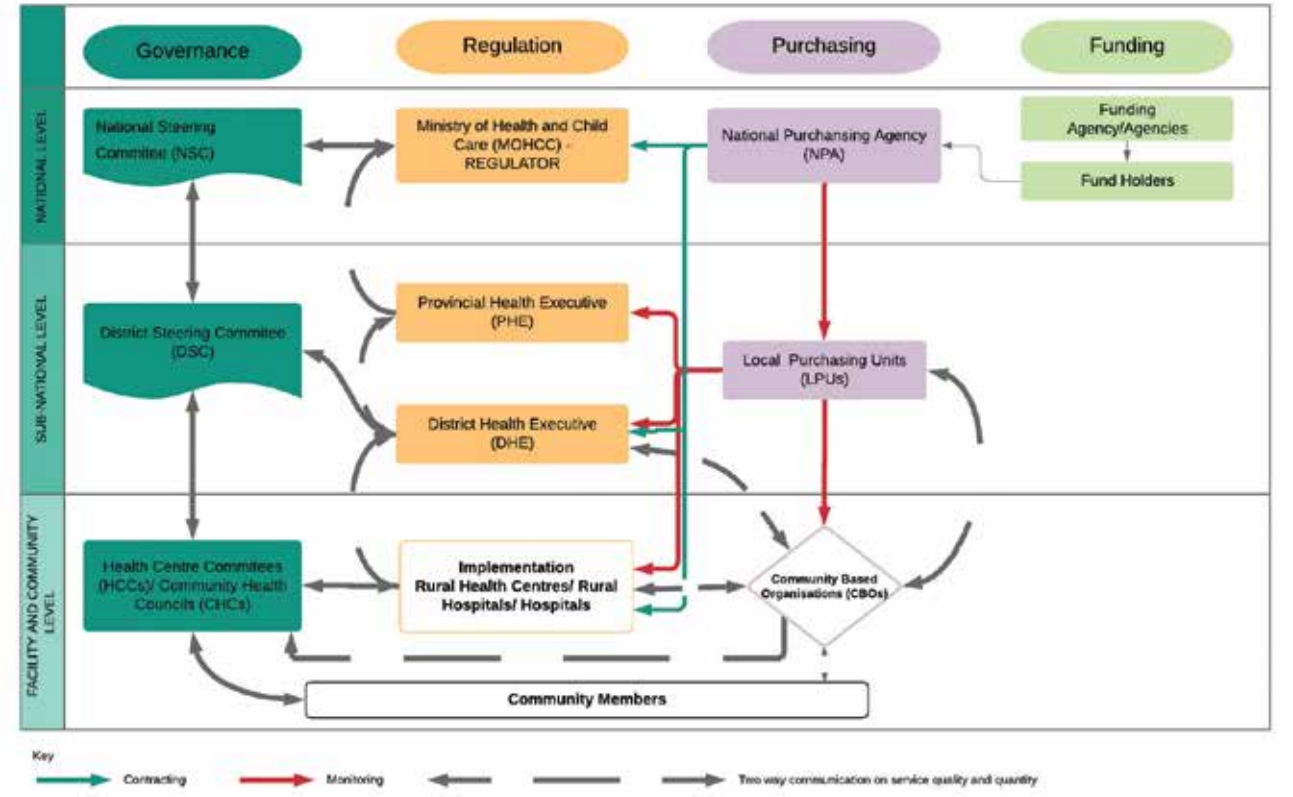
Figure 6: Institutionalisation Road Map: MTF




## 6.6. Institutional Arrangements

RBF institutional arrangements in Zimbabwe comprise all entities whose functions enable the fulfilment of key elements of separation of function, autonomy, and good governance. These are regulator, funder, fundholder, purchaser, and service provider. Figure 7 below illustrates these arrangements and how the entities interact with each other.

Figure 7: RBF Institutional Arrangements



### 6.6.1 Instuitional Entities and their Functions

#### 6.6.1.1 National Steering Committee

The RBF National Steering Committee (NSC) is appointed by the MOHCC to oversee planning and implementation and to ensure good governance of RBF in Zimbabwe. The NSC includes relevant representatives of the MOHCC and other line ministries, Provincial Medical Directors, NPAs, and national and international donors and NGOs, as well as Civil Society Organizations (CSOs). The committee reports to the MOHCC Permanent Secretary. Involvement of these key stakeholders ensures that RBF is harmonized into broader health financing mechanisms and that implementation involves close collaboration with other critical health system players.

**Table 2: NSC Membership**

| ORGANISATION | TITLE |
|---|---|
| MOHCC | Chief Director –Preventive Services Chairperson |
| MOHCC | Chief Director –Policy Planning,Monitoring &Evaluation (CD-PPM&E |
| MOHCC | Director – Family Health |
| MOHCC | A/Director Policy & Planning |
| MOHCC | Director –Human Resources |
| MOHCC | Finance Director |
| MOHCC | D/Director Rep. Health |
| MOHCC | PMD Mash East |
| MOHCC | PMD Mash West |
| MOHCC | PMD Masvingo |
| MOHCC | Planning and Donor Coordination Unit |
| ZACH | Executive Director |
| CWGH | Executive Director |
| Ministry of Public Works | Deputy Director |
| Ministry of Finance & E.D. | Economist |
| Ministry of Finance & E.D. | Director Budgets |
| ZNFPC | Executive Director |
| UNFPA | Technical Specialist |
| Cordaid | Team Leader |
| Crown Agents | Country Manager |
| World Bank | Health Specialist |
| European Union | Health Advisor |
| UNICEF | Country Representative |
| HDF | Coordinator |
| MCHIP | Country Representative |
| WHO | HSS Advisor |
| World Education | Chief of Party |
| CSOs (from CCM) | Seconded on a rotational basis |
| MOHCC | Director Nursing Services |
| MOHCC | Deputy Director Community Nursing |
| MOHCC | Deputy Director Hospital Planning |

| | |
|---|---|
| MOHCC | Director Pharmacy Services |
| Harare City | Director Health Services |
| Bulawayo City | Director Health Services |
| MOHCC | Deputy Director HIMS |
| Ministry of Public Services and Social Welfare | D/Director Social Services |
| MOHCC | Director Quality Assurance |
| MOHCC | PCU Coordinator |
| MOHCC | Director Aids and TB |
| MOHCC | Director - Malaria |
| MOHCC | Deputy Non-Communicable Diseases |
| Private Organization (Higher Life Foundation) | |

***Functions of the RBF National Steering Committee***

The functions of the RBF NSC are as follows:

- Oversee and monitor the development of the overall strategic direction and policy framework of RBF program in Zimbabwe according to the principles of the Paris Declaration on Aid Harmonization;
- Safeguard the main principles of RBF agreed upon in the official communication, such as the MOU, the Grant Agreement, and project design documents;
- Ensure that RBF is implemented in line with objectives of the NHS and other GOZ documents as outlined in RBF agreements and other strategic documents;
- Provide strategic direction on basic design issues such as indicators and prices, minimum package of services, roll-out/scale-up, and equity considerations;
- Review and endorse overall quarterly financial reports in line with Public Financial Management Regulations;
- Review semi-annual work plans, progress reports, training schemes, and capacity building plans;
- Provide guidance to the development of an institutional structure for an independent NPA mechanism based on the principles of good governance and separation of functions;
- Based on the steering committee member's specific expertise, contribute to sharing knowledge and experiences related to other issues concerning the health sector in Zimbabwe relevant to RBF.

### 6.6.1.2. The Regulator

The MOHCC Head Office, PMD, and DMO perform the regulatory function for the RBF programme. The regulatorsets, monitors, evaluates, and ensures adherence to national health system standards. The details of each level are listed below.

### 6.6.1.3. MOHCC Head Office Role

- Establish and chair NSC, which shall oversee the overall governance and implementation of RBF from a national perspective.
- Monitor the activities of the NPA and ensure adherenceto the MOU between the MOHCC and NPA.
- Determine health policies and set quality standards;conduct quality assessments for the PHEs and Central Hospitals.
- Define policies around health sector funding mechanisms, ensuring synergy between various funding portfolios and modes of operation.

### 6.6.1.4 Provincial Health Executive(PHE) Role

The PHE is the provincial level regulator.PHEs are obliged to provide office space for the local purchasing unit (LPU) at the PHE offices. Tasks and responsibilities in this role include:

- Ensure RBF service providers comply with national quality standards;
- Support DHEs in establishing a district steering committee (DSC), which shall oversee the overall governance and implementation of RBF at district level;
- Participate in peer evaluations of other PHEs, as needed;
- If need arises, lead or participate in conflict resolution together with theLPU/NPAand DHEs. Document the process of conflict resolution and send the document to the Permanent Secretary of the MOHCC with a copy to the NPA; and
- Sign a contract with the PS/NPA for carrying out these tasks.

### 6.6.1.5 District Health Executive (DHE) Role

The most decentralized level of MOHCC regulation, the DHE plays a key role in overseeing and supporting implementation of RBF activities. The DHE's primary task is guidance and supervision of health facilities to improve performance, planning of health service delivery, and coordination of stakeholders at district level. For RBF, this will be done in close collaboration with the LPU/NPA.

DHEs are the local regulators with the following tasks and responsibilities:

- Assist health facilities within the district to develop annual operational plans in cooperation with the LPU/NPA and the PHE;
- Validate and co-sign each health facility's quarterly operational plan and performance contract;
- Monitor implementation of health facility operational plans in the district (in collaboration with the LPU/NPA and the HCC/primary care facility);
- Conduct quarterly verification of quality of care of primary care facilities and follow up with coaching visits;
- Work with DSCand LPU/NPA to solve disputes or reported cases of malpractice concerning RBF activities, and resolve within existing MOHCC guidelines. Whenever there are disputes in the DHE regarding resolution of cases of malpractice within a district, the DMO will escalate the issue to the PHE;
- Keep records of the Temporary Deposit Accounts/Health Services Fund (HSF) and assure timely payments to HCC from this account;
- Provide quarterly reconciliations of RBF TDAs/HSF to LPU/NPA with a copy to the PHE; and
- Facilitate the DSC meetings.

### 6.6.1.6 District Steering Committees

Each RBF district has a DSC. The DSC is a multi-stakeholderoversight and advisory structure for a given district. The DSC falls under the existing GOZ structure and consists of an equally balanced number of government ministryand 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.

***Objectives***

The objectives of the DSC are to:

- Monitor the programme at district level and make recommendations to the DHE and NPA about district level RBF programme progress;
- Address critical issues that could hinder programme implementation;

- Advise NPA and DHE on complex cases or unresolved RBF issues brought to their attention by the NPA and DHE;
- Facilitate accountability for RBF results, and resources invested in the health sector linked to the RBF program within a district;
- Advise on relevant operational and strategic issues affecting the programme based on circumstances and issues unique to that district;
- Identify lessons learnt and organise intra district learning visits; and
- Act as an arbitrator/referee when a dispute arises among the contracting parties.

#### 6.6.1.7 The Funding Agency

The funding agency is responsible for providing the funds, which are used to purchase services as determined by the Regulator. Any funding agency that wishes to purchase services must engage the Secretary for Health in the MOHCC.

#### 6.6.1.8 Fundholder

The fundholder is responsible for managing funds on behalf of the funding agency. Currently the Directorate of Finance in the MOHCC and UNICEF are the fundholders for the GOZ and HDF respectively. The functions of the fundholders are:

- Request and receive funds from the funding agency on behalf of the purchasing agency;
- Disburse funds to the purchaser in a timely manner upon receiving request;
- Administer RBF funds according to generally accepted accounting principles;
- Organize audits of the NPA records throughout the programme levels; and
- Prepare periodic reports to the funding agency.

#### 6.6.1.9 The National Purchasing Agency

The NPA is responsiblefor the purchasing function, which includes contracting, verification, and capacity building of service providers. As RBF has become institutionalised within the MOHCC, the PCU within MOHCC and Crown Agents will play the role of the NPA. The PCU assumes the NPA role in the 18 districts formerly under Cordaid, while Crown Agents is NPA in the 42 HDF-supported districts. These functions are detailed below. The LPU is embedded within the PHEs or DHEs, as applicable. The main task of the LPUs will be to provide ongoing support to the NPA in executing RBF tasks at provincial and district levels. NPA responsibilities include:

- Draw up result-based contracts with healthfacilities, DHEs, PHEs and CBOs;
- Implement a verification system of quantity of the services provided;
- Monitor internal verification of qualitative data: for primary care facilities by the DHE; for District Hospitals by the PHE;and patient satisfaction by CBOs;
- Pay subsidies to all contracted service providers based on verified data;
- Contract independent organisations to conduct externalverifications and financial audits;
- Identify gaps, make recommendations, and participate in RBF related capacity building activities in liaison with the MOHCC;
- Prepare quarterly reports (financial and progress reports) and submit to the NSC,PS, and fundholder;
- Monitor programme progress throughout all levels of implementation;monitor program activities and achievements; and
  Participate in Steering Committee meetings at national/provincial/district levels.

In addition to the above tasks as NPA, the PCU will:

- Perform a coordination role for all the NPAs;
- Ensure that NPAs carry out provincial and national level programme management tasks in a

coordinated way;

- Lead NPA quarterly programme report consolidation and submission to NSC and MOHCC leadership;
- Consolidate key policy issues emerging from implementation reports and submit them to the NSC; and
- Serve asthe NSC secretariat.

### 6.6.1.10 Service Providers

Service providers are contracted to provide an agreed set of health services derived from the MOHCC priorities. These services comprise of quantity and quality indicators. Services providers currently include primary health facilities (health posts, clinics, rural health centres, rural hospitals, and urban health centres), and secondary facilities (district hospitals, mission hospitals, and other hospitals).

### 6.6.1.11 Health Centre Committees

The HCCis an entity created and regulated by the Public Health Act. Its broader responsibilities are outlined in the same Act, but for the purposes of RBF, HCC roles and responsibilities are outline here. Under the RBF programme, health centres and their committees shall be responsible for:

- Compiling annual operational plans in consultation with the DHE and LPU/NPA;
- Reviewing of quarterly plans and submitting a copy to the DHE;
- Signing the contract with the DHE and the LPU/NPA for services laid down in the operational plan;
- Managing RBF funds in an efficient and effective manner in consultation with local communities;
- Reporting issues related to delays or incorrect payments and other queries to LPU/NPA or DHE, based on guidelines provided by the regulator;
- Mobilising communities to utilize health services; and
- Mobilising resources for the development of the facility.

### 6.6.1.12 Community Based Organisations

CBOs/NGOs are contracted to collect feedback from communities through client satisfaction surveys and exit interviews. RBF requires household level verification of to what extent subsidized services took place, and to assessclient 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/NGOshave 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 will receive training to undertake the above tasks.

### 6.6.1.13 Counterverifier

The counterverifier is an agency that provides an independent verification of all services provided and paid for. 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 cover areas of training in both RBF and Counter verification. The HPA has got within its councils and its members the skills set necessary to carry out the Counter verification. As part of the RBF institutionalization process, the HPA

has been earmarked by the MOHCC to take over Counter Verification after the current World Bank grant comes to an end. 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 is 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.

The objective of the assignment is for an independent Organisation to conduct and manage both components of the external verification of the Zimbabwe RBF in the 18 districts financed by Treasury with services purchased by MOHCC-PCU (), which will check the accuracy of quantitative and qualitative data verified as well as the quality and completeness of services provided by RBF health facilities.

Specific Functions

- To verify the accuracy of reported service quantity data
- To verify the accuracy of reported data on quality of services
- To check the fidelity of CQI implementation in line with the design
- To check the validity of patient feedback data
- To evaluate treatment of voucher clients

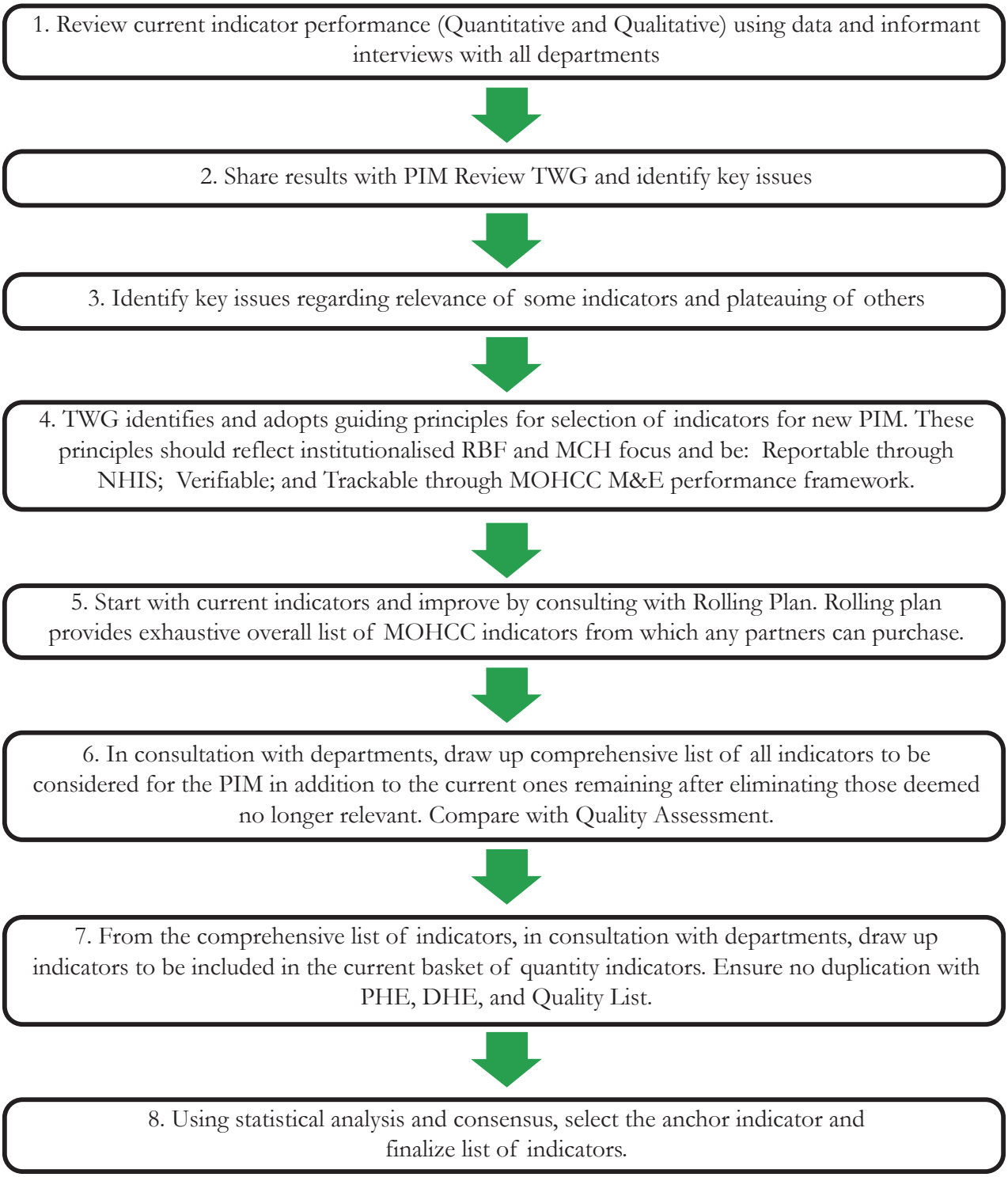
# 7. Indicators

## 7.1. Quantity Indicators

### 7.1.1. Indicator Selection Methodology

During the 2nd Quarter 2018 NSC meeting, a resolution was passed to revise the Programme Implementation Manual, including the revision of quantity and PHE/DHE indicators. The rationale for this revision of indicators was that many RBF indicators were plateauing (no further increase in performance after reaching a certain range), and some were no longer relevant to changing priorities. The approach was to further refine the indicators to reflect both national and global priorities in RMNCH and Nutrition. To achieve this objective, a systematic process was followed; this process is represented in Figure 8.

**Figure 8: Quantity Indicator Selection Process**



## 7.1.2 List of Indicators and Prices in USD

Quantity Indicators for Primary and Secondary Levels

| | Programme Area | Level | Indicator | Price/unit output based on 16mil USD[1] |
|---|---|---|---|---|
| 1. | RMNCH | Primary | No. of pregnant women who had first ANC visit before 16 weeks of gestation | 5.61 |
| 2. | RMNCH | Primary | No. of pregnant women who had focused ANC contacts (8) | 2.75 |
| 3. | RMNCH | Primary | No. of women who had HIV and syphiliscombinedtest during ANC | 0.50 |
| 4. | RMNCH | Primary | No. of pregnant women who had normal vertex deliveries (Skilled and Institutional) | 3.77 |
| 5. | RMNCH | Primary | No. of mother-baby pairs who attended at least 2 postnatal care visits | 1.88 |
| 6. | RMNCH | Primary | No. of family planning cycles given to women 15-49 (Short Term Methods) | 0.11 |
| 7. | RMNCH | Primary | No. of women 15- 49 who had family planning (Long Acting Reversible Methods) | 0.52 |
| 8. | RMNCH | Primary | No. of children with primary course completed | 0.38 |
| 9. | Nutrition | Primary | No. of eligible children administered Vitamin A supplementation | 0.06 |
| 10. | Nutrition | Primary | No. of children 0-24 months assessed through growth monitoring | 0.02 |
| 11. | HIV | Primary | No. of children and adolescents initiated on ART (0-24 yrs) | 5.61 |
| 12. | TB | Primary | No. of TB cases notified | 0.68 |
| 13. | NCDs | | No. of hypertension cases diagnosed | 3.13 |
| 14. | RMNCH | Secondary | No. of referred complicated cases delivered (Caesareans excluded) | 18.09 |
| 15. | RMNCH | Secondary | No. of Caesareans performed | 22.61 |
| 16. | RMNCH | Secondary | Number of women aged between 15-49 screened for cervical cancer through VIAC | 5.65 |
| 17. | RMNCH | Secondary | No. of women treated for positive VIAC | 13.56 |
| 18. | TB | Secondary | No. of pediatric TB cases notified | 11.30 |
| 19. | NCDs | Secondary | No. of new diabetes cases diagnosed | 26.63 |
| 20. | RMNCH | Secondary | No. of women who had manual vacuum aspiration for post-abortal care | 11.30 |

### 7.1.3. Broader Quantity Indicator Selection Mechanism

The MOHCC—in line with RBF institutionalisation and overallstrategic direction—has created a platform for possible inclusion of other indicators which are not part of the core indicators above. These indicators shall be funded from sources separate from the funding for core indicators until the basket of pooled funding is instituted. Currently voluntary medical male circumcision (VMMC) at all levels is being considered. Approvals for such indicators shall be done through the MOHCC and NSC.

### 7.1.4. Community Level Indicators

Zimbabwe is in the process of finalizing its Community Health Strategy, which will include a performance-based approach as part of its financing mechanism. This will make way for the extended supply-side and demand-side RBF. Currently Zimbabwe is implementing an extended supply-side RBF focused on TB indicators in Manicaland Province. This shall be evaluated to better inform the programme design.

## 7.2. Management Indicators

As RBF is institutionalised, there is need for strengthened management and coordination across all aspects of implementation. This is part of the further alignment of RBF to the IRBM framework, which will enhance management at all levels; DHE and PHE indicators have been revised to reflect this. Below is an outline of the process of indicator selection.

### 7.2.1. Indicator Selection Methodology

1. Current indicator perfomance review (Quantitative and Qualitative) using data and informant interviews with all department

↓

2. TWG with leadership of appropriate departments (PHEs and DHEs and National Level consulted) identifies indicators that have become irrelevant and need to be dropped

↓

3. Guiding principles for selection of indicators for new PIM identified and adopted by the TWG. They must be management indicators reflecting Institutionalised RBF including key pillars of Health System (Finance and Administration, HRH, M&E, Quality, Supply Chain)

↓

4. Start with current indicators and improve by consulting with all relevant management departments. Ensure that there is no duplication with aspects that are comprehensively catered for in the Quality Assessment.

↓

5. List of indicators drawn up and approved by the TWG

| | Indicator | Indicator description | Subsidy in USD |
|---|---|---|---|
| 1 | No. of Hospitals Supervised Using a Structured Quality Supervision and Assessment Tool | Health Facilities (Hospitals) have been supervised and quality assessments conducted at each hospital at least once per quarter with timely (refer to contract) submission of reports to NPA. | 350/hospital/quarter |
| 2 | Percentage of observations or recommendations made during QSS supervision that were implemented within the next quarter. | Percentage of recommendations made during supervision that were followed up within the next quarter. | 300/quarter |
| 3 | Percentage of staff with anup to date Appraised Performance Agreement | A complete set of performance agreements with quarterly appraisals in file for each staff member. | 200/quarter |
| 4 | No. of PHE meetings to review Operational Plans (DIPA) conducted once every quarter with minutes indicating revised priorities and updated procurement plans. | for all Hospitals and DHEs conducted once every quarter with minutes indicating revised priorities and updated procurement plans. Copy of report to be submitted to PHE and NPA as a supporting document for payment | 400/quarter |
| 5 | Availability of Reviewed Monthly Stock Status Report | Availability of a monthly stock status for all medicines and commodities for all districts with minutes of their discussions in the PHE reflecting actions taken, signed by PMD | 500/quarter |
| 6 | % of Maternal Death Notification and Audit Reports Submitted to FCH Department | 100% availability of all Maternal Death Notification and Audits submitted to the FCH department at Head Office in line with national policy. | 500/quarter |
| 7 | 100% expenditure reports submitted for GOZ, GF, RBF, HDF and UN Agencies With 80%+ Burn Rate. | PHEs submit to DFA, every quarter, financial reports which reflect at least 80% utilization rates for GOZ, GF, RBF, HDF and UN agencies based on acquitted funds. Variances should have supporting justification and approved by DFA | 500/quarter |

| | | | |
|---|---|---|---|
| 8. | 100% Monthly Submission Status of Returns (Transport, Fuel and Assets) | Complete Monthly Transport, and quarterly Fuel, Asset Returns submitted with minutes showing action points to the Director Finance and Administration<br><br>Submission Status of Returns (Transport, Fuel and Assets) | 400/quarter |

The average amount expected from the above would be $5,750 per Province/Quarter. This would mean a quarterly expenditure of $46,000 up from the previous $21,040. This is justified from an institutionalisation perspective due to greater responsibilities and because of current inflation rates.

### 7.2.3 DHE Indicator List

**DHE Indicator List**

| | Indicator | Indicator Description | Subsidy in USD |
|---|---|---|---|
| 1 | No. of Health Facilities Supervised Using a Structured Quality Supervision and Assessment Tool | Health Facilities have been supervised and quality assessments conducted at each clinic at least once per quarter with timely (refer to contract) submission of reports to PHE and LPU. | $60/hospital/quarter |
| 2 | Percentage of observations or recommendations made during QSS supervision that were followed up within the next quarter. | Percentage of observations or<br><br>that were followed up within the next quarter. | $120/quarter |
| 3 | Percentage of staff with an up to date Appraised Performance Agreement | A complete set of performance agreements with quarterly appraisals in file for each staff member | $50/quarter |
| 4 | Number of Health Facilities Verified | Health Facilities that have been verified by DHIO/Community Nurses and verification reports submitted to LPU within 15 days of the following month. | $60/quarter |
| 5 | Availability of Reviewed Monthly Stock Status Report | Availability of a monthly stock status report for all medicines and commodities for all facilities with minutes of their discussions in the DHE reflecting actions taken, signed by DMO | $60/quarter |

| | | | |
|---|---|---|---|
| 6 | Number of Maternal Audit Meetings Held According to Guidelines | Maternal and Perinatal death audit meetings conducted quarterly according to guidelines with proof that appropriate action was taken. Copy of report to be submitted to the PHE and FCH HQ | $500/quarter |
| 7 | Number of DSC Meetings Held | DHE organize and participate in the Quarterly DSC Meetings. Copy of report to be submitted to PHE and LPU as a supporting document for payment) | $200/quarter |
| 8 | Number of Operation Plan and Procurement Plan Review Meetings Held | DHE meeting to review Operational Plans for all facilities conducted once every quarter with minutes indicating revised priorities and updated procurement plans. Copy of report to be submitted to PHE and | $50/quarter |
| 9. | 100% expenditure reports submitted for GOZ, GF, RBF, HDF and UN Agencies With 80%+ Burn Rate. | DHEs submit to PHE, every quarter, financial reports which reflect at least 80% utilization rates for GOZ, GF, RBF, HDF and UN agencies based on acquitted funds. Use indicator statement as in PHE | $50/quarter |
| 10. | % of Ambulance Calls Responded to within the standard time. | Timely response of ambulance services to the clinics. Ambulance must be dispatched within 30 minutes of the call being received at the District command centre. | $100/quarter |

The figures indicate that on average a district allocation would be around $4,010 per quarter, up from $3,000 used in the previous pricing budget.

This means that the budget required per annum is $962,400 for DHE, $184,000for PHEs, and an additional amount ($1,200,000) for CBOs. The total amount, in addition to the assumed $16m for service subsidies, will make up the envelope for RBF, which is validated by the financiers.

# 8.Pricing

## 8.1. Overview of Previous Pricing Methodology

Steps in the selection of quantity indicators followed logically from an initial agreement on the focus of the RBF program in Zimbabwe. A full listing of all key indicators deemed to sufficiently align the program to the agreed focus was obtained and prioritized using a Modified Delphi Approach. This iterative process of individual-based ranking of the prioritized indicators required obtaining consensus through focused discussions, repeated ranking, and plenary-level rating.

The ranked and rated values assigned to the indicators by participants were then applied in the weighting of the indicators relative to an agreed base indicator: the highest-ranking indicator. The base indicator was regarded as the indicator of the highest importance in line with the program focus. This indicator was

determined using an analysis of epidemiological and coverage data. To minimize the distortion with the existing price profile and preserve the historical functionality of the RBF system, the current weights were also factored into deriving the final weights. Given that some new indicators were added, some weights were assigned based on perceived similarity of importance to already existing indicators. Manual adjustments were applied to the weights of a few select indicators based on expert opinion; consultations with key persons suggested an increase in specific indicators due to their perceived importance in the program.

The indicator weights allowed for default computation of prices of the indicators relative to price allocated to the base or anchor indicator. That is, by changing the price of the base or anchor indicator, the prices of other indicators were automatically computed by multiplying the relative weight of the indicator to the base price. The product of the price schedule and the estimated project coverage provided an estimate of the amount required to implement the RBF project. A top-down approach was used, however, i.e., starting from a fixed envelope (e.g. 50% of available budget for PHC). The base price was iteratively adjusted to optimize the usage of the envelope.

## 8.2. Limitations of the Previous Approach

Although the previous approach satisfactorily addressed key pay for performance principles, including correcting some equity imbalances between high and low catchment population facilities, the following limitations of the previous approach were noted:

1. The previous pricing method gave the anchor indicator a significantly higher value than other related indicators. This tended to lead to disproportionate focus being given to that indicator (e.g., Normal Delivery) with other indicators in the same continuum of care not performing well. This therefore affected such indicators as first ANC before 16 weeks and Post-Natal Care (PNC)
2. The effectiveness of the Delphi Technique, though fostering participation and buy-in, relies on the representativeness of those participating in the exercise. The relative importance and subsequent weighting of the indicators were open to bias depending on who attended the various consultations.
3. The projected coverage of the indicators, which determined the forecasting of the utilisation of the budget, were based on epidemiological assumptions, which at times could result in inflated targets. This scenario would have an overall effect of lowering the prices.
4. The pricing relied on a projected available envelope that was conservative without another option for an "ideal" budget, which could be used for additional resource mobilisation.

## 8.3. Current Pricing Methodology

The current pricing approach builds on the previous model, but seeks to address some of the observed limitations and potential bottlenecks, such as data availability for the new indicators. The principles of ranking indicators based on their importance in the package, identification of the anchor indicator, estimation of annual coverage, as well as the consideration of the budget envelope were maintained, albeit applied using different methodologies.

## 8.4. Assumptions Underlying Current Pricing Model

The following assumptions were considered in deriving the model for the pricing:

- The indicator coverage is national
- There is a heavy reliance on RBF earnings by facilities
- RBF prices are NOT cost recovery
- Resources for RBF are NOT infinite; there must be a budget for RBF in place
- Balance of Quantity and Quality earnings (50:50, 40:60)
- Outputs should strengthen Primary Care

- Cascaded transfers: Primary (60); Hybrid (20); Secondary (20)
- Remoteness bonus contributes 8% and is derived from the Primary Allocation of 60%
- Pricing should support continuum of care/referrals

## 8.5 Anchor Indicator Selection

Owing to the limitations mentioned in the previous section, the anchor indicator selection and pricing took a different approach for this cycle. The four main components of process are described below.

### 8.5.1 Calculating the Weights of the Quantity Indicators

The approach included an assessment of contributory effects of each indicator to the facility performance.RBF facility level monthly data for the selected indicators running from January 2015 to December 2018 was used to calculate an index using Principal Component Analysis (PCA), a multivariate statistics approach that extracts key components of the data and reduces dimensionality to PCA scores. Boruta, a Machine Learning (ML) algorithm based on a Random Forest Model, was then applied to model the PCA Score against the indicator values to determine the indicator importance scores for each indicator. These were transformed to determine the indicator weights. Indicators were weighted against the highest scoring indicators in each health grouping in order to determine their overall weight. Four health groupings were applied, i.e. Maternal Health, Child Health, and Communicable and Non-Communicable Diseases.

### 8.5.2 Estimating Coverage for Quantity Indicators

Once the weights of the indicators were determined, the next step was to forecast the coverage of the services represented by the incentivised indicators to determine the volumes that would be paid for under the incentive. The analysis used the existing secondary data from DHIS2 from January 2015 to December 2018 to forecast coverage. A time series analysis, using the Prophet Package in the statistical software R, was used to estimate the minimum, median, mean, and maximum coverage of the services based on trends and factoring in seasonality.

### 8.5.3 Available Programme Budget

The RBF programme in Zimbabwe was observed to have been highly cost effective at an average financing allocation of US$2.78/per capita. Over the past few years, there has been increased health facility dependency on the programme earnings for efficient service delivery. Using US$2.78 per capita allocation and the current available budget from the GOZ and HDF of US$20M, the prices of each indicator were determined.

An optimal scenario of allocating US$3.50/per capita with a budget envelope of US$50M was also used to determine optimal pricing of the indicators. Using these budgets together with the indicator weights and forecasted coverages, a set of prices was determined for quantity indicators.

**Pricing Effect on Retention in Care**

The updated pricing module ensures retention of women and children in the continuum of care at both primary and secondary levels. It supports the life-cycle approach, whereby each stage in the care of the woman and child from family planning to growth monitoring is

### 8.5.4 Per Capita Quality Pricing

In view of the need to factor Level of Effort in rewarding efforts towards quality, the model adopted the per Capita Quality Price as determined in the 2017 Price Review. The assumptions used in determining the per capita prices included:

- The number of facilities in each of the groups: Primary, Hybrid, and Secondary

- The average catchment population in each group
- The share of allocation of the budget across each group: 60:20:20
- The budget ($20m, $40m, $50m)

Based on a budget of $20 mil, the table below shows the maximum earnings per capita available to each level

| Primary ($) | Hybrid ($) | Secondary ($) |
|---|---|---|
| 0.59 | 1.15 | 0.33 |

## 8.6 Determining Facility Earnings

The following formula is applied to determine the earnings per facility:

$$T_e = \sum_{i=1}^{20} (Ind_i \, xIndPrice_i) + \{QualityScore \, x(PerCapitaPrice \, x \, FacPopn)\} + RemoteBonus$$

# 9. RBF Operational Components

The main components of the RBF programme are:

- Contracting mechanism
- Management and capacity building
- Monitoring and documentation

## 9.1 Contracting

### 9.1.1 Types of Contracts

Contracts formalize the relationships between actors in the RBF-system. In a contract, parties formalize mutual obligations, and as such, contracts include a financial component.There are eight different contracts within RBF, including:

MOUs between:

i. Funding Agency and MOFED;
ii. Funding Agency and Fundholder;
iii. NPA and MOHCC; and

Contracts between:

iv. Fundholder and the NPA;
v. NPA and the PHE;
vi. LPU and the DHE;Health Facility (RHC, Rural Hospital, Hospitals); and CBO

For all contracts entered into by service providers, they must develop and submit operational plans.

### 9.1.2 Contracting New Facilities

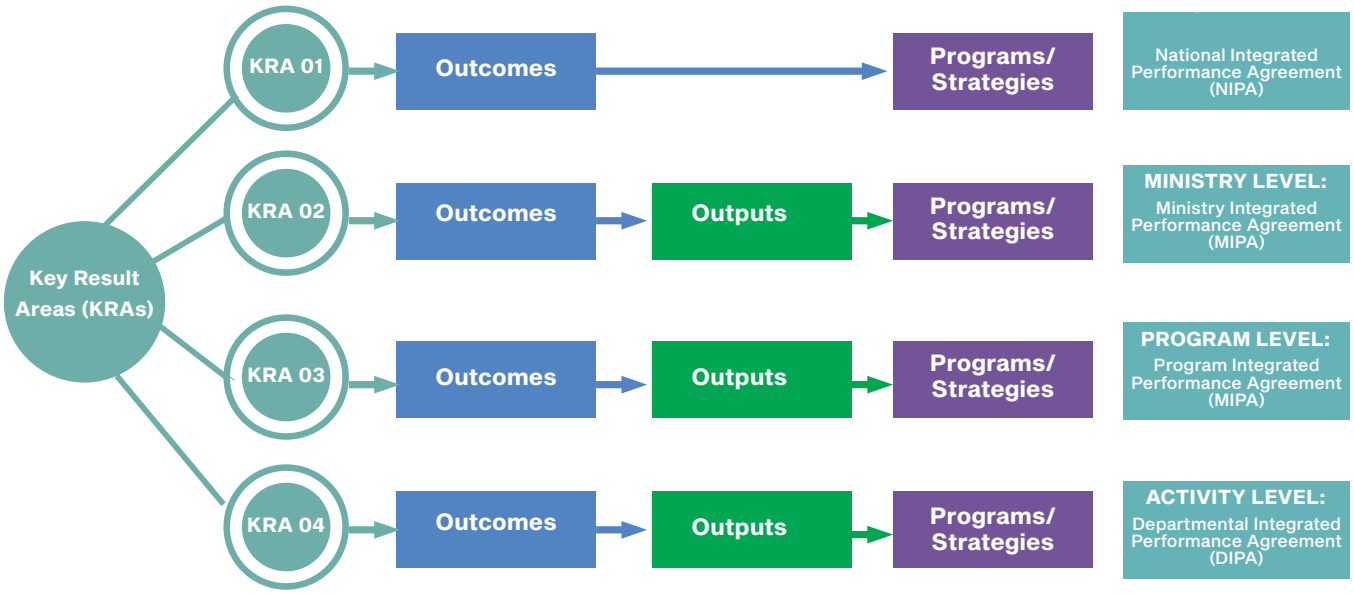
Every facility that is contracted under the rural RBF programme must meet minimum criteria (see Annex G). The NPA confirms availability of funds through the LPU to the NSC (at the beginning of the year and subsequently per rising need at quarterly NSC meetings), to the PS, to all PMDs, and to respective DMOs. The DMOs will notify all prospective facilities of the opportunity. The facility HCC then writes an application to the DMO. The DMO's office carries out an assessment of the facility together with a representative of the contracting entity, either from the NPA or LPU, to check for minimum criteria. The document setis then submitted to the PMD for approval and submission to the NPA, copying CD Policy.

The Chief Director of Policy, Planning and Monitoring and Evaluation (CD PPME)—also approves the submission, and the NPA receives the approvals and sets in motion the contracting process by requesting an Operational plan as detailed in the next section.

In accordance with the RBM framework, each level is required to prepare an Operational Plan describing services and investments for the year. The operational plan is not limited to RBF indicators but covers the whole scope of the appropriate health package. The Operational Plans are based on and aligned with the District's Department Integrated Performance Agreement (DIPA).

Figure 9 below shows how the Operational Plan is linked with the overall planning framework, which in turn is part of the government`s IRBM. Facility plans feeds into district performance agreements; district plans feed into provincial performance agreements; and provincial plans feeds into the Ministry Performance agreement.

**Figure 9: MOHCC Performance Management Framework**




## 9.1.3 Operational Plan

The Operational Plan is a document that describes planned services and investments for the year. The plan starts with community consultations through the HCCs, who in turn access Village Health Plans and Ward Development Plans. HCCsuse facility data and these consultations to identify priority health problems. They then conduct a Root Cause Analysis for each identified problem from their data review, and map available assets.Asset mapping is a new innovation added to the planning process to promote the utilization of resources within and by communities to solve their health challenges.

The operational plan must contain a realistic quarterly budget that aligns with identified priorities. The plan must specify the use of total revenues including RBF-subsidies for all service delivery. Each Operational Plan must also contain a procurement plan. All subsidy utilizations must be aligned with both the activities and procurement plan. The quality of the operational plan (the relevance of the priorities and solutions for problems, the involvement of community actors, budgeting, etc.) is assessed by the PHE, DHE, and NPA. The annual operational plan, once approved by the PHE, DHE, NPA, facility management, and HCC, is the first phase of contract negotiations between the health facility and the NPA.

Quarterly performance reviews of operational plans are conducted by comparing annual service delivery targets against planned targets using the Operational Plan Review form. The health facility reviews the targets, strategies, and procurement plans. The review shows the amount of services delivered during the previous quarter versus the planning of services for the next quarter, all per quantitative and qualitative indicators. The current priorities for the next quarter are identified, as well as problems and strategies to solve them.

## 9.2. Service Delivery

Contracted health facilities deliver services based on their Operational Plans. For health facilities, these services are quantity and quality in line with MOHCC policy and guidelines. Management structures such as DHEs and PHEs provide oversight and quality assessments to these health facilities as described under institutional arrangements. CBOs collect community feedback on behalf of clients as described in the quality verification section of this manual.

## 9.3. Verification

RBF requires both quantity and quality verification. Quantity verification is carried out for outputs of the 20 quantity indicators at primary and secondary levels. Quality verification iscarried out as assessmentof services rendered—both from a regulator`s perspective (by PHE/DHEs); and from the user/community perspective by CBOs.

### 9.3.1 Quantitative Data Verification

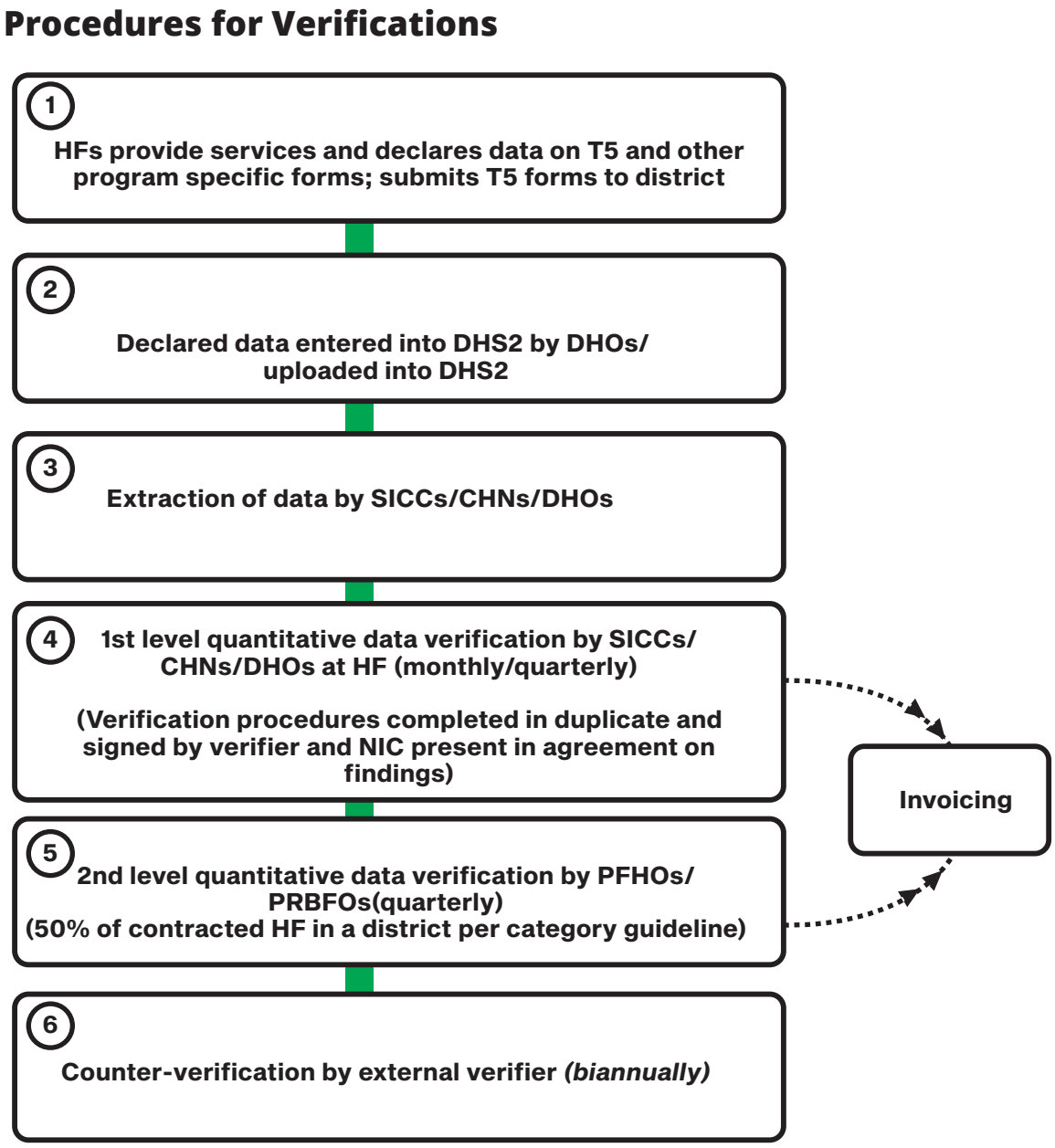
#### 9.3.1.1 1st level verification

Community Health Nurses (CHNs), or District Health Information Officers (DHIO) conduct 1st level quantitative data verification of predefined indicators to check for accuracy of reported/declared data. The CHN/DHIO officer are to visit all contracted health facilities within their areas of operation monthly or quarterly, depending on the risk category in which the health facility falls (see Table 4: Risk-Based Verification Categories)using the lighter verification model. Invoicing can be done based on 1st level verification with 2nd level providing checks and balances.

#### 9.3.1.2 2nd level verification

The LPU will conduct 2nd level quantitative data verification of predefined indicators. At least 50% of the health facilities per district will be verified each quarter per category guideline. Health facilities will be selected using stratified sampling as per the RBF categorisation. In order to have a fair distribution of samples among all three categories (Red, Amber, and Green), a random sample is taken from each category.Purposive verification can be done at any time.

Figure 10: Verification Flow Diagram




### 9.3.1.3 Description of Risk Categories

**Green Category (Low Risk)**

All health facilities qualifying for this category will have reported data within the 5% margin of error for each month in the past two quarters. These facilities will be considered low risk and quantity verification will be conducted once per quarter by SICC/CHNs/DHIOs.

**Amber Category (Medium Risk)**

Health facilities qualifying for the amber category will have reported data from +/-5% to +/-10% margin of error in the last two quarters.

**Red Category (High Risk)**

Health facilities qualifying for the red category will have reported data beyond a +/-10% margin of error in the last two quarters.

**Table 3: Risk Based Verification Categories**

| Category | Criteria | Quantity verification | Quantity verification |
|---|---|---|---|
| | Responsible Officer(s) | **SICC/CHNs/DHIOs** | **HFOs/RBFOs** |
| Green | Reported within 5% margin of error in the last 2 quarters | 1 visit per quarter to assess all 13 indicators across 3 months | 1 visit per 6 months per HF to assess only 13 indicators across 6 months |
| Amber | Reported over 5% to 10% margin of error in the last 2 quarters | 2 visits per quarter and verify 13 indicators across 3 months. Mentoring and focus on root cause noted. | 1 visit every quarter per HF to assess 26 indicators across 3 months |
| Red | Reported beyond 10% margin of error in the last 2 quarters | Monthly visit to assess all 13 indicators. Mentoring and focus on root cause noted. | 1 visit every quarter to assess all 13 indicators for each month |

**NB:** The NPA is responsible for categorisation of health facilities based on verified data uploaded by the LPUs.

**NB:** The secondary level facility and hybrid hospital indicators will fall under the red category by default.

**See Verification Guideline** Annex L

This **lighter verification model** is envisaged to create efficiencies by reducing the time spent in green and amber facilities for verification and to save on the cost of verification visits by moving to 6 monthly visits after 6 months of implementing this model.

To ensure all contracted parties use the RBF funding according to the operational plan and procurement and financial guidelines, the financial reporting system of the (decentralized) MOHCC will be applied. The district accountant will carry out the financial verification of the health facility expenditure. The PHE supervises the DHE and the Top Management Team supervises the PHE. The NPA and the LPU will be enabled to carry out verification of financial reporting as provided through the RBF financial monitoring framework.

### 9.3.2 Quality Verifications

Quality of care in RBF is assessed using Quality Checklists for hospitals (Quality Supportive Supervision, or QSS) and health centres and a Client Satisfaction Survey (CSS). Technical quality is assessed using the quality checklists while perceived quality is assessed using CSS tools.

### 9.3.2.1 Quality Supportive Supervision

QSS shall be conducted quarterly per each facility. QSS shall be conducted by DHEs and PHEs at health centres and district hospitals, respectively. DHEs and PHEs shall use the national QSS checklists to assess quality of care each quarter and will utilize tablets to administer the quality checklists. Currently, DHEs and

PHEs are reviewing patient files and registers to assess clinical process of care retrospectively. This method of assessment alone might not be sufficient; thus, the following additional methods can complement the current method of assessing clinical process of care:

- Direct observation: on quarterly basis. This method can be used to assess common treatments, for example ANC, and management of common childhood conditions and other conditions typically managed via the outpatient department.
- Simulation and/or vignettes: twice a year. This method is best suited to assess complications, for example complications related to labour and delivery and postnatal care.
- Standardised patients: once a year. This method can be used to assess ANC best practise and management of other chronic illnesses.

A tool kit shall be used as a reference to apply the above-mentioned additional methods of assessing quality of care in QSS.

To increase timeliness and efficiency of QSSand post-supervision support visits, practicing clinicians with MNCH skills (paediatricians, obstetricians, experienced GMOs, experienced midwives), and other cadres (pharmacists, environmental health officers, accountants, administrators), can be added to the pool of supervisorsfrom districthospitals to DHEs and from provincial and central hospitals to PHEs.

After QSS, DHEs and PHEs shall give written feedback to health facilities. In addition, after QSS in all health facilities in the district and province is completed, supervisors should sit down as a team, analyse the QSS data, make informed decisions, and develop action plans based on what post supervision support to health facilities will be provided. To develop a culture of analysing data, using it for decision making, and providing targeted post supervision support visits, specific PHE and DHE indicators need to be developed. The post support visits can also be made more efficient if the clinical mentorship program is integrated with quality supportive supervision. This necessitates joint planning at national, provincial, and district levels.

### 9.3.2.2 Client Satisfaction Surveys

CSSs shall be done by CBOs on a quarterly basis. Exit interviews and home-based tracing mechanisms shall be utilised interchangeably every other quarter. CBOs will use a mobile application to conduct the CSS. For home tracing, clients will be selected by CHNs and the list will be provided to CBOs. After the client satisfaction survey, CBOs should write a report using a standardised template and submit to the CHNs. The CBOs should also produce a summary report for the HCC and share a copy of the report and the summary to the DHEs via the CHN.

### 9.3.2.3 Continuous Quality Improvement

The quality assessment provides an opportunity for the health facilities to identify areas for improvement. It was, however, noted that the health facility teams do not have adequate knowledge and skills to analyse findings, prioritise problems, and conduct in-depth problem analysis to identify causes for gaps in performance. This has resulted in recurrence of problems,or improvements that are not sustained over time.

The RBF impact evaluation has also shown mixed but positive results on some clinical quality of care results. This has indicated the need for an initiative to amplify the effect of RBF on quality of care outcomes. Taking this into account, the MOHCC with World Bank and Cordaid support initiated

continuous quality improvement (CQI) as part of the RBF programme. The purpose of CQIis to amplify the effect of RBF on quality of care by applying and assessing ongoing changes and adjustments to the existing health care system and services. CQI createsa more conducive environment for the application of protocols and guidelines to close service and quality gaps. The initiative is in line with the 2016-2020 National QA and QI strategy that outlines the need for starting CQI in selected districts, facilities, and technical areas.

Preliminary results from the process monitoring and evaluation (PME) on CQI done by the World Bank has shown that the progress in internalisation of CQI is slowly gaining momentum and already exhibits positive changes in the system, processes, and outcomes. The positive changes are more evident at CQI facilities compared to comparison facilities, but not equally distributed among participating facilities. It is therefore high time to scale up the CQI initiative within the 5 districts to the remaining 55 districts. During scale up, the lessons from the PME should be considered.

### 9.3.3 Counter verification

To ensure accountability of the programme, counter verification for RBF will be done for both quantity and quality components by:

a) Provincial and district teams via a peer to peer verification
b) Internal quality verification: The MOHCC Quality Assurance Directorate—in collaboration with the National Technical Working Group on quality—will conduct quarterly spot audits of districts with outlier quality scores.
c) Use of an external agent/institution e.g. Health Professions Authority (HPA) to counter verify

Verification of reported primary care facility performance will be conducted once every six months by an independent organization or firm contracted by the Fund Manager. An independent local institution, the HPA, has been selected to ensure local ownership of the external verification function.

## 9.4. Invoicing

### 9.4.1. Subsidy Calculations

A subsidy-for-service is paid for the delivery of a package of selected health services. The programme also assesses the quality of delivered services using a standardised quality checklist. The subsidies paid to facilities are calculated as follows:

- Per quantity indicator (number of services, if necessary, adjusted for deviations according to the cross check) X the unit price paid for this service= earned amount (total of amounts earned for all quantity indicators). Per quality indicator: An assessment of the service provided by the health facility is conducted and a quality score attained. This score is checked against the four quality ranges in order to determine which percentage of the capped monthly amount the facility will earn.
- For purposes of equity, facilities that are in remote areas receive an equity bonus calculated according to pre-determined criteria. The assessment of a facility's remoteness is conducted by the DHE based on five remoteness indicators. Each indicator can have a maximum bonus of 6% meaning that the maximum remoteness bonus is 30% of the quantity amount.

Details of the remoteness indicators and accompanying criteria can be found in Annex D. The assessment of remoteness should be conducted by the DHE at the start of the programme and reviewed on a 6-monthly basis considering any changes in indicators (e.g. improved network coverage) and agreed with the LPU.

*Calculation of subsidy* - The total subsidy that the Health Facilities receive is calculated as follows:

**Total subsidy = amount paid for quantity of services + amount paid for remoteness bonus + amount paid for quality of services**

The overall quality score comprises:

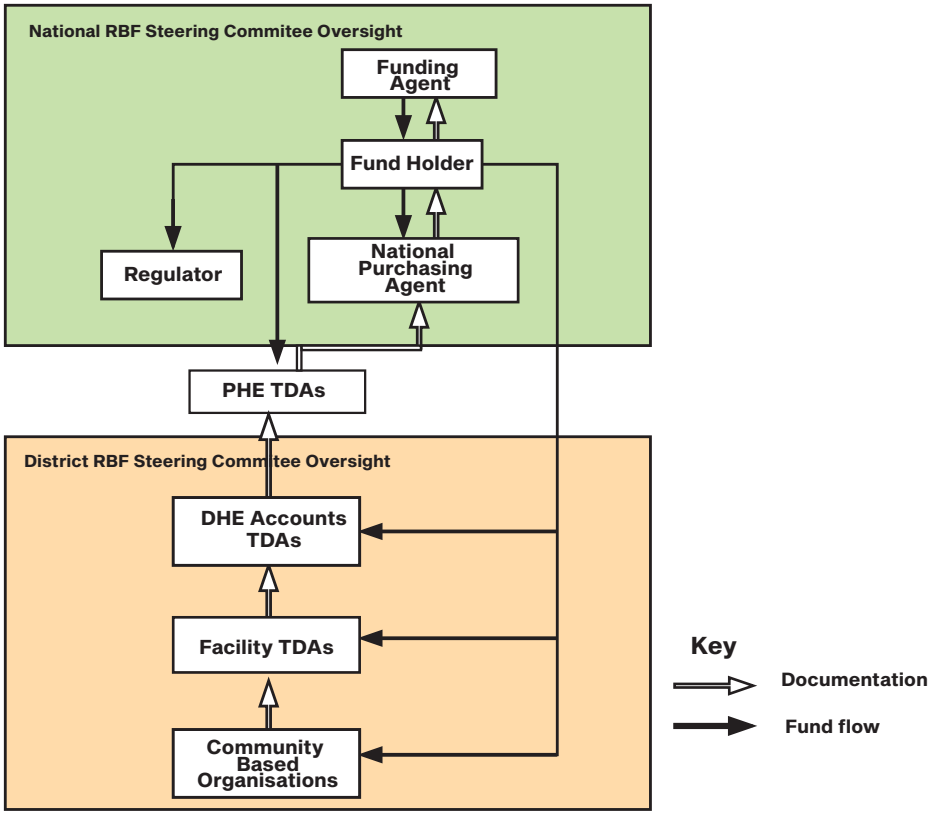
- The facility quality supportive supervision checklist done by PHE and DHEs at hospital and clinic level with a weight of 80% ofthe overall quality score. The quality checklist has three components: structural, management, and clinical.Each component has a different weight based on the available points for each.
- The client satisfaction survey score is based on the surveys conducted by the CBO with a weight of 20% of the overall quality score.

## 9.5. Funds Flow, Payments, and Financial Reporting

This section provides clarity on fund disbursement, payments, and financial reporting, and provisions for accountability at all levels.

### 9.5.1.1. The flow of funds

1. The fundholder submits a Withdrawal Application (disbursement request) to the Funding Agent account together with a Statement of Expenditure (SOE) based on an agreed format with the Funding Agent.
2. The Funding Agent reviews the SOE and Withdrawal Application and approves the disbursement. Funds will flow from the Funding Agent's account. The funding will be transferred into the denominated Designated Account to be opened by the fundholder's Harare office with a commercial (local) bank acceptable to the Funding Agent, and to be managed by the fundholder.
3. The fundholder will use the Funding Agent grant for management costs and for payment of subsidies to contracted health facilities.
4. Payments for services delivered will be made to a health facility upon a payment request. This request will be prepared by the LPU.



### 9.5.1.2 The payment request

The payment request is a filled-out form that includes following elements:

1. A report with verified quantitative data of the health facility on the agreed package of services, including:
    a. Amounts of services delivered per agreed output indicator on mother and child care;
    b. The agreed fee per output indicator, whereby – if applicable - the fee is adjusted for equity purposes; and
    c. A statement that these data have been verified by the local purchaser
2. Signatures of the management of the health facility and of the representative from the local purchaser
3. A report entailing a quality assessment of the facility, including:
    i. The score of the facility per quality indicator;
    ii. A statement that score has been checked by the DHE (for primary care facilities) or PHE (for hospitals)
4. Signatures of the management of the health facility and of the person that checked the quality on behalf of the DHE or PHE
5. A report from the local purchaser based upon the cross checks done by the CBO/NGO, including:
    i. An explanation of deviations between data on the quantity report and data randomly checked by the CBO/NGO;
    ii. An explanation of adjustments to be made to the quantity score based upon the cross check of the CBO/NGO
6. A calculation sheet prepared by the LPU including the following calculation:
    i. Per quantity indicator (number of services, if necessary, adjusted for deviations according to the cross check) X (fee for the indicator) = (earned amount) total of amounts earned for all quantity indicators;
    ii. Per quality indicator (number of services, if necessary, adjusted for deviations according to the cross check) X (fee for the indicator) = (earned amount) total of amounts earned for all quality indicators

### 9.5.2. Payments

1. Payments for services delivered by health facilities will be transferred into the health facility account.
2. The fundholder will inform the contracted health facilities of the payment, i.e. the amount paid and its calculation, and the date on which the payment has been effected. A copy will be submitted to the DHE, the PHE, and MOHCC headquarters.
3. Contracted health facilities shall request the DHE to authorize and sign withdrawal slips that are signed by the authorised representative of the HCC. A representative of the DHE will countersign the payment request and the representative of the health facility signs for receipt.
4. The District Accountant will send a written and signed confirmation of the receipt to the NPA. This confirmation includes:
    i. Previous balance of the sub-account;
    ii. Amounts withdrawn during the previous reporting period;
    iii. Exact amount received on the HF's Temporal Deposit Sub-Account during the reporting period;
    iv. New balance of the sub-account.

## 9.6. Subsidy Management

Of all facility earnings, 75% is used by the facility in line with their approved operational and procurement plans, while 25% is for staff incentives. The subsidies that facilities earn are utilized in accordance with the

Finance Manual for the GOZNPA. Health facilities, PHEs, and DHEs follow GOZ procurement guidelines. The facilities and lower level governmental offices will report financially in accordance with MOHCC and/or MOFED stipulations. The DHEs will assure that for RBF-funding of the health facilities – equal to other sources of income – the accountability procedures for health care are maintained. MOHCC Finance Department procedures are also applicable to RBF-funding. The NPA can be requested to participate in spot audits of the health facilities.

### 9.6.1 Staff Incentive Calculator Used for Payment of Staff Subsidies

The Staff Incentive Calculator assists facility management to calculate individual staff subsidy payments. Zimbabwe RBF implementation evidence has shown that the staff incentive has motivated staff to produce better health services. The earned subsidies by the health facility will be apportioned for the following areas:

- Staff incentives will equate to a maximum of 25% of total RBF subsidies earned by the facility.. The funds are distributed among the staff members using the staff incentive calculator. This tool has been developed into an electronic app that makes it easier to implement.
- From the overall earnings that each staff is eligible to earn, the app will be configured to factor in the overall performance score of the individual staff member based on the RBM framework and their appraisal by the supervisor. The individual total possible earnings as determined by the staff incentive calculator will therefore be pro-rated according to their appraisal score.
- Staff incentives will be variable up to a maximum of 25% of total earnings/subsidies depending on the quality score of the Health Facility, both clinical and structural.

A threshold approach will be applied to the 25% staff incentive as follows:

**Table 6: Staff Incentive Calculations**

| Quality Score | Staff incentives % |
|---|---|
| ***60% and below*** | 0 |
| ***61% -70%*** | 10% |
| ***71%-80%*** | 15% |
| ***81%-90%*** | 20% |
| ***91%-100*** | 25% |

### 9.6.2 Financial Reporting

HCCs and DHEs will account for RBF funding in line with overall MOHCC financial reporting requirements. HCCs will submit a financial statement plus supporting documents to the DHE, which will verify these against accountability norms. Payment requests will only be processed when the common accountability requirements for previously disbursed funds are met.
In case of proven or suspected violation of accountability or any other form of purposeful misappropriation, a report will be sent to the DHE with copies to PHE and local purchaser. If any anomalies are identified by the NPA,the PMD, and the Permanent Secretary should be formally and immediately informed.

Action should be taken immediately but no later than five days in cases where anomalies are identified.Both the DHE and the HCC are to be advised of sanctions that shall be effected in case of anomalies. Such sanctions should include but not be limited to:

- Stopping of allowances and subsidies
- Police action

The DHE will provide quarterly reports on disbursements effected, i.e. amounts disbursed per health

facility and RBF-subsidies for supervision by the DHE. The disbursement report will be sent to the NPA, , with copies to local purchaser (if applicable) and PHE.

In addition, the local purchaser will compile a report that provides an overview of reported results based on the agreed package of services against expected results according to the operational plans and contracts signed with the health facilities. The report will include an overview of payments to health facilities. A copy will be submitted to the DHE, PHE, and DSCs.

The NPA will consolidate the reports and share them with stakeholders. The quarterly report will include both financial and programmatic updates and information.

### 9.6.3 Financial Auditing

The auditing of the RBF programme shall be guided by the MOHCC guidelines for the audit of HSF funds.

## 9.7. Procurement and Financial Management

Financial and procurement procedures are described in the MOHCC Health Services Fund Manual and rural health centre financial guidelines for health facilities and in the PIE manual for project implementation. In case need arises to request for other reports than used so far, formats and explanations will be added to this manual.

### 9.7.1 . Procurement

The procurement of goods, works, or services are described in the procurement and financial manuals of the MOHCC and in the purchasing agent manuals. The following guidance should be used for all procurement:

- Public Procurement and Disposal of Public Assets Act [Chapter 22:23]
- The Public Finance Management Act [Chapter 22:19]

***Procurement of Health Services***

Besides these goods and consultancy services, the NPA purchases health care services from the health facilities, monitoring and verification services from PHEs and DHEs, and verification services and surveys from CBOs/NGOs. These purchases are all results-based and are not bound to procurement guidelines other than the RBF-principles explained in the previous chapters.

***Procurement Procedures for Health Facilities***

In accordance with the current law, the Public Procurement and Disposal of Public Assets Act[Chapter 22:23], clinics do not have the requisite institutional arrangements to conduct procurement. Unless otherwise informed or approved, clinic procurement is carried out by the District Medical Office using the Procurement Management Units (PMU) at that level.

Where framework contracts are available,the clinics—through the Districts—will order from approved service providers or suppliers, but payment will be made from the clinic funds.Guidance for utilisation of framework contracts will be used and are part of the rural health centre Financial and Procurement Guidelines.

Clinic procurement plans should be incorporated as part of the District procurement plans. The Annual Procurement plan—which should be approved by the accounting officer—should be available by 31 January of the budget year.

Monthly procurement returns of RBF funds utilisation should be shared with the Procurement Regulatory Authority of Zimbabwe (PRAZ), the MOHCC, and the NPA.

As per the mandate of the NPA, procurement verification and spot checks will be carried out on an adhoc basis.For all infrastructure or works, Ministry of Local Government, Public Works, and National Housing (MOLGPWNH) should be involved and certificate of completion approved by them after recommendation from the same.

Where approved, procurement steps required of health facilities are summarised below:

• Request for goods, works and services:
  - Health facilities list goods or services to be procured;
  - Districts must approve requests
  - Request for quotations for local shopping
  - Use of domestic and international competitive processes where necessary
  - The approved request for goods and services is used to source for quotations or decide the method of procurement that will be used, and this method should have been specified during the procurement planning process
  - Comparative schedule developed and evaluation done in accordance to the law
  - The requested quotations are adjudicated, and approved by accounting officer
  - Requisition raised and sent to supplier
  - An official order is sent /given to the supplier to deliver the goods or services
  - Goods receipt
  - Goods are received together with the delivery note, which is signed by the facility
  - Stock or bin card and asset register maintenance.
  - Received goods are recorded in the receiving registers and on the bin or stock cards before they are use.
• Disposal of public assets be done in accordance to the guidelines

## 10. Capacity Building in Results Based Financing

This component supports management and capacity building for HCCs/Primary Care Facilities, DHEs, PHEs, Local Authority and Mission Executives, CBOs, and District Steering Committees to strengthen the health system for effective implementation of the RBF initiative. The University of Zimbabwe, Department of Community Medicine has introduced a course in Results Based Financing, which will be valuable for sustainability of the programme. In addition, the programme will continue to support staff to exchange knowledge and further training in and outside the country.

**Training and support required:** Mentoring on the various aspects of RBF in all the districts will be provided by the Regulator (MOHCC) and the NPA through their National and Subnational Structures .Other essential training and support includes:

- Support of NPA/LPU on the RBF regulations and procedures with technical support provided by Cordaid and Crown Agents.
- Support forSICCs (up to three from each district) and HMIS officers.
- Should there be new staff, training of primary care facilities and rural hospitals in RBF procedures, envisaged as two-day training, as discussed with MOHCC.
- Support for the DHEs and Rural District Councils on RBF procedures on data verification and quality scoring.
- Training of new HCCs on RBF principles, community participation, health services, and the role of HCCs in managing the primary care facilities. This will include the Nurse in Charge and a

member of the HCC from the community,e.g., Chairperson or Treasurer.
- Training of local NGOs/CBOs on methodology and procedures for client satisfaction surveys.

Training manuals must be kept up-to-date.

# 11. Monitoring, Evaluation and Learning

## 11.1. Information Management Tools

The Information Management tools for RBF will include:

- A database for invoicing and report generation based in the MOHCC Data Centre, with NPAs having access to the data.
- The database will be linked to the DHIS.
- The database will provide pre-configured reports, such as monthly bills consolidated, but also interactive graphs. A spreadsheet with all health facilities included in the system will be used and contain information such as bank accounts. The database can also be accessed through the export of data in Excel, and trend analysis carried out using pivot tables or graphic options. Entities that conduct verification will enter the verified data directly into the database.

## 11.2. Monitoring and Evaluation Tools

- In a system of RBF, where performance is required as well as transparency in the use of funds, a monitoring and evaluation system is essential. The M&E system is objective and transparent towards beneficiaries about the preventive and curative care. The objectives of the performance monitoring are to:
    1. Establish and monitor both indicators of the project management process and RBF results indicators; and
    2. Show the effectiveness of interventions: whether results are being achieved and what type of changes should be made to improve the efficiency and/or effectiveness of the interventions.

### 11.2.1 The Monitoring and Evaluation framework

Monitoring and evaluation of the RBF system rests on three levels: National, Provincial, and District. The players at each level have a key role in operationalising the system. The monitoring and evaluation plan looks at reports and activities at each level.

RBF monitoring and evaluation tools will include:

- Monitoring and evaluation guidelines on the technical and financial aspects during the preparation, negotiation, and amendment of annual operational plans;
- Monitoring and evaluation of the performance of management strategies for the implementation of various RBFfunctions;
- A monitoring and evaluation framework for coordination and overall financial management, and for the impact of RBF at operational level. This will include:
    - Biannual process monitoring
    - Midterm evaluation
    - Impact evaluation

### 11.2.2 Reporting

All parties will report on their performance and compliance with their contracts. Funding will be made available according to the (verified) reports.

The following reports are required:

- A monthly report from the facility with quantitative data on services delivered during the month (T5 report) latest by the 7th of each month to the District Nursing Officer's office.
- On a quarterly basis, the PHE and DHE produce a quality report with the quality scores of the health facility, based upon the quality evaluation conducted.
- On a quarterly basis, the LPU compiles the monthly quality scores of the client satisfaction surveys conducted by CBOs.
- At the end of the quarter, the LPU raises the payment invoices which includes the quality, quantity and remoteness bonus.
- A report from the CBO outlining the results of the client satisfaction surveys (based on a random sample of patients that visited the health facility during the reporting period). The report of the CBO will include the following:
    - a cross check of the patients on the list, to confirm their existence and their visit to the health facility;
    - comparison of the number and type of services delivered to those patients – including fees paid - with the services reported by the health centres;
    - suggestions from the health care users for improvement of the quality of care; and
    - suggestions from the users on access to health care.
- The consolidated performance report – including payment request - by the LPU/NPA.
  The LPU/NPA receives all above-mentioned reports and will consolidate all performance scores per facility. Based upon the overall score the payment for the health facility will be calculated. If an LPU is applicable for the area, the LPU will submit the report to the NPA. Based upon these reports the NPA will make payments for the health facilities.

### 11.2.3. The RBF results framework

Whenever a new phase of the RBF programme starts, a set of results shall be agreed between the funders and the MOHCC. They are derived from the overall project objective and sub-objectives and aligned to the NHS and national performance framework. These results form the core of what the NPAs report onto the funders and the MOHCC. They shall also be the basis of monitoring of performance and shall be updated every quarter. The current results framework is in Annex F.

### 11.2.4. Quarterly financial report – Use of Performance subsidies

The reportsummarizes and documents the use of subsidies per health facility, according to the priorities outlined in the Operational Plan every quarter, including other most significant change stories. The report will be produced by the District Medical Officer who will submit it to the LPU and the PMD. The PMD will forward the report through channels to the Permanent Secretary. The report will be passed on to the NPA by the LPU for consolidation and presentation to the RBF Steering Committee.

### 11.2.5 RBF programme management indicators

The performance of the NPA will be measured against the following indicators:

- Completeness and timeliness of quarterly reporting (progress and financial) to MOHCC, NSC, and partners involved in the RBF program; and
- Number of health facilities, DHEs, PHEs, and CBOs that received their quarterly performance payment within 6 weeks after submission of invoices.

### 11.2.6 Data Generation, Storage and Analysis

- The programme will maintain a centralized invoicing system based on the District Health Information System 2 (DHIS 2). DHIS 2 is an open source software and currently is used by the MOHCC. NPAs will have access to the database for customization.

- The data will be stored in a dedicated server housed at the MOHCC data centre with strict system for back up to avoid loss of data.

### 11.2.7 Quarterly qualitative and quantitative progress reports from LPU to NPA

Progress reports consolidateactivities and results from quality and quantity assessments per health facility each quarter. The report will include, among other things, overall health facility performances per district; comparative analysis of health facility performance; and health facility quality scores, trend analysis, and contributions of CBO score towards health facility incentives earned per the quarter. The report also includes capacity building and coordination activities. For this report to be produced the following is needed: results of the indicators; verifications report of the results by the SICCs and the LPUs; DHE quality score of the services provided; and community satisfaction survey report. The report will be passed on to the NPA by the LPU for consolidation and presentation to the RBF Steering Committee.

### 11.2.8 Joint Monitoring

**Table 7: Joint monitoring between NPA & National level (Top Management Team)**

| *Objective*: Quality of program – National level; *Frequency*: Biannual for sampled districts and facilities | |
|---|---|
| **Processes monitored** | **Methodology** |
| Use of performance subsidies at health facility | ▪ Field visits; Group discussion- Health facilitydirect observation<br>▪ Review of health facility reports |
| Challenges noted in PHE and local authority supervision visits and possible way forward | ▪ Key informant interviews- PMD/DMO/local authority health director/ medical superintendent |
| Review of PHE and local authority supervision reports (recommendations for improvement) | ▪ Discussion |
| Provincial review of health facility performance (recommendations for improvement) | Performance review-province |

**Table 8:Joint monitoring by Provincial Management Team and LPU – Provincial Level**

| Objective: Quality of program - District level; Frequency: Quarterly | |
|---|---|
| **Processes monitored** | **Methodology** |
| DHE supervision visits (timely, follow up, use of quality checklist) | ▪ Key informant interviews with DMO, DHE, local authority, mission members<br>▪ Meetings with DHE Review of DHE supervision visits (recommendations)<br>▪ Review of Issues by the DSC<br>▪ Field visits to all health facilities in selected districts |
| District performance overview | |
| Challenges met at district level that hamper progress | |
| DSC, checking if review meetings are being held | |

**Table 9:Joint Monitoring Local Purchasing Unit – District Health Executive**

| Objective: Quality of program (at HF level); Frequency: Quarterly | |
|---|---|
| **Processes monitored** | **Methodology** |
| Quality supervisions at health facility | ▪ Field visits to all contracted HF<br>▪ Group discussion with HF staff<br>▪ Collect Stories of MSC (Most Significant Change)<br>▪ Focus group discussions with community<br>▪ Review of health facility performance (HMIS and Data Base usage)<br>▪ Review of financial reports + accounting books. |
| Health facility performance including trend analysis | |
| Outcome from client satisfaction surveys | |
| Community/HCC involvement & knowledge on the programme | |
| Use of subsidies in HF according to priorities in Operational Plan | |
| Challenges in HMIS and data capturing and recording | |
| Financial planning and reconciliation of health facility | |

## 11.3 Summary of Reporting and Payment Schedule

The quarterly cycle operational plan (monitoring), contracting, reporting, verification and payment requires a tight time scheme. Therefore, the following schedule should be adhered to for health facilities.

**Table 10: Summary of Reporting and Payment Schedule RHCs**

| What | From | To | Number of days | Deadlines on Completion dates (range) |
|---|---|---|---|---|
| *Ready before beginning of new year* | | | | |
| Writing / adjusting / discussing operational plan | HCC/Primary Care Facility or DH | DHE or PHE and local purchaser | 10 | *10th-14th Dec (submission to local purchaser)*[1] |
| Results based contract health facility | Local purchasing Unit | HCC/Primary Care Facility or DH | 5 | *10th–14th Dec (submission to local purchaser)* |
| *After end of month* | | | | |
| Verification report, quantity score for health facility | Community Health Sister | Local Purchasing Unit | 21 days after receiving declared data from MOHCC | *Verification of data for previous month to be completed by the 2nd – 6th of the second month, following the previous quarter* |

| | | | | |
|---|---|---|---|---|
| *After end of quarter* | | | | |
| Counter Verification report, quantity score for health facility | Local Purchasing Unit | National Purchasing Agency | 21 days after receiving declared data from MOHCC | *Verification of data for previous month to be completed by the 2nd – 6th of the second month, following the previous quarter* |
| Quality assessment report for health facility, and overall supervision report | DHE or PHE | Local Purchasing Unit | 14 days after the last month of the quarter. | *8th – 14th of first month of the new quarter* |
| Patient/ client data for community verification and patient/client satisfaction survey available | Community Health Sister | CBO/NGO | 5 days after CHS conducts quantity verifications for CBO specific health facility. | *5th - 7th of every month. To coincide with verifications* |
| Final report on community verification and patient satisfaction survey | CBO/NGO | Local Purchasing Unit | 1 days after CBO receives the last questionnaires from the Local Purchasing Unit | *15th – 18th of every month* |

**Table 11: Summary of Reporting and Payment Schedule for PHEs and DHEs**

| What | From | To | Number of days | Deadline submission dates (range) |
|---|---|---|---|---|
| *Ready before beginning of year* | | | | |
| Adjustment of contract details for number of districts and/or facilities | DHE / PHE and Purchaser (local) | National Purchasing Agency | 10 | 10-14 December (Submission to NPA) |
| Results based contract DHE / PHE | National Purchasing Agency | DHE / PHE | 5 | 10-14 Dec (Submission to NPA) |

| | | | | |
|---|---|---|---|---|
| *After end of quarter* | | | | |
| Results scores of previous quarter quality checklist & supervision report | DHE / PHE | National Purchasing Agency | 14 days after the last month of the quarter. | 8th – 14th of first month of the new quarter |
| Compilation and calculation of invoices for DHEs / PHEs | Local Purchasing Unit | National Purchasing Agency | 5 days after receiving reports from DHE/PHE | 15th–19th of the second month, following the previous quarter (verifications: Jan – March. Invoice calculation due 15-19th of May) |
| Validation and authorization of Invoices | Local Purchasing Unit | National Purchasing Agency | 5 days after receipt of complete and correct invoices. | 22nd – 26th of the second month, following the previous quarter. (Verifications: Jan – March. Payment due 22-26th of May) |

**Table 12:Summary of Reporting and Payment Schedule for CBOs**

| *Management cycle for CBOs/NGOs* | | | | |
|---|---|---|---|---|
| **What** | **From** | **To** | **Number of days** | **SUBMISSION DEADLINE DATES (RANGE)** |
| *Ready before beginning of year* | | | | |
| Adjustment of contract details for number of patients/ clients to be visited | Local Purchasing Unit | National Purchasing Agency | 10 | 10th – 14th December[l] (submission to NPA) |
| Results based contract CBO/NGO | National Purchasing Agency | CBO/NGO | 5 | 10th – 14thDecember (submission to NPA) |
| *After end of quarter* | | | | |
| Results scores of previous quarter (number of community verifications and number of surveys done) | CBO/NGO | National Purchasing Agency | 14 days after CBO receives the last questionnaires from the LPU | 15th – 18th of every month |
| Compilation and calculation of invoices for CBO/NGO | Local Purchasing Unit | National Purchasing Agency | 5 days after receipt of CBO reports | 15th – 19th of the second month, following the previous quarter (verifications: Jan – March. Invoice calculation due 15-19th of May) |

| | | | | |
|---|---|---|---|---|
| Validation and authorization of Invoices | Local Purchasing Unit | National Purchasing Agency | 6 weeks after receipt of complete and correct invoices. | 22nd – 26th of the second month, following the previous quarter. (Verifications: Jan – March. Payment due 22-26th of May) |
| Transfer RBF-bonus to account CBO/NGO | National Purchasing Agency | CBO/NGO accounts | 4 after validation & authorization of invoices. | 24th – 27th of the second month, following the previous quarter. (Verifications: Jan – March. Payment due 22-26th of May) |

## 12. Technical Assistance and Mentorship During Institutionalization

Cordaid and Crown Agents provide technical assistance to the MOHCC to strengthen institutional capacity for the GOZ to manage RBF and to incorporate RBF into national and subnational health systems. Areas for TA include:

- Strengthen the capacity of the PCU to function as NPA by seconding technical and implementation support consultants who shall eventually be absorbed into the PCU establishment
- Strengthen CQI innovations to improve verification, mentorship and supervision, and experience sharing
- Enhance the performance of the QA/QI Directorate of the MOHCC
- Provide technical guidance in the revision of the PIM so as to reflect institutionalisation and programme innovations and improvements
- Provide TA to inform widening the scope of operational planning and its alignment to the MOHCC planning framework
- Provide TA in promoting innovations in e-health for better program efficiency

## 13. Over-Reporting, Fraud, and Conflict Resolution

### 13.1 Introduction

Once a health facility, DHE, and PHE are enrolled into the RBF, they are expected to execute their RBF roles within the guidelines below. Based on the guidelines, RBF stakeholders such as the NPA, the Fundholder, the LPU, the health facility, HCCs,and Provincial and District Medical Officers will be able to address any irregularities and resolve any conflict that might arise between different RBF stakeholders at any given time during implementation.

These guidelines seek to create a mechanism by which: (i) health facilities, HCCs, DHEs, and PHEscan file complaints concerning payments (wrong amounts and delays in transmitting funds), and other aspects of the RBF project; and (ii) MOHCC national level, DHE, PHE, NPA, and LPU sensitise all stakeholders on the benefits of full compliance with RBF processes and reporting requirements.

The guidelines consist of four main sections: (i) over or under-reporting or not reporting in time; (ii) malpractice or use of funds for unintended purposes; (iii) appeals and complaints by health facilities, DHE, and PHE; and (iv) resolution of conflicts arising from executing any RBF processes.

The implementation of the RBF programme will be performed in line with the requirements of the Public Financial Management Act [22:19]. In addition, all stakeholders must comply with the requirements of funding partners, which strictly enforce a policy of zero tolerance concerning unethical, unprofessional, or fraudulent acts. Details of the requirements of funding partners will be outlined in the performance contracts to be signed.Further, these requirements will be highlighted in any RBF training to be delivered to ensure that stakeholders are aware of their responsibilities.

## 13.2. Over or Under Reporting or not Reporting in Time

The 5% rule is going to be applied for both over and under reporting. If a facility over or under reports on a particular indicator by more than 5%, that indicator should not be paid for that particular period.
Staff of the LPU will visit each facility on a quarterly basis to counter verify if the data reported by the community sister are in line with the data in the HMIS-registers. In case of discrepancy the verification staff of the LPU will determine causes of these discrepancies. In case of mistakes the verifier notifies and discusses with the health facility staff.A report is submitted to the DMO to come up with appropriate interventions and provides technical assistance by explaining how the data should be recorded. A margin of error within 5% of the reported figures will be acceptable.

In addition to applying government regulations, a facility will be subjected to penalties by the program. These include deduction of over claimed amount or equivalent of over-claimed services from the next payment and further action through the DMO/PMD will be instituted. The facility will be warned by the DMO/PMD, once informed by the NPA. The verification allows for a margin of error of 5%. However as noted in section 10.2 of the PIM, measures will be applied where over or under reporting by a health facility exceeds the 5% margin. In case of fraud, GOZ regulations apply.

***Facilities***

In case of not reporting at all or not reporting in time (up to 10 days after the deadline) facilities are not going to be paid for that particular period.

DHEs and PHEs are also expected to report on their activities on time for them to get paid. This mainly concerns the number of quality checklist assessment visits done and the RBF payments to facilities. For the DHMT, the following guidelines apply.

***District Health Management Team***

In case of not reporting at all and/or not reporting in time about quality verification of health centres and RBF payments to the health centres, the DHE will not be paid the performance subsidy for these verification visits. In case of reporting verification visits that did not take place or RBF payments that did not take place, the DHE will not be paid the quarterly subsidy payment.

***Provincial Health Management Team***

- In case of not reporting at all and/or not reporting in time about quality verification of district hospitals, the PHE will not be paid the performance subsidy for these verification visits; and
- In case of reporting verification visits that did not take place, the PHE will be exempted from that quarter's subsidy payment.

***Community Based Organisations***

CBOs are expected to report on time (for them to be eligible for payment) the numbers of:

- Patients verified; and
- Patient satisfaction and exit interviews conducted.

For CBOs, in case of over reporting the following penalties will apply:

1. If verification shows that a CBO did report more patients cross checked than indeed visited, the CBO:
    - Will not be paid at all for the particular period;
    - The work of the CBO will not be checked on a regular basis, and randomly checked by an independent verifier. Over reporting is therefore likely to be discovered once the payment has already been done. Therefore, the non-eligible funding will be deducted from the next subsidy.
    - Exemption will then be for the period following the independent verification.

2. If the above occurs again at the same CBO within a period of 1 year, the CBO:
    - Will not be paid any bonus at all for that period; and
    - Will be exempted from the RBF-program with immediate effect.

A standard letter for informing a facility, DHE, PHE, or CBO about their disqualification for RBF payments has been developed. A copy of any forms sent to CBOs will be filed at the LPU/NPA.

## 13.3. Malpractice

If there is a suspicion of malpractice or misuse of funding within any of the involvedorganizations,GOZ regulations and NPA anti-corruption guidelines will apply.If acts of malpractice or misuse are revealed, the involved stakeholder will be suspended from the RBFscheme with immediate effect pending investigations.

District Steering Committees also play a role. Upon their request, a DHE team can work closely together with the LPU to investigate a health facility. A PHE can work closely together with the LPU to investigate a DHE or district hospital if necessary. GOZ regulations will be used by all stakeholders to follow up on suspected cases of malpractice. In the form, RBF stakeholders will document actions and a final decision taken regarding future participation in RBF of the entity under investigation.

## 13.4. Appeals and Complaints by Health Facilities, DHE, and PHE

During implementation of any RBF project, there are always chances that certain decisions regarding execution of RBF processes will be contested by participating health facilities, DHEs, and PHEs. This merit establishing clear guidelines for those health facilities, HCCs, and other stakeholders who wish to raise concerns or issues regarding identified anomalies.Payment systems is one likely area where complaints might arise.

***Payment System:***

Complaints on payments might relate to:

(i) Providing agreed services and no payment is made within the stipulated period
(ii) Contested quality of care and quantity of services scores that affect the final subsidy payments
(iii) Unexplained delays in transferring health facility incentives from the fundholder
(iv) Health facility/DHE/PHE simply receives incorrect amount in its Bank Account from fundholder

Any appeals will be first handled by the DHE with the full knowledge of the PHE and LPU. In case the appeal is not resolved by the DHE, the case will be moved to the PHE.

## 13.5. Social Safeguards

In the course of implementing RBF and every other health care intervention, the MOHCC and its partners undertake to prioritize the patient`s needs. To that end the MOHCC has put in place a number of mechanisms both to ensure patient safety and patient satisfactions. This is also enshrined in the clients charter which should be displayed at every health facility and which complies with international norms and conventions. This manual outlines specific mechanisms in place to ensure that the clients are protected from harm and have pathways for redress of both complaints and other aspirations

### 13.5.1. Clients'Complaints

Patients' complaints regarding unsatisfactory service and unprofessional behaviour by health workers will have an impact on the quality score of health facilities. Individual complaints will be dealt with according to the guidelines set by the MOHCC. In concordance with these existing procedures, the DHE will create an enabling environment for patient complaints regarding quality of care and enhancing best practice in the country. District Steering Committees will be called upon in case there are further issues from within the district. The PMD's office will be called when complaints arise regarding the DHE.

### 13.5.2. Conflict Resolutions

Conflict may arise because of lack of information, differences in experience, and external factors.To resolve any conflict, "who, what, and how" must be analysed. Conflict analysis will be carried out by the MOHCC at all levels. All necessary information on the situation will be sourced to determine how the intervention can be conducted. Conflict analysis will identify the stakeholders (primary and secondary) in the conflict, the motivation behind the conflict, the issues of conflict and limitations of the problem.

For any case of dispute arising about the implementation of RBF, mediation by a superior level is recommended. At district level the District Steering Committee will form a subcommittee for conflict resolution concerning RBF within the district. In case of not reaching a compromise, the subcommittee of the NSC will make a recommendation and the NSC will make a final decision to settle the dispute. Any case raised and brought to the District Steering Committee will be recorded and the LPU will maintain a file for each district.

## 14. Environmental Safeguards and Health Care Work waste Disposal

### 14.1. Institutional Framework for Health Care Waste Management

Health care waste is generated during health service delivery and as such its management starts from the time it is generated in a health facility, to the time it is disposed of, either within the health facility premises or at other waste disposal areas such as local authorities dumpsites. As a result there are bound to be institutional overlaps making mandate boundaries relatively porous requiring serious institutional engagement to ensure efficiency, safe handling and disposal of health care waste. Annex 20 Provides details of the national policies on HCWM

### 14.2. Roles and Responsibilities under the Health Care Waste Management Plan

According to the Health Care Waste Management Plan (HCWMP), the plan falls directly under the responsibility of the Environmental Health Department of MoHCC. The department is given the role to implement and apply the multi-stakeholder approach so that all relevant players take part. The key targeted stakeholders included Ministry of Environment, Water and Climate and its Environmental Management Agency, Local Authorities, Non-Governmental Organisations and the private sector. The Environmental Health Department was chosen because the responsibility is part of its mission, it has competent staff cascading to ward level and it has capacity to offer health education services, public information and raising awareness. The department was thus tasked with the responsibility to procure consumables, maintain existing incinerators, build capacity among health care workers, and coordinate the whole HCWMP process.

The Environmental Management Agency has the responsibility of monitoring the implementation of the HCWMP as it is considered to have the overall responsibility of protecting the environment. Therefore, the Environmental Health Department's activities have to conform to the requirements of the Environmental Management Act. The EMA has the mandate to watch over the whole chain of the health care waste from generation to final disposal.

Local Authorities have the responsibility to ensure that their landfills (currently dumpsites) are designed to take in health care waste. To this end the landfills should have separate designated portions devoted to the disposal of health care waste followings norms and standards defined by the Environmental Management Act to avoid possible environmental pollution. The coordination of the activities has to be done by the local authorities' Environmental Health Departments.

At the health centre/clinic level the manager is responsible for the health care waste management. He or she must ensure that HCWM plans were in place, and that they met the national policy, regulations and standard operating procedures. He/she has to have a team of officers responsible for the segregation, collection, transportation and treatment of health care waste.

## 15. Annex A: Terms of Reference District Steering Committee

***Membership***

The District Steering Committee (DSC) consists of selected members of: Social Services Committee, Community Health Council, Health Centre Committees (HCCs) (maximum of 2 HCCs who serve on a rotational basis), District Health Executive (DHE) (maximum of 2 DHEs), an NGO working on relevant public health issues, a representative of church hospitals, a representative from the Ministry of Local Government, and other members as decided jointly by DHE and the National Purchasing Agency (NPA).

The DMO will chair the initial meeting.For subsequent meetingsthe substantive chairpersonshipshould be assumed by the District Administrator (DA). Members of the committee unable to participate in a scheduled Steering Committee meeting will inform the Chair and Secretary about their absence and nominate a representative to stand in for them.

***Practical arrangements***

- The RBF DSC will draw regulations and procedures necessary for the fulfilment of its functions;
- Decisions taken by the committee are binding;
- The DSC will provide minutes of their meetings to the DHE with a copy to the PHEs and tothe NPA within two weeks after the meeting;
- The DMO is obliged to raise RBF issues noted by the DSC through the Social Services Committee to get the support of the District Development Committee. The Provincial Medical Directorate (PMD) will bring the RBF issues from districts to the Provincial Development Committee (PDC).
- Members of the DSC should be enabled by their employer to attend RBF meetings, and will be given transport and food allowances according to government regulations;
- For the purposes of meetings, at least 60% of the DSC membership should be in attendance for a quorum to be constituted.

***Key roles of members of the DSC***

• *Chairperson:*

- Develops the agenda of the meetings, chairs meetings, and formulates decision statements, which could be put for vote if necessary;
- Approves and signs minutes of the previous meeting, which have been reviewed by a duly constituted steering committee;
- Approves the agenda proposed by members of the committee;
- Signs the official documents of the DSC; and
- Has the casting vote.

• *Vice Chairperson*
  - Acts as chairperson in the absence of the chair.

• *Secretary:* DHE with the support of the Local Purchasing Unit (LPU) shall be the Secretary
  - Ensures members present sign attendance lists and that the attendance list is annexed to the minutes of meeting;
  - Drafts the agenda for the meeting and submits to chair for review and finalization;
  - Records the agenda, as adopted by the meeting;
  - Records the different phases of the meeting and the different interventions during the debate;
  - Votes on different deliberations of the meeting that are put to vote;
  - Records the voting results of the meeting, with specification of the number of favourable and contrarily for the different deliberations;
  - Records the decisions and action points;
  - Sends the draft report to the Chairperson after the meeting
  - Disseminates minutes of the meeting after they are signed including the invitation for the next meeting, to the members of the committee; also, sent to the PMD and NPA;
  - Ensures the logistical arrangements for the meetings; and
  - Performs any other relevant duties assigned by the Chairperson and the committee.

• *Members*
  - Review and endorse the minutes of the last meeting;
  - Decide on the agenda for the current meeting or endorse a draft agenda set by the chair or vice chairperson and the secretary;
  - Participate in the deliberations;
  - Participate in the elections; and
  - Two members can request the Chairperson in writing to convene a meeting as an extraordinary session.

## 16.Annex B: Terms of Reference Health Centre Committee

The Health Centre Committee (HCC)terms of reference are enacted in the Public Health Act.
They are as follows:
(1) Every rural health centre shall establish a Health Centre Committee (HCC), whichshall include representatives of health workers and representatives of the communitiesin which they operate.

(2) The functions of the HCCs shall be to:
a) inform, educate and empowermembers ofthe community on health matters;
b) use information gathered from the communities to plan, monitor and evaluate health programmes;
c) coordinate health programmes in the area serviced by the health centre;
d) represent communities and their interests before relevant authorities;
e) support local health care planning activities, including resourcemobilisation;
f) support local community-based workers in health; and
g) perform such other functions and duties as the Minister may assign.

## 17.Annex C: Terms of Reference for Community Based Organisations

The District Health Executive (DHE) invites officially recognized community-based organisations (CBOs) active in the district to apply for a verification task focused on client satisfaction. The District Steering Committee (DSC) assists the DHE with the screening of the CBOs. For each health facility, a CBO will be

selected for a period of three years. Preference will be made forassociations with objectives related to the fight against poverty, and in support of general health, reproductive health, or the establishment of healthinsurance, in particular. If no CBO can be selected in the district, the DHE can consider contracting a local NGO for the purpose of verification.

To avoid conflict of interest, the selected CBO/NGO may not have a link to the formal health structure in the area.

***Selection of CBO/NGO***

The selection of CBO/NGOs will be based on the following criteria:

- Able to read, write, and understand the local language; knowledge of English is an asset;
- Availability for two weeks every three months to do cross checks and interviews;
- Ability and willingness to travel to households on foot for long distances;
- Ability to perform in a family atmosphere with loyalty, discipline, honesty and integrity.

***Process for conducting client satisfaction surveys***

The process for conducting client satisfaction surveys will be as follows:

- The CHN samples records per indicator according to a predefined format provided by the NPA; the format will change periodically to avoid fixing.
- The random selection is taken from the records for the 30 days preceding the visit
- The households selected must live not more than two hours of walking from the facility
- If patients live in another health area, the community sister picks another patient from the register
- If patients come from another country or province, it is not possible to verify the existence of the patient, so the community sister picks another patient. For each patient of the sample data is collected concerning patient identification (date of visit, any money that was paid, duration they waited before services were given, and how they rate the services).
- Once the LPU/Community Sister has collected the sample, s/he signs the number of samples given to CBO
- The CBO follows up with the patients within 14 days
- The CBO compiles a report from the narrative questions from the patients interviewed
- The CBO hands the completed forms to LPU
- The CBO and LPU checks the completeness of the forms
- The CBO and LPU signs the CBO declaration form stating the number of forms that were complete, the subsidy to be paid. The subsidy to be paid is arrived at by counting the number of forms that were submitted on time. The CBO keeps a copy of the signed form and the LPU takes the top copy for payment

***Contracting***

The CBO/NGO will sign a contract with the Local Purchasing Unit (LPU), which will be countersigned by the DHE. This contract will stipulate how many patient satisfaction interviews the CBO/NGO is expected to do, the time they should take to complete the interviews, how it must be reported, and how much the CBO/NGO will get paid for each questionnaire.

***Indicators of performance***

The performance of the CBO/NGO will be assessed against the number of questionnaires submitted on time. For each questionnaire, a fixed amount will be paid.

***Reporting***

The CBO/NGO will receive a format in which to do the reporting. CBOs will prepare and submit reports

to the HCC during the monthly meetings, with a copy to LPU who will submit it to DHE. The issues are also discussed in the nurse's review meeting so that facilities learn from each other.

***Verification and monitoring***
The reports of the CBO/NGO are part of the quality score that assesses services rendered by the health facilities.

***Payment***
Payment is provided by the NPA, based upon the amount of services delivered by the CBO/NGO, and preferably into a bank account.

***Capacity building and technical assistance***
The LPU/ DHE and Community Sister are responsible for capacity building and technicalassistance of the CBOs/NGOs.

## 18. Annex D: Criteria for Calculating Remoteness Bonus

**Table 12 : Remoteness Bonus Culculation**

| | Remoteness indicator | % | Rating |
|---|---|---|---|
| 1 | More than 50% of population lives more than 8 kilometres fromthe health centre | 1 to 6 | 1% = 8km to 9.9km<br>2% = 10km to 11.9km<br>3%= 12km to 13.9km<br>4%= 14 km to 15.9km<br>5%= 16 km to 17.5km<br>6%= 18 km or more |
| 2 | Non-availability of communication | 1 to 6 | Unreliable = 1%, no communication at all = 6%<br>0% = At least one means of communication is fully reliable<br>1% = Unreliable radio, unreliable fixed land lines, unreliable local networks (available at the facility but not always)<br>2% = Unreliable radio, unreliable fixed land lines, limited local networks (available away from facility)<br>3% = Unreliable radio system, limited local networks,<br>4% = Unreliable radio system, no local networks, regional networks to call, no fixed land lines<br>5% = No radio, no local networks, regional networks available for SMS, no fixed landlines<br>6% = No radio, no local cell phone network, no fixed land lines, no regional networks |

| | | | |
|---|---|---|---|
| 3 | Access roads to health centre in bad condition | 1 to 6 | 1% = bad road<br>2% = gravel road only accessible by high vehicles<br>3% = gravel or dust roads only accessible by 4-wheel drive<br>4% = inaccessible by road for example need to cross a flooded river, gravel roads, not accessible by all means of transportation<br>5% = inaccessible by road for example need to cross a flooded river, small bridges not accessible all the time, gravel roads, not accessible by all means of transportation<br>6% = inaccessible by road for example need to cross a flooded river, no bridges, dust slippery roads, not accessible by all means of transportation |
| 4 | Non-availability of public transportation | 1 to 6 | 1% = public transport available but unreliable<br>2% = public transport available during the day only<br>3% = public transport once a day at night<br>4% = public transport once a week<br>5% = relies on community transportation (Scotch carts, etc)<br>6% = no transportation at all |
| 5 | Nearest referral centre > 60 km away | 1 to 6 | 1% = 61km to 65km<br>2% = 66 km to 70km<br>3% = 71 km to 75km<br>4% = 76 km to 80 km<br>5% = 81 km to 85km<br>6% = 86km or more |

## 19. Annex E: Health Facility Minimum Criteria Enrolment

| Name of Health Facility: | Ownership: | | |
|---|---|---|---|
| District: | | | |
| | Establishment | In post | Vacant |
| Nurse/Midwives | | | |
| RGN | | | |
| SCN | | | |
| PCN | | | |
| EHT | | | |
| Nurse aides | | | |
| General hands | | | |
| Other (Non-medical staff or unqualified staff) | | | |
| Functional HCC | | | |

| Equipment | Yes (functional & present) | No (not present/broken down thus not being used) | Comments |
|---|---|---|---|
| **Criteria for the environmental waste management plan have been met:** | | | |
| Presence of a (simple) incinerator and/or lined pit | | | |
| Presence of a simple sanitation system (pit latrine or septic tank) | | | |
| Presence of a disinfection and/or sterilization facility | | | |
| Presence of infection control guidelines (are guidelines being followed)? | | | |
| Presence of sterilisation and disinfection guidelines (are guidelines being followed?) | | | |
| Presence of Health Centre Committee | | | |
| Has HCC have constitution? | | | |
| The facility is autonomous on the use of RBF funds? | | | |
| Health Facility staff (representative) has received RBF training? | | | |

**DHE DMO NAME:** _____ **NPA** **Rep NAME:** _____

**DMO SIGNATURE:** _____ **NPA Rep**

**SIGNATURE:**_____

**DATE:**_____ **DATE:** _____

## 20. Annex F: RBF Results Framework 2019

### Project Development Objective Indicators by Objectives/Outcomes

The Project Development Objective is to increase coverage and quality of key health interventions, with an emphasis on MCH services in targeted rural and urban districts, and strengthen institutional capacity for results-based financing contract management, consistent with the Recipient's ongoing health initiatives.

| Indicator Name | Baseline | End Target |
|---|---|---|
| **Increase coverage of key MCH services in participating districts** | | |
| Percentage of pregnant women receiving first antenatal care during a visit to a health provider in participating rural districts | 70 | 72 |
| Percentage of pregnant women receiving first antenatal care before 16 weeks of gestation during a visit to a health provider in participating rural districts | 10 | 22 |
| Percentage of births attended by skilled health personnel in a health institution in participating rural districts based on survey data | 58 | 88 |
| 3.a Percentage of births attended by skilled health personnel in a health institution in participating rural districts based on facility-based HMIS | 91 | 94 |
| Percentage of women 15-49 years who currently use any of the modern family planning methods in participating rural districts | 56 | 70 |
| Percentage of children under 5 with diarrhea receiving ORT and Zinc in participating districts | 13.8 | 16 |
| Average quality scores by health facilities in participating rural and urban districts | 68 | 81 |
| Percentage of maternal deaths given audits as per protocol in participating districts | 0 | 80 |
| Percentage of partographs correctly filled in participating districts | 0 | 65 |
| Percentage of children under 5 years with Pneumonia correctly managed in the participating districts | 0 | 87 |
| Percentage of health facilities managed under RBF contracts by the MOHCC Program Coordination Unit in participating rural districts | 0 | 32 |

| Intermediate Results Indicators by Components | | |
|---|---|---|
| **Indicator Name** | **Baseline** | **End Target** |
| **Component 1: Delivery of Packages of Key Maternal, Child and Other Related Health Services** | | |
| !"! Cumulative number of health facilities enrolled in RBF program in participating districts | 0 | 426 |
| #"! Cumulative number of pregnant women receiving first antenatal care during a visit to a health provider in participating urban districts | 12,737 | 89,031 |
| $"! Cumulative number of pregnant women receiving first antenatal care under 16 weeks of gestation period during a visit to a health provider in participating urban districts | 572 | 4,035 |
| %! Cumulative number of pregnant women living with HIV who are initiated on anti-retrovirals to reduce the risk of MTCT in participating rural districts | 9,399 | 60,000 |
| &! Cumulative number of births attended by skilled health personnel in health institutions in participating urban districts | 0 | 39,469 |
| '"! Cumulative number of births attended by skilled health personnel in health institutions in participating rural districts | 0 | 723,104 |
| ("! Cumulative number of births attended by skilled health personnel in health institutions for all participating rural and urban districts | 0 | 762,573 |
| )"! Cumulative number of children completing primary course on immunization in participating districts | 0 | 663,409 |
| *"! Cumulative number of children 6-59 months who were given Vitamin A supplementation in participating rural districts | 0 | 1,544,493 |
| !+"! Cumulative number of Project beneficiaries | 0 | 4,021,394 |
| 10.a. Cumulative number of female beneficiaries | 0 | 2,087,103 |
| !!" ! Number of health personnel receiving training in participating districts | 3,120 | 4,000 |
| !#"! Percentage of health facilities implementing Continuous Quality Improvement model in the participating rural districts. | 0 | 23 |
| !$"! Percentage of RBF contracted facilities in CQI districts with CQI Standard Operating Procedures | 0 | 80 |
| !%"! Number of District Health Executives (DHEs) in participating districts using quality tool for supervision of health facilities. | 0 | 20 |

15.Process evaluation to examine cost-effective options for verifying results under RBF approach finalized and disseminated to key stakeholders (Yes/No)

## 21. Annex G : Verification Guidelines (Shall be done after completion of PIM)

## 22. Annex H : A Summary of the National Policies and Legislation Governing Waste Management in Zimbabwe

| Document | Relevance for the Health Care Waste Management |
|---|---|
| Environmental Management Act [Chapter 20: 27]<br>Section 72-73 Hazardous Waste<br>SI 10 of 2007<br>Environmental Management (Hazardous Waste Management) Regulations 2007 | ▪! Prohibits discharge of hazardous substances, chemicals, oil or a mixture containing oil into any waters or any parts of the environment.<br>▪! Hazardous waste is classified by determining whether it is hazardous waste; corrosive waste; flammable waste; toxic waste; radioactive waste or any other category of waste.<br>▪! SI 10 empowers the Environmental Management Agency to issue licences in four bands the blue, green, yellow and red categories. |
| Environmental Management Act [Chapter 20:27]<br>Sections 69-71 Waste<br>SI 6 of 2007<br>Environmental Management (Effluent and Solid Waste Disposal) Regulations 2007 | ▪! Prohibits discharge of any wastes, whether generated within or outside Zimbabwe in such a manner as to cause pollution to the environment or ill health to any person.<br>▪! Expects any person whose activities generate waste to employ measures essential to minimize wastes through treatment, reclamation and recycling.<br>▪! Empowers the Environmental Management Agency to issue licences in four bands the blue, green, yellow and red categories. |
| SI 72 of 2009<br>Air Pollution control Regulations 2009 | ▪! Its objective is to provide for prevention, control and abatement of air pollution to ensure clean and healthy ambient air. It provides for the establishment of emission standards for various sources such as mobile and stationary sources.<br>▪! It empowers the Environmental Management Agency to issue licences in four bands the blue, green, yellow and red categories. |
| Zimbabwe Standard for Air Quality and Emissions<br>ZWS 977:2014 | ▪! Specifies the minimum requirement for air quality and emissions in respect of point source emissions from static sources and fugitive emissions.<br>▪! It gives requirements for specified processes and activities and classifies the classes for licences by process. For example those for waste incineration are given for particulates, acid mist, sulphur dioxide, nitrogen oxides and carbon dioxide for the blue, green, yellow and red categories. The Standards will be linked to the revised Statutory Instrument 72 of 2009. |
| Environmental Management Act [Chapter 20:27]<br>Sections 57-62<br>Water Pollution | ▪! With regards to water pollution the Act prohibits discharge of any poison or toxic, noxious or obstructing matter, radioactive waste or other pollutants or permits any person to dump or discharge of the damaged environments such matter into the aquatic environment in contravention of water pollution control standards. |

| Document | Relevance for the Health Care Waste Management |
|---|---|
| Water Pollution<br>SI 6 of 2007<br>Environmental Management (Effluent and Solid Waste Disposal) Regulations 2007 | ! Emphasizes the polluter pays principle including the cost of restoration.<br>▪! Requirement for licence to discharge effluents into the environment.<br>▪! Empowers the Environmental Management Agency to issue licences in four bands the blue, green, yellow and red categories. |
| Water Act<br>Section 67 Water Quality Control and Environmental Protection | ▪! Due consideration to be given to the protection, conservation and sustenance of the environment. |
| Public Health Act | ▪! Defines solid waste as a nuisance, whereby it is listed among other nuisances as any accumulation or deposit of refuse, offal, manure or other matter whatsoever which is offensive or which is injurious or dangerous to health.<br>▪! No person shall cause a nuisance, or shall suffer to exist on any land or premises owned or occupied by him, or of which he is in charge, any nuisance or other condition liable to be injurious or dangerous to health. |
| Urban Councils Act | ▪! Applies to every city or city council, municipality, municipal council, town or town council, every local government area and every local board.<br>▪! Gives powers to the Council to provide and operate a service for removing and treating trade or other effluent, refuse and human waste for the council area or any portion thereof and to make the use of the service compulsory.<br>▪! Council may make by-laws for removal and disposal of human waste; effluent, water or refuse, decaying and other offensive or unhealthy matter. |
| Rural Districts Act | ▪! Council is to do all things necessary to prevent pollution in any form whether of water and the atmosphere.<br>▪! Council is required to provide and operate a service for removing the treating trade or other effluent, refuse and human waste for the council area or any portion thereof and to make the use of the service compulsory.<br>▪! gives the Rural District Councils the powers to make by-laws in relation to certain urban areas including the maintenance of health, cleanliness and good order |



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The Ministry of Health and Child Care