INTEGRATE
Catalyzing Integrated Sustainable Subnational Biomedical Prevention in Zimbabwe

From partner to government-led programming in Zimbabwe: Increasing sustainable subnational ownership of VMMC through integrating input and output financing with existing health financing systems for sustainability

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Background

Zimbabwe's INTEGRATE program seeks to strengthen the Ministry of Health and Child Care (MoHCC) managerial, financial, and operational capacity, and to transition from vertical partner-led VMMC programming to sustainable, horizontal, and integrated HIV biomedical prevention.

VMMC input and output financing have been partner-led, compromising MoHCC ownership of program management and coordination, and leaving partners the capacity for efficient translation of service and demand inputs to quality outputs. INTEGRATE channels input and output financing through existing health financing systems to increase subnational ownership, management, and coordination.

Materials and Methods

Milestone-based fixed-price sub-agreements channel VMMC service and demand input financing through MoHCC to 27 districts. Sub-agreements defined input milestones with prices based on historical costs. Milestone definitions tied to outputs align demand and service planning. Districts were paid for milestone delivery over six months.

Integrating VMMC output financing with Zimbabwe's results-based financing (RBF) in four pilot districts harmonized VMMC and RBF verification, invoicing, and payment systems and capacitated communities, facilities, and districts to integrate VMMC with RBF implementation. VMMC RBF shifts from individualized (80:20) to structural (25:75) incentives in the service delivery: structural split.

Results

Transition to sub-granting did not result in substantially reduced VMMC delivery. Partner handholding reduced at different paces as provinces and districts overcame challenges in fund management, translating inputs to outputs. Sites reporting VMMC outputs increased under RBF, with quality scores and data improving at some sites, districts, and provinces leading quality support and supervision. Integrating input and output financing gives signs of eliminating the "blank check" risk of spending decisions that do not translate to outputs. Outreach team size and per diem efficiencies were realized.

Conclusions

Integrating VMMC input and output financing with health financing systems is feasible and shows potential for increasing subnational ownership, management and coordination, improving quality and accountability, and supporting institutional RBF by expanding purchased indicators. Tying subgrant milestones to outputs can promote the translation of input spending to quality outputs. Integrated input and output financing can expand to other RBF indicators.

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