



Supporting MoHCC Leadership and Decision-Making **Through Strategic Input Financing**

Challenges with Partner-Led Management and Coordination

Voluntary Medical Male Circumcision (VMMC) services are primarily delivered through public-sector clinics with support from external partners such as Population Services International (PSI) and Population Solutions for Health (PSH). Traditionally, these partners manage the program budgets, supplying essential resources like vehicles, fuel, and travel allowances to local health authorities. Partners decide the allocation of funds for key activities such as staff training, outreach, demand creation, and service delivery. While this model ensures a wide reach of services, it restricts local health authorities' ability to plan and manage these services based on local needs and achieve optimal results. Health authorities often perceive budgets as limitless, as they lack visibility into how funds are managed and allocated.

Recognizing these gaps, local health executives have expressed a strong desire to manage these funds to better prepare them for the sustainability phase, where they are expected to take up this role. Transitioning budget management and coordination from external partners to local health authorities could help the VMMC program become more integrated into existing program management and coordination structures. Local health authorities would have the autonomy to allocate funds where they are most needed, make decisions that reflect the unique health priorities of their community, and ensure that VMMC programs are both effective and responsive to the people they serve. However, this shift requires training local health authorities in budget management, strategic planning, and implementation, areas that implementing partners currently lead. This also requires establishing clear guidelines for budget allocation and a monitoring system of transparency and accountability.

Localizing Coordination and Management through Sub-Granting with Fixed Pricing Agreements

To support the transition from partner-led to Government of Zimbabwe-led VMMC programming, the INTEGRATE project, together with the Ministry

of Health and Child Care (MoHCC), introduced an innovative capacity-building model in the form of input financing through subgrants with fixed-price agreements. This approach supports local health authorities, including provincial and district health executives, in assuming greater responsibilities, ownership, and management of their VMMC programs.

How Fixed Price Agreements Worked

Workplan development and identification of milestones.

Previously, workplans were developed through collaboration between partners and donors, with limited input from district-level stakeholders. INTEGRATE shifted ownership of workplans to local health authorities, supporting districts to take full responsibility for developing VMMC program workplans. Together with PSH and MoHCC, districts then translate their workplans into clear milestones, each representing a significant achievement (output) necessary for the success of the VMMC program.

Sub-granting with fixed-price agreements.

Unlike traditional methods where external partners reimburse expenses as they occur, INTEGRATE negotiated fixed-price agreements with provincial and district MoHCC. These agreements establish predetermined payments for specific outputs or milestones that district teams must meet. For instance, if a milestone involves training 100 health workers, the district agrees to receive a predetermined sum upon completing this training. Historical data and the effort required to achieve each milestone determine the milestone prices. The district receives funds only after completing the work, which incentivizes efficient resource management. This method allows districts to retain any savings, promote careful budget planning, and potentially reduce overall project costs. This approach contrasts with previous cost-reimbursement contracts, where health authorities may feel less compelled to minimize costs since they expect reimbursement for all expenses incurred.

Milestone-based payments.

District health authorities are responsible for achieving these milestones and then submitting proof of completion. Once verified, they receive payment for the milestone. This model reduces the administrative burden, requiring only proof that the work was done according to the agreed standards, rather than a detailed review of every expenditure.

Financial incentives for efficiency.

If districts can deliver the milestones under budget, they can keep the remaining funds. For example, if they find a cheaper way to conduct training or lower transport costs, any money saved becomes a surplus they can use for other needs or roll over to further improve their services.

Tying costs to outputs.

Each dollar spent is directly connected to a specific output. This predefined cost mechanism ensures that all aspects of the VMMC program, from personnel to VMMC procedural costs, are budgeted in advance and funded based on historical cost data, leading to more efficient and accountable use of funds.

Support in budget management and planning.

The project placed sub-granting officers to support the transition of budgetary responsibilities. These positions provided training and supportive supervision to local health authorities in budget management and strategic planning.



Figure 1. Input financing through fixed-price, outcome-based milestone agreements

Impact of New Financing Model

Sub-granting through fixed-price agreements provides a structured, incentive-driven pathway that enables local authorities to develop the skills necessary for managing complex health programs. This model encourages local health authorities to take ownership of financial and operational aspects, fostering a strong sense of commitment and accountability essential for the success and

sustainability of programs. Alongside effective budget management and strategic planning tools, this approach facilitates a shift from external dependency to local leadership. Initially, the transition faced challenges, with only 41% of milestones achieved in the first year; however, by the second year, districts had adapted well, successfully meeting milestones, and operating autonomously. Please see Figure 2 and Figure 3.

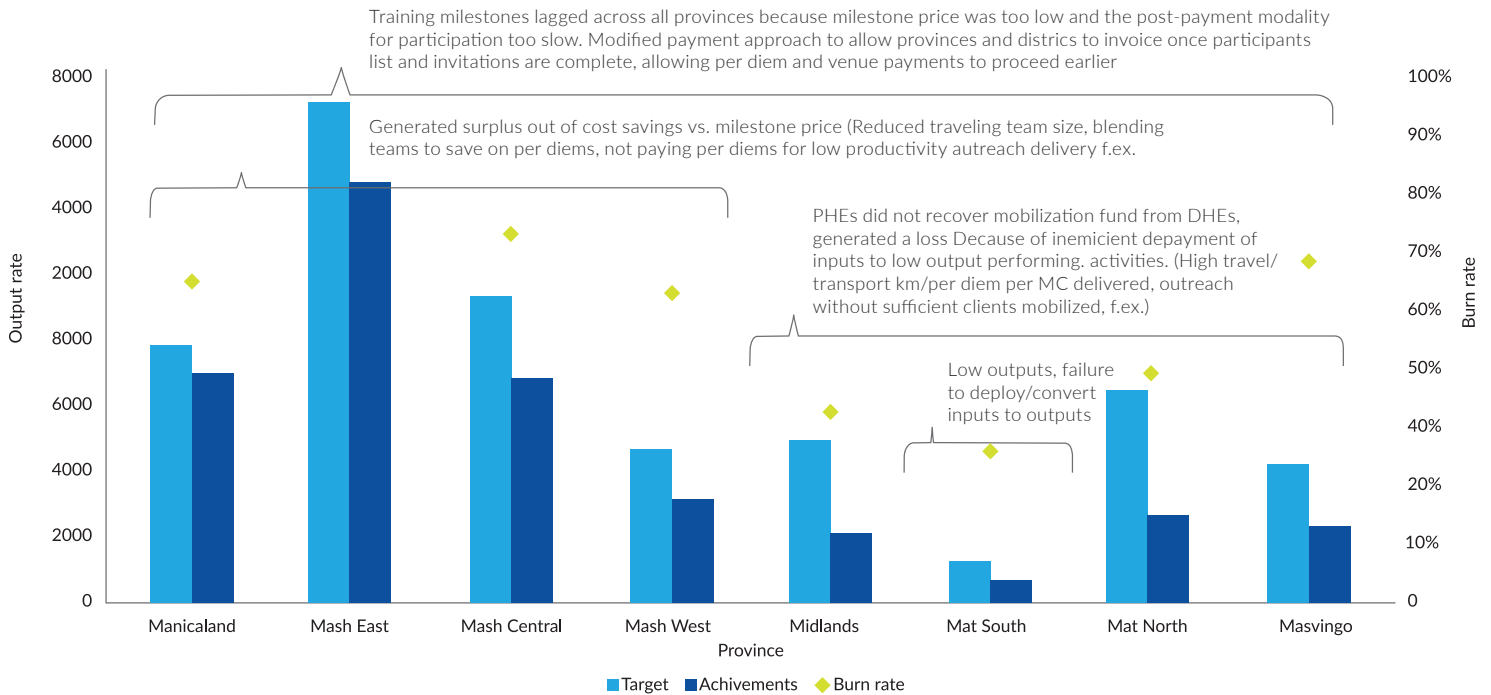


Figure 2. First year phe sub-granting performance vs. Target and burn rate, by province April 2022 to March 2023

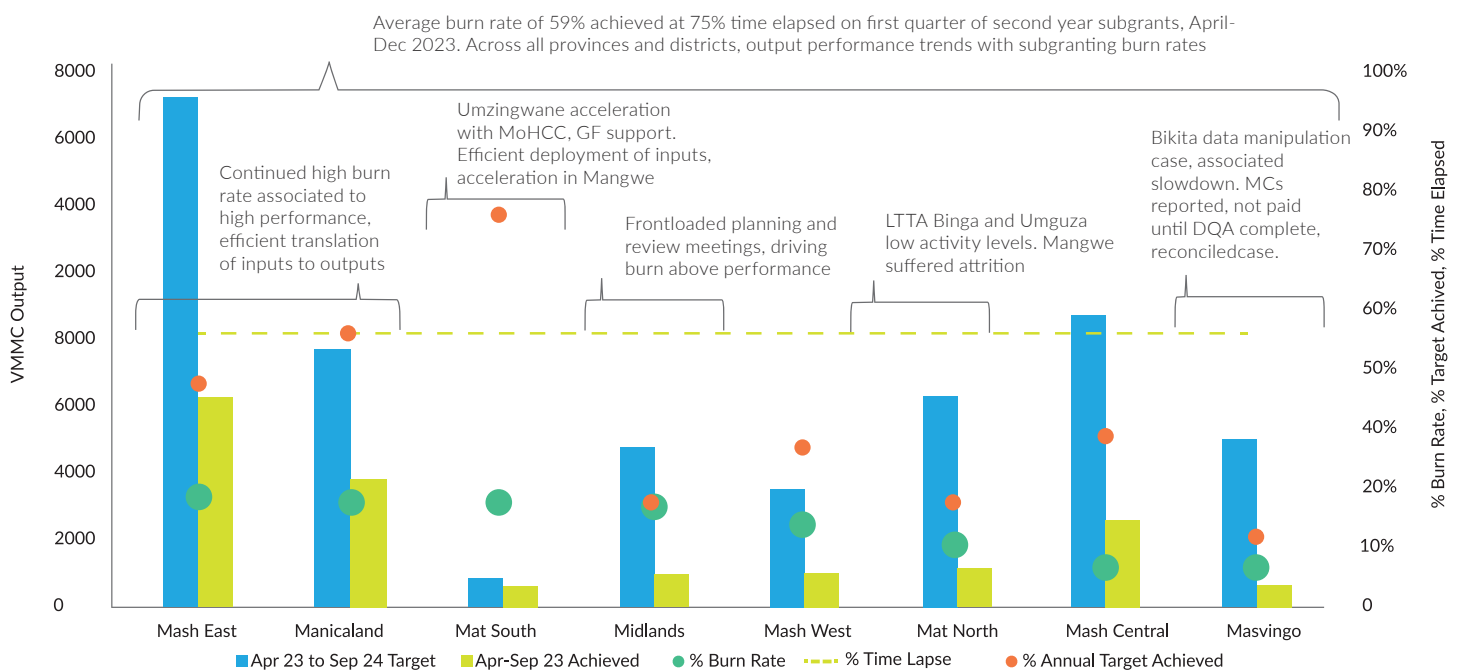


Figure 3. Second year PHE Sub-granting performance vs. target and burn rate, by province, April - Dec 2023

Highlighting Success from Buhera District

From May 2022 to February 2024, districts demonstrated efficiency gains. Through efficiencies, Buhera district saved \$29,063. The district health authority was able to reinvest these savings into:

- Purchasing 10 laptops for district health staff who lacked them and buying five office desks.
- Responding to Zimbabwe's cholera outbreak in 2023-2024, which included:
 - » Purchasing fuel for administrative duties and disease surveillance, particularly during the cholera outbreak.
 - » Providing provisions for Cholera treatment centres.
 - » Conducting vehicle maintenance during the cholera outbreak.
 - » Benefiting from surplus diesel due to savings. Excess fuel was used to refuel the ambulance and other vehicles to support various programs and administrative activities.

Key Insights and Lessons Learned

The INTEGRATE experience provides valuable lessons, offering insights to guide others in strengthening local capacity and transitioning ownership through a similar framework.

Structured support upfront is essential for success.

Local health authorities initially struggled with a new model where they managed and implemented resources for VMMC activities. This shift caused initial inefficiencies, such as delayed fuel procurement, stockouts, and financial mismanagement, resulting in overspending, failure to meet targets, and inadequate service delivery. To address these challenges, the INTEGRATE team increased support and guidance to the district health management teams. Hands-on support through the subgrant officers was necessary

to help districts effectively manage their budgets and resources in alignment with the services provided and expected results. The new model required district teams to plan more carefully, ensuring resources like fuel and daily allowances directly correlated with the number of circumcisions delivered.

Fixed-price agreements reduce administrative burden.

The adoption of a fixed-price, milestone-based payment model significantly streamlines the administrative process for both partners and local health authorities. It reduces the need for detailed, frequent reviews of expenditure documents, typically required under partner-managed cost-reimbursement agreements. Simplifying administration directly contributes to health system strengthening, enabling local health authorities to focus more on service delivery and less on bureaucratic procedures.

Financial and operational planning cannot be overlooked.

While districts are accustomed to receiving technical assistance for service delivery quality and training, they often lack familiarity with financial and operational planning. This underscores the importance of not neglecting financial responsibilities, which are key capacities for local ownership and long-term success. Other programs emphasizing technical support and capacity building should incorporate operational and strategic planning activities, or else sustainability efforts are put at risk.



Digital Health Program. Zimbabwe, 2021

Sustainability and Scalability

The fixed-price, milestone-based payment model implemented under the INTEGRATE project offers a replicable and scalable approach. However, scaling and sustaining this model requires addressing several prerequisites: first, given the weaknesses often present in government systems, processes must be strengthened to support effective implementation. Second, a reliable funding source for sub-granting, whether from donors or government funds, must be identified. Additionally, districts need funding to initiate programming and mobilize activities.

Governments and partners aiming to transition from vertical, partner-led programming to sustainable, government-led initiatives can benefit from this model. Providing early and structured support, engaging in meticulous planning, and ensuring engagement at all implementation levels are critical to overcoming initial challenges. Adapting the approach to local contexts and maintaining flexibility in management practices can increase the effectiveness of this model. Aligning sub-granting with existing government accounting structures is crucial for sustainability.



Contributing Authors:

- » Brian Maponga
- » Karin Hatzold
- » Nehemiah Nhando
- » Noah Taruberekera
- » Olivia Chatsama
- » Shingirai Makaure
- » Tasha Vernon



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