INTEGRATE Insight Series

Institutionalizing **Results-Based Output Financing for VMMC**

Population Solutions for Health

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Catalyzing Integrated Sustainable Subnational Biomedical Prevention in Zimbabwe

Integrating VMMC into the National Results Based Financing System

As Voluntary Medical Male Circumcision (VMMC) was scaled up in Zimbabwe, it used a partner-led output-based cost reimbursement financing model. This model reimbursed service providers, sites, and district and provincial management and coordination structures, focusing primarily on service delivery volumes. While this model supported VMMC providers to remain motivated in a system facing significant staff turnover, it also had drawbacks. Specifically, it risked demotivating staff in supportive roles. These staff members managed other health services, and often felt overlooked as resources and attention were disproportionately directed towards VMMC services.

To address these issues, the Ministry of Health and Child Care (MoHCC), with support from the Bill and Melinda Gates Foundation, transitioned output financing for VMMC into an existing framework known as Results-Based Financing (RBF). This system, also used for maternal, neonatal, and child health (MNCH), makes payments only when health facilities meet specific goals, such as high patient satisfaction rates or successful follow-up care, which encourages providers to focus on the quality and efficiency of their services. Under RBF, payment incentives are split between the quantity of services provided and the quality of those services, as measured by specific health indicators. Further, the incentives are no longer paid exclusively to VMMC providers but rather shared among all providers at the facility.

In the transition from individualized cost reimbursement to the National RBF system, the responsibility for program coordination is shifted from external partners to MoHCC. This shift centralizes oversight of data and service quality assurance under MoHCC, with districts and provinces conducting regular audits and supervision. It also provides local healthcare facilities greater autonomy in managing their operations.

By adopting RBF, the VMMC program seeks to align with broader health system objectives, improve the quality of care by connecting payments to performance, and strengthen local ownership and management, supporting long-term sustainability.

Circumcision session at Tusilago. Zimbabwe, 2011

Key Steps in the Transition to RBF

The integration of VMMC into the existing RBF system took two years. This transition was managed by the MoHCC, specifically by a specialized group within the ministry called the MoHCC RBF Program Coordination Unit. Support was provided by external organizations such as Population Services International (PSI), Population Solutions for Health (PSH), and the Clinton Health Access Initiative (CHAI). The steps were as follows:

1. Clarifying institutional roles:

Initially, under the cost reimbursement model, roles like the fundholder, purchaser, and verifier were not clearly distinguished, which could lead to conflicts of interest. Under RBF, roles were clearly delineated:

- Funding agent and fundholder: The Bill and Melinda Gates Foundation acts as the funding agent, providing the necessary funds. PSI holds these funds, ensuring they are allocated correctly.
- Purchaser: The MoHCC RBF Program Coordination Unit serves as the national purchasing agent, buying services on a larger scale. PSH acts as the local purchasing agent, managing the purchasing of health services within specific localities.Verifier: Verifiers check and confirm that services are delivered as agreed. MoHCC Community nurses (primary health facility supervisors) serve as first-level data quality verifiers at the service delivery points. PSH, Provincial RBF Officers, and District Health Executives are second-level data quality verifiers. Local community-based organizations, contracted by the MoHCC RBF Coordination Unit, perform third-level physical client verification through client satisfaction surveys.
- Service Delivery: Service delivery is carried out by MoHCC healthcare providers.

2. Adapting tools:

Tools used in VMMC were adjusted to align with those used in RBF. This included integrating service delivery and demand creation indicators into the existing MNCH RBF contracts; modifying the existing VMMC Quality Support and Supervision tools and integrating them into the MNCH Quality Support and Supervision tools, and developing a new invoicing format that matches the electronic RBF standards for easier processing and tracking.

3. Educating stakeholders:

An education campaign was conducted across all levels of the healthcare system to explain the changes from the old VMMC payment system to the new RBF system. This included:

- Changing verification, invoicing, and payment schedules from monthly to quarterly.
- Introducing new standards for verifying quality and effectiveness of VMMC services.
- Shifting the focus of incentives from just delivering services to a balanced approach that emphasizes both quality and successful implementation of operational plans.

4. Restructuring incentives:

The way incentives are distributed was changed to better support the health system's long-term improvement while still rewarding staff. Previously, 80% of incentives went directly to service providers for performing VMMC, and 20% went to the Provincial and District management and coordination structures. Under RBF, 75% of the incentives now support broader institutional development, strengthening the overall health system, and 25% are distributed among facility staff members, ensuring that all contributions are valued and rewarded.

Digital Health Program. Zimbabwe, 2021

Implementation Progress

From October 2021, the INTEGRATE team supported the MoHCC and the RBF technical working group to integrate VMMC into the existing RBF system in four districts: Seke, Chikomba, Mangwe, and Zvishavane. Since then, there have been nine quarterly rounds of verification and invoicing for VMMC services provided through public sector sites. The insights gathered from these districts are guiding the expansion of RBF into PEPFAR-funded VMMC programs in four USAID and three CDC districts.

To monitor data quality and assess quality of care, service provision is verified on three levels. At the first level, community health nurses conduct data quality verifications at local sites. The second level involves DHE, PSH, and RBF provincial officers performing further data quality checks. In addition, the DHE and PHE undertake RBF Quality Support and Supervision using an adapted quality assessment tool. The third level verification consists of physical client verification and client satisfaction surveys, independently carried out by a community-based organization, on a sample of clients.

Following this verification process, the MoHCC generates invoices using adapted RBF standard formats, with payments made directly to the facilities by the fundholder, PSI. This method of direct payment to primary health facilities represents an improvement over the previous cost reimbursement system, where payments were processed through DHEs and subject to delays in reaching the facilities. RBF's direct payment system supports timely and reliable financial support to health facilities, with oversight of fund utilization from the DHE and Health Centre Committees.

Lessons Learned in Setting Up and Implementing VMMC RBF

The integration of VMMC into Zimbabwe's RBF system provides valuable insights into both its potential benefits and operational challenges. Key insights from the INTEGRATE project include:

Well-defined roles and responsibilities, coupled with expert guidance and oversight, are essential for successful RBF.

A functioning RBF system requires clear institutional arrangements and defined responsibilities. Implementation involves healthcare providers at all levels, from community health nurses to District and Provincial Health Executives, who are increasingly engaged in RBF processes. A structured approach promotes local ownership by clearly delineating roles and responsibilities, facilitating a transition from roles previously managed by implementing partners to those led by MoHCC.

Demand creation poses a challenge for RBF implementation.

To effectively motivate local VMMC providers, the program needs to perform a significant number of male circumcisions. Historically, demand creation initiatives have been driven by partners, resulting in facilities not taking ownership of their own demand creation processes. With the integration of RBF, there is a need to transition demand creation from partner-led to district- and facility-led. This shift will help align service delivery with demand planning and implementation more effectively.

RBF Quality Support and Supervision tools require customization and refinement to meet the needs of the VMMC program.

Initially, the MNCH quality support and supervision tools were not adequately tailored for VMMC, requiring revisions. These tools were streamlined and made more user-friendly over several pilot rounds, incorporating essential VMMC scoring criteria which are now integrated into the DHIS2-based electronic RBF platform. These revised tools enable a more effective and efficient verification process at all service delivery points but required time and investment to customize.

RBF can increase both service delivery outputs and provider earning potential.

The introduction of RBF has led to adaptations in service delivery. For instance, primary health facilities without VMMC-trained providers have adopted a "hub and spoke" model. This approach, driven by direct RBF payments and team-based incentives, has expanded VMMC services by increasing the participation of VMMC clinicians, with support from larger hospitals. As a result, the number of facilities offering VMMC in the first four districts increased from 30 in April 2021 to 70 by March 2023.

Transitioning to RBF did not reduce performance. Performance metrics did not decline as anticipated with the change in incentive structures; instead, they showed a steady growth over time, underscoring RBF's effectiveness in strengthening program performance and quality of services.

Key Takeaways for Future Programming

RBF is effective in maintaining VMMC outputs.

The transition to VMMC RBF has shown that maintaining or even increasing male circumcision outputs is feasible across most quarters. Quarterly performance has not only remained stable but has grown over time, as illustrated in **Figure 1.**

Invest in demand creation to drive services uptake.

Earnings from VMMC services are partially driven by service volumes, highlighting the critical role of demand creation. Future programs should invest in demand creation and community engagement strategies to sustain and increase service uptake.

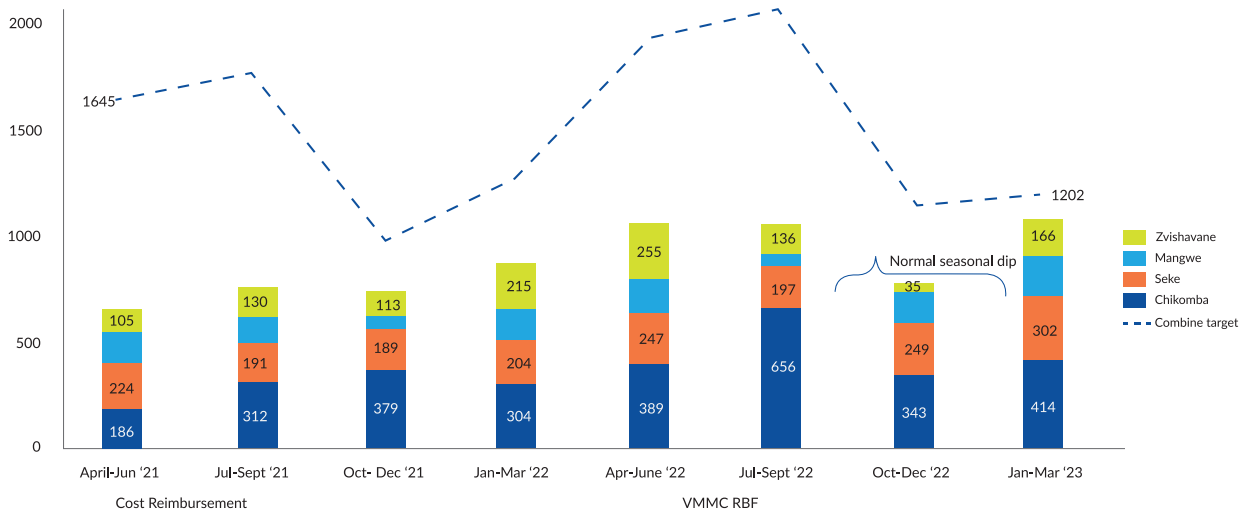

Figure 1. Monthly VMMC Performance During the Transition to RBF, By District

RBF can better motivate facilities.

RBF incentives and payments motivate facilities to activate their demand structures and deploy mobile teams from larger circumcising hubs. This approach has steadily increased the number of facilities reporting outputs, demonstrating the effectiveness of the RBF model in engaging more facilities, thereby making VMMC services more accessible.

RBF led to improvement in service and data quality scores.

Under the RBF model, District Health Executives have taken a leading role in the quality assurance process, resulting in improved VMMC service and data quality scores. The transition from partner-led and inconsistent assessments to district-led and consistent evaluations marks a significant improvement in the program's integrity and effectiveness, as highlighted in **Figure 2.**

Increased transparency and accountability through community-based oversight and cost-effectiveness.

Community-based organization led client satisfaction surveys and third-level verification. Community-led verifications achieve a high client verification factor, suggesting that expanding this model could increase transparency and accountability.

Districts	VMMC RBF QA Scores						Sparklines
	Oct-Dec '21	Jan-Mar '22	Apr-Jun '22	Jul-Sept '22	Oct-Dec '22	Jan-Mar '23	
Chikomba	72.9%	77.3%	83.5%	85.5%	87.9%	86.9%	
Seke	68.3%	75.0%	79.9%	82.2%	79.4%	84.4%	
Mangwe	75.0%	81.5%	88.3%	89.8%	91.1%	92.9%	
Zvishavane	56.5%	85.3%	79.4%	90.2%	95.0%	94.1%	

Figure 2. Improvement in VMMC Service Quality Across Four Districts, October 2022 to March 2023

Next Steps

Increasing VMMC Integration and Expanding RBF to Additional Health Areas.

To further solidify the integration of VMMC within Zimbabwe's RBF framework, the following strategic actions are proposed:

Capacity building and supervision:

Conduct systematic reviews and strengthen the capacity of local health structures to support the expanded implementation of RBF. This will ensure teams are well-equipped to manage RBF processes effectively.

Scale and evaluate RBF implementation:

Expand the RBF model to additional districts and health areas. Implement comprehensive evaluations of RBF implementations.

Continue fundraising for RBF support:

Funding primarily comes from external sources; without it, the RBF system cannot sustain itself. At the policy level, it is essential to keep fundraising to maintain and expand RBF beyond the current districts.

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Digital Health Program. Zimbabwe, 2017