Assessment of the funding, accounting and monitoring of Zimbabwe's Health Services Fund

Training and Research Support Centre (TARSC)
working with

Community based researchers

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1. Introduction

The Health Services Fund (HSF) began in 1994 when "…*the largest hospital in the country, the Parirenyatwa Group of Hospitals, was allowed to keep a proportion of its revenue and in 1996 the Cabinet agreed to the creation of Health Services Funds in which all facilities could keep the collected revenue. The latter could be used to meet any locally determined needs, but not staff salaries*" (Bennet et al 1998:7);

The Health Services Fund was established in September 1996 in terms of Section 30 of the Audit and Exchequer Act (Chapter 22:03), repealed by the PFMA (Chapter 22:19) Section 18 "...*to collect and administer fees to supplement the health budget, both recurrent and capital budget allocations for the development and maintenance of health services, programmes, and related activities such as may be approved from time to time by the Secretary for Health and Child Care in consultation with Treasury*" (MoHCC Manual 2012a:10). It was meant to improve the billing and collection of user fees and provided the flexibility in responding to the emergencies and other exigencies (MoHCC, 2009). At its inception, the aim of the HSF was to provide additional revenue to fund health services by collecting fees from users of services, and retaining 40% of these at district level to cater for health promotion and prevention activities, while the remaining 60% was surrendered to the Ministry of Health. This 60% share was meant for use in rural health centres in the district the HSF was being collected.

1.1 Health Services Fund and User Fees

The HSF is still in operation at the secondary and tertiary levels of the health system. The inability of the patients to pay for health services has continued to inhibit the functionality of the HSF, resulting in the failure of health facilities in investing in operational activities necessary for improving quality and delivery of health services (Crown Agents 2013a). While at all levels of care, user fees continue to be a key source of revenue for many health facilities, as shown in *Figure 2*; where these fees are being imposed especially at rural and urban clinics contrary to national policy, they have led to financial barriers to access, such as in maternal and child health services, with many mothers not having the funds to pay for services and delivering at home, contributing to higher maternal mortality (See Figure 3). The Maternal Mortality Rate (MMR) is 960/100 000 live births and currently Zimbabwe is ranked among the 40 countries in the world with high maternal mortality (UN 2013). According to the same United Nations report, MMR has increased by at least 28% between 1990 and 2010. One of the major barriers to access to maternal and child health services is the cost of services. While the national average user fee for nomal delivery in 2012 was found to be $26, the cost was found to be above $50 in mission hospitals ($89) and private health facilities ($51) –see *Figure 4* (MoHCC, 2012)A study on sources of financing and expenditure for health services for the city of Harare in 2011 also found out that the average cost for prenatal care and delivery was high ($129); the average cost per visit ranged between $1.84-$7.78 and the aveverage cost for Antenatal care services was $59.52. (Shamu et al, 2011). This study also found out that households were willing to pay $3, with $5 if services improved (62%), and waiting time reduced (53%). These high costs appear to confirm the the condition reported in the National Health Accounts Report of 2010 which showed that above a third (37%) of health sector financing came from household out of pocket financing. The same survey reports that when people fell ill, the major cost component was for consultation (95%). Services like investigations, food for patients accounted for proportions below 1% while medicines and transport accounted for 2.11% and 1.17% respectively. The Zimbabwe Health Sector National Investment Case 2010-2012 also noted that the causes of low utilization of health services at clinic level included user fees, as well as lack of knowledge, religious and cultural barriers and poor male involvement. The Results Based Financing programme in Zimbabwe is seeking to reduce the demand side financial barrier to access to services by abolishing the need to pay user fees for a specified package of services in repsect of maternal and child health services.

Figure 1: Share of user fees, 2011

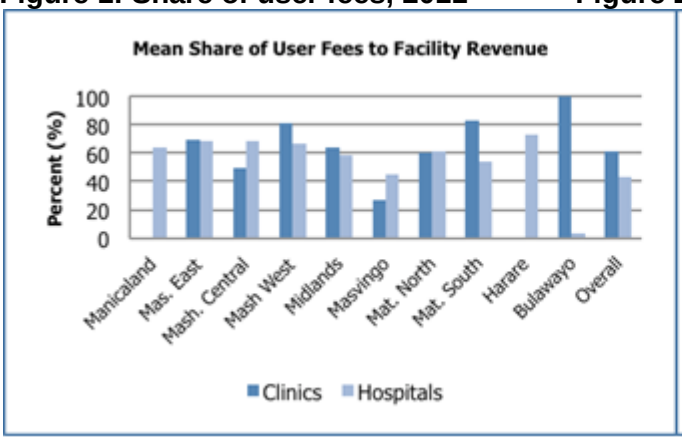
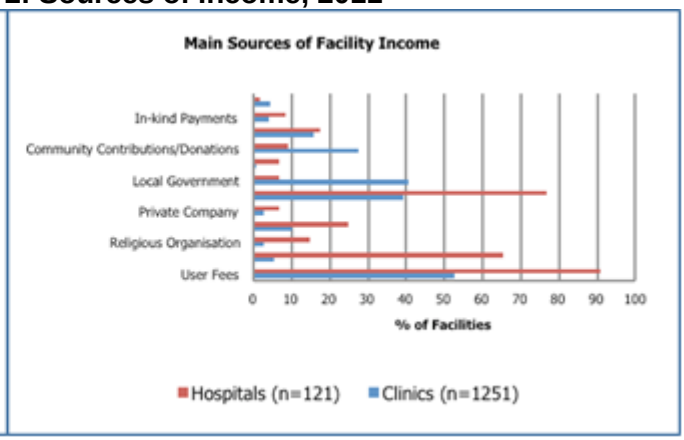
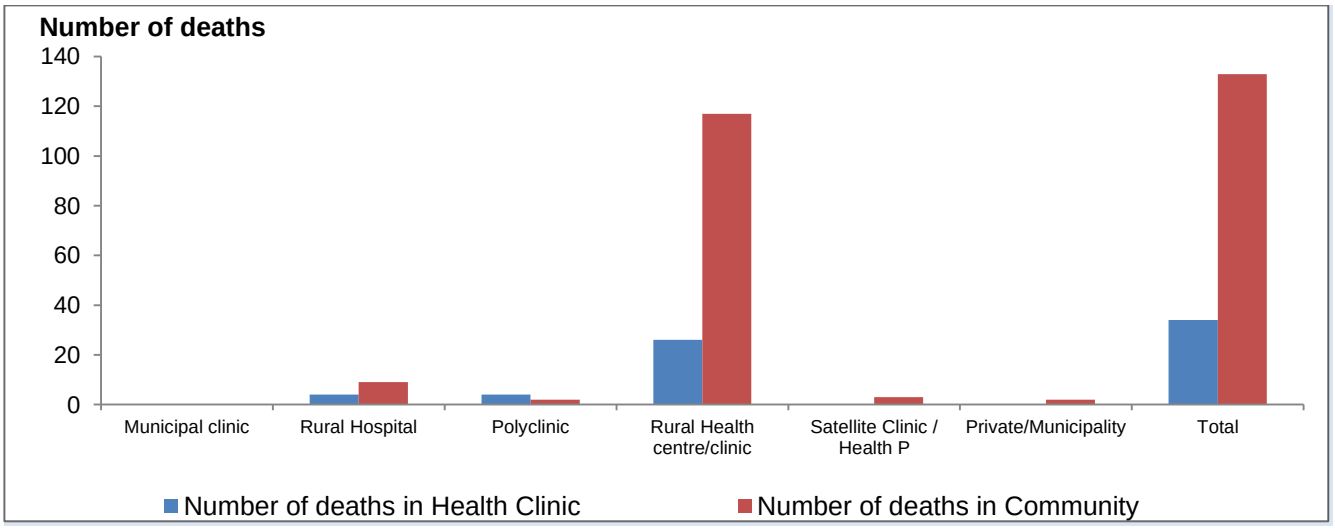


Figure 2: Sources of Income, 2011



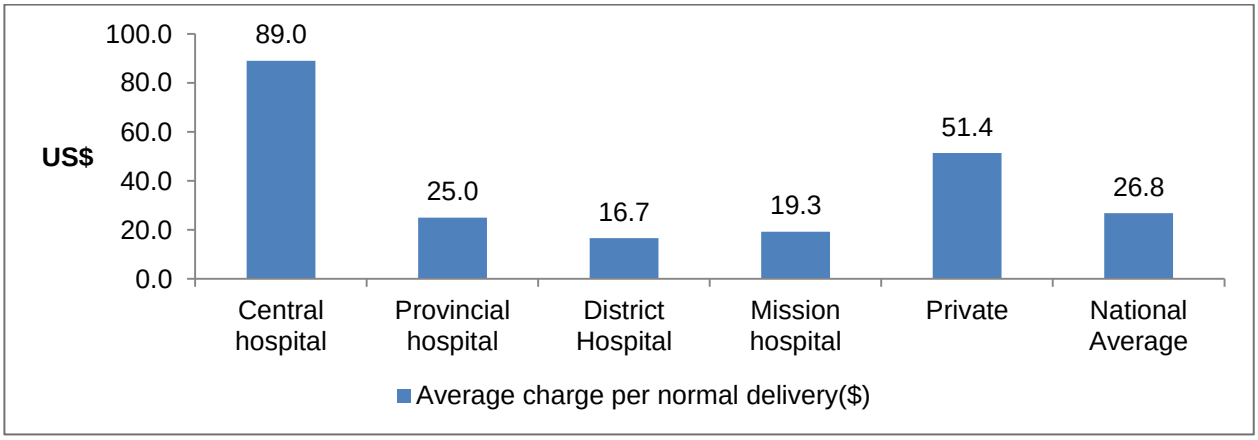
Source: MoHCC 2012b

Figure 3: Maternal deaths by facility type, 2011



Source: MoHCC 2012b

Figure 4: Average user fees for normal delivery, 2011



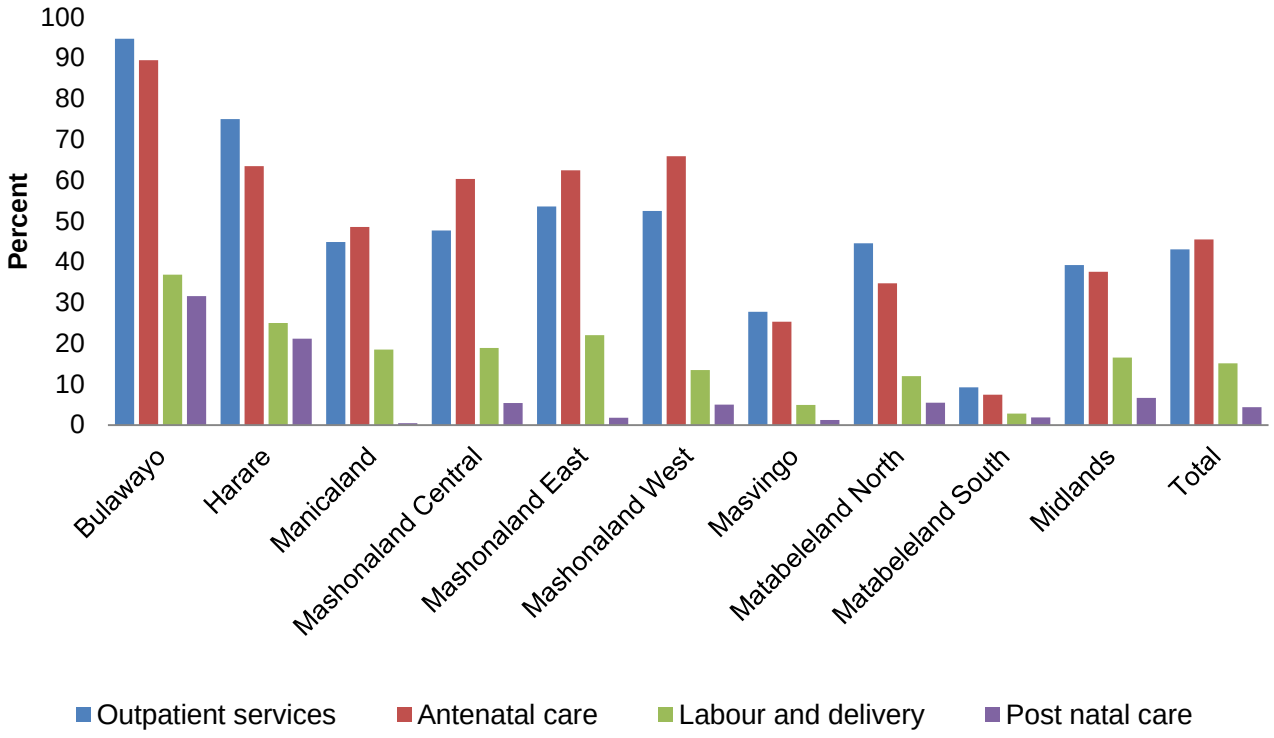
Source: MoHCC 2012b

Public funds should be audited as a norm and not an exception. According to the National Integrated Health Facility Assessment (NIHFA) report, with 30% of hospital administrators and executive officer posts still vacant, there is likely to be a challenge in achieving this. For example, 25 % of level 1 facilities had financial records, 10% had accounting procedures, while 16 had financial reports and 22% had periodic audit visits. Hospitals reported 70% periodic audit visits (MoHCC NIHFA 2012b). A Public Financial Management system needs to be improved and that also calls for the development of a medium term expenditure framework that promotes efficiency in resource allocation. The role of the District Health Executives (DHEs) in the allocation of resources should be strengthened. There is need to provide clear operational guidelines on how to allocate, manage and account for the allocated funds in their respective areas.

1.3 Sources of Funds

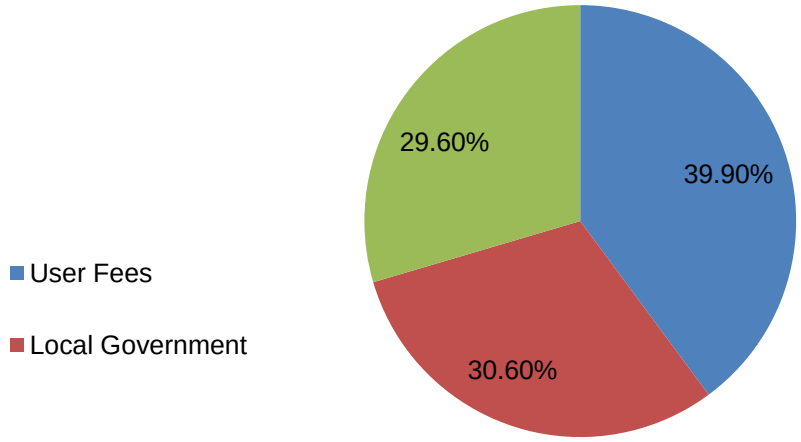
The sources of revenue for the HSF as set in its constitution are as follows: hospital fees (ambulance fees, consultation fees, dental fees, drugs, laboratory fees, maternity fees, physiotherapy fees, theatre fees, ward fees and x-ray fees; (see Figure 5), government budget, external funds and other donations, interest receivable from investment funds. Investments from HSF can only be made when the facilities' total operational requirements have been taken into account. It also includes other fees, such as social protection fees. With inadequate central government support to clinics, user fees became the main source of funds as shown in Figure 6.

Figure 5: Health services and user fees by Province, 2011



Source: MoHCC 2012b

Figure 6: Sources of major funding reported by Level 1 facilities, 2011



Source: MoHCC 2012b

Ordinarily the HSF was also supposed to get funds from the Social Welfare Department for people on public assistance, National Social Security Authority (NSSA) for its pensioners and from the workers' Welfare Compensation Insurance Fund. Ideally the HSF should also claim fee reimbursement from NSSA's maternity benefit scheme that caters for the lowly paid and the unemployed, enabling them to get free medical care from hospitals. For employed people, the scheme reimburses 75% of one's salary for 45 days before and 45 days after delivery. The Ministry of Finance continues to allocate funds to the HSF in the form of what it terms an 'equalisation grant' allocated to districts that do not have enough capacity to generate as much revenue as other districts. Thus, it appears that several sources of increasing the HSF resource envelope are available, but are currently not being followed up. These potential sources have the potential to increase the financial reasources for the HSF without impoverishing poor people, such as those from NSSA's Workers Compensation Insurance Fund. In addition making effective claims on private medical aid funds for their clients using public services could also feed into the HSF. Tapping into these potential sources could reverse the declining share of public financing of health reported in 2010; government funding on health reduced from 39% in 2001 to 18% in 2010 (MoHCC, 2010). In addition, this pooling of funds can help alleviate problems associated with the current fragmentation of the sources of funds for the health sector.The HSF also gets money from external funders (through the Health Transition Fund and the RBF) through the new arrangement called the HSFplus. Thus, there is the basic HSF (which gets money from people who pay for health services, that is patient user fees and other sources and the HSFplus which involves monies coming from external partners through the HTF and the Results Based Financing for specific health services). Both the HSF and HSFplus are meant to cover specific expenditures and hospitals are expected to be having manuals that state what should be covered, that is what the money can be used for and what it cannot be used for. The HSFplus has adopted and revitalised the old HSF structures by factoring in the Results Based Management framework; where funds are only disbursed to health facilities on the basis of their performance. Thus, the HTF- HSF is transitioning from the input approach on maternal and child health services to the ouput based approach using Results Based Financing. Thus, prepaid funds will be availed for the delivery of MCH services that are free at point of care.

1.4 The new HSFplus

The Health Services Fund is currently being revitalised under the Health Transition Fund (HTF), a multi-donor fund managed by UNICEF. This revitalisation initiative is now referred to as HSFplus, to describe the revitalisation of the HSF, reflecting the fact that it is drawing on pre-existing HSF systems, procedures and knowledge, whilst evolving into something new by drawing from the Results Based Financing (RBF) components (Crown Agents 2013a). The HSF manual has also gone through some revisions to incorporate these new elements. Under the HTF framework, the HTF is supporting the Ministry of Health and Child Care (MoHCC) deliver a primary health package free of charge to pregnant and lactating women and children under-5 years (MoHCC 2012a).

Its purpose is therefore "*to improve maternal, newborn and child health (MNCH) by strengthening health systems and scaling up the implementation of high impact MNCH interventions through support to the health sector*" (Crown Agents 2013a:p 6)

Under the HTF and the RBF funding mechanisms, the health facilities are reimbursed agreed funds for providing certain monthly maternal and child health services. It appears that the HSF is strategically positioned to be used under the World Bank Results Based Financing given that the HSF is now handling funds from external funders as one of its functions. Thus, the RBF could potentially do away with the use of Temporary Deposit Accounts in the hospitals and use the HSF instead. In the case of the HTF, funds are disbursed directly to health facilities' bank accounts on a quarterly basis. All districts are supported by the HTF, apart from those in provinces of Harare and Bulawayo. Districts that are on the RBF do not get the HSFplus support as this is covered under the RBF framework using the Temporary Deposit Accounts instead of the HSF. The following table shows how the funds are disbursed to the different facilities. Funds can only be disbursed if the HTF has received acquittals of previous quarter disbursements.

Table 1: Monthly support from the HTF

Type/Level of Health Centre/Facility	Monthly Support (US$)	Quarterly disbursements (US$)
Rural Health Centre	750	2250
Rural Hospital	1000	3000
Mission hospital not designated as district hospital	1500	4500
District Hospital	1500	4500
District Health Executive	1000	3000
Provincial Hospital	2000	6000
Provincial Health Executive	1000	3000

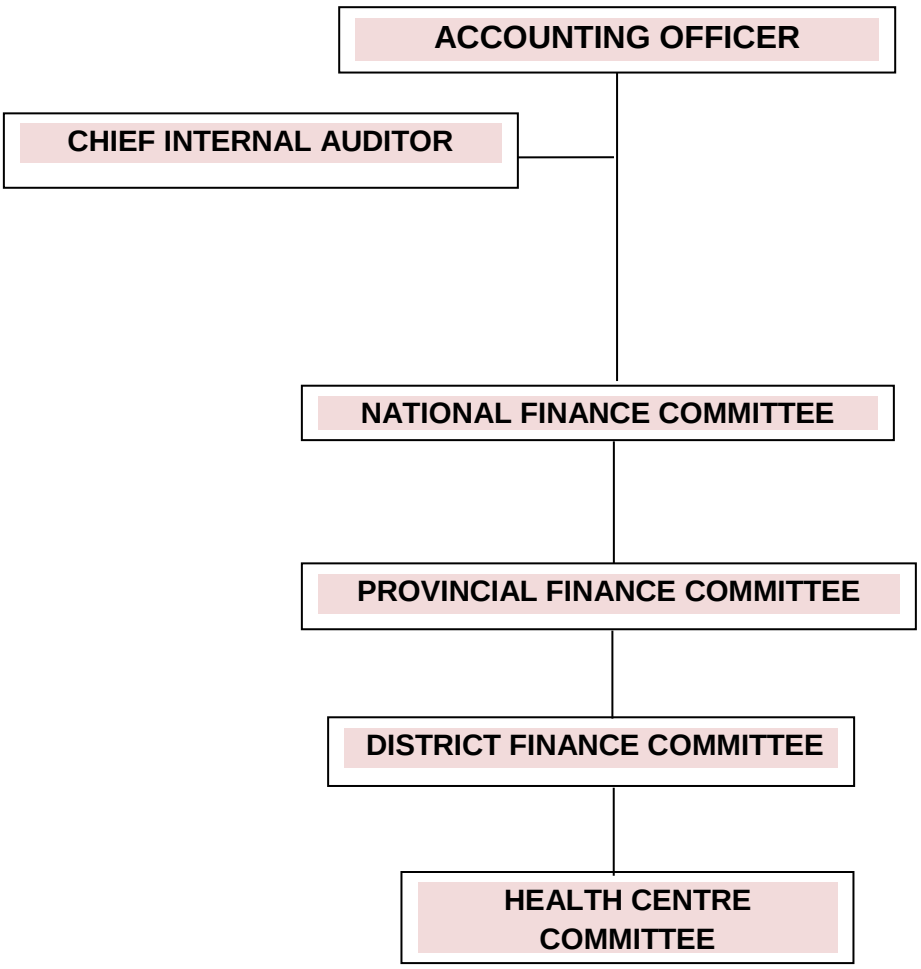
Source: Crown Agents 2013b,c

While this HTFplus manual gives autonomy to health institutions to buy what they can with the funds, the facilities are expected to give priority to items of critical importance such as soap, detergents and child health cards. The current national average of facilities that issue child health cards at the lower level is 75% (MoHCC 2012b). In general, allowable expenses for the HSFplus include "*basic medical consumables, cleaning materials and laundry, bedding and linen, community outreach activities, emergency patient referral costs, District Health Executive and provincial Health Executive supervision and monitoring costs, utilities and repairs and maintenance*" (Crown Agents 2013b:p 3). The HSFplus expenditure is also restricted to certain

functions and the general expenditure comes with certain conditionalities. For example, no salary or salary top-ups are allowed for facility staff except for casual wages of employees not on establishment and no borrowing is allowed from the HSFplus funds. Rural health centres are allowed to spend US$1250 without any conditions. Any amounts above this can only be spent after having submitted monthly T5 forms and balanced accounts, having achieved or improved a set of health access indicators. The range for timely submission of T5 forms is 50% -100%, and the national average is 80.8% (MoHCC 2012b). Further, the expenditure still has to be undertaken according to the facility's operational plan (Crown Agents, 2013b).

The new HSFplus reporting structure is shown in Figure 1 below.

Figure 1: The Structure of the HSF



1.5 Financial Governance

Successful monitoring of all funds disbursed to health facilities not only depends on sound financial skills, but heavily depends on the availability of the requisite human resources with the relevant skills as shown in Figure 1. Non-availability of the critical staff only makes accounting for the funds difficult. According to the 2012 NIHFA assessment, there are still provinces in the country that have not reached the full establishment for all the financial accounting posts as shown in Table 2.

Table 2: Number of Administration and Financial Accounting posts versus establishment at a hospital level by Province, 2011

Province	# of Hospitals	Hospital Administrator		Executive Officer		Accountant		Accounting Assistant	
		Applied	Filled	App	Filled	App	Filled	App	Filled
Bulawayo	3	1	1	3	1	5	4	80	65
Harare	6	4	5	0	1	4	4	45	67
Manicaland	22	7	8	7	3	5	6	16	11
Mashonaland Central	12	8	4	13	11	7	5	25	24
Mashonaland East	17	9	7	10	7	7	6	19	16
Mashonaland West	14	11	7	8	4	6	4	17	13
Masvingo	14	8	6	8	8	6	6	13	14
Matabeleland North	10	7	3	1	0	6	3	12	10
Matabeleland South	10	8	2	4	1	7	6	18	13
Midlands	17	11	9	8	7	9	9	23	20
Total	**125**	**74**	**52**	**62**	**43**	**62**	**53**	**268**	**253**

*Proportion of Level 1 facilities and hospitals with various types of financial monitoring systems in place, 2011

	% Reporting financial records produced		% Reporting periodic audit visits		% Reporting periodic audit visits	
	Level 1	Hospital	Level 1	Hospital	Level 1	Hospital
National Average (%)	25.1	88.8	21.8	70.4	3.8	13.6

Source; MoHCC 2012b:

*Having financial monitoring systems is dependent on facility charging user fees.

Participation of communities in managing the HSF also ensures improvement in allocation of resources. According to the NIHFA report, 78.2% of level 1 facilities have Health Centre Committees. However, overall only 9.2% of the HCC operated bank accounts, showing their low level of involvement in the financial management of facilities (MoHCC 2012b). This position is likely to have improved given that for HSF plus to operate, each rural health centre is required to have a separate bank account which is a subaccount of the HSF at the district. The rural health centre is also supposed to have a functional Health Centre Committee to allow for the operational planning and use of HSF funds. All the rural health centres under the RBF in the 18 districts also have functional HCC's, as a requirement to be on the programme

2. Aims and Objectives of the Assessment

2.1 Aim of this Assessment

In this assessment, we aimed to assess the HSF in terms of its revenue flows and management, accounting and reporting on its funds. Specifically, the assessment sought to determine;

- The sources of funds in the HSF;
- The administration, management and use of HSF funds, and criteria used to allocate them;
- The accounting measures (books of accounts; accounting practices) used for the HSF;
- The auditing, evaluation practices on the HSF; and
- The reports or statements produced on the HSF.

3. Methods

3.1 Research Design

The assessment was done through a single cross sectional sample survey of district hospitals from all provinces with district hospitals that manage the HSF, shown in Table 3 below.

Table 3: Targeted Provinces, Districts and District Hospitals

Province	**District**	**Districts- Population** As per list from MoHCW (excluding Designated District Hospitals)	**Districts-Sample** (Purposive sampling)
Mashonaland West	Chegutu	Chegutu DH	Any 3
	Hurungwe	Karoi DH	
	Kadoma	Kadoma DH	
	Kariba	Kariba DH	
	Zvimba	Banket DH	
Mashonaland East	Chikomba	Sadza DH	Any 3
	Goromonzi	Makumbe DH	
	Hwedza	Hwedza DH	
	Mudzi	Kotwa DH	
	Mrewa	Mrewa DH	
	Mutoko	Mutoko DH	
	UMP	Mutawatawa DH	
Mashonaland Central	Shamva	Shamva DH	Any 3
	Guruve	Guruve DH	
	Mazowe	Concession DH	
	Mt Darwin	Mt Darwin DH	
	Rushinga	Chimhanda DH	
Manicaland	Chipinge	Chipinge DH	Any 3
	Makoni	Rusape DH	
	Mutare	Sakubva DH	
	Mutasa	Hauna DH	
	Nyanga	Nyanga DH	
Masvingo	Chiredzi	Chiredzi DH	Any 3
	Chivi	Chivi DH	
	Mwenezi	Neshuro D H	
	Zaka	Ndanga D H	

Midlands	Chirumanzu	Mvuma DH	Any 3
	Gokwe	Gokwe South DH	
	Kwekwe	Kwekwe DH	
	Shurugwi	Shurugwi DH	
	Zvishavane	Zvishavane DH	
Matabeleland North	Binga	Binga DH	Any 3
	Bubi	Inyathi DH	
	Hwange	Victoria Falls DH	
	Nkayi	Nkayi DH	
	Umguza	Nyamandhlovu DH	
	Tsholotsho	Tsholotsho DH	
Matabeleland South	Beitbridge	Beitbridge DH	Any 3
	Mangwe	Plumtree DH	
	Kezi	Maphisa DH	
	Insiza	Filabusi DH	
	Umzingwane	Esigodhini DH	

The districts were purposively selected so as to include all the eight provinces with district hospitals that manage the Health Services Fund. Thus, the assessment covered eight out of ten provinces and from each province three government district hospitals were selected. On average there are about 6 district hospitals per province. We limited our sample to only three hospitals per province due to time and resource constraints. However, since selecting three hospitals per province gave a sample of almost 50% of the population, the sample was considered as sufficiently representative of all the district hospitals in Zimbabwe. A team of researchers was assigned to conduct key informant interviews using a pre-coded questionnaire. The key informants that were targeted at each facility were the District Accountant or District Administrator or the District Medical Officer.

3.2 Sampling

A list of all district hospitals in each province was obtained from the Ministry of Health and Child Care (MoHCC) and all government district hospitals identified. A team of eight community based researchers who have participated in other health and budget tracking assessments with TARSC were identified based on their skills. In each province, one community based researcher collected data from three government district hospitals out of the total government district hospitals. Purposive sampling was used to select the sample of three district hospitals in each district. Thus, a total of 24 government district hospitals were included in the sample covering all the eight provinces.

3.3 Ethical considerations

Permissions for the work were sought and obtained at two levels prior to the work; from the MoHCC at national Level and the Provincial Medical Officer in each province. At each of the sampled district, the community based researchers set up appointments with the respondents (DMO, Accountant or Administrator). After scheduling the meetings, the respondents participated voluntarily and confidentiality of information collected was guaranteed. Respondents were allowed to withdraw at any point during the interviews.

3.4 Data collection, analysis

Data was collected using a standardized pretested questionnaire. Before fieldwork, the community based researchers were briefed on the methods and the tools used in the research. In addition, they were provided with a manual containing background information to the research, the research objectives and questions and methods on how they would collect the

data in the field. The manual contained explanations of each question in the data collection tool and also provided guidance on how to ensure data quality. Fieldwork monitoring was implemented through visits to two of the sites and telephone calls to the remaining sites to clarify any queries the researchers had. Data was entered in Microsoft Excel Worksheet, and was cleaned before analysis. Any data sets that had queries were cleaned by phoning the respective field officers for clarifications. Data tables were produced using the frequency function in Microsoft Excel.

3.5 Limitations

In two district hospitals, the respondents said they would want to self complete the questionnaires instead of being asked questions by the community based researcher. While these self administered questionnaires could have introduced bias in the results, we analysed the responses from these questionnaires and compared them with responses from questionnaires that had not been self administered and found no significant differences. The assessment was also limited by the resources available; a larger sample or even all district hospitals could have been covered. In addition, limited resources meant that we could not carry out the assessment at the rural health centre level, which are receiving HSF funds directly from external partners through the HTF and RBF initiatives. An assessment at this level could have provided some challenges and opportunities in the way in which HSF operates, especially in remote Rural Health Centres where human resources and access to banking facilities is also huge challenge

4. Results

The report presents results from the assessment within the following sections;

i. Characteristics of reporting districts
ii. Rules and Systems
iii. Accounting Practices
iv. Auditing/Evaluation systems

4.1 Characteristics of reporting districts

The assessment covered a total of 23 district hospitals out of the initial sample of 24, giving a 96% response rate, with the one site lost due to respondents being not available despite several call backs. Table 4 provides the list of the district hospitals that participated in the assessment.

The districts included those districts under the RBF (35%) and those under the HTF health services fund support as shown in Table 5.

With the general government budget support to the HSF having gone down drastically, the remaining meaningful support came from user fees and external support. On average a district received US$98 000 in the 2013 fiscal year from external partners compared to US$145 600 from direct user fees payments (See Table 6). There were variations in terms of respondents report of the percentage of funds that should be retained by health facilities. Some (26 %) facilities thought they should retain 100%, while some (58 %) thought they should retain 60%. The varied responses could have arisen as a result of the concurrent operations of the old HSF and HSFplus.

Table 4: The participating sites and district hospitals

Province	Districts
Mashonaland East	Goromonzi
	Mrewa
	Mtoko
Mashonaland Central	Guruve
	Concession
	Shamva
Mashonaland West	Hurungwe
	Kadoma
	Zvimba
Midlands	Shurungwi
	Gokwe
	Kwekwe
Matabeleland South	Esigodini
	Mangwe
Matabeleland North	Nyamandlovu
	Inyathi
	Tsholotsho
Manicaland	Makoni
	Chipinge
	Mutare
Masvingo	Chibi
	Zaka
	Chiredzi

.**Table 5: Information on the facilities**

Characteristic	Response
Total number of District Hospitals assessed	23
Average number of Clinics in each district	26.9
Average number of clinics the district hospital was monitoring on HSF	15.8
Districts on results based Financing	
Total Number of Districts on RBF	8
Percent on RBF (N=23)	35

Table 6: Average funds received by the district hospital

Mean amount received in 2013 for HSF plus from the external funders	US$ 980 32.14
Mean Amount Received as user fees for HSF in 2013	US$ 145 611.00

4.2 Rules and procedures

While funds received for the HSFplus are allocated on the basis on the facility's operational plan and expenditure plans, various methods are used by the different district hospitals to allocate funds. Some allocated the funds according to priority needs, some according to the volume of work and some on the basis of demand. According to the MoHCC HSFplus manual, funds received for HSF purposes can be invested, provided the health facilities have taken care of the priority health issues in their operational plans. However, all the district hospitals interviewed stated that they were not allowed to invest funds by the MoHCC.

The HSFplus introduced a standardised accounting system for all districts that are getting assistance from the HTF and RBF funds. The accounting systems are handled by competent and qualified accountants who report to a well structured system. There are separate accounts for different hospital activities to minimise misuse and to make accounting for the various HSF funds easier. The district accounting teams have been trained in how to handle and account for the HSF and HSF plus funds. Reports are produced on a quarterly basis and are a certified by the District Medical Officer and other accounting officers at different stages. A number of districts (26%) reported delayed submission of reports from some of their facilities as a result of personnel shortages and the volume work involved in collating and producing the final reports.

The following books and systems of accounts should be maintained by the district hospitals as a minimum requirement for accounting for the HSF funds; cash book, commitment register, stock control book, creditors' ledger, debtors' ledger, asset register, general journal and general ledger. In the assessment only the cash book was used by 95% of the district hospitals, the ledger by 65% and receipt book by 52%, while the other books and systems of accounts were used by less than a quarter of facilities (See Table 7). For HSFplus the findings are similar (See Table 8).

One reason cited for no or low use of books and accounting systems was the cumbersome nature of the whole accounting exercise. The accounting process is yet to be completely standardised in all facilities as some hospitals were still using manual systems while others are computerised. The MoHCC has also recommended in 2012 that district hospitals and their facilities provide for many accounts rather than too few to avoid mixing different types of transactions in one account (MoHCW, 2012)

Table 7. Reported Books of accounts for recording HSF funds

Name of Book of Accounts/ System	Number of district hospitals using the book/system	Percent districts using the system N=23
Cash Book	22	96
Ledger	15	65
Receipt book	12	52
Invoice book and token books	5	22
Commitment register	4	17
Bank reconciliation statements	3	13
Payment vouchers	3	13
Income and expenditure	2	9
Sub-collectors	2	9
Segment requisition	2	9
Balance sheet	1	4
Petty cash	1	4

Most district hospitals keep their money at the bank, as is required and stated in the Health Services Fund Manual. Funds received for the HSFplus are kept in Temporary Deposits Accounts (TDA), which also includes external funds, clutch deposits, funds received from the Salary Services Bureau (SSB) and recoveries by SSB. However, the new HSFplus requires individual institutions to open their own bank accounts for easier disbursement and accountability. For obvious reasons, such as distance from the banking institutions and need for petty cash purposes; some funds are kept at the district hospital (See Table 9).

Table 8: Books or statements the district hospitals are reporting on the HSFplus

Name of Book of Accounts/ Statement	Number of district hospitals reporting using the book/statement	Percent districts using the system N=23
Income and expenditure	19	83
Cash book	13	57
Bank reconciliation	8	35
Balance sheet	6	26
C-form	5	22
Trial balance book	4	17
Debtors ledger book	3	13
Receipt book	3	13
Invoice book	2	9
Quarterly reporting	1	4
Creditors register	1	4
HSF Plus district return	1	4
Are the reports disaggregated by facility		
Yes	17	74
No	5	21

*na make up the difference

Table 9: Responses on where HSFplus are kept

Hospitals reporting that funds are kept	Number of District Hospitals	Percent district Hospitals N=23
In Bank account	22	97
In Safe	6	26
In a cash Box	2	9

NB: Multiple responses were possible

Standard risk prudence would require that district use more than one banking institution so as to spread risk, about 87% of the districts use only one banking institution. This could be as a result of the geographical access to banking institutions in various districts, where only one or two banks could be found at the nearest district town centre. Popular among the banking institutions are the government controlled CBZ Limited bank and the three international banks (Barclays, Standard Chartered and Stanbic banks). (See Table 10). The MoHCC has no directive about which banking institutions district hospitals should use. The District Health Executive facilitates the opening of bank accounts by Rural Health Centres.

Table 10: Banking of HSFplus

Number of Banks Used		
	Number of DH using the Bank	Percent Using the Bank (N=23)
District Hospital using one bank	20	87
District Hospital using two Banks	3	13
Names of Banks used		
ZB Bank Limited	2	9
CBZ Bank Limited	9	39
Barclays Bank of Zimbabwe Ltd	4	17
Standard Chartered Bank of Zimbabwe Ltd	8	35
Stanbic Bank Zimbabwe Limited	0	0
Agricultural Development Bank of Zimbabwe (Agribank)	2	9
Allied Bank of Zimbabwe Ltd	1	4

The HSF rules require the HSF funds and HSFplus funds to be kept separately. Contrary to this rule, one facility reported that it was keeping both funds in the same bank account. Most facilities reported that the clinical officer, DNO and DEHO are signatories to the accounts. The nutritionist and matron were reported as signatories by only one facility each. On average, three people were signatories per each facility (See Table 11 overleaf).

The HSF rules require that there be a committee to oversee the funds. Nearly all facilities had such committees except for one; the reasons for this facility to fail to establish the committee could not be established. Most of the facilities noted that the committees meet monthly (39%) while a significant share had committees meeting weekly (35%). Interestingly, four facilities had committees that meet "when the need arises" and questions could be raised as to what triggers the committee to meet or who defines this "need".

Two of the facilities were not very clear regarding the frequency of the meetings, stating that the committee meets "regularly" (See Table 12). Most committees had six members and surprisingly six facilities had three members or less.

Table 11: Facility responses on rules and procedures

Responses on keeping of HSF and HSF Plus funds separately		
Number of facilities responding as		Percent facilities (N=23)
Yes	1	4
No	18	78
Na	4	17
Responses on Signatories to the accounts		
Number of facilities responding as		Percent facilities (N=23)
DNO	10	43
DEHO	8	35
DHSA	7	30
HPO	6	26
Accountant	3	13
Clinical officer	12	52
Nutritionist	1	4
HCC	2	9
Administrator	6	26
Rehabilitation Technician	8	35
Matron	1	4
Average number of signatories per facility = 3.08		

Committees are meant to provide democratic spaces for planning, monitoring and evaluation and the facilities with fewer committee members raise questions regarding the full representation of the stakeholders who should be involved. The Accountant, DEHO, DNO and matron were cited by most facilities as the officers who sit in the committees.

All facilities reported correctly that the Ministry does not allow them to invest the funds. The most cited allowable expense for the HSF is fuel and lubricants. It was not clear whether its higher reported frequency was linked to it being the major cost or not. This may need to be further investigated. Other allowable expenses with higher reported frequencies are domestic travel, communication and information and maintenance of mobile and fixed assets. No facility raised salaries, which is one of the expenses that are not allowable. The most cited expense for the HTFplus was maintenance of physical structures (see Tables 13a and b).

Table 12: Responses on Fund Committees

Is there a committee that oversee the funds		
Number of facilities responding as		Percent facilities (N=23)
Yes	22	96
No	1	4
How often does the committee hold meetings to review the HSF		
Number reporting response as		Percent facilities (N=23)
Weekly	8	35
Monthly	9	39
Quarterly	2	9
When the need arises	4	17
Not clearly specified/ “reported as regularly”	2	9
Responses on Number of members constitute the committee		
Number of facilities reporting number of members as		Percent facilities (N=23)
1-3	10	43
4-6	12	52
7-8	1	4
Responses on the designations of the people who make the committee		
Number of facilities reporting response as		Percent facilities (N=23)
DNO	13	57
Medical superintend	3	13
Accountant	17	74
Pharmacist	9	39
DEHO	10	43
DHSA	5	22
Heads of departments	4	17
Health Committee	7	30
Administrator	8	35
Lab scientist	2	9
Dentist	1	4
Matron	12	52

Facilities reported on the criteria they use to allocate HSF funds. Most facilities reported prioritisation of needs for both HTF and HTFplus funds (See Table 14). Some responses were however not clear, such as “volume of work”.

Table 13a: Reported list of allowable expenses for the funds HSF

Reported List of activities that are supposed to be funded by the HSF/Allowable expenses:		
Number of facilities reporting response as		Percent (N=23)
Medical and surgical services	21	91
communication and information	19	83
Fuel and lubricants	23	100
Maintenance of mobile and fixed assets	21	91
Institution provision	22	96
soaps and detergents	18	78
Domestic travel	20	87
Stationary	12	52
Training and development	7	30
Rentals and hire services	5	22
Food	19	83

Table 13b: Reported list of allowable expenses for the funds HTF plus

Reported HTF Plus allowable expenses		
Number of facilities reporting response		Percent (N=23)
Medical and surgical services	14	61
Soaps and detergents	12	52
Maintenance of physical structure	16	70
stationary	10	43
Institutional provisions	15	65
Fuel	14	61
Maternity services	4	17
Beds and linen	13	57
Domestic travel	12	52
Salaries	4	17
Workshops	2	9
Refreshments	1	4
Entertainment	1	4
Allowances	1	4

Table 14: Reported criteria for allocating funds

HSF Funds

- Prioritise needs /critical areas - 12 responses
- Hospital health committee . district executive committee / district health executive priorities; - 3 responses
- As per budget and purchase plans – 2 responses
- Based on demand – 2 responses
- Medicines get higher percentage, vehicle maintenance, instructional provisions, fuel, oils and lubricants
- Based on bed capacities, distance from referral centre, specialist services offered, previous expenditure trends
- Volume of work

HSF Plus Funds

- Depends on institutional needs, prioritise needs - 10 responses
- Hospital committee . executive priorities / plan – 3 responses
- Demand based- 2 responses
- Challenges on baseline indicator of set target, specific challenges to the area
- Volume of work
- The hospital does not either collect or allocate HSF to clinics
- Fuel, drugs requirements
- Give priority to drugs, infrastructure, stationary, water and linen

4.3 Budget Accounting Practices

At the time of the survey, two out of the twenty three facilities did not have a qualified accountant. The non availability of a qualified person to handle the finances compromises the financial management system if such skills are not sourced from elsewhere. In both facilities, the Accounting Assistant was reported to be handling the HSF accounting system. All facilities reported that they have a system for accounting HSF (See Box 1). All facilities reported that the HTF accounting is separate from the HTFplus accounting

Box 1: Responses on description of the system used for accounting the HSF

Responses relating to use of Accounting Books

- Receipting daily banking, maintenance of cash books, use of bank reconciliation statements and income and expenditure statements, ledgers, vouchers, purchase orders x 8

Responses relating to management of cash through banking system

- Banking of user fees before they are used x 4
- There are three signatories for the bank, safe and security for safe keeping of keys.

Responses relating to use checks and balances in the preparation, management, reporting of financial transactions

- Authorisation of Expenditures before funds are utilised x 3
- Payments/ Expenditures authorised by DMO,
- Segregation of duties to assistant clerk

Responses relating to whether a manual or Information Technology System is used

- Use of a manual system to prepare bank reconciliation, income and expenditure statements x 3
- We use an IT system to prepare statements x 2

Responses relating to use of provisions in regulations/Acts of parliament/ Mannuals

- Provisions in the Public finance management Act, treasury instructions, finance and accounting procedures for HSF, circulars, manuals x 4

Twenty two of the facilities reported that the financial statements are reported in accordance with recognised set of accounting standards. Only 14 facilities had some personnel who had attended some training in financial management during the previous year, mostly provided by the Public Service Commission (4 facilities) and MoHCC (three facilities). Mostly, district accountants attended the training courses (seeTable 15).

Table 15: Reponses on financial statements

Who provided the training: PMO x 2, Provincial Accountant, Head Office x 3, PHE, PMD Accounts Department, Public service commission x4, Crown Agents, District Accountant, Cordaid (RBF)
Who attended the training District Accountant x 7, Assistant Accountant x 3, Administrator x 5, DMO x 2, DHE x 2 *NB: Multiple responses were possible eg Accountant and Administrator attending together*

Only 11 out of 23 of the facilities said they were receiving regular reports on HSF and in most cases (90%) the reports were received on time. All the facilities were sharing the HSF reports as shown in Table 16 overeaf.

All the facilities reported that they had district operational and expenditure plans and that the plans were endorsed by the District Health Executive.

4.4 Auditing/Evaluation systems

Nearly all facilities (87%) correctly noted that there are government manuals on the HSF funds that they were aware of. The list of manuals cited is shown in Table 17 below. All the fourteen (14) facilities who knew about the Financial Accounting Manual for HSF and the HSF Procedure Manual had the manuals at the facility. Nine facilities correctly identified that the HSF manuals were different from the HSFplus manual. All facilities reported that there are checks and balances in the system.

Table 16: Reported sharing of HSF reports

Stakeholder	# of facilities	Percent N=11
ZRP	1	9
Education sector	1	9
Business Community	1	9
Agritex	1	9
Ministry of Youth	3	27
Politicians	3	27
Community Health committee	3	27
Provincial office	2	18
Development Committee	1	9
ministry of health	3	27
district health executive	2	18
head office	3	27
DMO	3	27
PMD	1	9
Farmers	0	27

Table 17: Responses on HSF Manuals

Name of manual	No responding Yes	Percent
Financial accounting for HSF Manual	14	61
HSF procedure manual	18	78
Public financial managed account	7	30
Treasury instruction	5	22
The blue book	1	4
Health strategy	1	4
Manuals the facility actually had		
Financial accounting for HSF Manual	14	61
HSF procedure manual	18	78
Public financial managed account	7	30
Treasury instruction	1	4
The blue book	2	9
RBF Guide	1	4
Health strategy	1	4
Other questions		
There are rules provided by the ministry to govern how money is used	21	91
The rules are different from the HSF + rules	9	39
There are checks and balances in the system (external and internal audit)	23	100

All facilities said the MoHCC Provincial office monitors the HSF funds, and 13 of the facilities said the MOHCC head office also does monitoring. Ten facilities said the head office had not visited the facility during the year, 7 facilities had two visits, 5 facilities reported three visits and no facility more than five visits. In contrast, the provincial office had visited five facilities three times, five facilities four times, and seven facilities more than five times. On average, district health accountants had done five monitoring visits to facilities. Facilities reported on the frequency of intervals for carrying out facility level monitoring, shown in Table 18 below.

Table 18: District Accountants monitoring activity frequency

Activity	Frequency	Facilities reporting frequency (%)
Bank reconciliation	Monthly	100%
Cash reconciliation *non response make up difference	Daily	34%
	Weekly	9%
	Monthly	48%
Stock reconciliation * non response make up difference	Daily	4%
	Weekly	9%
	Monthly	57%
	Quarterly	17%
Financial and Expenditure reports *non response make up difference	Monthly	78%
	Quarterly	4%
	Annually	4%
Budget and Actual expenditures reports *multiple responses possible eg monthly and annually	Weekly	9%
	Monthly	39%
	Quarterly	17%
	Annually	43%

Nearly all (83%) of the facilities said the HSF funds are audited by internal auditors while 57% said they are audited by external auditors. HSF funds were reported to have been audited during the previous year in 21 facilities by the time of the assessment. Client surveys were reported to be less carried out (52% doing them) and in most cases, results are not published (See Table 19).

Table 19: Reported responses on auditing of HSF

Variable	# of facilities responding Yes	Percent responding yes
Auditor's report was issued for the last financial year	21	91
They are established mechanisms for pursuing reports from auditors if they fail to avail them	17	74
Auditors /evaluators follow certain standards in carrying out audits (na make up difference in percentage)	20	96
Auditors/ evaluators have provided findings and system improvements	20	87
Client surveys are routinely and frequently carried out as part of these evaluations for HSF	12	52
The results of the client surveys and evaluations are published	11	48
There is a systematic collection, analysis and reporting of performance information to verify compliance with strategic goals and to provide a sound basis for future policy making and implementation	18	78

5. Discussion

This assessment gathered evidence on the governance and financial management of the HSF from twenty three district hospitals from eight provinces of Zimbabwe, or about 50% of all hospitals. Although in-depth data could have been obtained had the rural health centres been included in this assessment, we consider the findings from this sample as reasonably robust to allow for insights into the governance and financial management of the HSF at district hospital level.

All district hospitals reported having operational and expenditure plans. This is the basis of establishing a working financial management framework in any system. The facilities reported having a number of books of accounts; primarily cash books, ledgers, receipt books and commitment registers. Some key books were less reported than others particularly the petty cash registers which were only reported by four percent of the facilities. Of concern is the reported lower level of use of bank reconciliation statements, with only 3 facilities reporting effectively using them. Perhaps it may be important to explore further whether facilities are using other methods (eg the cash book) to check and track their funds at the bank or this function is being neglected. Districts also reported reporting the HSF using primarily the income and expenditure statement and cash book.

Most facilities keep their money in the bank and a significant share also use safes (26%). The most popular banks were CBZ, Barclays, Standard Chartered and Stanbic. However, a high share of the facilities (87%) used only one bank institution for banking their funds, potentially insecure in a volatile financial environment.
Although the HSF rules dictate that the HSF and HSFplus funds are kept separately for tracking purposes, one facility reported that it was keeping both funds together. This means that tracking these two separate funds may not be possible for this facility. The reasons for this keeping of both funds together may need to be explored further.

Committees should meet at regular intervals to discuss issues relating to the HSF and to improve its management. Although nearly all (96%) facilities reported having committees to oversee the HSF funds, the findings show that six committees had three or less members. Most committees meet regularly (weekly, monthly) but four committees meet in an undefined way, only “when the need arises”.

All facilities were aware that the MoHCC does not allow them to invest the funds and were also generally aware of the allowable expenses. The most cited and common allowable expense for the HSF was fuel and lubricants. Most facilities reported allocating the HSF and HSFplus funds based on priorities and needs, which may support equity. This would need further investigation with actual expenditures. However, some facilities reported more demand based criteria for allocating the funds.

Two facilities did not have a qualified accountant and the roles where being done by assistant accountants in both instances. Given the central and important role of accountants in financial management, all district hospitals ought to have a qualified accountant for the system to work as expected. Use of assistant accountants may compromise accounting. However, all facilities were keeping the HSF accounting separate from the accounting for the HSFplus. In addition, accountants’ skills need to be regularly updated with regular training from the MoHCC, Public service Commission and so on. Training was reported to be infrequent, with only 14 facilities

reporting that some personnel from the district hospital had received training in the past two years. Most of the training was provided by the MoHCC and Public Service Commission and in most instances, the district accountants and administrators were attending the training courses.

Not all facilities were aware of the manuals that relate to financial management of HSF. Only 14 out of 23 facilities were aware of the Financial Accounting for HSF manual. A higher share (78%) was aware of the HSF procedure manual. It would be difficult to imagine how facilities that did not have these key manuals were accounting and managing the HSF without a reference point of the guidelines. This may need to be investigated further.

HSF monitoring was reported to be higher by the provincial office compared to the MoHCC head office. HSF funds were reported to have been audited during the previous year in 21 facilities at the time of doing the assessment. However, fewer facilities (52%) reported implementing client surveys and where they are done; they are not usually reported and published.

The HSFplus has a comprehensive manual that details the structure of the HSFplus, the functions of each structure and a comprehensive accounting procedure. It has also a well developed monitoring and evaluation framework that covers the monitoring of the functionality of the HSFplus system, fund disbursement, training and capacity building. The new system, while strengthening the institutional governance structures also have provided new challenges in the form of increased workload for the facilities and a narrow focus at maternal and child health services at the expense of other health services. A number of districts reported the cumbersome nature of the accounting and reporting system of the HSFplus and its potential to divert attention from other critical areas. While opening individual facility banking accounts can improve accountability it also exerts more pressure of work for the one district accountant. The incentive system can widen the gap between facilities that have different health systems and capabilities, sometimes to the disadvantage of those with poorer capabilities and systems. Further paying incentives for specific outcomes can raise future problems when such incentive support is eventually withdrawn. The HSFplus is also heavily anchored on external support, making it susceptible to failure in the event of withdrawal of external support.

6. Conclusion and recommendations

The HSFplus has introduced innovative accounting systems at the district and rural health facility levels that have improved the use and governance of the HSF funds. The findings from this assessment seem to suggest that the following needs to done to strengthen the governance and administration of the HSF:

i. The HSF and HSFplus accounting systems should be harmonised to maintain rigour in the accounting system and make it less cumbersome;
ii. The HSF should strongly encourage the opening up of more than one bank account with different reputable banks for the facilities to spread their risk;
iii. Constant and frequent courses on accounting procedures should be run for all those involved in the accounting and overall governance of the HSF funds;
iv. A clear exit strategy needs to be set for the HSFplus that indicates other sources of funds to be used in the event that external assistance is withdrawn or scaled down;
v. While decentralisation of the management of HSFplus funds to lower level facilities is a noble idea, constant monitoring should be done. The Ministry budget for supervision should also be increased so it is not dependent solely on external support;

vi. All district hospitals should have a qualified accountant. Use of accounting assistants alone may weaken the financial management system.
vii. Regular and timely training courses should be implemented for district teams in financial management through the MoHCC, harmonised with other training;
viii. Committees that oversee the management of funds should be standardised and standards strictly adhered to.
ix. Client satisfaction surveys should be an integral part of district health system operational and financial management frameworks. These surveys should be reported and published at regular intervals.

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