

# Review of financing of semi-autonomous health institutions in Zimbabwe

Zimbabwe Economic Policy Analysis and Research Unit



For  
Training and Research Support Centre  
With  
Ministry of Health and Child Care



With the Regional Network for Equity  
In health in East and Southern Africa (EQUINET)



March 2014



**REBUILDING THE FOUNDATIONS FOR UNIVERSAL HEALTH  
COVERAGE WITH EQUITY IN ZIMBABWE**

With support from  
Rebuild programme: LSTM

## Table of Contents

Executive Summary .....	3
1. Introduction .....	5
Methods .....	5
3. Financial Records Review .....	6
3.1 Health Transition Fund.....	6
3.2 National Aids Trust Fund .....	8
3.4 Accident Prevention and Workers' Compensation Scheme .....	15
3.5 Health Services Fund.....	18
4.0 Discussion.....	22
4.1 Recommendations for the research .....	29
References.....	30

**Cite as:** Chigumira G, Matsika W, Nyamadzawo J, Chiwunze G (2014) Review of financing of semi-autonomous health institutions in Zimbabwe, ZEPARU for TARSc and MoHCC in the Rebuild programme, Harare

**Acknowledgements** to Dr Rene Loewenson TARSC and Jurien Toonen KIT for peer review; to Dr Gibson Mhlanga and Mr Gwati Gwati from the Ministry of Health and Child Care (MoHCC) for official documents provided; to the Rebuild Consortium, Liverpool School of Tropical Medicine (LSTM) for funding.

## Executive Summary

This desk review was conducted as part of the 'Rebuild' programme supported by Liverpool School of Tropical Medicine to Training and Research Support Centre (TARSC) and Ministry of Health and Child Care (MoHCC) Zimbabwe. The ReBUILD Programme in Zimbabwe seeks to take forward a programme within the context of the work in Zimbabwe on health financing policy and on Universal Health Coverage (UHC). It aims to implement health systems research, stakeholder dialogue and capacity building of the Zimbabwe health system, that seeks to move from the immediate recovery measures implemented in 2009-2012, towards building the foundation for long term rebuilding of the Universal Health system, as set out in the National Health Strategy (NHS) 2009-2013, taking into account equity in access and coverage.

This report presents evidence on the funds pooled in and paid by semi-autonomous institutions funding health, specifically the Health Transition Fund (HTF), the National AIDS Trust Fund (NATF), Health services Fund (HSF), the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), and the Workers Compensation Investment Fund (WCIF). The review presents the revenue sources and trends, how funds are pooled, how the budgets and expenditure relate, the criteria governing allocations and the targets and shares of expenditure.

The HTF is a pooled health fund for external funders, reducing overhead costs and streamlining reporting, operations and administration. This means that funding can be directed towards programme impact, and reduces duplication of efforts by external funders. By the end of 2012, pooled funds were US\$ 84.99 million, or 19.52% of the targeted amount of US\$ 435.33 million by 2015. Expenditure allocations for HTF are guided by needs and priorities of the MoHCC as articulated in the NHS 2009 – 2013, Programme Documents and Annual Work Plans approved by the HTF steering committee. The expenditure allocations of the HTF fall under four categories namely: medical products, vaccines and technology; planning and financing; maternal, new-born and child health and nutrition; and human resources for health. The category with the highest funding is the medical products, vaccines and technology.

The NATF pools funds collected from the AIDS Levy, a 3% tax on income tax paid by formal employers and employees. The income has grown over the period 2009 to 2012 from US\$ 5.1 million in the 1<sup>st</sup> quarter of 2009 to US\$ 32.5 million in the 4<sup>th</sup> quarter of 2012. The levy is contributed to by 11% of the 5.4 million employed people in Zimbabwe, namely those in formal employment. The remaining 89% of employed people in the informal sector or in non-classifiable employment do not pay the AIDS Levy as there is no mechanism for collecting from them, suggesting an untapped source funding. The mining sector is also exempt from paying the levy. The funds are pooled and cross subsidies applied as the fund is applied nationally to all people in need of intervention around HIV, irrespective of employment status. The interventions are purchased by the National AIDS Council (NAC) and may be implemented by NAC and by other providers, particularly Ministry of Health and Child care, but also non state actors. The expenditure allocations by NAC are guided by predetermined percentages set by the NAC Board, within areas of: planning; prevention; treatment and advocacy.

The HSF income comes predominantly from hospital fees, 100% of which are retained by the health facilities. The full retention of fees at each facility means that there is no cross subsidy across facilities. Other sources of income for the HSF contribute less than 2% of total funds. The dominant expenditure overheads in the HSF includes medical supplies and services,

salaries, institutional provisions, maintenance of vehicles and mobile equipment and fuel, oil and lubricants. In 2012 these line items they accounted for almost 66% of total expenditure, whilst salaries accounted for 8.43% of total expenditure. Income and expenditures for the HSF have been increasing over the period 2009 to 2012. A share of the income is not in hard cash, for that share of health service provision funded by medical aid, where the provider has a delay in reimbursement for the service offered that affects the cash flow of the fund. .

The Workers Compensation Investment Fund (WCIF) is a Social Security Scheme, whose main objective is to prevent accidents at the work places and compensate workers who get injured in work related accidents or contract work related diseases. The scheme is fully funded by employers who are obliged to cover all employees regardless of the period of employment, even if employment is for hours. Employees do not contribute anything. Government and employers of domestic workers do not contribute to the scheme, and do not benefit from it. The minimum insurance premium the employer is required to pay is calculated using a risk factor depending on the type of industry the employer is involved in. The scheme is also funded by interest earned from investment projects financed by savings from the WCIF and occupational health and safety. Over the period 2010 and 2011, total funds pooled into the WCIF fell from US\$49.15 million in 2010 to US\$45.36 million in 2011, mainly due to company closures and the subsequent job losses. The WCIF pooled resources are disbursed to meet medical claims in relation to accidents at the work place or work related illnesses, as well as costs related to transport and provision of artificial appliances. The WCIF uses the Association of Healthcare funders of Zimbabwe rates. The WCIF funds safety training and inspection activities, operating expenses and investments. The fund is underutilized with claims accounting for only 35% and 43% in 2010 and 2011 respectively, possibly due to a lack of knowledge amongst beneficiaries to make claims when is injured at work. This may partly explain the surpluses the fund has had in 2010 and 2011. Operating expenses are also high and more than double the amount spent on claims in 2011. Payments under the WCIF are made direct to beneficiaries/ claims using the warrant system through ZIMPOST, with short term benefits (e.g., periodical payments, lump sum, funeral grant, medical costs) being decentralized to the six Regional Offices. In a separate scheme, the payment of long term benefits is centralized at Head Office, in Harare.

The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) is a global not a national fund, but funds activities in Zimbabwe. It is included as a significant source of health care funding, even though it is not the same as other semi-autonomous funds. It is managed by the Global Fund Secretariat in Geneva, which is responsible for managing the global grant portfolio, screening proposals submitted, issuing instructions to disburse money to grant recipients and implementing performance-based funding of grants. Zimbabwe has been a recipient of 17 grants from the Global Fund between 2003 and 2013. These grants had a total signed amount of US\$857.65 million, but the total disbursed funds amounted to US\$594.87 million. The gap between signed and disbursed funds may be attributed to underutilisation and to lags in the implementation of programs. The funds are channelled through various recipients namely the NAC, Zimbabwe Association of Church related Hospitals (ZACH), the UNDP and the MoHCC, particularly for HIV/AIDS programmes, and less so for malaria and tuberculosis programmes.

It is very difficult to get financial information of these semi-autonomous funds. The paper recommends measures for greater financial transparency for the funds, and areas for follow up information gathering to better understand their operations.

## 1. Introduction

This review was conducted as part of the 'Rebuild' programme supported by Liverpool School of Tropical Medicine to Training and Research Support Centre (TARSC) and Ministry of Health and Child Care (MoHCC) Zimbabwe. The ReBUILD Programme in Zimbabwe seeks to take forward a programme of work within the context of the work in Zimbabwe on health financing policy and on Universal Health Coverage (UHC). It aims to implement health systems research and stakeholder dialogue and capacity building of the Zimbabwe health system, that seeks to move from the immediate recovery measures implemented in 2009-2012, towards building the foundation for longer term rebuilding of the Universal Health system, as set out in the National Health Strategy (NHS) 2009-2013, taking into account equity in access and coverage.

This report presents evidence on the funds pooled in and paid by semi-autonomous institutions funding health, specifically the Health Transition Fund (HTF), the National AIDS Trust Fund (NATF), Health services Fund (HSF), the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), and the Workers Compensation Investment Fund (WCIF). The review presents the revenue sources and trends, how funds are pooled, how the budgets and expenditure relate, the criteria governing allocations and the targets and shares of expenditure. The study period is from 2009 to 2012.

This review complements the "Desk Review of institutional arrangements for health financing in Zimbabwe", undertaken by ZEPARU (2014), which provided a background on the institutional arrangements for managing pooled resources in Zimbabwe, viz the organizational, institutional and governance and accountability arrangements and procedures for pooling funds, for cross subsidies and for provider payments at different levels in the public health system.

## Methods

The review analysed the financial records and reports from the following semi-autonomous health institutions:

- Health Transition Fund (HTF);
- National AIDS Trust Fund (NATF);
- Health Services Fund (HSF);
- Global Fund Grant for Zimbabwe for HIV and Malaria prevention; and
- Workers Compensation Investment Fund.

These institutions were selected, given their key role in Zimbabwe's health financing architecture. Whilst some of the institutions such as the HTF seek to complement government efforts to finance health, the other institutions such as NATF seek to ensure a guaranteed and predictable funding stream for the combat of HIV/ AIDs in Zimbabwe. Equally important is the fact that these institutions have different financing models, which makes them interesting case studies to investigate. For instance, the HTF is mainly donor funded; the NAC is funded through an earmarked tax in the form of the AIDS levy; and the WCIF, under the National Social Security Authority (NSSA) is funded through mandatory employer contributions.

While initially intended, the team was not able to analyse other semi-autonomous bodies such as Natpharm and the Zimbabwe National Family Planning Council, due to unavailability of data.

In doing the review, the study analysed available data from financial records of the aforementioned institutions/ funds, covering the period 2009 – 2013. The Review is mainly descriptive in nature, to identify the various elements of the financing system in these semi-autonomous institutions in Zimbabwe, and focusing on:

- Sources of financing;
- Total expenditure;
- Expenditure allocations; and
- Rules governing how funds are managed and spent

### **3. Financial Records Review**

#### **3.1 Health Transition Fund**

The HTF is a 5-year plan formulated by the Government of Zimbabwe, UNICEF and other international partners to pool funds in support of critical health interventions for the period 2011 to 2015. It was set up in 2011, following an agreement between the government and development partners to have a separate pool of funds, amounting to US\$435.34 million over 5 years, to support the implementation of the National Health Strategy (NHS) (2009 – 2013). The HTF is governed by a Steering Committee, chaired by the Permanent Secretary of MoHCC, comprising government and the donor community and representatives from civil society, who have contributed to the Fund. External partners who have pledged to contribute to the Fund, includes: CIDA, European Union, Irish Aid, Norwegian Government, Swiss Embassy, Swedish Government and United Kingdom Aid/ DFID, (MoHCC, 2011).

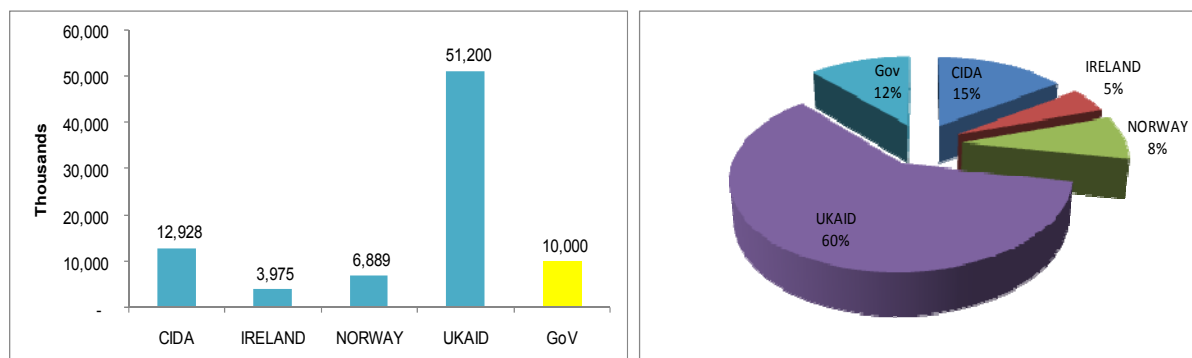
The pooled mechanism in principle reduces overhead costs in operations, reporting and fund administration so that funding is channeled toward achieving direct programme impact. This allows achievement of results against national scale indicators over 5 years and reduces potential duplication of efforts by development partners, (MoHCC, 2011). The HTF's broad objective is to improve maternal, new-born and child health by strengthening health systems and scaling up the implementation of high impact interventions through support to the health sector. The HTF's key areas of support are (i) Maternal, New-born and Child Health and Nutrition, (ii) Medical Products, Vaccines and Technologies (Essential Medicines), (iii) Human Resources for Health (Health Worker Retention Scheme) and (iv) Health Policy, Planning and Finance(Health Services Fund and Research).

Allocations from the HTF are in accordance to needs and priorities of the MoHCC as articulated in the NHS (2009 – 2013), and in line with the Programme Document and annual work plans approved by the HTF Steering Committee, (HTF Report 2011). The MoHCC ensures that HTF processes are in line with all rules, regulations and the legal framework in Zimbabwe, as stipulated by the PFM Act Chapter 22:19 and the Constitution of Zimbabwe. Funds come into UNICEF financial systems and are pooled together, and UNICEF ensures financial regulations are met with contracts signed between funders and UNICEF. UNICEF tracks funds received and funds spent using existing financial systems (IPSAS – International Public Sector Accounting Standards) and financial updates are shared and discussed with HTF Steering Committee in monthly meetings.

As at end of 2012, actual pooled funds into the HTF amounted to US\$84.99 million, which is about 19.52% of the targeted US\$435.33 million over the 5-year lifespan of the HTF. The Highest contributor to the Fund was the UKAID, with US\$51.20 million, accounting for 60% of

the available funds, (Figure 1). Other partners weighed in with the following amounts: CIDA – US\$12.93 million, Norway– US\$6.89 million and Ireland – US\$3.97 million. Furthermore, the Government of Zimbabwe through the 2012 National Budget made an allocation of US\$10 million towards the HTF, (MoF 2011), accounting for 12% of the funding available in the HTF pool, by the end of 2012, (Figure 1). There is however no information as to whether the Government allocation in the 2012 National Budget was actually disbursed, hence the Government allocation in Figure 1 is an estimate.

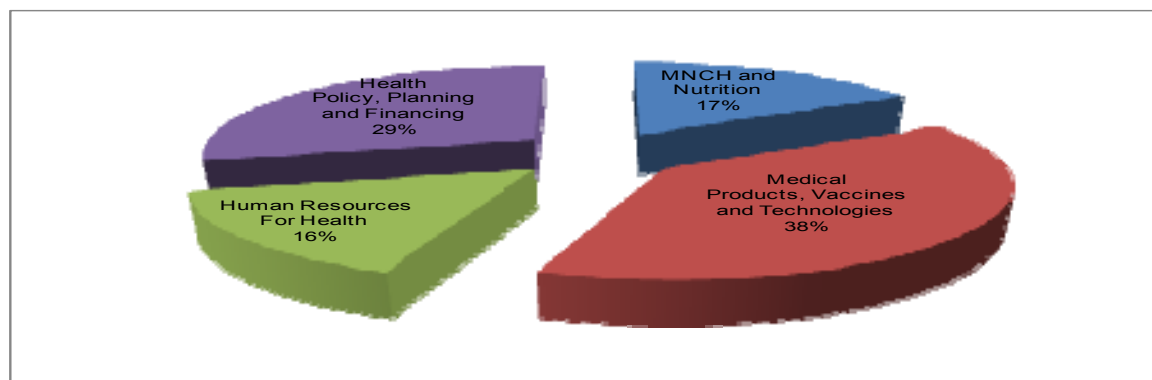
**Figure 1: Actual Pooled Funds into the Health Transition Fund as at end of 2012**



Source: Ministry of Finance and Economic Development, 2012

We were not able to access detailed expenditure data of the HTF. Ministry of Health and Child Welfare indicated that they do not have expenditure reports on the HTF and this is held by Crown Agents and UNICEF. In principle, if the funds available are less than those needed in the estimated budget, then the goals are reduced proportionally, (MoHCC, 2011). Expenditures are this determined based on the available resources. The summary budget allocations in 2013 were as shown in Figure 2, although as above the actual expenditures were not available.

**Figure 2: Budget allocations for 2013 Programmes under the HTF**



Source: MoHCC, (2011)

Priority under the HTF is given towards health system components that together will result in reduced child and maternal mortality, such as training midwives, providing essential medicines, and paying health workers, (MoHCC 2011). In the 2013 HTF budget, the highest budget share was allocated towards medical products, vaccines and technologies (38.5%), followed by health

policy, planning and financing (28.70%), maternal, new-born and child health and nutrition (17%) and human resources for health (15.7%), (See Figure 2).

The expenditure allocations are decided by the HTF Steering Committee, which is also responsible for the oversight and decision making of the HTF, MoHCC, 2011. Whilst it is clear that total expenditures are a function of the resource pool in the HTF, it is not clear as to how the Steering Committee decides on the expenditure mix or how the resources are apportioned to the various components as shown in Figure 2. The expenditures projects implemented by the HFT are monitored by the Steering Committee, which is co-chaired by the Permanent Secretary of the MoHCW and a Funding Partner. Funding partners select, annually the specific funding partner who serves as Co-Chair of the HTF Steering Committee.

The role of the HTF Steering Committee includes, but is not be limited to:

- Approving funding allocations to thematic areas and related activities in accordance with the framework of the agreed HTF objectives;
- Ensuring alignment of HTF allocations with the MoHCW Performance Contract/Annual Plan within the thematic areas agreed upon in the Programme Document;
- Approving terms of reference for implementing partners;
- Participating in tender review committees and approving selection of implementing partners in accordance with UNICEF rules and regulations;
- Reviewing and approving annual, mid-term and end-of-programme programmatic and financial progress reports submitted by UNICEF. The programme report will present results-based progress against the log frame indicators
- Appointing an evaluation sub-committee consisting of three to five independent professionals who will have responsibility for managing all aspects of the impact evaluation conducted by the independent evaluation contractor, (MoHCC 2011).

Despite the requirement that the Steering Committee should produce monthly reports on programme implementation, the authors could not get any reports from the MoHCC and were referred to Crown Agents and UNICEF, who were not forthcoming. There is no information on financial records for the HTF on the UNICEF and Crown Agents websites. It was thus not possible to do an expenditure analysis to determine the relative shares for administration and programming.

### **3.2 National Aids Trust Fund**

The National Aids Trust Fund (NATF), commonly known as the AIDS Levy Fund, was established in terms of Section 14, subsection 14 and 15 of the Finance Act [Chapter 23: 04] of Zimbabwe and National AIDS Council of Zimbabwe Act [Chapter 15: 14], to provide domestic funds that are sustainable and predictable in the financing of the national response against HIV/AIDS. The Fund is administered by the National AIDS Council of Zimbabwe (NAC), which was established by the National AIDS Council of Zimbabwe Act [Chapter 15: 14]. NAC is mandated to coordinate national HIV/AIDS responses and to manage the NATF. Its main objectives are to:

- Ensure effective leadership and coordination of the wide range of activities in the national response to HIV/AIDS;
- Mobilise resources to scale up HIV/AIDS interventions; and
- Monitor progress and impact of the national responses against HIV/AIDS.



According to the National AIDS Council of Zimbabwe Act [Chapter 15: 14], the funds of NAC may consist of:

- Any moneys that may be payable to NAC from moneys appropriated for the purpose by Act of Parliament – AIDS Levy; and
- Fees and charges raised for services and facilities provided and other things done by the Council; and
- Donations, which may be accepted with the approval of the Minister; and
- Loans, which may be raised with the approval of the Minister and the Minister responsible for finance; and
- Any other moneys that may vest in or accrue to the Council, whether in the course of its operations or otherwise.

NAC is empowered by the National AIDS Council of Zimbabwe Act [Chapter 15: 14] to draw, make, accept, endorse, discount, execute and issue for the purposes of its functions promissory notes, bills of exchange, bills of lading, securities and other negotiable or transferable instruments. NAC is also empowered to establish and administer such funds and reserves not specifically provided for in the National AIDS Council of Zimbabwe Act [Chapter 15: 14] as the Board may consider appropriate or necessary for the proper exercise of the Council's functions. The bulk of the domestic funds for financing the national response to HIV/AIDS come from the AIDS levy (MoHCC, 2012).

As a state enterprise, NAC's management of finances is subject to the Public Finance Management Act [Chapter 22:19] which provides for the budgeting, management accounts, and appointment of both internal and external auditors. NAC is also subject to State Procurement Act [Chapter 22:14] which provides for issues related to procurement by the Council.

The NAC Act [Chapter 15: 14], provides for the NAC Board to ensure that proper accounts and other records relating to such accounts are kept in respect of all the Council's activities, funds and property, including such particular accounts and records as the MoHCC may direct. At the end of each financial year, the Board is obliged to prepare and submit to the MoHCC a statement of accounts in respect of that financial year or in respect of such other period as the MoHCC may direct. The statements are examined by internal and external auditors who make a report to the Minister and the NAC Board on their opinion about the financial state of NAC. Management and audited final accounts are sent to Ministries of Finance and Economic Development, MoHCC and Ministry of State Enterprises. The NAC Board also appears before Parliament Portfolio Committee on Health on regular basis.

There is a national Monitoring and Evaluation (MandE) Plan to systematically monitor implementation of the Zimbabwe National AIDS Strategic Plan 2011 to 2015 (ZNASP II), and measure progress towards the achievement of both national targets and international commitments in the national response to HIV and AIDS. However, in the literature reviewed it was not clear if there is a mechanism that separately tracks outcomes for AIDS Levy and attribute outcomes to AIDS Levy funding.

Funds are allocated through an annual work plan and budget approved by the MoHCC. Plan is part of the operational plan that was crafted from the Zimbabwe National HIV Strategic (ZNASP II) 2011-2015. Key stakeholders such Ministry of Health, People Living with HIV, Youth, Business participated in the preparation of the plan. Final accounts are prepared at the end of each year.

Funds that are not used immediately, for example the funds earmarked for the procurement of goods and services, are placed in short investments in the money market while awaiting completion of the procurement process. A sum of US\$ 11.4 million was put in investments during the 2009-2011 (NAC, 2012).

NAC uses both direct and indirect modes of disbursement of resources to implementers. NAC carries the responsibility of purchasing and payment, but the contractual mechanisms for service delivery are contained in the Results Based Format through the MoHCC Integrated Performance Agreement (Gwati, 2014).

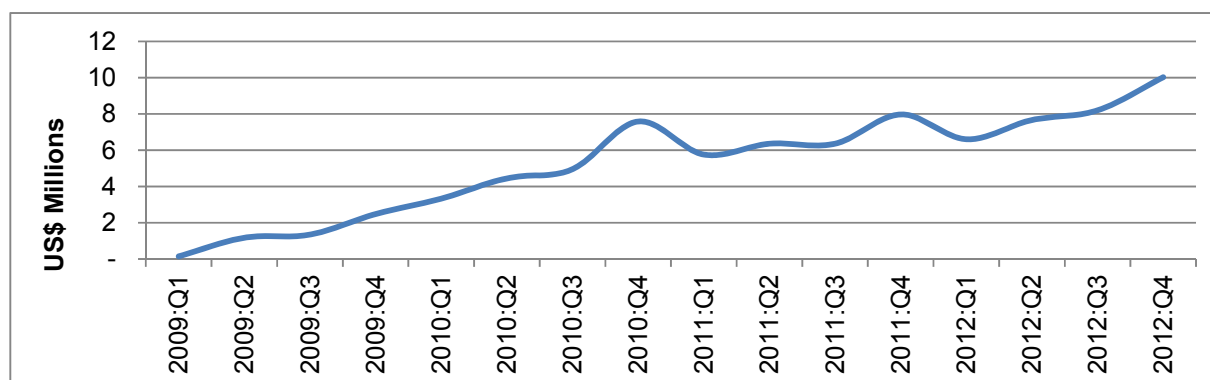
### ***AIDS Levy collections***

The AIDS Levy is charged on individuals, companies and trusts at a rate of 3% of income tax assessed (Finance Act [Chapter 23: 04]). However, informal employees are not charged the AIDS Levy because there is no mechanism in place for collecting from them. The mechanism in current use, where the employer collects from employees and remits to ZIMRA, is not compatible with the informal sector. According to Zimstat (2012), out of the 5.4 million employed people, 84% of them are informally employed, 5% are in employment not classifiable and only 11% are formally employed. Thus, 89% of the employed people in informally employment and in non-classifiable employment are not contributing to the AIDS Levy, a loss of potential contributors to HIV/AIDS financing. Females dominate the informal sector employment as they occupy 53% of the informal jobs (Zimstat, 2012).

Apart from the informally employed and those in non-classifiable employment, mining firms are also exempted from the AIDS Levy. This is despite the fact that the mining sector has been growing and anchoring economic growth since 2009, on the back of discoveries of new minerals, such as diamonds and firming international mineral prices. The sector performed very well compared to all other sectors in 2010 (GoZ, 2013). It grew by 18.9% in 2009, 60.1% in 2010, 43.2% in 2011, and 8% in 2012 (GoZ, 2013).

Figure 3 below shows that the quarterly AIDS Levy collections generally trended upwards, with peaks in the 4<sup>th</sup> quarters of 2010 and 2011, over the period 2009 to 2012. The AIDS Levy quarterly collections have increased from US\$ 5.1 million in the 1<sup>st</sup> quarter of 2009 to US\$ 32.5 million in the 4<sup>th</sup> quarter of 2012.

**Figure 3: AIDS Levy collections, US\$ millions, 2009 to 2012**



Source: NAC, 2012

The upward trend in AIDS Levy collections is attributed to the economic recovery experienced since dollarization in 2009. The peaks in the 4<sup>th</sup> quarters of 2010 and 2011 may be explained partly by the facts that 35% of the tax liability is paid in the 4<sup>th</sup> quarter and that economic growth rates were higher in these years compared to the other years, about 9.6% in 2010 and 10.6% in 2011.

#### Utilization of AIDS Levy

As of 2009, there were an estimated number of 1,189,279 adults and children living with HIV/AIDS (MoHCC, 2012) – see Table 1 below. The estimated number of people living with HIV/AIDS has declined to 1,159,097 in 2011.

**Table 1: Estimated number of people living with HIV/AIDS, 2009 - 2011**

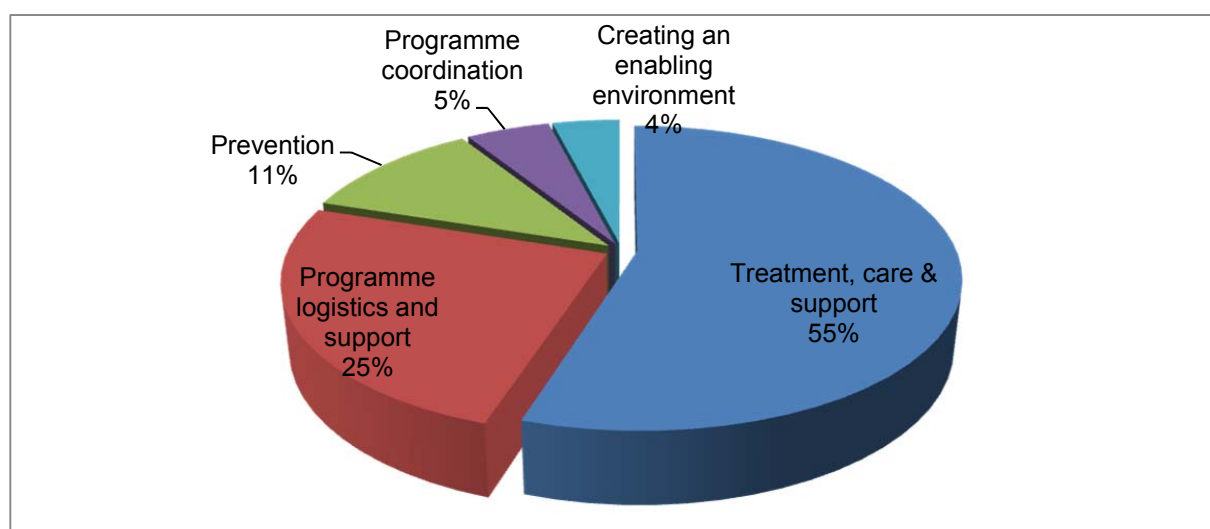
	2009	2010	2011
Adults and children	1,188,279	1,168,263	1,159,097
Adults (15+ years)	1,037,530	1,023,038	1,020,455
Female (15+ years)	617,792	608,700	605,894
Children (0 – 14 years)	151,749	145,224	138,642

Source: MoHCC, 2012

The AIDS Levy is allocated and spent by NAC across programmes according to predetermined percentages set by the NAC Board as shown in Figure 4. The Board of NAC consist of the Secretary of the MoHCC for which the Minister is responsible; the Executive Director of NAC; a representative from the Traditional Medical Practitioners Council appointed by the President; a representative from the Law Society of Zimbabwe appointed by the President; and not fewer than seven nor more than ten other members appointed by the President, to represent the interests of health care providers, women, youths, religious groups, organisations that protect the interests of persons infected with HIV and AIDS, industry, commerce, information media and trade unions.

From the documents reviewed it was not explained how the predetermined percentage allocations to interventions/programmes are arrived at and how frequently they are revised by the NAC Board. This may be followed up in the field work.

**Figure 4: Allocation of AIDS Levy by intervention by NAC, 2013**



Source: MoHCW, TARSC, KIT, 2013

Most of the funds are spent on treatment, care and support. As alluded to in the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP II) 2011-2015, and given the rise of new AIDS cases over the years 2010 to 2012, the allocations need to be revisited so that allocations to prevention interventions are increased. This would help to keep new infections at minimal and reduce future costs on treatment and care interventions.

According to the MoHCC (2013), NAC spent 17% on administration and salaries of which salaries were just above 10% in 2010 (MoHCC, 2013), and this leaves more resources towards activities and programmes for HIV/AIDS. This is a positive practice compared to health insurance organisations which spend on average 50% of subscriptions on administration at the expense of health expenditures (MoHCC, 2013).

Table 2 shows that there was an increase of resources allocated across other programmes areas throughout the period 2009 – 2011, except for community home based care, information and communication and advocacy programmes where resources were reduced in 2011 relative to 2010.

**Table 2: Utilisation of AIDS Levy by year end by programme area, 2009 – 2011 (in US\$)**

	2009	2010	2011
Prevention	24,000	718,000	1,609,000
Care and support	1,247,000	6,944,000	16,657,000
<b>Community home based care</b>	<b>27,000</b>	<b>841,000</b>	<b>141,000</b>
Mitigation	23,000	285,000	407,000
Behaviour change	1,000	164,000	176,000
Information and communication	4,000	235,000	218,000
Advocacy	72,000	497,000	383,000

Source: NAC, 2012

### HIV and AIDS prevention activities funded by NATF

The primary mode of HIV/AIDS transmission in Zimbabwe is heterosexual contact, which accounts for 92% of HIV infections (ZIMSTAT and ICF International, 2012). The second most important mode of HIV/AIDS transmission is the vertical transmission where a mother passes HIV to their child either at pregnancy, child birth or breast feeding (ZIMSTAT and ICF International, 2012). Despite this, in 2009 and 2010 NAC did not fund PMTCT (Table 3). It may be that the programme was seen to be adequately covered by external funders. In 2011 NAC funded PMTCT to the amount of US\$ 643114. Youth programmes have also been prioritized as interventions to fight HIV/AIDS over the years.

**Table 3: HIV/AIDS prevention activities funded by NATF, US\$, 2009 - 2011**

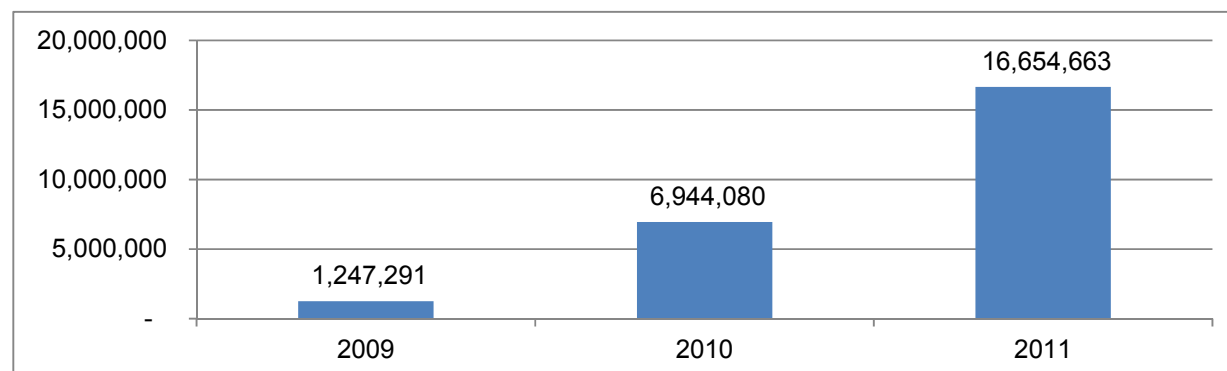
	2009	2010	2011
Behaviour change	...	15,770	175,833
Youth programme	24,000	269,441	610,367
Gender	...	34,700	178,291
Workplace	...	64,104	171,734
<b>PMTCT</b>	...	...	<b>643,114</b>
Male circumcision (MC)	...	23,000	69,830
HIV Testing and Counselling (HTC)	...	175,000	179,000
<b>Total</b>	<b>24,000</b>	<b>582,015</b>	<b>2,028,169</b>

Source: NAC, 2012

### Treatment care and support financing

The financing of treatment and care of HIV/AIDS increased over the period 2009 to 2011 as economic performance improved and more funding became available from the AIDS Levy. In 2009, NAC spent US\$ 1,247,291 and this increased to US\$ 6,944,080 in 2010 and to US\$ 16,654,663 in 2011.

**Figure 5: Treatment, care support financing, US\$ 2009-2011**



Source: NAC, 2012

NAC supports about 40% of the people on ART (Magure, 2013). Expenditures on ART are broken-down as shown in Table 4 below. ARVs constitute the largest share of ART expenditures. Generally, all components of ART expenditures were increasing over the period, owing to the increase in AIDS Levy collections.

**Table 4: Breakdown of ART expenditure from the NATF, US dollars, 2009 - 2011**

US\$ expenditure on	2009	2010	2011
ARVs	888,457	3,309,706	11,943,832
Reagents	...	444,635	2,863,439
Equipment	...	2,317,231	291,974
Blood safety and test kits	358,644	589,767	406,007
Outreach allowances	...	2,396	175,292
<b>Total</b>	<b>1,247,101</b>	<b>6,663,735</b>	<b>15,680,544</b>

Source: NAC, 2012

In 2012, people living with HIV/AIDS (PLWHIV) demonstrated against NAC and handed over a petition to NAC outlining their grievances which included, among others, shortage of ARVs, user fees and lack of transparency in the administering of the Aids levy. The shortage of drugs was a result of other development partners delaying disbursements of funds to procure drugs resulting in declining stocks of ARVs and patients being given one or two months supply instead of three months' supply of ARVs (Magure, 2013). In an interview recorded in the Herald, 27 March 2013 Dr T Magure the Executive Director of NAC noted that:

*"The issue of user fees is really an issue affecting ART adherence. People are being charged user fees to cater for administration costs of clinics and hospital, our mandate does not, however, allow us to determine user fees of clinics or health service institutions. As NAC we will lobby the necessary Government departments to ensure that PLWHIV access treatment and care services.*

*On lack of transparency being put on the petition I think that is purely due to limited understanding on how NAC functions. As highlighted earlier the NAC board has multi-sectoral representation and that NAC accounts are audited every year and the audited financial accounts are made public".*

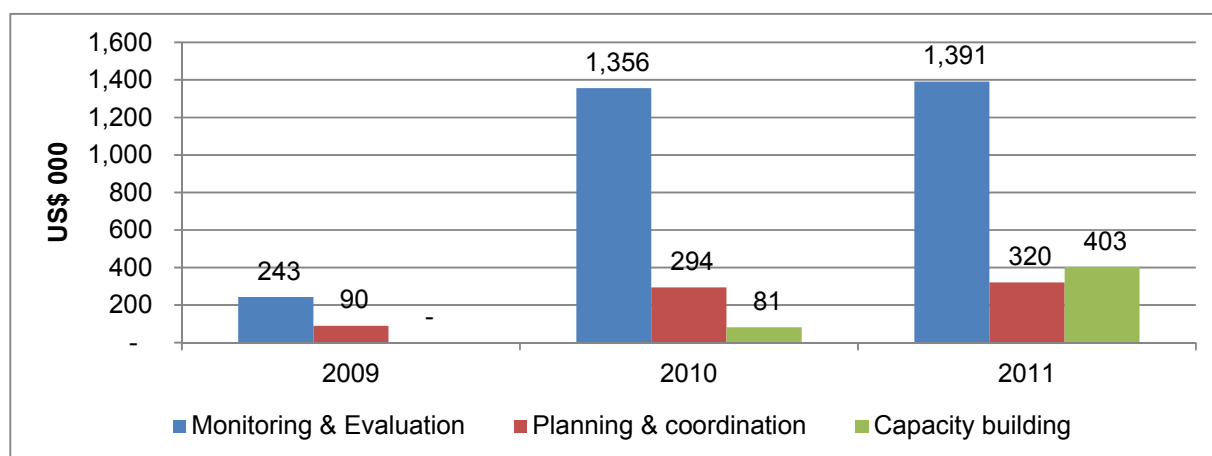
### **Programme coordination**

NAC has spent US\$ 4,178,000 on programme coordination which includes monitoring and evaluation, and capacity building over the period 2009 to 2011 (Figure 6). Expenditures on the components of programme coordination have been increasing over the review period. Monitoring and evaluation has consistently been the highest expenditure component of programme coordination.

NAC administers the national Monitoring and Evaluation (MandE) system for the National Response to HIV/AIDS to systematically monitor implementation of the Zimbabwe National AIDS Strategic Plan 2011 to 2015 (ZNASP II), and measure progress towards the achievement of both national targets and international commitments in the national response to HIV and AIDS. Programmes/projects run by organisations which offer HIV/AIDS services are linked to the national MandE system and are gradually being harmonized. The MandE Plan for ZNASP II envisages that data for MandE of the national HIV/AIDS response is collected from implementers using tools such as the Organisational Details Form (ODF), ART and PMTCT Registers, T-series and primary data collection tools. The data is used to produce reports that are shared with stakeholders, and these reports include District AIDS Coordinator (DAC) District Quarterly Statistical reports, Provincial AIDS Coordinator (PAC) Provincial Quarterly Statistics Reports, District and Provincial Health Information Quarterly Reports, NAC National Quarterly

Reports, Quarterly AIDS and TB Unit reports, NAC MandE Bulletin, NAC Annual MandE Report, Annual AIDS and TB Unit reports, and Thematic Reports. The reports include data on selected key indicators by strategic area, baseline and progress towards achieving targets. The implementers and decision makers use the information for planning, management, supervision, coordination and implementation.

**Figure 6: Expenditure on programme coordination, US\$000s, 2009-2011**



Source: NAC, 2012

### 3.4 Accident Prevention and Workers' Compensation Scheme

The Accident Prevention and Workers' Compensation Scheme, referred to as the workers' compensation investment fund (WCIF) is a Social Security Scheme under the National Social Security Authority (NSSA). NSSA is a statutory body established in terms of the NSSA Act Chapter 17:04 to establish a social security scheme for the provision of benefits to contributors. The authority has two schemes namely the Accident Prevention and Workers' Compensation Scheme (WCIF) and the Pension and Other Benefits scheme (NPS).

NPS's main objective is to provide cash benefits to insured persons during periods of income stoppage due to retirement, invalidity and death. It was introduced in 1994, and is based on a 50%-50% monthly contribution from the employers and employees. It provides an important cushion for Zimbabwean citizens during invalidity, retirement or death of a breadwinner who was a member of the scheme. Each insured person (employee) and his/her employer is required to make monthly contributions of 4 % of the employee's salary/wage to the scheme. Thus, the employee and his/her employer contribute a total of 8% of the employee's basic salary/wage, which the employer shall remit to NSSA by the 10<sup>th</sup> day of the following month in which the contribution is due, (NSSA website, <http://www.nssa.org.zw>, accessed on 3 March 2014).

On the other hand, WCIF is a Social Security Scheme, whose main objective is to prevent accidents at the work places and to compensate workers who get injured in work related accidents or contract work related diseases. The scheme, established by the Statutory Instrument 68 of 1990, is fully funded by employers. Employees do not contribute anything. The Government and employers of domestic workers are exempted from contributing to the scheme,

hence they also do not benefit from the scheme. The minimum insurance premium the employer is required to pay will be calculated using a risk factor depending on the type of industry the employer is involved in.

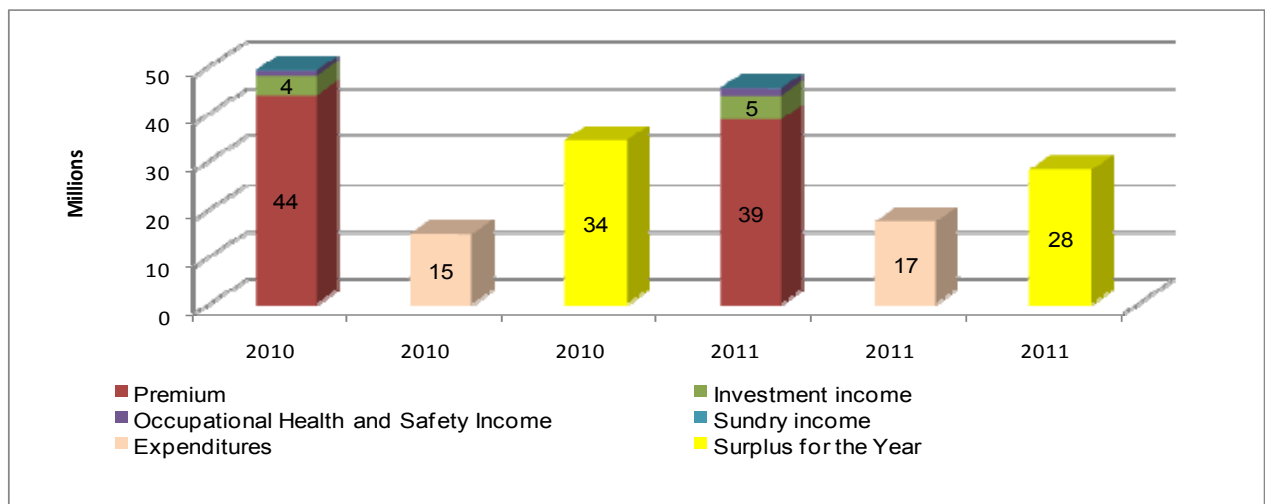
Employers are obliged to ensure that all employees are covered under the scheme, regardless of period of employment, even if it is for a few hours. The scheme pays all medical expenses related to the injury at work. Other related costs that are met by the scheme are in respect of transport and provision of artificial appliances, (NSSA website, <http://www.nssa.org.zw>, accessed on 3 March 2014).

The management of the WCIF falls under the broad management of the General Manager of the NSAA, who reports, to the Ministry of Labour and Social welfare as outlined in the NSSA Act Chapter 17:04. NSAA is obliged to produce annual financial reports, which are audited by the Comptroller and Auditor General, in line with the PFMA Chapter 22:19.

### Pooling of funds under the WCIF

A review of NSSA financial statements for the period 2010 and 2011 show that total funds pooled into the WCIF fell by 7.72% from US\$49.15 million in 2010 to US\$45.36 million, (Figure 7). This was mainly on account of company closures and the subsequent job losses. NSSA (2012) reported that two banks closed in 2011 and one was placed under curatorship. Furthermore, a total of 4 400 employees lost their jobs in 2011 due to company closures as a result of viability issues, (NSSA 2012). Given that the main source of finance under the WCIF are monthly premiums payable by employers, company closures affects the income available for the Fund. Other sources of financing for the WCIF include; investment income from investment projects financed by savings from the WCIF and occupational health and safety.

**Figure 7: Total income for the WCIF for 2010 and 2011 in US\$ Millions, 2010 – 2011**



Source: NSSA 2012

The WCIF pools resources from employers for the purposes of compensating workers who get injured in work related accidents or work related diseases. In 2011, income from premiums accounted for 85.33% (US\$38.70 million) of total income, having fallen from 89.19% in 2010,



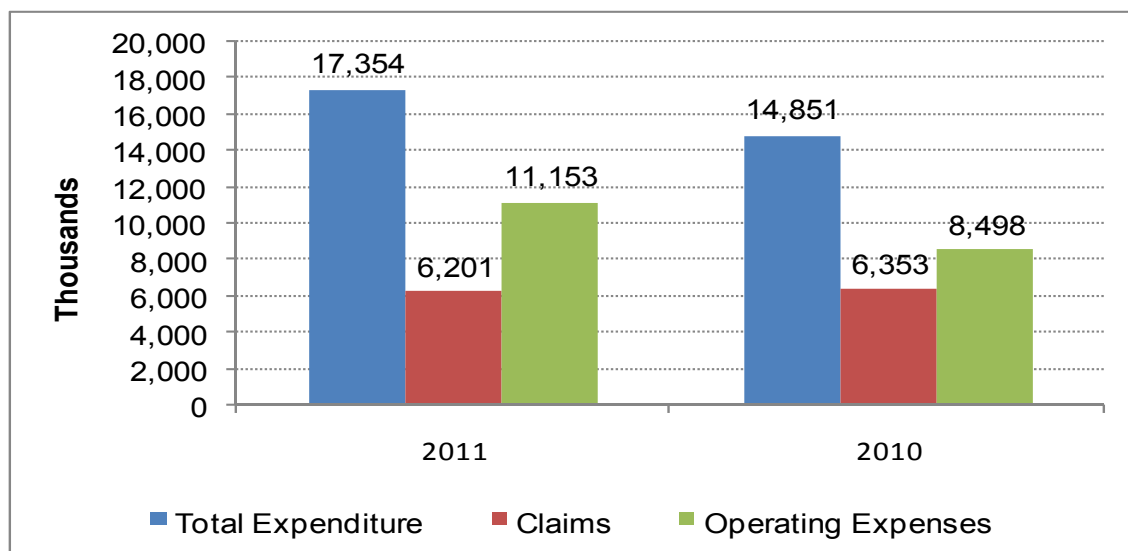
(US\$43.83 million). Other key contributors to total income for the WCIF included occupational health and safety income, investment income and sundry income.

Total expenditures for the WCIF increased marginally from US\$15 million in 2010 to US\$17 million in 2011. Hence, against incomes of US\$49.15 million in 2010 and US\$45.36 million in 2011, the WICF was in the surplus of US\$34.15 and US\$28.36 million in 2010 and 2011, respectively. The surpluses can be attributed to lack of knowledge on the demand side to claim for medical expenses when one is injured at workplace, resulting in individuals making out of pocket payments (Gwati, 2014), hence some of the intended beneficiaries do not make claims contributing to low claims hence surplus. These surplus funds are then invested in interest earning assets/ investments to generate additional income for the WCIF, which interest earned contributes to the surpluses as it is not premiums generated/ employer contributions. All the income earned from investments or premiums form part of the WCIF which is used to meet claims from contributing employers. Only surplus income is invested, only after meeting claims and administration expenses of the Fund and the decisions for such, rests with the Management of the Fund with approvals of the NSSA Board.

### Expenditure composition of the WCIF

The management of the fund is in line with the National Social Security Authority Act, Chapter 17:04 and the Public Finance Management Act (PFMA) Chapter 22:19. Once, pooled in the WCIF, resources are then disbursed to meet claims in relation to accidents at the work place or work related illnesses. In 2011, claims accounted for 35.73% (US\$6.20 million) of total expenditures, down from 42.78% (US\$6.35 million) in 2010, (Figure 8). The marginal decline can be attributed to the number of accidents in 2011. In 2010, 4 410 accidents were reported with 90 fatalities and 4 158 accidents were recorded in 2011 with 75 fatalities, (NSSA 2012). An improvement in injury frequency translates into a good occupational safety health delivery and also the structural shift in the economy, where more workers are informally employed, may have contributed to low claims.

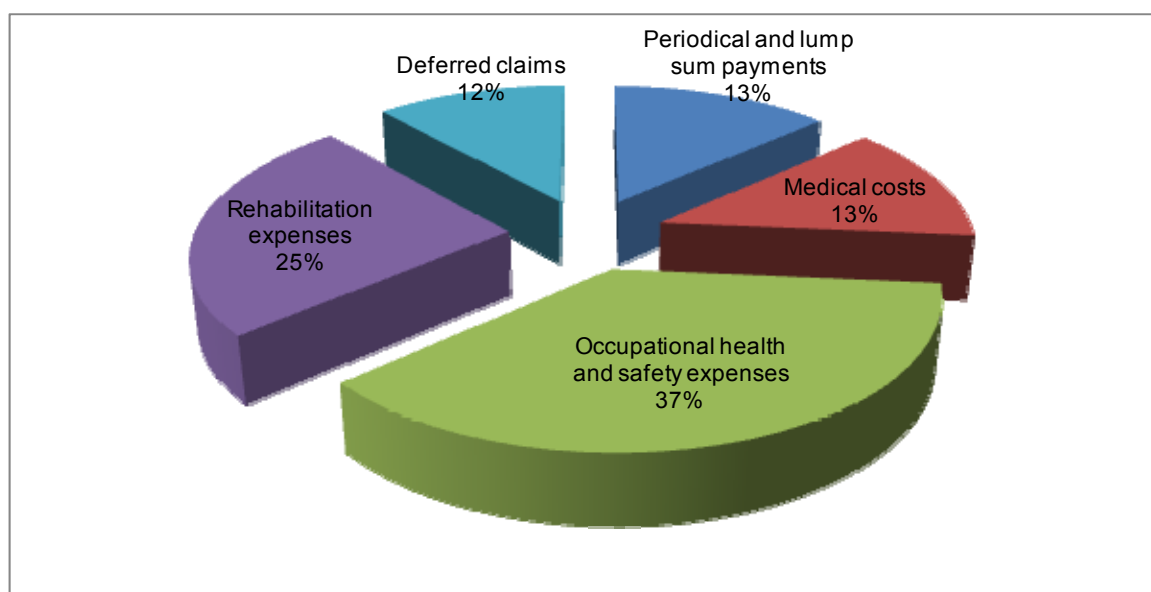
**Figure 8: Expenditure composition of the WCIF, US\$, 2010 and 2011**



Source: NSSA, 2012

Of concern however, is the fact that more funds are expended on operating expenses, mainly administration. In 2011, operating expenses accounted for 64.27% (US\$11.15 million) of the total expenses, (includes; administration costs, revaluation loss on investment property, directors' fees and other expenses) more than double the amount spent on claims, (Figure 8). Payments under the WCIF are made direct to beneficiaries/ claims using the warrant system through ZIMPOST, with short term benefits (eg, periodical payments, lump sum, funeral grant, medical costs) being decentralized to the six Regional Offices, whereas payment of long term benefits is centralized at Head Office, in Harare. The distribution of claim payments in 2011 is as shown in Figure 9.

**Figure 9: Percentage distribution of claims in 2011**



Source: NSSA, 2012

Claims in relation to occupational health and safety expenses accounted for 37% of the total claims in 2011, rehabilitation expenses accounted for 25% , whilst medical and periodic lump sum payments accounted for 13%, each and deferred claims accounted for 12%, (Figure 9). Under the WCIF, NSSA pays all medical fees including transport, drugs and hospital using the Association of Healthcare funders of Zimbabwe rates, (NSSA website, <http://www.nssa.org.zw>, accessed on 3 March 2014).

### 3.5 Health Services Fund

The Health Services Fund (HSF) was established in 1996 through section 30 of the Audit and Exchequer Act (Chapter 22: 03). The Audit and Exchequer Act was replaced by the Public Finance Management Act (Chapter 22: 19) in 2009. Its objectives are to collect and administer fees for purposes of supplementing the health budget for the development and maintenance of health services, programmes and other related activities approved by the Secretary of MoHCC in consultation with Treasury. The sources of income for the HSF are hospital fees, interest earned from credit bank balance and from financial investments, Government grants,

donations/funding from development partners, and fund raising. The expenditures of the HSF are guided by the objectives of the HSF, the approved budget, the chart of accounts used for government expenditure, the procurement procedures, and the value for money principles.

In accounting for income and expenditure, the HSF is obliged by the Public Finance Management Act (22: 19) to keep a complete set of books of accounts – the cash book, ledger and relevant journals. The financial reports for the HSF include monthly income and expenditure reports submitted to a higher authority and quarterly and annual statutory returns which are income and expenditure/receipts and payments, statement of comprehensive income, statement of financial position, bank reconciliation statement, and bank statement. These reports should be certified as correct by the Head of Station or Accounting Authority.

The accounting tools used to manage the HSF include: Public Finance Management Act (Chapter 22 : 19), the Constitution of HSF, Financial and Accounting Manual, Treasury Instructions, Accounting Officer’s Instructions, Procurement Act, Regulations and/or Procedures, Circulars issued by the Accounting Officer, Circulars issued by Treasury and the Comptroller, and Auditor-General, and Circulars issued by other Ministries. Procurement procedures are guided by the Procurement Act Chapter 22:14.

**Sources of income and expenditures for the HSF**

For the period 2009 to 2012 the sources of income for the HSF were hospital fees, donor funds, interest earned and other income. The main source of HSF income is hospital fees, which account for 98.70% on average over the period 2009 to 2012 (Table 5). Hospital fees are retained 100% by the health facilities and this implies that effectively there is no cross subsidisation across health facilities. On average, over the period 2009 – 2012, external funds have contributed 0.01%, while interest earned and other income contributed 0.01% and 1.28%, respectively (See Table 5).

**Table 5: HSF income (US\$, nominal), 2009 – 2012**

	2009	2010	2011	2012	Average	% Average Contribution
Hospital Fees	20,329,146	30,311,717	32,817,323	37,699,395	30,289,395	98.70
External Funds	8,607	5,505	361	-	3,618	0.01
GoZ Budget Support	-	-	-	0	-	0.00
Interest Earned	9367	1,841	1,904	2,539	1,805	0.01
Other Income	141,932	305,151	943,244	178,134	392,115	1.28

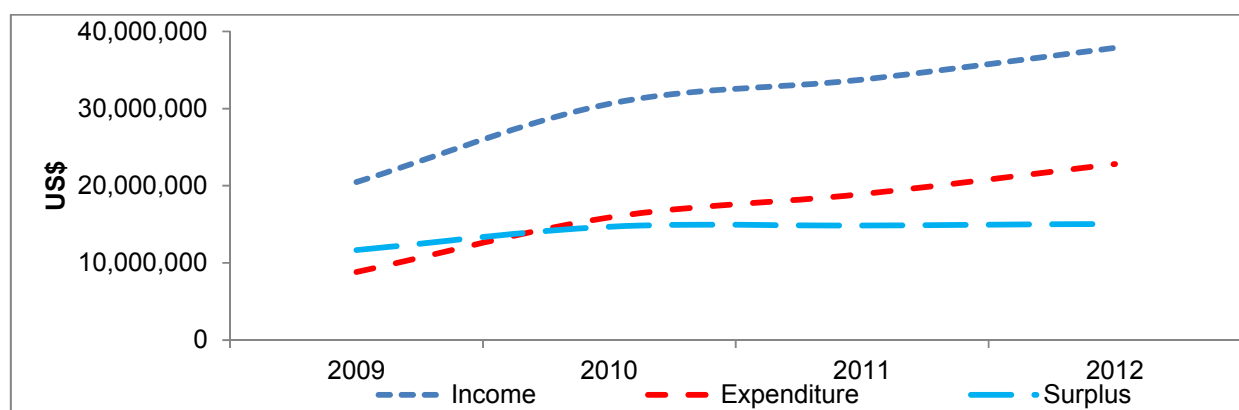
Source: MoHCC, 2009, 2010, 2011, 2012

Interest earned includes interest income on positive bank balances and debts. Other income includes income from fundraising activities, tuck shops run by hospitals, and other projects that health facilities run for purposes of raising funds. The Government is also supposed to contribute through budget support which was introduced to cater for prenatal care for pregnant mothers after realising that pregnant women were not accessing prenatal services because they could not afford, resulting in them visiting health facilities towards the time of giving birth.

However, the budget support has not been forthcoming from the Government over the review period.

The expenditures for the HSF have been increasing over the period 2009 to 2012 (Figure 10) amounting to US\$8.82 million and US\$22.82 million respectively. The main expenditure heads for the HSF are medical supplies and services, salaries, institutional provisions, maintenance of vehicles and mobile equipment and fuel, oil and lubricants. In 2012, these expenditure heads constituted 65.97% combined, with medical supplies and services taking 21.88%, institutional provisions 16.39%, fuel, oil and lubricants 13.75%, salaries 8.43% and maintenance of vehicles and mobile equipment 5.52% of total expenditure.

**Figure 10: HSF: Total income, expenditure and surplus of income over expenditure (US\$, nominal), 2009 – 2012**



Source: MoHCC, 2009, 2010, 2011, 2012

Over the period 2009 to 2012, income and expenditure for the HSF have been increasing, as has the surplus (i.e. excess of income over expenditure) (See Figure 10). Hospital fees represent hard cash but claims on medical aid societies do not, as most patients do not pay cash up front for the health services they receive. Health expenditures, however, are incurred on a cash basis. The non-synchronization of cash expenditure and cash income results in a mismatch that results in a transitory cash flow constraint for health institutions.

### 3.6 Global Fund Grant to Zimbabwe for AIDS TB and Malaria

The Global Fund galvanizes support for the fight against AIDS, TB and malaria, working with partners to support the most effective prevention and treatment. Programs supported by the Global Fund have made an increasingly significant contribution to the international targets for key services such as the provision of lifesaving antiretroviral therapy for people living with HIV, TB treatment under DOTS and insecticide-treated nets to prevent the transmission of malaria. The Global Fund Secretariat manages the grant portfolio, including screening proposals submitted, issuing instructions to disburse money to grant recipients and implementing performance-based funding of grants.

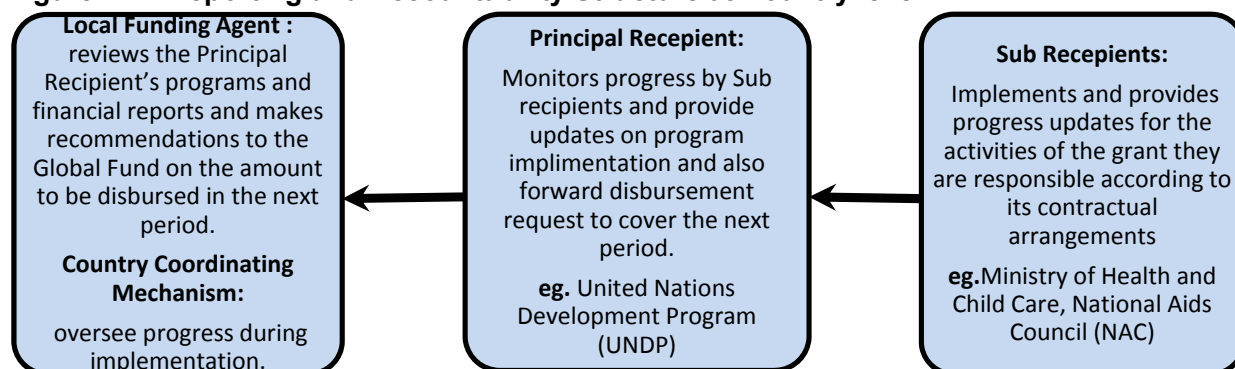
At the country level in Zimbabwe, Global Fund activities are coordinated by the Country Coordinating Mechanism through, Local Fund Agent, Principal Recipient (UNDP) and Sub Recipient. These country-level multi-stakeholder partnerships develop and submit grant

proposals to the Global Fund based on priority needs at the national level. After grant approval, they oversee progress during implementation. The Country Coordinating Mechanism include representatives from both the public and private sectors, including governments, multilateral or bilateral agencies, non-governmental organizations, academic institutions, private businesses and people living with the diseases. The CCM members represent the interest of their sectors and not their organizations or self. For each grant, the Country Coordinating Mechanism nominates one or more public or private organizations to serve as Principal Recipients.

Funding is disbursed to the implementers incrementally throughout the grant's lifespan, and each disbursement is based on performance. A Performance-based funding model is used in making funding decisions and it ensures funds disbursements are based on a transparent assessment of results against time-bound targets. Thus the mechanism promotes accountability and provides incentives for recipients to use funds efficiently to achieve results.

The Local Fund Agent verifies the performance of grant-funded programs each time recipients report results. The agent works closely with the Global Fund and in particular with the relevant Fund Portfolio Manager and the Country Team. In Zimbabwe, Price Waterhouse Coopers (PWC) is the local funding agent responsible for managing the Global Fund funds, evaluating the financial management and administrative capacity of the nominated Principal Recipient in this case the United Nations Development Program (UNDP). They also monitor progress in the implementation of the grant and verify progress reports and disbursement requests and alerts the Global Fund secretariat of any areas of concern.

**Figure 111: Reporting and Accountability Structure at Country level**



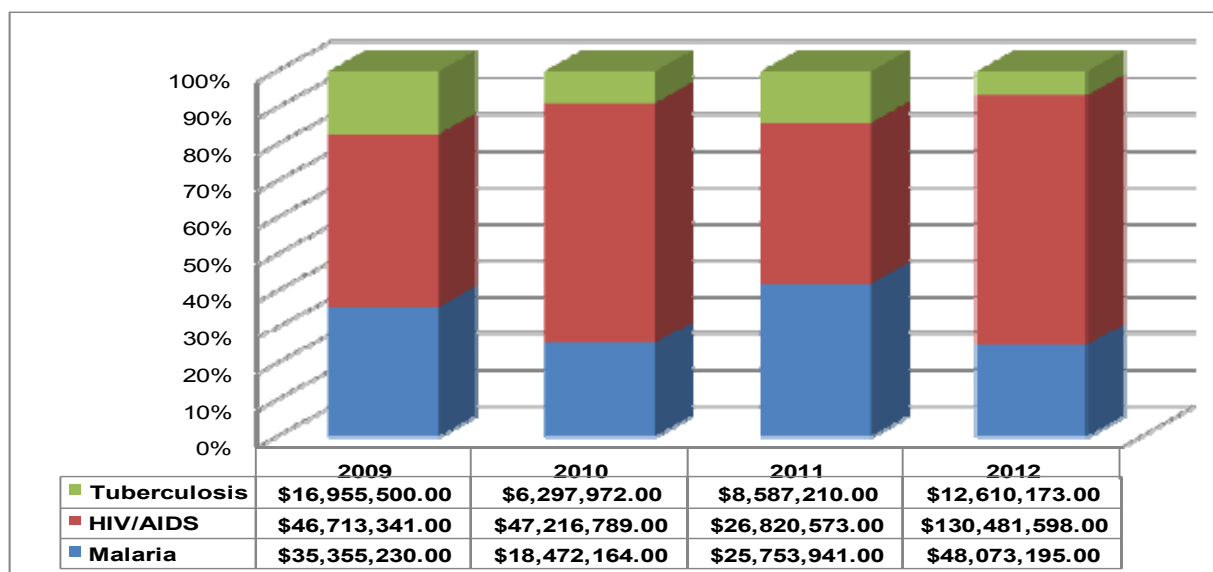
Source: Global Fund (2014)

During the lifetime of the grant, the sub-recipient implements the activities of the grant for which it is responsible according to its contractual arrangements with the Principal Recipient and in turn the sub-recipient provides the Principal Recipient with progress updates on the on the implementation of those activities for which it is responsible.

The Principal Recipient submits an update on the progress of the program to both the Local Funding Agent and the Country Coordinating Mechanism, with a disbursement request to cover the next period. In turn the Local Fund Agent reviews the Principal Recipient's programs and financial reports and makes recommendations to the Global Fund on the amount to be disbursed in the next period. Funds disbursed to government through the Ministry of Health and Child Care as a sub recipient are also managed and accounted for in line with the Public Finance Management Act.

Zimbabwe has been a recipient of 17 grants from the Global Fund between 2003 and 2013. These grants had a total signed amount of US\$857.65 million with US\$616.15 million for HIV/AIDS, US\$62.60 million for Tuberculosis and US\$178.90 million for Malaria. From 2003 to 2013 disbursed funds amounted to US\$594.87 million, with US\$368.36 million going towards HIV/AIDS, US\$59.05 million went towards Tuberculosis and lastly US\$167.46 million going towards the fight against malaria. These funds were channelled through various sub-recipients namely the NAC; Zimbabwe Association of Church related Hospitals (ZACH), the MoHCC and the UNDP as the principal recipient.

**Figure 12: Global Fund annual disbursements to Zimbabwe, US\$, 2009-2012**



Source: Global Fund (2014)

In 2009, of the total disbursed amount of US\$99.024 million (35%) went to Malaria programs, 47.17% went to HIV/AIDS related programmes, whilst programmes focusing on Tuberculosis got 17.12%. However, by 2012 Tuberculosis programmes got 6.6%, whilst HIV/AIDS programs got the large chunk of 68.26% and malaria programs got 25.15% of the total disbursement of US\$191.16 million.

## 4. Discussion

The report reviewed financial records for the semi-autonomous health funding institutions such as the Health Transition Fund (HTF), the National AIDS Trust Fund (NATF), Health services Fund (HSF), the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), and the Workers Compensation Investment Fund (WCIF). The key objective was to identify evidence for pooling funds, and how provider payments are made for the various purchases made at different levels in these semi-autonomous health institution.

The review sought to establish how budgets and expenditure relate by providing answers to such questions as: how much is spent, on what, where, for whom, within the context of the identified semi-autonomous bodies.

It was not possible to assess whether expenditures were in line with the goals and if goals were being met, given that the records reviewed did not provide this information. For instance, it is very difficult to tell if the claims declared under the WCIF for 2011 covered the total level of injury or work related illness, or whether they were simply payments to claims made.

As a summary of the evidence:

1. The HTF is a pooling mechanism for external funds which can significantly reduce overhead costs in reporting, operations and administration, supporting funds being directed to programme impact, and reducing duplication of efforts by external funders. . The HSF is a substantial resource with pooled funds of US\$ 85 million in end 2012, 19.52% of the targeted amount of US\$ 435.33 million by 2015. Expenditure allocations for HTF are guided by needs and priorities of the MoHCC as articulated in the NHS 2009 – 2013, Programme Documents and Annual Work Plans approved by the HTF steering committee. Expenditure allocations of the HTF are made in line with available resources to four categories namely: medical products, vaccines and technology; planning and financing; maternal, new-born and child health and nutrition; and human resources for health. However, it was not possible to get information on expenditures to see how they related to allocations or the shares on different areas, including administration costs of the Fund and the fund reports are not publicly available.
2. The AIDS Levy Fund collections have been steadily growing between 2009 and 2012 from US\$ 5.1 million to US\$ 32.5 million. The levy is pooled from formal employees and companies, but the lack of a mechanism to collect funding from people employed in the informal sector or in non-classifiable employment and the exemption of the mining sector implies a loss of potential contribution. The funds pooled through the AIDS Levy are applied nationally, to HIV/AIDS interventions provided by NAC or purchased from MoHCC and non state providers. There is thus a form of cross subsidisation from men, who dominate the formal sector, to women who dominate the informal sector. The expenditure allocations by NAC are guided by predetermined percentages set by the NAC Board, according to 5 intervention areas.
3. WCIF is a Social Security Scheme, whose main objective is to prevent accidents at the work places and to compensate workers who get injured in work related accidents or contract work related diseases. The scheme is fully funded by employers and from interest earned from investment projects and occupational health and safety fees. Between 2010 and 2011, the total funds pooled in the WCIF fell from US\$49million to US\$45 million, mainly due to company closures and job losses. The pooled resources are disbursed to meet all medical claims in relation to accidents at the work place or work related illnesses, as well as costs related to transport and provision of artificial appliances. Generally, the fund is underutilized with claims accounting for only 35% and 43% over 2010 and 2011, attributed to the lack of awareness on how to make claims when one is injured at work resulting in an increase in out of pocket payments. This could also partly explain the surpluses the WCIF has recorded over the period 2010 and 2011. Concerns have been raised on the fact that more funds are spent on operating expenses, which more than doubled the amount spent on claims in 2011.
4. The HSF draws its income mainly comes from hospital fees. As these are 100% retained by the facility there is no cross subsidy across facilities. Other sources of income for the HSF contribute less than 2% on average. The dominant expenditure heads of the HSF are medical supplies and services, salaries, institutional provisions, maintenance of vehicles and mobile equipment and fuel, oil and lubricants. In 2012 they

accounted for almost 66% of total expenditure and salaries for only 8.4% of total expenditure. Income and expenditures for the HSF have been increasing between 2009 to 2012 but the lag in reimbursement by medical aid societies create a cash flow problem, as expenditures are made on a cash basis. Nevertheless there has been a surplus of income over expenditure since 2009.

5. The Global Fund supports the fight against HIV/AIDS, TB and malaria and is managed by the Global Fund Secretariat. Zimbabwe has been a recipient of 17 grants from the Global Fund between 2003 and 2013. These grants had a total signed amount of US\$858 million and the total disbursed funds amounted to US\$595 million. The gap between signed and disbursed amounts is attributed to underutilisation in some programmes and lags in the implementation of other programs. The funds are channelled through various recipients namely the NAC, Zimbabwe Association of Church related Hospitals (ZACH), the UNDP and the MoHCC. A larger and increasing share of the disbursements from the Global Fund is channelled towards HIV/AIDS related programmes relative to malaria and tuberculosis programmes.

Table 6 provides a summary of the features of the semi-autonomous institutions whose financial records were reviewed.



**Table 6: Summary features of the semi-autonomous bodies whose financial records were reviewed**

<b>FUND</b>	<b>HTF</b>	<b>NATF</b>	<b>HSF</b>	<b>WCIF</b>	<b>GFATM ZIMBABWE</b>
Governance mechanism	Steering Committee, co-chaired by the Permanent Secretary of the MoHCW and a Funding Partner	Administered by NAC, under the MoHCC. NAC is run by a 12 member Board of Directors representing different sectors. NAC Secretariat is headed by the CEO who runs the day to day business.	Governed through a Constitution under the MoHCC presided over by the Secretary for MoHCC.	A tripartite Board of government, Labour and employer representatives and NSSA management	At the country level Global Fund activities are governed by the Global Fund's Code of Conduct for Recipients of financial resources, as periodically amended. Local activities are coordinated by the Country Coordinating Mechanism through a Local Fund Agent, the Principal Recipient (UNDP) and various Sub Recipients
Legal basis (Act etc)	-	The fund is established by the Section 14 subsection 14 and 15 of the Finance Act [Chapter 23: 04] and NAC Act [Chapter 15: 14].	Established in terms of section 30 of the Audit and Exchequer Act [Chapter 22: 03] which was replaced by the Public Finance Management Act [Chapter 22: 19] in 2009.	NSSA Act Chapter 17:04	Any dispute, controversy or claims arising are settled by arbitration in accordance with the United Nations Commission on International Trade Law (UNCITRAL) Arbitration Rules and the Host country laws.
Key purpose	To pool funds in support of critical health interventions for the period 2011 to 2015.	To raise sustainable and predictable domestic funds for the National Response to AIDS.	To collect and administer fees for purposes of supplementing the Health Budget, for the development and maintenance of Health Services, programmes and related activities such as may be approved by the Secretary for MoHCC in consultation with Treasury.	To establish a social security scheme for the provision of benefits to contributors and help to prevent accidents at the work places and to compensate workers who get injured in work related accidents or contract work related diseases.	To increase resources for the fight against AIDS, Tuberculosis and Malaria through partnerships between government, civil society, the private sector and communities living with the diseases

<b>FUND</b>	<b>HTF</b>	<b>NATF</b>	<b>HSF</b>	<b>WCIF</b>	<b>GFATM ZIMBABWE</b>
Source of funds	Government of Zimbabwe and Contributing donors: CIDA, European Union, Irish Aid, Norwegian Government, Swiss Embassy, Swedish Government and United Kingdom Aid/ DFID	AIDS Levy as an earmarked tax on formal employees and company tax contributions. The mining sector is exempt.	Hospital fees, donor funds, Government grants, interest earned on credit bank balances and financial investments, and fund raising activities.	Premium contributions by employers and investment income	Governments,, Multinational funders and private sector players.
Income 2012 US\$	N/A	US\$ 32,500,029	US\$ 37,880,068 This income excludes income from Parirenyatwa Hospital.	N/A	NA
Expenditure targets set by	HTF Steering Committee	NAC Board sets expenditure targets.	N/A	NSSA Management	NA
Key expenditure targets	Vaccines and technologies health policy; planning and financing; maternal, new-born and child health and nutrition; and human resources for health	55% on Treatment, care and support 11% on Prevention 4% on creating an enabling environment 5% on M and E Program Coordination 25% on Program logistic and support.	Expenditures are incurred in pursuance of the objectives of the Fund and in line with an approved budget and chart of accounts used for government expenditure.	NA	N/A
Expenditure 2012 US\$	N/A	N/A	US\$ 22,818,465 This expenditure excludes Parirenyatwa.	N/A	N/A
Income-Exp 2012 US\$	US\$85	NA	US\$ 15,061,603	N/A	N/A
Use of surpluses	NA	NA	Surplus largely represents hospital fees debtors. The surplus is carried to the Accumulated Fund.	Invested in income earning investments	N/A

<b>FUND</b>	<b>HTF</b>	<b>NATF</b>	<b>HSF</b>	<b>WCIF</b>	<b>GFATM ZIMBABWE</b>
% funds spent on admin in 2012	NA	About 17% in 2010 was spent on salaries and administration.	About 9% in 2012 was spent on salaries and employment allowances. In 2010 about 4% was spent on salaries and employment allowances.	N/A	N/A
Accounting procedures set by which law	PFM Act Chapter 22:19; the Constitution of Zimbabwe; and UNICEF financial systems (IPSAS – International Public Sector Accounting Standards)	Public Finance management Act [Chapter 22: 19]. NAC Act [Chapter 15: 14].	Public Finance management Act [Chapter 22: 19].	Public Finance management Act [Chapter 22: 19].	Accounting procedures used in accounting Global Fund resources are usually the generally accepted accounting standards in the Host Country , in Zimbabwe they are the International Financial Reporting Standards (IFRS)
Expenditures monitored how? By whom?	Steering Committee reporting to the MoHCC	Management accounts prepared at the end of each quarter. Final accounts prepared at the end of each year. Board of directors meet quarterly after Committee meetings. Financial and other records are audited by internal and external auditors. Management and audited final accounts are sent to Ministries of Finance, Health and State Enterprises, Reports made to Parliament Portfolio Cttee on Health.	Every station maintains a complete set of books of accounts for the Fund Income and Expenditure /Receipts and Payments reports are produced monthly for submission to higher authority from district, provincial to central Government level. Quarterly and Annual Statutory Returns are prepared and must be certified as correct by the head of station or accounting Authority.	Management who reports to the board and the Ministry of Labour and social services	Local Fund Agent reviews the Principal Recipient's programs and financial reports and makes recommendations to the Global Fund on the amount to be disbursed in the next period. Funds disbursed to government through the Ministry of Health and Child Care as s sub recipient are also managed and accounted for in line with the Public Finance Management Act.

<b>FUND</b>	<b>HTF</b>	<b>NATF</b>	<b>HSF</b>	<b>WCIF</b>	<b>GFATM ZIMBABWE</b>
Outcome tracking how	N/A	There is a national M and E Plan to monitor implementation of ZNASP II, and measure progress towards national and international targets. Unclear how outcomes for AIDS Levy are tracked separately.	Not clear how outcome tracking is done for the HSF.	N/A	The Principal Recipient monitors and evaluates progress toward the program objective, including the activities in accordance with the monitoring and Evaluation plan approved by the Global Fund.
Reports produced for	MoHCC	Audited financial statements are produced for Ministries of Finance, Health and State Enterprises and other stakeholders.	Financial statements are produced for the MoHCC and other stakeholders.	Ministry of Labour and social services, contributors	The Principal Recipient submits an audit report, and auditor's management letter, to the LFA for review within 6 months their financial year ending
Year of latest report	No reports could be obtained	Latest available audited financial statements for year ended 31 Dec 2011.	Latest Consolidated financial statements are for the year ended 31 December 2013.	2011	NNA
Key strengths/ achievements	Pooling of resources provides an opportunity for reducing overheads, co-ordinating funding and improved increased health financing and outcomes.	A sustainable way of funding HIV/AIDS response. NATF delivery of services uses local existing health providers leading to low overhead costs. Reports accessible.	The HSF is decentralized and rides on existent health structures and its employment costs are relatively lower on average.	The Fund is well resourced and claims can be met with surpluses	Performance-based funding has promoted evidence-based decision-making, encouraging fund allocations to AIDS, TB and malaria programmes. Strong financial oversight and management procedures.
Key weaknesses/ challenges	No financial reports submitted to MoHCC No reports on websites	Collection from formal sector only and mining sector exemption limits revenue flows. Unclear how outcome tracking is done for NATF.	Debts due to delayed medical aid payments create cash flow issues. Local fee retention weakens cross subsidies. Gaps in timely delivery of financial reports.	Low levels of claims relative to injury/ illness due to low awareness of claims process. High administration costs	The governance and monitoring and evaluation functions, have created parallel structures to the national systems with possible duplication and inefficiencies.

## 4.1 Recommendations for the research

The report highlights the range of semi-autonomous institutions managing health financing in Zimbabwe. The review has identified some gaps that may be followed up in the field work.

Greater pooling of health financing and reduced fragmentation would reduce administrative costs and improve from economies of scale. This raises the question of how fragmentation between different fund pools can be achieved, and how pools are co-ordinated to meet issues such as the health systems platform through which specific interventions are delivered.

It appears that government managed institutions are avoided. If this is due to lack of proper management of funds, then the specific areas for improvement of public finance management need to be identified, and the capacities and inputs needed to achieve this.

It was very difficult to get financial information from many of the semi-autonomous bodies. There is need to examine how to improve the standardisation of reporting requirements of the different institutions, as they varied, and how to harmonise their obligations to disclose information on their expenditures, and the frequency with which such reporting takes place, to enhance co-ordination, transparency and accountability. Their books of accounts should be audited annually and published on their websites or other such media for the public.

Within specific funds there are particular questions, such as the reasons behind the lack of AIDS Levy funding for PMTCT in 2009 and 2010, despite it being a major public health burden, and the options for improving the funding from employee and employer categories not currently contributing to the NATF.

Whilst the sources of funds are very clear, further research is needed on

1. how pooling is done across the different sources for semiautonomous institutions
2. how spending decisions and mechanisms are set and made to allocate resources across programme areas. For instance, it was unclear how the expenditure allocations under the HTF and NATF were determined. It was not clear how expenditure to interventions/programmes are arrived at and how frequently they are revised by the NAC Board.
3. How priority setting responds practically to resource scarcity to operationalize the principles of opportunity cost and margin.
4. In relation to the HSF, how user fees can supplement health facility budgets, how cross subsidies can be achieved, and given the variance on user fees policies among providers, how to harmonise practice across public and private services.
5. What expenditure or purchasing rules, criteria, targets apply for the HSF and how these differ with the observed actual expenditures.
6. What percentage share of income is from medical aid reimbursements in the HSF; the time lag to payment of the reimbursements in practice compared to the 60 days of making a claim stipulated by law and the implications for funding flows and service delivery.
7. How provider payments are made for the various purchases at different levels, across all funds.
8. What purchasing criteria, goals and strategies are used and how these are monitored and reported.

## References

- 1 Finance Act [Chapter 23:04].
- 2 Global Fund <http://portfolio.theglobalfund.org/en/Country/Index/ZWE>, accessed 6 March 2014.
- 3 Gwati G MoHCC (2014) 'Desk review for purchasing arrangements for public health services in Zimbabwe. MoHCC with TARSC: Harare.
- 4 Ministry of Health and Child Care (2013), The Health Transition Fund (HTF) Report 11 April 2013.
- 5 Magure T, (2013) 'Interview with Herald' The Herald, Harare <http://www.herald.co.zw/question-and-answer-how-nac-works/>, accessed on 6 March 2014.
- 6 Ministry of Health and Child Care, (2010) 'Consolidated statement of comprehensive income for the year ended December 31, MoHCC Harare 2009.
- 7 Ministry of Health and Child Care, (2011) 'Consolidated statement of comprehensive income for the year ended December 31, MoHCC Harare 2010.
- 8 Ministry of Health and Child Care, (2012) 'Consolidated statement of comprehensive income for the year ended December 31, 2011. MoHCC Harare
- 9 Ministry of Health and Child Care, (2012) 'Global AIDS response progress report 2012, follow-up to the 2011 political declaration on HIV/AIDS: intensifying our efforts to eliminate HIV/AIDS': MoHCC Harare
- 10 Ministry of Health and Child Care, (2013) 'Consolidated statement of comprehensive income for the year ended December 31, 2012 MoHCC Harare.
- 11 MoHCC, TARSC, KIT (2013) Report on meeting to review institutional options for management of earmarked funds for Health, 11 April, Bronte Hotel, Harare, MoHCW, TARSC/ EQUINET Zimbabwe.
- 12 National AIDS Council of Zimbabwe Act [Chapter 15:14].
- 13 National AIDS Council, (2011) 'Zimbabwe national HIV and AIDS strategic plan [ZNASP II] 2011-2015: resource mobilisation strategy 2012-14', NAC: Harare.
- 14 National AIDS Council, (2012) 'Zimbabwe National AIDS Trust Fund (AIDS Levy): HIV and AIDS domestic funding of the national response to HIV and AIDS - A success initiative in a constrained economic environment. National AIDS Council: Harare.
- 15 National Social Security Authority (NSSA), (2012), Annual Report 2011, NSSA, Harare
- 16 National Social Security Authority <http://www.nssa.org.zw>, accessed on 3 March 2014.
- 17 UNICEF and MoHCW (2011) Health Transition Fund, A multi-donor pooled fund for health in Zimbabwe supporting the National Health Strategy to improve access to quality health care in Zimbabwe. UNICEF, MoHCW: Harare
- 18 ZEPARU, 2014, Desk Review of institutional arrangements for health financing in Zimbabwe, ZEPARU, TARSC, MoHCC, EQUINET in the ReBUILD project: Harare
- 19 Zimbabwe National Statistics Agency, 2012 '2011 Labour force survey'. Government of Zimbabwe: Harare
- 20 Zimbabwe National Statistics Agency, 2013 'Quarterly digest of statistics, 1<sup>st</sup> quarter 2013'. Government of Zimbabwe: Harare.