Zimbabwe CTAP II - Country-Specific Health Sector Accountability Report

cTAP COVID-19 TRANSPARENCY & ACCOUNTABILITY IN AFRICA | magamba | Follow The Money

Disclaimer

Table of Contents

List of Figures

List of Tables

List of Abbreviations

ASRH	Adolescent's Sexual and Reproductive Health
CSOs	Civil Society Organisations
FGD	Focus Group Discussion
MoHCC	Ministry of Health and Child Care
NatPharm	National Pharmaceutical Company
NAP for OVC	National Action Plan for Orphaned and Vulnerable Children
NHS	National Health Strategy
RBM	Results-Based Management
UHC	Universal Health Coverage
SDGs	Sustainable Development Goals
WHO	World Health Organisation
ZADHR	Zimbabwe Association of Doctors for Human Rights
ZNASP	Zimbabwe National HIV/AIDS Strategy Plan
ZSHP	Zimbabwe School Health Policy

Executive Summary

The study focused on conceptualizing the health sector in Zimbabwe. For a deeper understanding of the sector, a plethora of questions was developed emanating from research themes such as the governance, political economy, financing, and fiscal management of the health sector. The research also focused on legislative oversight, procurement and citizens' voices on healthcare access, quality, and vision. **The study employed mixed methods to explore diverse perspectives and uncover relationships that exist between the intricate layers of the multifaceted research questions. The research revealed that the health sector in Zimbabwe is saddled with several challenges that continue to affect the delivery and access to quality health services.**

The COVID-19 pandemic erupted when the country's health sector faced numerous challenges. The country has not been spared by the ravages of the COVID-19 pandemic, which over-stretched and tested the resilience of the sector to major shocks. Inflation, exchange rate depreciation, and frequent monetary policy shifts remain major risks to programming with negative impacts on budgets, and the quality and coverage of healthcare services. **Insufficient health sector funding remains a challenge to safeguard gains made, and progress towards achieving universal health coverage; whereas, corruption constitutes the major stumbling block to Universal Health Coverage (UHC) and is exacerbating inequalities in access to healthcare. Other challenges include a shortage of skilled professionals and healthcare staff due to brain drain, inadequate maternal health facilities, lack of essential medicines and instruments to carry out basic procedures, eroded infrastructure with ill-equipped hospitals, and many lacking functional**

laundry machines, kitchen equipment and boilers.

In an attempt to fight corruption, the government of Zimbabwe set up an Anti-Corruption Commission. Despite this move by the government, corruption is still rampant. There is a need for the government to set up and enhance Anti-Corruption initiatives and enforce transparency in public legislation to help in combating corruption in the health sector. The government should promote Universal Health Coverage (UHC) through the removal of health services fees or substantially subsidization of medical expenses. The government is also encouraged to monitor the operations of health insurance organisations or more appropriately can establish a program of national health insurance. The central government should prioritise health expenditure in the national budget and come up with efficient working public legislation on healthcare in the country.

SECTION 1

Background and Methodology

1.1 Background of the Healthcare Sector in Zimbabwe

Zimbabwe gained her political independence in April 1980 after an armed struggle dubbed Second Chimurenga (the second liberation struggle). The new country adopted a constitution that was agreed upon at the Lancaster House Conference peace talks. Zimbabwe then adopted a new constitution in 2013 and this constitution has been described as being progressive compared to the first one. The 2013 constitution[1] lists access to healthcare as a right in Section 76 which means it is supposed to be guaranteed by the government. The rights are in response to the Abuja Declaration[2] which the country signed, agreeing to allocate 15% of the annual budget to fund healthcare. However, Zimbabwe has never met the Abuja commitment[3] and every time there is a budget presentation, every minister of finance has highlighted that there is no financial legroom to meet the requirement. This has seen the health sector deteriorating over the past two decades. The deterioration of the health sector has resulted in a brain drain in the health sector where skilled health practitioners have left the country for greener pastures while others have left the public sector to go into private practice. Most Zimbabweans, due to economic hardships in the country, rely on the public health system.

1. https://www.veritaszim.net/constitution

2. https://www.un.org/africarenewal/magazine/october-2020/public-financing-health-africa-when-15-elephant-not-15-chicken

3. https://kubatana.net/2021/12/28/zimbabwe-national-2022-budget-abuja-declaration-still-a-dream-for-zimbabwe-december-2021-access-to-public-health-monitoring-report/

In addition, Zimbabwe has underperformed across a variety of healthcare indicators. Maternal mortality in Zimbabwe currently stands at 614 deaths per 100,000 live births which constitutes one of the highest maternal mortality rates worldwide. The infant mortality rate slightly decreased but there is more to be done. The infant mortality rate in Zimbabwe as of 2022 is 35. 025 death per 1000 lives birth which indicates a 2.52% decline from the 2021 figure. Under 5 mortality rate per 1000 live birth in Zimbabwe was reported at 53.9% in 2021. Life expectancy at birth, total (years) in Zimbabwe was reported at 61.49 years in 2021. Although much has been done to improve access to quality healthcare in Zimbabwe, there is more to be done.

Poor funding in the health sector has also resulted in the dilapidation of hospital equipment and machinery. This is evident in the health sector's failure to acquire certain machinery needed to treat such diseases as cancer in Zimbabwean hospitals thereby rendering the health sector in Zimbabwe donor-dependent[4] , especially in the response to HIV/Aids, Malaria, TB, and even COVID-19 (Chene,2015). Global Fund, PEPFAR, and other development partners account for the majority of ARVs that are administered in Zimbabwe's public health institutions. According to the government, the country has received about 10 million[5] doses of COVID-19 vaccines from China since February 2021 when it kicked off the vaccination program. Poor funding has also hit public health workers who always demand better working conditions, protective clothing, equipment, and revised remuneration among others in the last decade. At a point, public doctors went on strike for over three months as they demanded better wages.

The COVID-19 pandemic also exposed the situation in the health sector where the country has few beds[6] and was not adequately equipped to provide oxygen. Besides poor funding, the health sector in Zimbabwe is also poorly managed as was evidenced by the expiry of huge quantities of drugs at NatPharm, including drugs that were donated for Cyclone Idai also expired while in storehouses[7]. Moreover, the issue of corruption in the procurement of drugs and equipment in the health sector which mostly features politicians' arm-twisting bureaucrats to award them tenders to supply is prevalent. This has resulted in various officials[8] in the health sector being arrested for corruption in the past decade. The Auditor-General Special Audit Report on COVID-19 funds exposed gross mismanagement of funds, with some funds still locked up in money transfer systems.

To critically examine Zimbabwe's downcast health sector situation, this study evaluates the country's healthcare system from the lenses of accountability, governance structures, fiscal management and financing, reforms, legislative oversight, and citizen engagement and access. This is in a bid to inform multidimensional and coherent recommendations, as regards mechanisms to improve health sector resourcing and performance in the country.

The study was commissioned under the COVID-19 Transparency and Accountability in Africa Project (CTAP) Phase II - a collaboration between BudgIT, Connected Development (CODE), Global Integrity, as well as partners in 7 African countries: Cameroon, Ghana, Kenya, Liberia, Malawi, Nigeria, and Sierra Leone. Following African governments' response to COVID-19 which was characterised by instances of mismanagement, waste, blatant corruption, unlawful procurement, political use of monetary and other reliefs, and diversion of funds which all reproduced increased inequality, CTAP was commissioned as a civil society-led effort to bolster citizen engagement and promote change in the ways that governments use public resources and increase the capacity of governments to meet people's needs.

4. https://reliefweb.int/report/zimbabwe/donor-aid-backbone-zimbabwes-health-sector-state-coffers-almost-run-dry

5. https://www.reuters.com/world/africa/zimbabwe-says-china-donate-10-mln-doses-covid-vaccine-2022-2022-01-12/

6. https://www.newsday.co.zw/2021/06/covid-19-hospitals-run-out-of-beds/

7. https://openparly.com/index.php/2021/07/14/cyclone-idai-medicines-were-left-to-expire-in-warehouses-auditor-general/

8. https://cite.org.zw/dr-mnangagwira-arrest-welcome-zimcodd/

1.2 Research Questions

01

What are the healthcare governance policies, structures, systems, and processes at the national and sub-national levels in Zimbabwe; including gaps, the role of stakeholders, and fields of cooperation and competition among critical actors?

02

What are the features and extent of reforms in Zimbabwe's health sector including political economy analysis, as well as the nature and extent of corruption?

03

What is the role and impact of oversight institutions on health sector systemic efficiency including the nature of procurement practices?

04

In what ways has healthcare financing and fiscal management at national and sub-national levels evolved including the existing financing patterns, forms of expenditure, gaps, and issues of citizen participation and accountability?

05

What are citizens' perceptions and visions on healthcare access and of quality of service of healthcare as a public good?

1.3 Methodology

The research deployed a mixed method that leveraged primary and secondary data. For the latter, books, journals, policy documents, dailies, periodicals, and other online sources were extensively reviewed and analysed. For the former, the research leveraged surveys, KIIs and FGDs to collect data from a diverse set of respondents for the research questions.

1.3.1 Key Informants Interviews

Purposive sampling was used to identify Key Informants (KI) at the national level based on their knowledge and involvement in the healthcare industry. Three key informants were interviewed and these include the executive director for the Zimbabwe Association of Doctors Human Rights (ZADHR), the Zimbabwe Coalition on Debt and Development (ZIMCODD) programs manager, and Honourable Daniel Molokele who is a Member of Parliament for the Hwange Constituency in Zimbabwe's National Assembly. Key informants were approached by email and telephone to provide them with a brief explanation of the research project. Before the interview, the researcher explained the study objectives and the scope of the interview for the KI to have enough information about the focus of the study. Confidentiality was assured and informed consent was obtained in writing. Consent was requested for recording to enable the researcher to capture all the important information. Key informants were interviewed in English using a semi-structured interview guide, structured around the political economy analysis framework. Most of the interviews took place at the consultancy workplace where privacy was assured. Interviews lasted from 30min to 2hrs with an average of one (1) hour.

Similarly, interviews were conducted with community members using the online platform via Google Forms. We managed to interview 5 community members from marginalized communities (Epworth and Chitungwiza) where access to healthcare is a challenge.

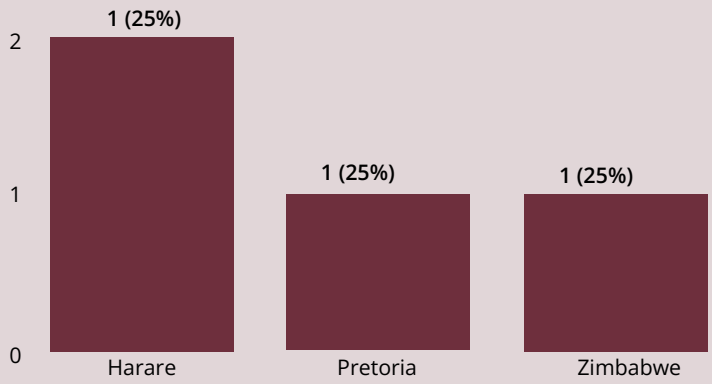
1.3.2 Focus Group Discussion

A Focus Group Discussion was conducted with 10 journalists from different parts of Zimbabwe representing various media houses including Standard Newspaper, Spiked Online, 263 Chat, The Feed, Studio 7, the Business Connect, Bustop TV, and Heart and Soul. Others were freelance journalists. The media houses represent both print media and online media. The discussion was very informative as the journalists managed to unleash and exhaust all the questions they had prepared; these were discussed extensively. The facilitator was the freelance journalist and presenter Lynette Manzini who articulated the discussion very well.

1.3.3 Online Survey

An online survey was done as well; we managed to receive 6 responses from Harare, Pretoria, and Zimbabwe (as indicated in Figure 1). An open-ended questionnaire was administered online and the respondents answered all the questions asked. Figure 1 shows the location of the respondents.

Figure 1.0: Respondent's Location (Optional)
4 responses



1.3.4 Document Review

We searched for documents to extract data that were essential for the research. The documents included the following:

- National Health Strategic Plans
- The 2016-2022 National Budget Statement
- Zimbabwe National Health Financing Policy 2016-2022
- Zimbabwe Health Sector Performance Monitoring and Evaluation Policy Guidelines and Strategy.

A snowball technique was adopted by checking the references provided in the documents analyzed and retrieving further relevant documents. Similarly, during key informant interviews, they were asked if they could share other relevant documentation.

1.3.5 Data Analysis

Data analysis was done iteratively. A thematic analysis based on the Political Economy Analysis (PEA) framework of the documents collected was conducted before the interviews and guided the discussion during the interviews and FGD. Later on, new documents were added to the review, and a final thematic analysis was conducted. Information from the gathered sources, FGD, and interviews were written up together to allow triangulation and complementary between data sources. Some quotations were provided to give texture and substance to the research. The accretion and analysis of quantitative data were accomplished using the Statistical Package for Social Sciences (SPSS) in directive to create graphs and tables.

1.3.6 Ethical Considerations

Exploring the healthcare delivery systems in Zimbabwe implies that the researcher has to act with sensitivity and tact. Bryman (2007) defines ethics as the moral guidelines, standards of behaviour, and applied procedures that researchers are anticipated to follow. The researcher achieved informed consent from the research themes before engaging and informing them about the nature of the research. Consent forms were administered before the interviews and the Focus Group Discussion. Verbally, the researcher took time to enlighten the participants on the full details of the project, its purpose, and for whom it was envisioned. Confidentiality and privacy were also assured.

SECTION 2

Health Sector Overview, Governance, And Stakeholders

The delivery of health services in Zimbabwe is guided by national-level governance frameworks in form of the Constitution and the National Economic Plan. The National Economic Plan feeds into the National Health Policy and the National Health Strategy, which are directly responsible for the governance of the health sector. Implementation of the activities of ministries within Zimbabwe is guided by the Results-Based Management (RBM) system, which was adopted in 2013 to ensure improved public sector performance and accountability. From the RBM framework, every year the MoHCC develops operational plans to coordinate all stakeholder activities required to meet the objectives outlined in the National Economic Plan and the National Health Strategy.

The Ministry of Health and Child Care (MoHCC) is the government ministry responsible for health in Zimbabwe. The role of MOHCC is to provide, administer, coordinate, promote and advocate for the provision of equitable, appropriate, accessible, affordable, and acceptable quality health services and care to Zimbabweans while maximizing the use of available resources in line

with the Primary Health Care approach. However, since the attainment of independence, the government has been failing to offer quality health services to the citizens. The sector has been politicized and; thus, failed to deliver appropriate services. Corruption is one of the factors that crippled the health sector, following the embezzlement of public funds by politicians for personal use.

The Ministry of Health and Child Care (MoHCC)[9] is responsible for coordinating the development of health policies, programs, and strategies and set-up up national standards and guidelines in the following ways:

- Monitor disease trends, quality of care, and health status of the population;
- Create a conducive health regulatory environment for both private and public health service providers;
- Commission research and ensure inter-agency coordination;
- Liaise with international health organizations and donor agencies on health matters;
- Develop and implement comprehensive population health programs including child care; and
- Provide financial, human resources management, and administrative support services including risk management.

The Health Sector in Zimbabwe is made up of private, public, and mission health centres or institutions- private health consists of privately owned hospitals, clinics, and specialist hospitals; public health comprises government hospitals and clinics in major cities, towns, provinces, and districts. The sector also consists of rural and urban council clinics and health centres; while mission health centres or institutions consist of hospitals and clinics at schools and colleges. In recent years, economic decline and political instability have led to a reduction in healthcare budgets, affecting provision at all levels. In the past five years, the country's poorest have suffered the most with a 40% drop in healthcare coverage.

2.1 Health governance and policies

The health sector is governed by a plethora of legal frameworks which include and are not limited to:

- the Constitution of Zimbabwe Amendment (No.20) Act,2013),
- the Public Health Act Chapter [15:17],
- the National Health Strategy 2021-2025 (NHS) is being crafted,
- the Zimbabwe School Health Policy (ZSHP),
- the User Free Policy for pregnant women, children under 5 years and above,
- the HIV Prevention on Revitalisation Roadmap,
- the Adolescents Sexual and Reproductive Health (ASRH) Strategy,
- the Zimbabwe Community Health Strategy (2021-2024),
- the Zimbabwe National HIV/AIDS Strategy Plan (ZNASP IV) 2021-2025,
- the National Action Plan for Orphaned and Vulnerable Children (NAP for OVC),
- the Mental Health Policy
- the National Health Policy.

9. http://www.mohcc.gov.zw/

2.2 Systems, Structure, and Processes

The Ministry of Health is at the apex of the health sector in Zimbabwe. The Health Service Board[10] is the regulatory institution that determines the course of health services such as salaries, and working environment and advises on policy formulation, implementation, and evaluation. **The structure of the Public Health is as includes the 8 central hospitals at the apex of health in terms of referral, followed by 6 provincial hospitals, then 44 district hospitals, 1122 clinics and 15 polyclinics primary health facilities and 307 rural health centres.** In terms of administration, the District Medical Office heads all health facilities within the district, and the Provincial Medical Director heads and manages all health facilities in the province. The next step will be the Head Office which is headed by the Permanent Secretary (Secretary for Health). For a comprehensive understanding of the health, structure sees Table 1 attached below.

Table 1: Health facilities profile for Zimbabwe

Facilities level / Managing Authority	All facilities	Hospitals	Primary Health Facilities
General Hospitals	6	6	0
Provincial Hospitals	8	8	0
District Hospitals	44	44	0
Mission Hospitals	62	62	0
Rural Hospitals	62	62	0
Private Hospitals	32	32	0
Clinics	1,122	0	1,122
Polyclinics	15	0	15
Private clinics	69	0	69
Mission clinics	25	0	25
Council/Municipal clinics/FHS	96	0	96
Rural Health Centre	307	0	307
TOTAL	1,848	214	1,634

Source: ZSARA, 2015

Zimbabwe Association of Doctors for Human Rights (ZADHR)[11] stated that there are approximately 3500 registered doctors in Zimbabwe and 1000 are specialists in various areas. Every district has at least 2 medical doctors, and each primary health care facility has at least 2 nurses. 59% of administrative wards are serviced by an Environmental Health Technician and 60% of rural areas have a village health worker (ZimFact, 2018). **The doctor-to-patient ratio is 0.16 doctors per 1,000 patients and 0.03 specialist doctors per 1,000 patients. The ratio is against the World Health Organisation (WHO) benchmark and standards.**

10. https://hsb.co.zw/
11. https://www.hrforumzim.org/contact-us/members/zimbabwe-association-for-doctors-for-human-rights/#:~:text=Zimbabwe%20Association%20for%20Doctors%20for%20Human%20Rights%20(ZADHR)%20is%20an,promote%20the%20right%20to%20health.

2.3 Challenges and Gaps

From the Focus Group Discussion (FGD) conducted, participants noted that the country's health sector is facing a plethora of challenges, and these include:

- Shortage of skilled professionals and healthcare staff due to brain drain,
- Eroded infrastructure with ill-equipped hospitals that experience a lack of functional laundry machines, kitchen equipment, and boilers.
- Inadequate ambulances (currently Zimbabwe has 134 ambulances for a population of 15 million people).
- Inadequate maternal health facilities.
- Lack of essential medicines and instruments to carry out basic procedures. For instance, radiotherapy for diagnosing cancer.
- Poor remuneration for public health workers.
- Corruption

Hopewell Chin'ono an investigative journalist at Geneva Summit for Human Rights and Democracy (2022)[12] argued that maternity hospitals are scarce in Zimbabwe and that only two out of the existing ones are working. These two functional maternity hospitals were both established and built during the colonial regime in 1977. Zimbabwe's healthcare services continue to fall drastically. Participants further articulated that, the introduction of user fees introduced during the Structural Adjustments Policies in 1992 continues to have negative implications on the healthcare delivery systems. Drastic economic meltdown and rampant corruption are other factors leading to poor healthcare delivery systems in Zimbabwe.

2.4 Roles of Stakeholders

Participants were asked about the role of stakeholders in the healthcare sector, they articulated that stakeholders play a major role in the direction of the healthcare industry. Their support is vital as they provide funding, support, strategic direction, solutions, and more to the overall healthcare industry. Different types of stakeholders in Zimbabwe and their roles were mentioned and these include:

- Financing (Development partners, USAID, Global Fund, WHO, IMF, Private Organisations, and Individuals)
- Monitoring and Evaluation (CSOs, Development Partners, and Citizens)
- Technical Expertise (Private Organisations Hospitals)

However, the FGD gave much emphasis on the role of media in providing transparency and accountability in the health sector. Honourable Daniel Molokele (MP for Hwange Central) alluded that the media in Zimbabwe plays an important role in ensuring transparency and accountability in the health sector. This is important if the country is to attain its vision of promoting health and the quality of life of the people in Zimbabwe. He further argued that the media can work with Civil Society Organisations to do advocacy and acquire technical support on issues such as capacity-building. CSOs can also train Members of Parliaments, collaborate with journalists, and capacitate them on issues such as corruption. However, journalists articulated that the proposed Private Voluntary Organisations Amendment Bill seeks to whip CSOs into towing the government line. The media should keep the citizens knowledgeable and articulate to build a well-informed critical mass.

12. https://ms-my.facebook.com/hopewelljournalist/videos/today-i-addressed-the-geneva-summit-for-human-rights-and-democracy-in-switzerlan/1696950977340221/

The pictures below show journalists and Honourable Daniel Molekele (MP) addressing journalists during the FGD at Moto Republic, Harare.

Plate 1: Journalists in an FGD

Plate 2: Honorable Molekele addressing Journalists

2.5 Health insurance and pooling of funds in Health

The development of health insurance in Zimbabwe has been highly limited and is not equitable. Zimbabwe has not developed systems of social health insurance or community-based health insurance. The insurance sector is dominated by private health insurance which only offers financial protection to the upper quartile of the economy. Pooling of funds for financial protection and equity is mostly done through government public spending and private not-for-profit funds that are mostly externally funded.

Zimbabwe has more than 30 private insurance schemes that cover approximately 10% of the population. Membership in these funds is on a voluntary contribution basis. A significant number of employers contribute funds for their employees either as full premiums or part of the premiums to which employees will also contribute the remaining portion. However, with most employers, employees choose the insurer and package they prefer. ZADHR argued that the bulk of Zimbabweans do not have access to health insurance and mainly use the public health sector for services, there is a need for the Ministry of Health to enhance its investment in these facilities so that bulk of the population can also get quality health care.

SECTION 3

Political Economy In The Health Sector

From the interview conducted with the Zimbabwe Association of Doctors for Human Rights ZADHR, they argued that through the Ministry of Health and Child Care (MoHCC), the government of Zimbabwe adopted many reforms and policies to move toward Universal Health Coverage (UHC). They stated that the government employed the Health Financing Policy to ensure that all citizens have access to the quality health services they need without suffering financial hardship. Some of the most significant policies/reforms have been the AIDS Levy, which has seen significant funds targeted towards the HIV/AIDS pandemic response and Results-Based Financing, which has addressed critical gaps in the maternal and child health area. Despite these initiatives, significant challenges within healthcare delivery remain the same.

The discussion narrowed down to the political economy of the health sector in which they highlighted that the political economy factors that slow down UHC reforms are not rooted in the ambiguities of ideas on what needs to be done. Instead, the missing link is how to move

from intention to action by aligning espoused ideas with interests and institutions which is an inherently political and redistributive process. International and domestic actors involved in UHC in Zimbabwe need to explicitly consider the politics of health financing reforms to improve the implementation feasibility of desired reforms.

Participants in the FGD argued that the health sector has been a victim of institutionalized corruption. They stated that corruption manifests in various dynamics which include but are not limited to:

- Public procurement corruption,
- Nepotism
- Theft of essential medicines
- Bribery and absenteeism by the medical health workforce
- Under-the-counter payments.

The group articulated that corruption occurs in Zimbabwe as medical personnel battle to make ends meet. For instance, nurses at local health facilities purportedly charge ladies US$5 each time they shouted while conceiving their offspring as a punishment for raising a false alarm.

A senior medical practitioner mentioned that because of low pay rates, medical personnel create adapting methodologies to top up their salary including working two jobs or running private practices while on the civil service payroll. Doctors running private practices usually refer their public patients to their private clinics thus denying the more unfortunate patients access to quality health services. 73 per cent of HIV-positive respondents had been asked by health workers to pay a bribe. In some instances, HIV patients are told that certain drugs are unavailable or that diagnostic equipment was broken until they paid a bribe. Many patients are also asked to pay for services that they are supposed to receive for free. For instance, asking pregnant women or children under age 5 to pay a "consultation fee" when they are entitled to free medical treatment. In addition, HIV drugs that are meant to be distributed to patients for free are being sold at a fee by local nurses.

SECTION 4

Financing And Fiscal Management

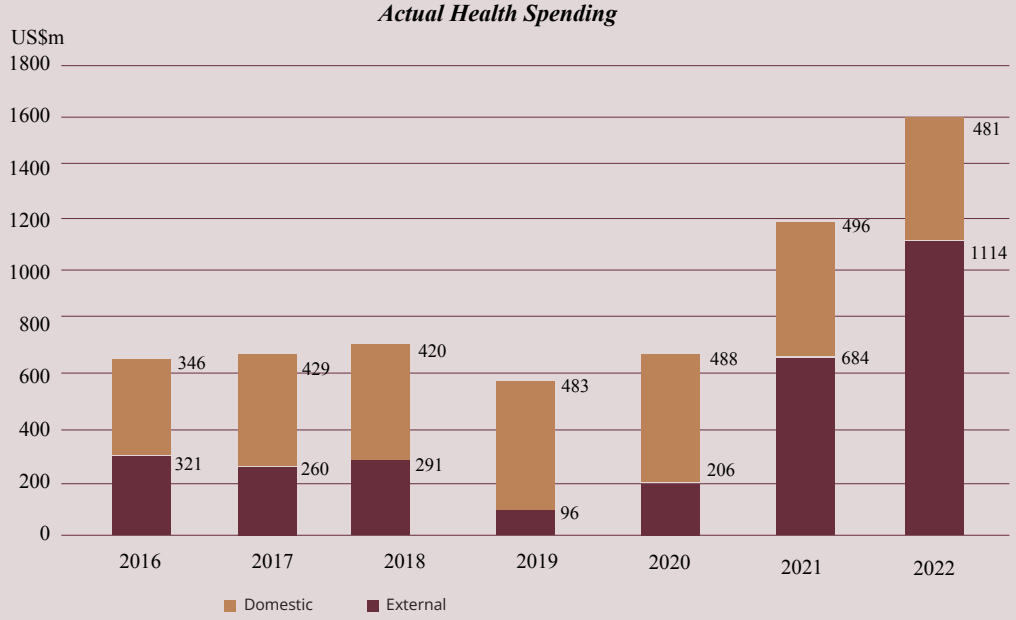
The online survey which was conducted did indicate that Zimbabwe's health system has been consistently financed by a mixture of domestic funding sources. Respondents stated domestic funding sources which include:

- Central Government through budget allocation
- sub-national government (local authorities)
- Households
- NGOs (including religious organizations and local philanthropies)
- private companies.

Participants from the FGD highlighted that since 2018 the government of Zimbabwe pledged to improve health service delivery in line with Sustainable Development Goals (SDGs) by the year 2023 and ensure that the treasury allocated at least 15% of the national budget to health care in line with the Abuja Declaration which has never been met. The government of Zimbabwe adopted many policies in a bid to provide universal quality healthcare for every Zimbabwean. The government employed the Health Financing Policy informed by WHO guidelines, recognizing health financing as one of the health systems

strengthening building blocks. The policy and strategy acknowledged that the way funds are allocated and the way services are paid for influence how services are accessed by the population. Participants further discussed the actual health spending in Zimbabwe, and the money accrued to the health sector domestically and externally. The graph below shows funds allocated by the government and external partners to the healthcare system from 2016-to 2022.

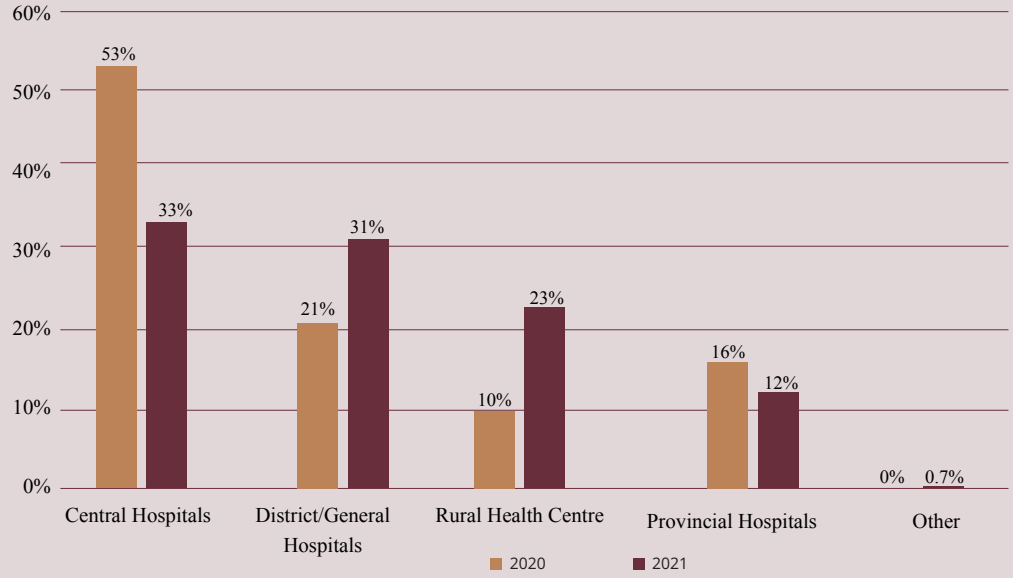
Figure 2: Actual Health Spending in Zimbabwe



Source: MOFED, Budget Statements, and Outturns, 2020 Annual Budget Review, MoHCC and 2020 Resource Mapping Report.

Figure 1 shows that the total health spending averaged US$668 million over the period 2016 to 2018. While health spending from external partners remained stable at around US$433 million per year, national budget health spending declined sharply from US$321 million in 2016 to US$96 million in 2019 because of the economic meltdown and inflation. However, from 2020 to 2021 the government increased the money accrued to the health sector to fight the scourge of the COVID-19 pandemic. The National budget health spending increased by 114% from US$96 million in 2019 to US$ 206 million in 2020. Compared to 2021 when the government doubled the finances for healthcare and delivery systems. Public health funding has increased significantly and accounts for 13% of the total 2021 national budget although the government has not reached the Abuja Declaration target. The online survey indicated that central hospitals and district hospitals are earmarked for the highest proportions of the budget. **However, the budget statements reviewed showed that the proportion for central hospitals declined from 53% in 2020 to 32% in 2021 (as indicated by Fig 2), while that for district/general hospitals increased from 21.1% to 31%. In addition, Rural Health centre (RHCs) allocation doubled from 10.1% in 2020 to 23.5% in 2021.** The increase in Rural Health Centres' support is a welcome development as it will assist in decongesting Central Hospitals, especially by ensuring that services are available at local levels for the population.

Fig 3: Composition of the curative services budget, percent of total



Source 2020 and 2021 Budget Statements

Concerning accountability, transparency and citizen participation in Zimbabwe's health sector spending, citizens are not directly involved in the health sector budgeting. The government made some public hearings at the provincial level specifically for the national budget, including the health sector which made it difficult for the citizens to properly articulate their needs. Citizens in Zimbabwe do access health sector budgets both at the national and local authority levels. However, accessibility does not always mean that the budget will reflect their aspirations.

In some instances, citizens' demands might be so clear and eloquent that the government cannot ignore them. A good example is the 2021 national budget consultation. The majority of the citizens expressed their concern for the government to fulfil the Abuja Declaration Commitment of having 15% of the national budget channelled towards health in response the government allocated 13%. Nonetheless, there was a great under-expenditure- only 46% of the health budget was utilised despite the scale and magnitude of challenges that are experienced by the health sector. Some laws allow citizens to access information from government MDAs as long as it does not fall under the category of national security. The Freedom of Information Act [chapter10:33] allows citizens to have access to state information. However, there is limited access to information from state-led institutions or agencies at every level for public accountability.

Participation of communities is of paramount importance in improving health outcomes and the performance of health systems. Despite this, decisions made at higher levels continue to have weak public input and consultation. Participation in the governance of the health system is indirect, through health or elected structures, with the public a step removed from the negotiations and choices that are being made increasingly in the context of limited resources. Thus, communities do not have an influence on the health sector budget based on their needs and priorities. The government use the top to the bottom-up approach, which hinders

communities from directly contributing to issues that concerns them. If needs assessment were propelling projects to be inclined in the national budget, the health budget or national budget could be speaking to the citizens' needs and aspirations. The failure by the government to speak to citizens' aspirations attests to the fact that needs assessments in Zimbabwe do not always lead to project inclusion in the national budget.

Civil Society Organisations (CSOs) in Zimbabwe play a major role in the delivery of health services. They contribute to enhanced health care by providing services in response to community needs and adapting to local conditions. However, in Zimbabwe CSOs cannot participate in health sector bid evaluation. Besides, post bids evaluation data is not available in the public domain. Zimbabwe is not part of the Open Government Partnership (OGP) thus making it difficult to be more accessible and responsive, and accountable to the citizens. The government is failing to enhance transparency, accountability and public participation, especially in the health sector.

SECTION 5

Legislative Oversight And Procurement

The study revealed multiple pieces of legislation that exist in Zimbabwe to govern the various components of health financing functions and the delivery of healthcare. Participants mentioned the main legislation for health is the Constitution, which guarantees health as a right for all citizens. The Constitution of Zimbabwe Section 76 clearly states that:

- Every citizen and permanent resident of Zimbabwe has the right to access basic health care services, including reproductive health services.
- Every person living with a chronic illness has the right to have access to basic health care services for the illness.
- No person may be refused emergency medical treatment in any health care institution.
- The State must take responsible legislative and other measures within the limits of resources available to it to achieve the progressive realization of the rights set out in the constitution.

Within the health sector, major regulations include the

- Health Services Act (2002)
- Public Health Act(2002)
- Public Finance Management Act (2010)
- Medical Services Ac
- Mental Health Act,
- Health Professions Act (2000).

Some regulations include the private sector. Other acts and policies that govern specific components of the health system draw from these major pieces of legislation. The various pieces of legislation also create various bodies and institutions that oversee the enforcement of these laws and regulations.

From the Focus Group Discussion conducted, ZIMCODD highlighted that the healthcare system delivery is failing because of the outdated laws that are implemented. The laws benefited those in power rather than the majority to keep on having lucrative ways/means to loot health funds for self-enrichment at the expense of the public.

Parliamentary Portfolio Committee on Health and Child Care is responsible for over-sighting the Ministry of Health and Child Care in Zimbabwe. It is responsible for the supervision of operations and activities of the ministry and this takes a variety of forms and utilizes various techniques. The committee's function is supported by a variety of authorities; mainly, the Constitution, public law, and chamber and committee rules. It's an integral part of the systems of checks and balances between the legislature and the executive. The Committee also work with other regulatory departments, the Public Accounts Committee and Auditor General which oversees government health expenditures. As part of its oversight role over the MoHCC, in the recent past, the Committee enquired into the state of affairs of the health delivery system in Zimbabwe. The inquiry was focused on the management of the five central hospitals. The Committee conducted site visits, oral evidence (interviews), workshops and Focus Group Discussions. In addition, the Committee

also enquired into the roles and responsibilities and deployment of Village Health Workers in the provision of primary health care in Zimbabwe. During the COVID-19 pandemic, the Committee has been getting regular updates from senior officials from the ministry on the situation on the ground to help formulate appropriate policies.

From the above, it is clear that the over-sighting Committee is, to some extent, carrying out its responsibilities but the continued deterioration/dilapidation of the health system leaves much to be desired, which the committee must have addressed. The Committee is not effectively working as evidenced by rampant corruption in the health delivery systems, dilapidated infrastructure, unequal access to care services and brain drain as a result of poor remuneration of public health workers. These issues should be pointed out and corrected through an effectively functioning oversight board. However, these have flourished under the watch of the Committee.

5.2 Procurement in the Health Sector

ZADHR mentioned that Zimbabwe has various fragmented purchasing arrangements that closely reflect and follow the financing and pooling mechanisms that are used. The largest single purchaser of health services is the GoZ which purchases services through its various ministries primarily the MoHCC. The MoHCC provides inputs through line items in the national budget and also funds the wage bill for health workers. It also funds the procurement of drugs and other essential commodities while the supply of drugs specifically is by the National Pharmaceutical Company (NATPHARM). They postulated that, domestically, NATPHARM is underfunded with 99% of all the drugs available at NATPHARM being donor-funded.

The available drugs are mostly essential medicines used for primary care resulting in perennial stock ruptures of vital medicines. Other government purchasing arrangements include the Assisted Medical Treatment Order. The Provincial Medical Directorate is responsible for the purchasing function at the provincial level and specifically negotiates service contracts with the district and hospital service providers whilst services at the district level are handled by the District Health Executive. The local government ministry purchases healthcare services through their budgets which are funded by general levies and rates collected from residents. However, most local authorities are facing challenges to keep their facilities running because of poor revenue collection at the overall council level resulting in high user fees at points of access for patients. The central budget has been paying for salaries of some local authority health workers but challenges remain with costs to cover commodities and operating costs.

The FGD participants revealed that, at some point, the National Pharmaceuticals (NatPharm) managing director, "Newman Madzikwa, was jailed for an effective 14 months after he was found guilty of criminal abuse of office to the arbitrary increase in drug prices. The price increases, with the effect of precipitating a crisis in the sector and endangering public health, were against the directive of the Ministry of Health and Child Care and the NatPharm board. They further argued that recently, there have been reports that some wholesalers are procuring drugs from NatPharm using RTGS payments; yet, they sell to the public in foreign currency.

Recently, the Minister of Health and Child Care, Obadiah Moyo was arrested, as were three executives at the state-owned National Pharmaceutical Company. Moyo was arrested and charged with criminal abuse of office over the awarding of a $60m (£47m) contract to a company that allegedly sold supplies to the government at inflated prices. According to court papers, Moyo allegedly awarded a multimillion tender to Drax International LLC headquartered in the United Arab Emirates, which was concluded without the consent of the Procurement Regulatory Authority of Zimbabwe. Besides, the Deputy Minister of Health bought media equipment in India without using the tender process and sadly, it is reported that the drugs and equipment are about to expire. The balance between the original and cut-down prices is pocketed by politicians. Corruption is rampant in the procurement of drugs in Zimbabwe. There is a need for the decentralization of pharmaceutical procurement and to have other players in the industry who will initiate competition that would enable the delivery of access to quality and good healthcare for the majority.

Corruption within the health care sector in Zimbabwe is a serious concern. It deepens inequality and disenfranchises low-income individuals and households from accessing basic health care rights. It has a negative effect overall on the welfare and health of the citizens as it undermines the efficiency in the delivery of health care services. Chirizeni (2013) postulated that corruption violates human rights as people are denied the care that their governments are obligated to provide. Corruption in the health sector has been seen to be unfavourable as it affects the health of the population and also economic development. "Patients are left to die because they cannot afford tertiary care services. The service providers have withdrawn their services or are demanding cash up front, theft of drugs and equipment from hospitals, and the flouting of tender processes by hospital officials for personal gain.

SECTION 6

Citizens Voices On Healthcare Access, Quality And Vision

Health care access is generally bad. Since the introduction of user fees in 1992 healthcare delivery services have been falling drastically. Such fees act as a barrier to basic health service provision. The respondents indicated that the shortage of medicine and equipment poses a problem at healthcare centres.

"Access to healthcare is really difficult. We are dying from curable diseases. Our clinics here do not even have painkillers like paracetamol. All they are giving us are prescriptions but we do not have money to buy the medicines at pharmacies. The hospitals do not give us the required medicines." Zimbabwe Association for Doctors and Human Rights spokesperson further indicated: "Appropriate medicines are normally out of stock for the treatment of some diseases and under such circumstances, we normally resort to painkillers or advise the patient to go and buy from pharmaceutical centres."

The respondents indicated that the shortage of human resources poses a problem at healthcare centres. All the health practitioners interviewed concurred that health personnel shortages pose healthcare challenges in the districts. In support of the shortage of human resources as a health care challenge, a senior nurse at Chitungwiza central hospital in the district had this to say:

"Due to shortage of nurses, nurse aides often work as nurses in some clinics in the district"
Respondents also highlighted that, they normally travel long distances to access health care in clinics and hospitals despite constitutional provisions compelling the government to provide this basic right to its citizens. From the online survey that was conducted, most of the respondents argued that the quality of Healthcare delivery is terrible, See Fig 4

Figure 4: Healthcare delivery systems in Zimbabwe

Source: Statistics from the online survey

Vision

The study revealed citizen's vision of healthcare delivery which is as follows:

- Equal access to healthcare services in Zimbabwe
- Improved access to essential medicines and commodities.
- Increased access to water, sanitation, and a healthy environment.
- Improved health infrastructure and medical equipment for Health Service Delivery.
- Improved governance of the Health Service
- Improved health sector human resources performance
- Increased domestic funding for health
- Reduced morbidity and mortality due to communicable and non-communicable diseases.
- Improved reproductive, maternal, new-born child, and adolescent health and nutrition
- Improved public health surveillance and disaster preparedness and response
- Improved primary, secondary, tertiary, quaternary, and quinary care.

Recommendations

- The deterioration of Zimbabwe's health care system coincided with the introduction of user fees. The fees are often very high in Zimbabwean healthcare centres. Such fees act as barriers to basic health service provision. In the absence of substantial government financial support, user fees provide the main income for many health care facilities enabling them to provide at least the minimum service (UNICEF, 2011). It is recommended that the government removes health service fees or substantially subsidize medical expenses. The government is also encouraged to monitor the operations of health insurance organizations or more appropriately can establish a program of national health insurance. In a bid to promote equal access to healthcare in Zimbabwe.

- A proper review of the public health policies is needed in Zimbabwe. The government should consult the public to come up with efficient working public legislation on healthcare in the country and therefore in the districts. Research conducted by (TARSC, 2011) revealed that the Public Health Act in Zimbabwe is poorly implemented and that the public health system is somewhat ineffective (TARSC, 2011). The government of Zimbabwe should, therefore, give higher priority to public health policy by making the policies known to the people and ensuring proper implementation. There is a need to include the rights of people to health in the Public Health Act of the country. The rights to be included in public health policy should encompass the rights to drinking sufficient water, eating healthy food and providing good housing, providing free health care services, and having access to public health information.

- The central government should prioritise health expenditure in the national budget by honouring its commitment to the Abuja Declaration. This would then enable the government to acquire enough health resources such as essential medicines, health personnel and facilities, and equipment. Such a strategy will go a long way in ameliorating the health care system of the country.

- There is a need for restructuring the public health sector's hierarchical management levels to reduce abuse of office and discretion.

- The sector should effectively implement the Anti-corruption Act without favour and ensure punishment for corrupt health officers to reduce the number of corrupt cases.

- The government should enhance Parliament's oversight of the public health sector to ensure resources are used for what they were allocated for and that they are effectively used.

- Civic Society Organisations must capacitate parliamentarians so that they can scrutinize government spending effectively and push for open governance.

- Civil Society Organisation must also help mobilize citizens in providing effective public oversight on health government spending. They should monitor budget implementation and advocacy for reforms for more openness in Zimbabwe's health sector by raising community preferences in resource allocation, mobilising and organising community co-financing of services, promoting pro-poor and equity concerns in resource allocation, building public accountability and transparency in raising, and allocating and managing resources.

- CSOs should monitor responsiveness and quality of health services by giving voice to marginalised groups, promoting equity, representing patient rights in quality of care issues and channelling and negotiating patient complaints and claims.

- The government should increase the salaries and improve the working conditions of public health officials in a way to reduce cases of bribery or diversion of health funds for personal interests.

- The government must adopt open procurement systems and also publish beneficiary ownership of the companies that get tenders to supply equipment and sundries in the health sector to prevent corruption.

- The government should subscribe to the Open Government Partnership process to enhance transparency in its procurement.

Conclusion

Although much has been done over many years to restructure the healthcare system and improve the quality of care being rendered to users, primary findings and literature from this study reveal that millions of people in Zimbabwe still face numerous healthcare challenges. Inequality in access to healthcare is rife and the mortality rate is high in the public health sector. This situation was exacerbated by COVID-19 which launched the brain drain of public health workers and shortages of essential drugs and equipment. The COVID-19 pandemic erupted when the country's health system faced numerous challenges. The country has not been spared by the ravages of the COVID-19 pandemic, which over-stretched and tested the resilience of the sector to major shocks. The current state of Zimbabwe's health service delivery is disgraceful. Therefore, much still needs to be done by the government and society at large to address the issues of poor-quality service delivery. The government of Zimbabwe should prioritize the health sector and equal access to health services. Section 29 of the Constitution recognises health as a fundamental human right. Since signing up for the Abuja Declaration, Zimbabwe has still not reached the 15% agreed allocation of the national budget to fund the health sector.

There is underfunding of the health sector by the government in its budget thus leading to the deterioration of the sector, while also leading to failure by the health institutions to repair equipment, adequately pay workers, and buy essential drugs. This has seen development partners and non-governmental organizations (NGOs) coming in to cover the gap thereby creating a donor dependency on Zimbabwe.

Although Zimbabwe has a plethora of laws to govern the operations of the health sector, economic challenges in the country have created avenues for corruption perpetrated by politicians, bureaucrats in the health sector, and health personnel. The health sector is politicized leading to the implementation of outdated laws and rampant corruption. Thus, creating a dysfunctional institution that is failing to deliver basic services to the citizens. Corruption comes in many forms but mostly through procurement, nepotism, theft of essential medicines, and solicitation of bribes by the workers in the sector in exchange for good services. The corruption is not because of a lack of laws, but a total disregard of them by politicians, bureaucrats, health personnel, and a lack of effective oversight on the use of public resources. As far as this project is concerned, there is a need for the media to be capacitated to understand how corruption happens in the health sector so that they can expose it. Media plays an important role in ensuring transparency and accountability in the health sector.

References

Arrow, J.K. (2010). Uncertainty and the welfare economics of medical care. The American Economic Review,71(1),41-61.

Bryman, A & Bell, E. (2007). Business research methods. Oxford University Press, USA.

Berlan, D. (2012). Holding health providers in developing countries accountable to consumers: a synthesis of relevant scholarship. Health Policy and Planning 27, 271–80.

Cain, G. (2015). Bad Governance in Zimbabwe and its negative consequences, The Downtown Review, 2 (1): 1-8.

Chene, M. (2015). Overview of corruption in health and education sectors and in local governments. U4 Anti-corruption Resource Centre. Harare, Zimbabwe.

Charizeni, E. (2013). People's state of health in Zimbabwe: A spatial Perspective. International Journal of Research in Economics & Social Sciences, 3(8):1-18.

Dickson, G. (1997). Participatory action research and health promotion: The grandmothers' story. College of Graduate Studies and Research: College of Medicine University of Saskatchewan Saskatoon.

Evans, D. (2013). Universal health coverage and universal access. Bulletin World Health Organ, 91:546-546A.

Few, R. (2017). Urban primary health care in Africa: a comparative analysis of city-wide public sector projects in Lusaka and Dar es Salaam. Health Place 9: 45–53.

Gilson, L. (2018). Strategies for promoting equity: experience with community financing in three African countries. Health Policy 58: 37–67.

Khumalo, G. (2019). How can household-health system accountability mechanism at primary health care level be strengthened to support provision of chronic disease care? Johannesburg: Centre for Health Policy, University of Witwatersrand.

Meltzer, J. (2000). The Micropolitics of Civil Society and Citizen Participation, Report for IDRC (Canada), Canada.

McGrail, R. (2012). Spatial accessibility of primary health care utilising the two step floating catchment area method: an assessment of recent improvements. International Journal of Health Geographics, 11:50.

McCoy, D.C. (2012). A systematic review of the literature for evidence on health facility committees in low- and middle-income countries. Health policy plan. BMC Health Services Research,12, 449-66.

MOHCC (2019). Zimbabwe Health Sector Performance Monitoring and Evaluation Policy Guidelines and Strategy. Harare, Zimbabwe: Government Printer.

MOHCC (2015). The National Health Strategy for Zimbabwe 2016-2020. Harare, Zimbabwe: Government Printer.

Nyoni, T. (2017). The curse of corruption in Zimbabwe. International Journal of Advanced Research and Publication, Vol (5), pp 285-290.

Sharma, S. (2015). Improving Availability and Accessibility of Medicines: A Tool for Increasing Healthcare Coverage. MedPub Journals, 7(5):12.

Sadeghifar, J. (2015). Strategic Planning, Implementation, and Evaluation Processes in Hospital Systems: A survey from Iran. Global Journal of Health Science, 7(2).

Robinson, M. (1997). The role of civil society in the provision of social services: the non market, voluntary sector, Mimeo, IDS (Sussex), UK.

UNICEF. (2016). Zimbabwe National Health Financing Policy: Resource Pathway to Universal Health Coverage. Equity & Quality in Health. UNICEF, Harare.

UNICEF. (2016). 2016 Zimbabwe Ministry of Health and Child Care Budget Brief. Harare, Zimbabwe.

World Health Organisation, (1997). A new global health policy for the twenty first century: An NGO perspective, WHO, Geneva.

Zimbabwe Government. (2013). Zimbabwe Constitution. Harare: Government Printers.

The Guardian (2020). Zimbabwe health minister facing coronavirus corruption charge sacked. Available at https://www.theguardian.com/global-development/2020/jul/09/zimbabwe-health-minister-facing-coronavirus-corruption-charge-sacked.

The independent (2018). Zimbabwe runs out of Health drugs. Available at http://www.theindependent.co.zw/2018/10/05.

The Independent (2013). Massive Corruption at government hospitals. Available at https://www.theindependent.co.zw/2013/01/18/massive-corruption-at-govt-hospitals/

The Herald (2019). Newman Madzikwa was jailed for criminal abuse of office. Available at http://www.herald.co.zw.

Annexes

ANNEX: 1 CTAP Heath Sector Accountability Report

Online Survey questionnaire

The COVID-19 Transparency and Accountability in Africa Project is a collaboration between BudgIT, Connected Development (CODE), Global Integrity, as well as partners in 7 African countries: Cameroon, Ghana, Kenya, Liberia, Malawi, Nigeria, and Sierra Leone. Two phases of information and fact-finding will be established. In the CTAP phase I, a combination of methodologies were utilized to generate data aimed at investigating how the COVID-19 relief funds were used by governments. This information was leveraged to advocate and collaborate with governments to bring about change. The focus now is on the CTAP phase II, where the different partners will work with the government, communities, and other stakeholders to establish mechanisms for health sector accountability, foster effective & equitable COVID-19 vaccine distribution, and mount effective advocacies that mainstream health sector's best practices in focal countries.

Please kindly answer the following questions to help us understand the health sector in Zimbabwe. (Your identity will not be disclosed without your consent)

Research Questions

Q1. What are the healthcare governance policies, structures, systems, and processes at the national and sub-national levels in Zimbabwe, including gaps, the role of stakeholders, and fields of cooperation and competition among critical actors?

Q2. What are the features and extent of reforms in Zimbabwe's health sector including political economy analysis, as well as the nature and extent of corruption?

Q3. What is the role and impact of oversight institutions on health sector systemic efficiency including the nature of procurement practices?

Q4. In what ways has healthcare financing and fiscal management at national and sub-national levels evolved including the existing financing patterns, forms of expenditure, gaps, and issues of citizen participation and accountability?

Q5. What are citizen's perceptions and visions on healthcare access and of quality of service of healthcare as a public good?

ANNEX 2: Key Informant and Focus Group Discussion Tool

Research Questions

1. What are the healthcare governance policies, structures, systems, and processes at the national and sub-national levels in Zimbabwe, including gaps, the role of stakeholders, and fields of cooperation and competition among critical actors?

2. What are the features and extent of reforms in Zimbabwe's health sector including political economy analysis, as well as the nature and extent of corruption?

3. What is the role and impact of oversight institutions on health sector systemic efficiency including the nature of procurement practices?

4. In what ways has healthcare financing and fiscal management at national and sub-national levels evolved including the existing financing patterns, forms of expenditure, gaps, and issues of citizen participation and accountability?

5. What are citizen's perceptions and visions on healthcare access and of quality of service of healthcare as a public good?

ANNEX 3: Attendance Register

magamba

Magamba Network CTAP Stakeholders Meeting

Date: 07 April 2022

Venue: Moto Republik

FULL NAME	ORGANISATION	SEX	PHONE NUMBER	EMAIL
Lawrence Kanyasa	Business Connect	M	076 29 269	lorchots@gmail.com
Tanyaradzwa Nyabvure	Connect Online	M	0772124678	tanyaradzwaroy@gmail.com
Allan Mbotshwa	Freelancer	M	0777534907	allanbryanmbotshwa@gmail.com
Tatenda V Chafuka	Business Connect	F	0774292 501	vickyfeedlacky@gmail.com
Fortunate Mildred Rekai	Business Connect	F	0783 783166	mildredrekai@gmail.com
Wallace Mawire	Pan African Visions	M	077469374	wmawire@gmail.com
Melissa Musodzi	Bustop TV	F	0776440828	melissamusodzi@gmail.com
Lynette Maurim		F	0772973552	lnmanzini2@gmail.com
Nyasha J. Mukapiko	Magamba	M	0773 653 326	nyasha@magambanetwork.com
Byron Mutingwende	Spiked	M	0774017070	bmutingwende@gmail.com
Spangoge Madzima	Zimbo Live TV	M	0714168775	spangogemadzima@gmail.com
Tafadzwa F. Mukwangwa	Freelance	M	0774 36960	tafadzwamukwangwa@gmail.com