# Community Working Group on Health (CWGH)
## Position Paper on the 2023 National Health Budget

**Key Sector Priorities and Considerations**

- Raising domestic public funds is essential for universal health coverage (UHC). No country has made significant progress toward UHC without increasing reliance on public revenues. Therefore, domestic tax systems that are essential to support country's fiscal space expansion are central to the UHC agenda.
- Ensure the allocation of at least 15% of the National Budget to health care in line with the Abuja Declaration target. Importantly, the Government must implement the Health Financing Policy and Strategy.
- Prioritise primary health care for the achievement of universal health coverage and national development targets, especially that of an empowered upper middle-income economy. Primary health care is the frontline of Zimbabwe's health system, as enshrined in all the health strategic plans and on the Ministry logo. A strong, well-funded and accessible primary health system keeps people healthier and out of hospital by supporting them to manage their health issues, including chronic conditions, in the community, while also accessing referrals and specialist services whenever needed. This reduces Zimbabweans' reliance on costly acute care, such as specialists, emergency departments or other hospital services. Its therefore vital to revitalize primary health care implementation and specifically budget for primary health care.
- Strengthen the national referral, provincial, district, health facility and community systems/centres and the health governance mechanisms at each level. The district and community health systems are the foundation of the national primary health care system.
- Improve the availability, accessibility, affordability and quality of health services (including human resources and drugs) through decentralisation and devolution of decision making and budgets in line with Primary Health Care (PHC) for UHC.
- Reinforce institutional capacity to facilitate intersectoral collaboration and stakeholder engagement and partnership (government ministries and departments, private, development partners, NGOs and community) for health care delivery. This will help to promote synergy and leverage capacity to address the social determinants of health. The private sector presents opportunities to improve access and increase coverage of services to meet national goals. A private sector policy has been developed to coordinate and deepen the engagement and requires implementation.
- Strengthen coordination, cohesion and accountability in the health sector. In particular, enhance transparency, efficiency and accountability in the governance and management of all resources including public funds, the AIDS levy, the Health Levy, ratepayers' contributions, donor funds etc through deliberate training of specific office bearers in

PHC for UHC, participation of civil society in the Ministry of Health, Social Welfare, Finance their management Committees. This is in line with ensuring the attainment of the national targets, (NDS1 & 2, NHS 2020-2024) as well as regional and international best practice.

- Review the health staff establishment to reflect the current environment of increased population, high disease profile with very high death rates and reduced access to health care services. Appropriate incentives must be designed to ensure equitable distribution across urban and rural areas ensuring access to under-served populations.
- Intensify prevention and control of non-communicable and communicable diseases, conditions such as mental, substance abuse, injuries from high level of road accidents, nutritional deficiencies and epidemics/pandemics.
- Improve health information management systems including reporting of community events for rapid action .
- Improve research funding and output in the health sector as well as in the sectors hosting key determinants of health for generation of evidence and more locally appropriate actions and achievement of goals and targets.
- Explore options and possibilities for domestic resource mobilization and the introduction of a national health insurance scheme to ensure universal health coverage. Currently only about 7% of Zimbabweans have access to medical insurance and this number is insufficient to ensure decent public healthcare. No country can prosper without a healthy citizenry. In line with regional and global best practices, the National Health Insurance can be publicly funded through a combination of sin taxes as well as sugar taxes to ensure primary health care to every Zimbabwean. The WHO has been advocating for a sugar tax on sugar-sweetened beverages to fight the scourge of non-communicable diseases. The sugar tax, apart from reducing consumption of sugary drinks, also raises additional revenue for the treasury.
- Enhance health service delivery through leveraging digital economy e-Health platforms such as telemedicine.
- Improve investments in mental health. The mental health effects of the economic crisis and the COVID-19 pandemic can be counteracted through investments in social welfare and the implementation of other policy measures such as active labour market policies to help citizens to enter the labour market or to prevent already employed individuals from losing their jobs.
- Support adolescents to acquire skills and knowledge for healthy sexual development and behaviour.

## 1.0 Introduction

There is a positive correlation between health expenditure and economic growth. Health care spending stimulates economic growth: as health is a form of capital, investment into health can increase both human and physical capital accumulation (through enhancing productivity, incomes, and wellbeing), leading to overall economic growth and development. Healthier people are wealthier and more productive. Thus, prioritizing health can be a catalyst for a broader virtuous cycle of growth. Empirical evidence has found that for every $1 invested in health there is an economic return of between $2 to $4 across developing countries[1].

The Government has committed itself in the 2013 Constitution and National Health Strategies, (2016-20, 2021 – 24) and the ZIMASSET, NDS 1 & 2, to ensuring healthy lives and promote well-being for all at all ages. The country therefore has a strong institutional and policy framework to ensure healthy lives and promote wellbeing for all. Health is recognised as a fundamental right in the Constitution. Health and well-being is one of the priorities under the National Development Strategy 1. At the continental level the country has committed itself to the Abuja Declaration of 2001, the Addis Ababa Declaration of 2006 on community health, the 2008 Ouagadougou Declaration on Primary health care and health systems in Africa and the 2012 Tunis Declaration on value for money, sustainability and accountability in the health sector. Sustainable Development Goal 3 of the United Nations (UN) seeks to ensure healthy lives and promote wellbeing for all at all ages by 2030. However, there is an urgent need to translate these noble commitments into actions through adequately and efficiently allocating resources to the health sector if the 2030 goals and targets are to be met.

A key lesson from the COVID-19 pandemic is that the benefits of health investment go beyond the health sector to the general prosperity and security of the population more broadly. The COVID-19 pandemic has highlighted the importance of strengthening the public health security system and ensuring universal health coverage (UHC) and confirmed the need for greater and more secure public funding for health. However, while health has long been recognized as a key aspect of development, investment decisions around health have too often been evaluated purely as a cost, not as an investment with an economic return. This is a mistake because improving health is necessary for prosperity.

The Community Working Group on Health (CWGH) is a network of community/civic based organisations whose aim is to collectively enhance community participation in health in the country. The formulation of the National Budget is an area that requires greater participation of the community. Community participation in health matters and budget formulation gives the citizens an opportunity for their voices to be incorporated in the National Budget as provided for in the Constitution and the Public Finance Management Act. The CWGH undertook consultations in the 10 provinces of the country where the CWGH is operational and the sample of respondents included CWGH national members, Health Centre Committee (HCC) members and District Health Executive (DHE) members with a balance between men and women. We also incorporated submissions from the Project Steering Committee and Core Group of the PHC for UHC, the PHC Policy Brief and from the Pre-Budget consultations of the Parliament Portfolio Committee. This submission captures the main issues that came from these stakeholder consultations across the country on the state of health, its social determinants and on the consensus that revitalization of Primary Health Care

[1] https://www.brookings.edu/blog/future-development/2020/07/21/how-investing-in-health-has-a-significant-economic-payoff-for-developing-economies/

is the best way for the country to revive the fragile health delivery system and unlock the human potential that will spur the country to achieve its 2030 targets of an "empowered upper middle-income economy", and the SDGs. The question on what must be done to address the challenges plaguing the health care system must therefore be urgently addressed. This position paper is therefore a synthesis of the views of the citizens towards the National Budget.

## 2.0 Key Social Determinants of Health

The 1976 charter of the World Health Organization (WHO) has defined health as "a state of complete physical, mental and social well-being" and not simply as the absence of disease or infirmity. Thus, the concept of health is not only defined from a medical perspective, but also as something influenced by other non-medical factors, such as the state of the economic (or macroeconomic environment); education; water and sanitation; housing; and the physical environment. For instance, an underperforming economy has a negative impact on health indicators such as life expectancy, morbidity, mortality, access to health services, and weakening of the healthcare system. This is all well-articulated in the formative documents that shaped our health care delivery system at independence, the White paper on Health, Planning for Equity in Health, the National Health Strategy 1997-2007, the national Constitution, 2013, the national development strategies; ZIMASSET, NDS 1 & 2 and the National Health Strategies, 2016-2020 and 2021-2024. Implementation which has to date been lacking will now require serious planning and auctioning if the country is to achive its 2030 goals.

**2.1 Macroeconomic Environment:** The economy continues to face structural challenges that include: erratic growth pattern; high levels of informality; a huge competitiveness gap; poor infrastructure; weak institutions; high levels of public indebtedness; high inequalities; and high levels of poverty. The COVID-19 pandemic has exacerbated these structural challenges. The economy is estimated to have grown by 7.8% in 2021, following 2 years of successive economic decline in 2019 and 2020 (see Table 1). This improvement in 2021 is largely on account of a good 2020/21 agricultural season and increasing international commodity prices among others. Zimbabwe's economic growth for the year 2022 is officially projected at 4.6%, the 2022 official projection is above the International Monetary Fund (IMF) projection of 3.5% and the World Bank projection of 3.7%. The agriculture sector is projected to decline by -5.0% in 2022 from an estimated 33.6% in 2022. The manufacturing sector is projected to slow down to 3.6% in 2022 from an estimated 5.5% in 2021. Mining is expected to grow by 9.5% in 2022 from 5.5%. To achieve inclusive and sustainable development there is need to ensure that this growth is associated with decent job creation and poverty reduction. The tragedy for Zimbabwe is that even in those years in which we have registered positive economic growth, the positive economic growth has not resulted in the creation of jobs and poverty reduction. Economic growth is vital to sustaining health care financing and realising the right to health care especially as we move towards universal health coverage and the SDGs. It is not just the quantum/pace of economic growth that is vital but also the quality/pattern of that growth. Erratic economic growth has contributed to limited domestic resources being channelled to health.

**Table 1: Selected Macroeconomic Indicators**

| | 2009 | 2010 | 2013 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|---|---|
| Real GDP (% change) | 7.4 | 16.7 | 2 | 0.7 | 4.7 | 3.5 | -7.4 | -8 | 7.8 |
| Average Inflation (%) | 6.2 | 3 | 1.6 | -1.6 | 0.9 | 10.6 | 255.3 | 557.2 | 144 |
| Gross Savings (% of GDP) | -10.1 | -5.1 | -5.5 | -1.5 | -1 | -3.7 | 6.6 | 5.9 | - |
| Investment (% of GDP) | 9.9 | 17 | 9.2 | 9.8 | 8.9 | 5.7 | 7 | 7 | - |
| Budget Balance (% of GDP) | -2.2 | 0.2 | -1.3 | -6.5 | -8.3 | -4.7 | -1.4 | 0.4 | -0.5 |
| Current Account Balance (% of GDP) | -9.7 | -12 | -13.2 | -3.58 | -1.66 | -8.3 | 4.4 | 4.7 | - |
| Public Debt (% of GDP) | 157 | 118 | 49 | 69.7 | 74.1 | 51 | 93.2 | 102.7 | 69.5 |
| FDI inflows (% of GDP) | 1.09 | 1.38 | 2.10 | 1.81 | 1.59 | 3.06 | 1.28 | 0.89 | 0.70 |

**Source:** International Monetary Fund, World Economic Outlook Database, April 2021; World Development Indicators, Last Updated Date: 15/09/20221; 2022 National Budget Statement.

The country is facing a currency crisis which has spawned chronic high inflation. Inflation has been on an upward trend since January 2022. The main drivers of inflation in Zimbabwe are money supply growth, the black-market premium (exchange rate developments), and energy and fuel price developments. Annual inflation rate rose from 60.61% in January 2022 to 191.6% in June and 285.0% in August, the highest annual inflation rate in the world (Sudan's June annual inflation rate is 148.9%; Lebanon's July annual inflation rate is 168%; and Venezuela has a July 2022 annual inflation rate of 137.1%). In Zambia, annual inflation rate in July 2022 was 9.9%, in South Africa annual inflation rate in July 2022 was 7.8%, while in Botswana it was 14.3%. The chronic high inflationary environment continues to erode real incomes and thrown many citizens including health professionals into absolute poverty. The proportion of the working poor has increased markedly with average salaries lagging the poverty datum line (PDL). As at September 2022, the average net salary for a nurse comprised ZWL$250,000 (US$330-403) and US$175. In South Africa, the average monthly salary for a nurse is about ZAR29,000 (US$1,600).

Zimbabwe is in debt distress with total Public Debt estimated at US$13.7 billion as at the end of September 2021 up by 28% from 10.7 billion as at end of December 2020, according to the 2022 National Budget Statement. This increase is on account of the assumption of the blocked funds (historical foreign currency obligations) estimated at US$2.9 billion and other non-guaranteed facilities. The December 2020 figure represents 72.6% of Gross Domestic Product (GDP). This is higher than the 70% threshold provided for in the Public Debt Management Act (Chapter 22:21) and the SADC Regional Indicative Strategic Development Plan (RISDP) Public Debt-to-GDP Macroeconomic Convergence Target of 60%. The high public debt represents an impediment to sustainable economic growth and employment creation in the economy. The huge debt stock has reduced the availability of both local and external resources for health-related investments. The high public debt has crowded out public resources from health care.

The cost of servicing the debt continues to crowd out fiscal resources that could have been invested in critical social services such as health care and education. As a result, Government spending on critical sectors such as health remains relatively low. According to the Statement of Public Debt issued on 24 November 2021, during the period January to September 2021, debt service payments amounting to US$44.217.0 million were made to external creditors. A Joint World Bank-IMF Debt Sustainability Analysis carried out in February 2020 shows that Zimbabwe is classified as 'in debt distress', with unsustainable PPG external and total debt and large external arrears. The country's current debt-carrying capacity is classified as 'weak'

according to the methodology employed in the revised DSF Framework (2017). As at end of 2021, the country had a Present Value (PV) of PPG external debt-to-GDP ratio of 74.1%; a PV of PPG external debt-to-exports ratio of 277.1% per cent; a PPG debt service-to-exports ratio of 10.0%; and a PPG debt service-to-revenue ratio of 11.5%. The high external debt to export ratio is of great concern because of its negative effects on investment and savings. The high ratio points to debt servicing problems, because most of the cash required to service the external debt largely comes from export earnings. The high debt-to-exports ratio also points to the fact that Zimbabwe's debt is unsustainable and likely unrepayable.

**Table 2: Debt Sustainability Indicators**

| | **2018** | **2019** | **2020** | **2021** | **2022*** |
|---|---|---|---|---|---|
| PV of PPG external debt-to-GDP ratio | - | - | 69.5 | 74.1 | 68.1 |
| PV of PPG external debt-to-exports ratio | - | - | 286.4 | 277.1 | 272.2 |
| PPG debt service-to-exports ratio | 12.7 | 10.7 | 8.5 | 10.0 | 11.9 |
| PPG debt service-to-revenue ratio | 12.0 | 20.0 | 12.6 | 11.5 | 11.8 |

**Source:** IMF 2022 Article IV Consultation—Press Release; Staff Report; and Statement by the Executive Director for Zimbabwe. * The 2022 figures are based on projections.

Meanwhile, the challenges to the health service delivery have multiplied and accumulated; that is, increased burden of communicable diseases due to the poor water, sanitation, hygiene and socio-economic status as exemplified by outbreaks of common diarrhoea, cholera, typhoid, pneumonias and skin diseases, reduced immunization coverage resulting in previously controlled measles resurgence and other vaccine preventable diseases, a huge unaddressed burden of non-communicable diseases and conditions, (mental health, substance abuse, malnutrition, traffic crashes, eye, ear conditions, disability, elderly health). These against a background of a growing population, and much dwindled resources now demand a much bigger investment in health beyond the 15% budgetary allocation to health and the fulfilment of the WHO per capita spending on health ($37 with NCDs) if universal coverage of quality health and the other developmental goals are to be achieved.

Zimbabwe continues to face huge labour market challenges related to poor job quality and high levels of working poverty. This state of affairs is directly related to the high prevalence of informal and vulnerable employment. The country faces a scarcity of regular wage employment for all who would like wage jobs and are capable of performing them. Would-be wage employees cannot afford to remain unemployed and continue to search, so they find it better to create their own self-employment opportunities in the informal economy. The few that are formally employed[2] contribute only 10% of the nationals who are formally medically insured (commercial medical aid) which have largely short-changed the subscribers by not providing comprehensive cover, with paid up members failing to access health care services even in facilities they run, (PSMAS, CIMAS clinics and hospitals), and having to pay co-payments and shortfalls. They have also not provided for referrals for specialized care including out of the country when indicated for some of their clients resulting in complications and avoidable deaths. According to the 2019 Labour Force and Child Labour Survey, the share of informal employment to total employment is estimated at 75.6% in 2019. Informal employment is characterised by low productivity, low incomes, high poverty, no social protection, and lack of workers' representation among others. High levels of informality implies that the country has abundant resources that are not being fully and productively utilised. A dwindling taxable formal sector has contributed to limited domestic

[2] According to the 2022 Q1 Labour Force Survey by ZIMSTAT, 88% of total employment is informal.

resource revenue raising capacity and constrained public sector health financing in the country.

The unstable macroeconomic situation has negatively affected the key determinants of health such as levels of household income and economic well-being; access to safe water, sanitation and other basic needs; access to essential food and nutrition; levels of literacy and education.

**2.2 Access to safe water and sanitation:** Water and sanitation are essential for good health outcomes and sustainable development. Inadequate access to water and sanitation infrastructure is a major source of health challenges and disease outbreaks such as common diarrhoea, cholera, typhoid, pneumonias, and skin diseases. Poor and inadequate water and sanitation is a leading cause of poverty, morbidity and mortality in a number of countries. Providing water and sanitation in schools is key to keeping girls and children in school, and also protecting them and women from gender-based violence and sexual abuse when they try to access scarce or distant water, or wait for nightfall to relive themselves. The occurrence of drought and low rainfall patterns result in reduced availability of safe drinking water. Children, particularly girls, are then forced to walk long distances to fetch water in some cases from unprotected sources often affecting their ability to go to school.

Access to adequate, safe water and sanitation remains a major challenge particularly in rural areas and informal urban settlements. The increase in population in the large urban settlements coupled with poor equipment maintenance and upgrades to the water and sewerage works and solid waste management sites has put a lot of pressure on the national water resources. The country has also experienced a rise in informal settlements where water supply and sanitation services are virtually non-existent and waterborne diseases are prevalent. Results from the 2019 LFCLS show that 77.1% of households have access to improved sources of drinking water down from 78.3% in 2017 (see Table 3). These figures however hide a wide disparity in access to safe drinking water between urban areas and rural areas and also even within urban areas. For instance, 97.3% of the urban household population has access to improved sources of drinking water as compared to 67.9% of the rural household population. Harare has the highest percentage of households with access to improved water sources at 96.6%, when compared with 64.8% in Matabeleland South.

Meanwhile, 68.8% of households have access to improved not shared sanitation facility as at 2019 up by 1% from the 2017 figure. Chronic water shortages are more pronounced in urban areas of Zimbabwe, and are being experienced in the context of increasing water consumption needs by a rapidly rising housing and population which is not matched by a corresponding increase or expansion of the amenities.

**Table 3: Access to improved water and sanitation among households**

| Indicator | 2005/06 | 2010/11 | 2014 | 2015 | 2017 | 2019 |
|---|---|---|---|---|---|---|
| Proportion of population using safely managed drinking water services | 75.8 | 76.7 | 76.1 | 78 | 78.3 | 77.1 |
| Proportion of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water | 42.0 | 37.3 | 62 | 37 | 67.8 | 68.8 |

**Source:** 2014 Multiple Indicator Cluster Survey (MICS); 2015 ZDHS; 2017 ICDS; 2019 MICS.

There are no social services, (clinics, community centres, recreational centres, etc) nor meaningful and productive use of time for socio-economic advancement of the individuals,

families and the communities, resulting in these unregulated urban settlements demoting rather than promoting health. There is therefore an observed rising trend in idleness of young able-bodied persons, promiscuity including pimping of young girls (Epworth), substance abuse, and crime all of which are contrary to the national development and health agenda.

**2.3 Education:** Education and literacy are among the major determinants of health and development. It's fundamental and indispensable to the realisation of good health. It is the primary vehicle by which economically and socially marginalized adults and children can lift themselves out of poverty and obtain the means to participate fully in their communities. Education equips people with knowledge and skills for problem solving, ability to access and understand information on health, and helps to provide a sense of control over life circumstances. Education increases opportunities for job and income security and ultimately household wealth status all of which have direct impact on the health and well-being of individuals. Low education and literacy levels are linked with poor health, more stress, low income and lower self-confidence. The country was previously ranked very high for literacy levels above 80% but there is evidence of this declining in recent years.

The country continues to face a serious challenge with the high levels of school dropouts. There were 20,400 dropouts at primary school level (including ECD) and 37,081 at the secondary school level as at 2018. The main reasons for dropping out of primary school are absconding (45.1%) and financial reasons (32.9%). A total of 231 learners drooped out of school for marriage reasons and 180 for pregnancy ones, most of them being females. At secondary level 3 836 learners (female 3,558: males 278) dropped out of school for marriage reasons and 2 912 (females 2,861: males 51) for pregnancy ones. Similarly, the main reasons for dropping out of secondary school are financial reasons (46.6%) and absconding (27.8%). More males than females dropped out of secondary school because of financial reasons, absconding, death and expulsion. In times of economic hardships, older boys may be dropping out of school to supplement household incomes. This is contrary to the general belief that people have sceptical attitudes towards the benefits of educating girls.

Investing in school infrastructure especially in the rural areas is vital to improving overall learning outcomes. Enrolments at rural schools are much lower than for the urban due to the massive rural urban migration, but this trend should shift with good PHC implementation which should re-establish value in the rural areas and return to the nation's cultural values, tradition and the re-placing/appreciating of our values and dignity in contrast with the current situation befalling the urban poor. It has been demonstrated that good school infrastructure enhances pedagogy, improves student outcomes, enable schools and learners to realise the full potential of technology, as well as contributing towards the reduction of drop outs. While urban schools are better equipped than the rural schools, there is the challenge of overcrowding in many urban schools with a number of schools having to resort to hot sitting (operating shifts) to accommodate the many students.

**2.4 Food security:** A combination of the below average 2021/22 agricultural crop production and the macroeconomic instability typified by chronic high inflation have exacerbated food insecurity within the country. According to the WFP HungerMap LIVE, the number of estimated people with insufficient food consumption increased from 5.4 million in the first week of July 2022 to 5.6 million during the third week of September 2022. According to the World Bank Food Security Update of 15 September 2022, Zimbabwe had the highest nominal annual food price inflation of 353% in August 2022, followed by Lebanon (240%) and Venezuela (131%). With the deliberate implementation of primary

health care, individuals, families and communities should find value in returning back to the traditional and cultural food production, preparation and consumption methods that ensured that each household within a community had food. The seed for locally consumed vegetables, crops, fruit trees etc had ensured local availability and was shared at special community convergence events such as *nhimbe, jakwara, mukwerera* all of which have died down in favour of unregulated and unproductive urbanization which is characterized by food insecurity and malnutrition among both children and adults. For universal health coverage to be realised in Zimbabwe, there is need to identify and adequately address the key determinants of health for all nationals regardless of their income status and geographical location. Furthermore, there has to be a return of the school feeding programme in order to address nutritional deficiencies as well as attract back and keep children in school particularly in the arid regions of the country.

**2.5 High levels of poverty:** According to the World Bank Zimbabwe Economic Update of June 2021, the number of extremely poor Zimbabweans reached 7.9 million – almost 49% of the population in 2020, up from 42% in 2019. The high levels of poverty have necessitated the need for greater social protection support, which has made the role of NGOs even more significant given the limited fiscal space in government. In urging for the revitalization of PHC for UHC while also at the mid-point of the SDGs reporting, there is need to work on improving community resilience and self-sustenance to better take up the responsibilities that come with the rights to health and all its determinants as the country seeks to become an empowered upper middle-income economy. On account of the high levels of poverty, a lot of citizens have been unable to bear the healthcare costs resulting poor health outcomes, even of otherwise simple, easy to manage diseases and conditions. However, with deliberate implementation of primary health care, defined as a strategy for organizing health systems so they effectively promote health. It encompasses **"*essential health care made universally available to individuals and families by a means acceptable to them and at a cost that the society can afford at every level of their development*"**. It includes actions across different sectors; (education, environment, agriculture, water and sanitation, social welfare, finance, culture and tradition) to promote health. To this end, all actors in health and its determinants must rally around the communities to empower them for health, explore all possible funding mechanisms to ensure each health institution is well supplied and managed and the community health needs met. The health centre committees, district, provincial and central hospital management boards must now be capacitated to rise up and implement PHC for UHC.

## 3.0 Health Situational Analysis

The country's health sector has been facing numerous challenges. Even before the COVID-19 pandemic, the health sector was already facing deep structural challenges. The COVID-19 pandemic only exposed and worsened those challenges. The sector has suffered from years of gross underfunding and investments, with public health spending accounting for a relatively small proportion of total government spending, with health sector allocation standing at 10.6% in 2022 down from 13.0% in 2021. Employment costs constitute 21% of the total health budget while recurrent expenditures account for 84.6% of the total health budget. The Abuja target remains an elusive target for Zimbabwe (see Figure 1). According to the WHO countries such as Malawi, Rwanda, Madagascar, Togo and Zambia have managed to reach the Abuja target. As of 2015, Rwanda was spending at least 23% of its budget on health care. Meanwhile the Abuja target 20 years later now falls far short of what is required to resuscitate the national health system, as it was looking to ensure that countries addressed the

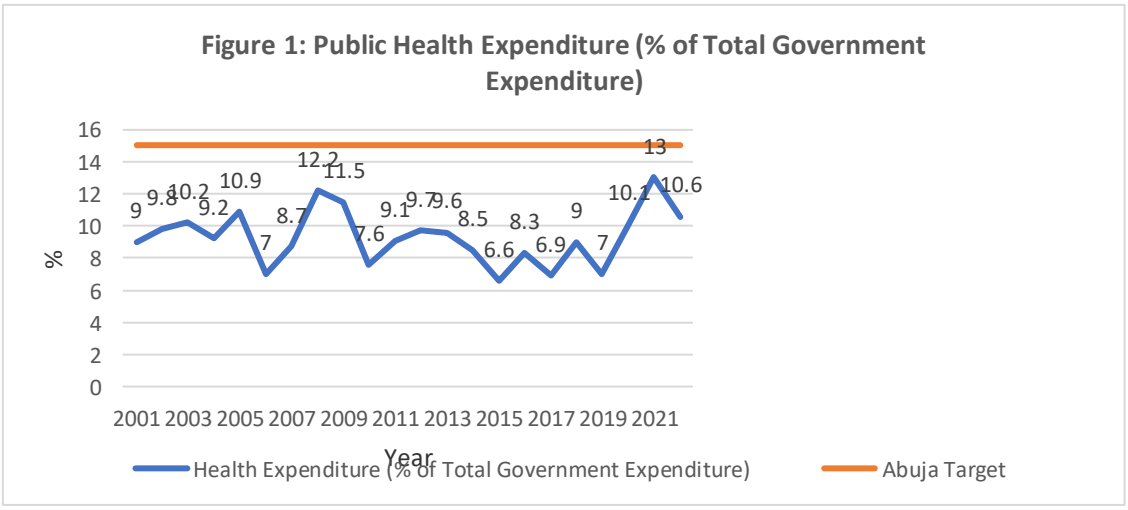
then big challenges of AIDS, TB, Malaria and Maternal and Child Health to the exclusion of all other diseases and conditions. Furthermore, on these it was estimated that allocating at least 15% of the national budget to health would result in at least 60% coverage on these selected interventions. The current challenge now as we move towards UHC is that of bridging this financing gap to adequately address all diseases and conditions in order to realise universal health coverage, that is100% of the population requiring health services reached with the appropriate quantity and quality service anytime all the time.

The Government also spends a relatively small share of its gross domestic product (GDP) on health care. Per capita public health spending also remains inadequate with per capita public health allocation at US$20 in 2022 down from US$45 in 2021 (as shown in Table 4). Lower levels of per capita health expenditure indicate that health expenditure in the country is insufficient to guarantee adequate access and quality of healthcare for the communicable, non-communicable diseases, injuries and other conditions, other services. The per capita allocation is much lower when you remove the employment cost component. The per capita health allocation is lower than the SADC average of US$140. Per capita health expenditure is US$650 in South Africa, US$90 in Zambia and US$200 in Angola. The country must spend at least $271 per capita in order to achieve universal health coverage by 2030. This will allow the fulfilment of the unfinished MDG business and quick movement towards the SDGs, enroute to attaining the much-desired *empowered upper middle-income economy*. According to the WHO, global spending on health averages US$1,080 per capita.

**Table 4: Trends in Public Health Expenditure, 2016-2020**

| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|
| Public Health Expenditure (percent of total Public Expenditure) | 8.3 | 6.9 | 9.0 | 7.0 | 10.1 | 13.0 | 10.6 |
| Per capita public health expenditure | 23 | 18 | 20 | 7 | 14 | 45 | 20 |
| Public health expenditure (percent of GDP) | 2.3 | 1.9 | 2.7 | 2.8 | 1.4 | 2.5 | 1.7 |

**Source:** Calculations based on Ministry of Finance figures.



The inadequate public financing of health has resulted in an overreliance on out-of-pocket and external financing which is highly unpredictable and unsustainable. As shown in Table 5, as at 2019 the main source of health financing are external aid/financing (29.55%), followed by voluntary health insurance contribution (27.27%), then out-of-pocket spending[3] (24.38%), and lastly government transfers (17.65%). There is an over-reliance on external aid and out-of-pocket spending. Out of pocket payments by households have driven many households deeper into poverty. The high dependency on external financing is inadequate, unreliable, unpredictable, unsustainable and highly dependent on the political environment, raising concerns on the sustainability of health financing institutions and the vulnerability of government's budget should external funding be withdrawn. In fact, donor funding is limited to their areas of interest, subject to change, and not to the country or community needs and therefore falls far short of what is required for PHC for UHC. External funding has also been dwindling owing to global economic constraints, and of late the war in Ukraine. Erratic economic growth and a dwindling taxable formal sector contribute to limited domestic resource revenue raising capacity and constrain public sector health financing in the country.

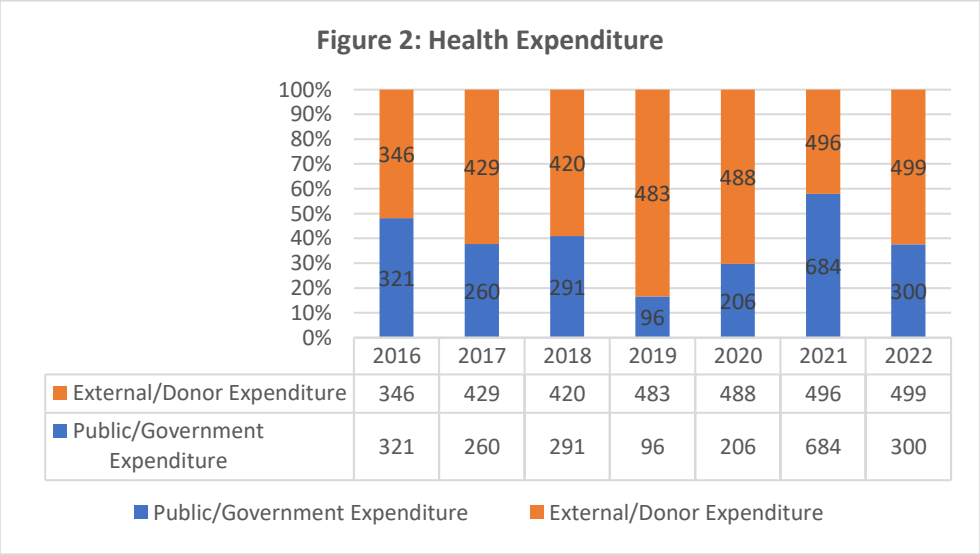
The policy on free treatments for pregnant women, children under 5s and those aged 65 years and above has not been backed by resources nor financial jurisprudence, and has resulted in impoverishing the health system as these constitute the majority and most regular users of the health services. It has therefore translated into poor service, over-crowding amidst limited resources, and a frustrated health workforce all levels who are poorly remunerated and yet have to provide free services to all including those that can pay. This is in contrast to yester years when all those earning below the minimum wage would be screened by the social and health services and provided with assisted medical treatment orders (AMTOs) for treatment at Ministry of Health facilities. The MOHCC would subsequently present these for re-imbursement at the Ministry of Social Welfare's Social Dimensions Fund, (SDF) thus ensuring both quantity and quality of services were maintained. Moreover, the blanket cover does not look at ability to pay, and this has resulted in those who have the means including those pre-paid on medical aid accessing the services for free, impoverishing the system. We therefore call on stronger management and governance of the health delivery system in engaging the requisite sector ministries notably Finance, Social Welfare in order that all the WHO building blocks of a stronger health system are addressed for UHC, *leaving no-one behind*.

**Table 5: Sources of Health Spending**

| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Government Transfers** | 26.28 | 26.23 | 28.89 | 28.38 | 33.58 | 20.82 | 23.31 | 24.02 | 32.06 | 17.63 |
| **External Aid** | 27.48 | 19.21 | 15.34 | 20.13 | 20.22 | 24.26 | 27.91 | 20.7 | 25.71 | 29.55 |
| **Out-of-Pocket Spending** | 34.43 | 37.22 | 34.97 | 29.76 | 24.83 | 25.79 | 23.31 | 22.81 | 19.7 | 24.38 |
| **Voluntary Health Insurance Contribution** | 11.55 | 16.88 | 20.19 | 21.05 | 20.97 | 28.92 | 25.01 | 21.78 | 22.03 | 27.27 |

**Source:** **https://apps.who.int/nha/database/country_profile/Index/en**

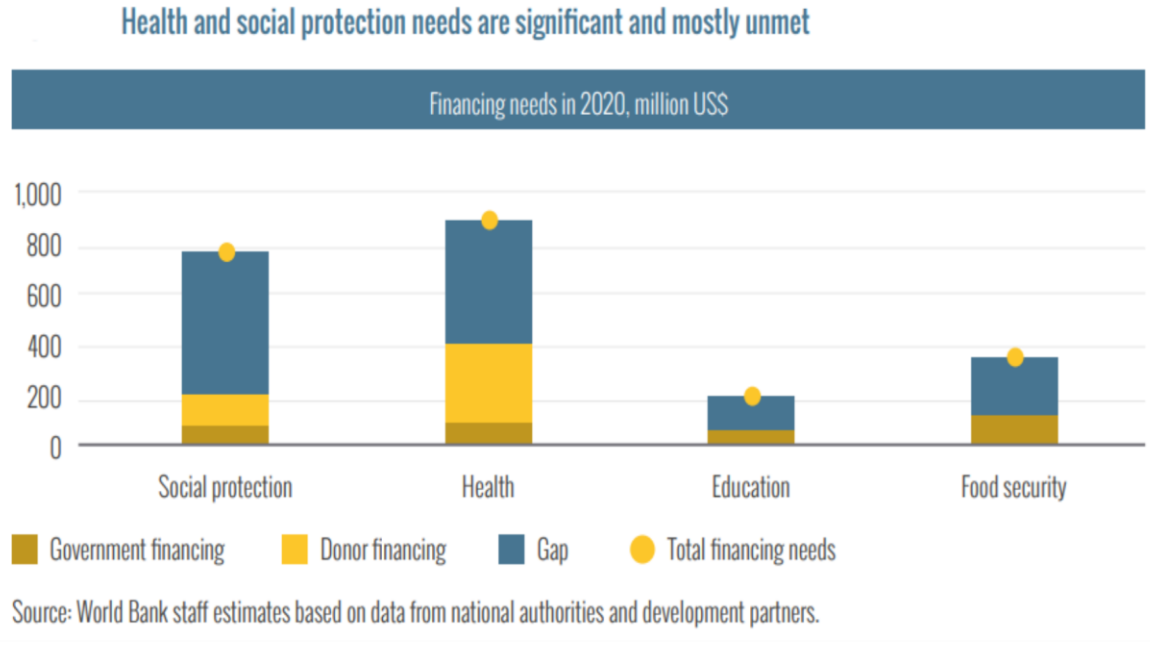
[3] According to the 2021 Global Expenditure on Health report by the World Health Organisation (WHO), health spending in low-income countries was financed primarily by out-of-pocket spending (OOPS; 44%) and external aid (29%), while government spending dominated in high income countries (70%).




**Source:** [https://apps.who.int/nha/database/country_profile/Index/en](https://apps.who.int/nha/database/country_profile/Index/en)

Figure 3 shows the financing needs across different sectors including health. For instance, the total financing needs for the health sector is about US$900 million, with the government only financing about US$100 million, while external donors are financing about US$300 million, with the balance of about US$500 million being unmet financing needs. As we move towards UHC these financing levels require reconsideration and special considerations made for additional resources to be availed to health and the determinants of health.

**Figure 3: Social sector financing needs**




As shown in Table 6, the country still falls short of investments in critical sectors of the economy such as social protection, health, education, water and sanitation. These sectors underpin the key determinants of health and are critical for enhancing health outcomes and development. For instance, current public spending on health is too insignificant to ensure a wealthy and productive nation, that is the empowered upper middle-income economy or the

SDGs. The allocations on Health and Basic Education are below the Abuja Declaration (2001) and the Education for All Initiative (2000) targets/benchmarks of 15% and 20% respectively, while the social welfare services have been invisible.

**Table 6: Sectoral spending targets and performance for Zimbabwe**

| Sector | Agreement | Target | 2019 | 2020 | 2021 | Jan-June 2022 | Revised 2022 |
|---|---|---|---|---|---|---|---|
| Social protection | Social Policy for Africa (2008) | 4.5% GDP | 0.3% | 0.7% | 0.8% | 0.5% | 0.9% |
| Health | Abuja Declaration (2001) | 15% government expenditure | 7% | 10.1% | 13.0% | 6.5% | 10.6% |
| Education | Education for All Initiative (2000) | 20% government expenditure | 14.6% | 13.3% | 13.1% | 11.2% | 13.4% |
| Water & Sanitation | eThekwini Declaration (2008)<br>Sharm El-Sheik Commitment (2008) | 1.5% GDP | 0.7% | 0.7% | 0.2% | 0.2% | 0.5% |
| Agriculture | Maputo Agreement (2003) | 10% government expenditure | 12.7% | 17.5% | 11.0% | 20.2% | 13.6% |
| Infrastructure | African Union Declaration (2009) | 9.6% GDP | 8% | 7.2% | 5.5% | 1.3% | 4.8% |

**Source:** Calculations based on the National Budget statements.

An analysis of the 2022 Mid-term Budget shows that out of the original budget to the Ministry of Health and Child Care of ZWL$117.7 billion, only ZWL$31.8 billion (representing 27% of the total original budget) had been spent during the first half of the year. This is a very low utilisation rate and is a worrisome development which brings to the fore issues of budget credibility, management oversight and overall governance of the health delivery system. The Ministry of Health and Child Care has lamented the late disbursement of funds which has been constraining the Ministry's operations and by the time the funds are eventually released if they are released at all, they would have been eroded by inflation. For instance, out of the allocation of ZWL$800 million to Parirenyatwa Central Hospital, nothing had been disbursed as at 30 September 2022[4].

In line with PHC there has to be decentralisation and devolution of the resources, decision making and services to ensure availability at the point of greatest need, and so that no-one is left behind. This points to a huge need to improve on the current low levels of health literacy, financial literacy and health-financial literacy to enable better appreciation of health as a social, economic and public good, and therefore the vehicle through which the country's sustainable development can be guaranteed.

[4] https://www.newsday.co.zw/local-news/article/200001130/payout-delays-constrain-health-ministry

### 3.1 Composition of Public Health Spending by Programme

The Ministry of Health and Child Care budget has four programmes namely: Policy and Administration; Public Health; Curative Services; and the Bio-Medical Engineering, Bio-Medical Science, Pharmaceuticals and Bio-Pharmaceutical Production (BME-BMS-P-BPP). As shown in Table 7 curative services (Programme 3) was allocated the highest percentage of the Ministry budget with 66.4%, followed by policy and administration (Programme 1) with 15.9%, while public health got 15.1%.

**Table 7: Composition of 2022 Public Health Budget by Programme**

| Programme | 2021 Revised Estimate | % of 2021 Total Revised Estimate | 2022 Appropriation | % of 2022 Total Appropriation |
|---|---|---|---|---|
| Programme 1: Policy and Administration | 10,136,159,990 | 18.4 | 18,684,184,000 | 15.9 |
| Programme 2: Public Health | 5,268,426,980 | 9.6 | 17,736,227,000 | 15.1 |
| Programme 3: Curative Services | 38,492,728,030 | 69.8 | 78,123,155,000 | 66.4 |
| Programme 4: Bio-Medical Engineering, Bio-Medical Science, Pharmaceuticals and Bio-Pharmaceutical Products | 1,238,144,000 | 2.2 | 3,170,649,000 | 2.6 |
| **TOTAL** | **55,135,459,000** | **100** | **117,714,215,000** | **100** |

**Source:** Proposed Budget Estimates.

Table 8 shows the breakdown of the curative services programme budget. Sub-programme 5: Rural Health Centre and Community Care got the biggest allocation (30.2%) followed by Sub-Programme 2: Quaternary Care (Central Hospitals) (29.5%), then District/General Hospital Services (26.0%), and Sub-Programme 3: Tertiary Care (Provincial Hospitals) has the fourth biggest allocation.

**Table 8: Breakdown of Curative Services Programme Budget**

| Sub-Programme | 2021 Revised Estimate | % of 2021 Total Revised Estimate | 2022 Appropriation | % of 2022 Total Appropriation |
|---|---|---|---|---|
| Sub-Programme 1: Quinary (Research Hospital) | 164,672,000 | 0.4 | 357,409,000 | 0.5 |
| Sub-Programme 2: Quaternary Care (Central Hospitals) | 12,359,328,820 | 32.1 | 23,073,926,000 | 29.5 |
| Sub-Programme 3: Tertiary Care (Provincial Hospitals) | 4,529,576,300 | 11.8 | 10,512,657,000 | 13.5 |
| Sub-Programme 4: District/General Hospital Services | 11,966,295,420 | 31.1 | 20,336,222,000 | 26.0 |
| Sub-Programme 5: Rural Health Centre and Community Care | 9,359,075,490 | 24.3 | 23,629,354,000 | 30.2 |
| Sub-Programme 6: Traditional Medicines | 113,780,000 | | 213,587,000 | 0.3 |
| **TOTAL** | **38,492,728,030** | **100** | **78,123,155,000** | **100** |

**Source:** Proposed Budget Estimates.

Table 9 shows the breakdown of primary health programme budget. Communicable diseases account for 70.8% of the total appropriation for 2022, followed by family care at 14%. To achieve the NDS 1 target of reducing non-communicable diseases mortality rate to less than 5% by 2025, there is need to public spending on NCDs.

**Table 9: Breakdown of Primary Health Programme Budget**

| Sub-Programme | 2021 Revised Estimate | % of 2021 Total Revised Estimate | 2022 Appropriation | % of 2022 Total Appropriation |
|---|---|---|---|---|
| Sub-Programme 1: Communicable Diseases | 1,782,181,000 | 33.8 | 12,549,308,000 | 70.8 |
| Sub-Programme 2: Family Health | 1,862,128,420 | 35.3 | 2,482,058,000 | 14.0 |
| Sub-Programme 3: Non-Communicable Diseases | 145,677,720 | 2.8 | 861,064,000 | 4.9 |
| Sub-Programme 4: Environmental Health | 1,478,439,840 | 28.1 | 1,843,797,000 | 10.4 |
| **TOTAL** | **5,268,426,980** | **100** | **17,736,227,000** | **100** |

**Source:** Proposed Budget Estimates.

Zimbabwe suffers from inadequate public infrastructure and ill-equipped hospitals. The infrastructure which was fashioned during the colonial era and characterized by large hospitals in the urban areas, rural hospitals, faith-based hospitals and clinics in the rural areas (tribal trust lands) polyclinics and clinics in the large urban areas, and general hospitals and clinics in the smaller urban areas. In line with the primary health care approach adopted at independence in 1980, the health system was reformed and health services decentralized, district hospitals were built and the general hospitals were designated provincial hospitals and a referral system put in place. According to the national health strategy, 1997-2007 this put 85% of the population within a 10 km radius of a clinic. There have been no efforts to further characterize or improve the access of the remainder 15%, nor to reassess the access to health-to-health services in the aftermath of the 2000 land reform program. A number of patients are still enduring having to travel inordinately long distances to access primary health care facilities. A number of rural clinics face funding and supply water and electricity challenges, and in Harare there have been 7-9 clinic closures and massive downsizing of the work at the two infectious diseases hospitals at a time when the city should have been expanding in accordance with increase in disease burden and the population increase.

The country also faces a critical shortage of healthcare staff with the number, quality and capability of health care workers as a ratio of the population being critically low. The depleted health personnel are also highly demotivated owing to dwindling real incomes, poor working conditions and underequipped and under supplied health institutions. For instance, according to the World Bank, Zimbabwe had 0.2 physicians (per 1,000 people) as at 2018 when compared with 0.1 in Zambia, 0.8 in South Africa, 0.3 in Botswana, 2.5 in Mauritius, and 0.6 in Namibia[5]. According to the WHO database, as at 2014 Zimbabwe had a skilled health professionals' density (per 10,000 population) of 12.44. This points to a huge deficit. WHO identified in 2006 a minimum density threshold of 22.8 skilled health professionals/10,000 people to provide the most basic health coverage. Most rural health

[5] https://data.worldbank.org/indicator/SH.MED.PHYS.ZS

facilities have on average 2-3 nurses. This is grossly inadequate as the catchment area of the clinics is increasing with population increase (13,061 million in 2012 and 15,179 million in 2022), land resettlement and with the influx of gold panners and this negatively affects service delivery. Consequently, nurses are forced to attend to critical conditions while ignoring primary health care issues. District hospitals also lack specialised health personnel.

The country continues to experience an exodus of health care professionals. For instance, between January and March 2022, 379 health practitioners, including 28 medical doctors and 236 nurses, resigned[6]. High drop-out rates in public sector health care posts have resulted in vacancy rates of over 50% for doctors, midwives, laboratory, and environmental health staff. Emergency medical services in Zimbabwe remain relatively under-developed and under-resourced especially in the rural and resettlement areas, but also in the urban areas where accident and emergency services remain way behind the levels of injuries currently experienced on the roads. Zimbabwe has among the worst rates of road traffic crashes given the human, vehicle population and state of roads, yet the corresponding capacity to handle injuries has not risen to math this high burden. This has resulted in large numbers of avoidable deaths, complications and disabilities. There is no surveillance nor provision of emergency services even along the major transport routes where frequent traffic crashes are repeatedly reported. The institutions located along these routes remain ill equipped to adequately handle injuries, while referrals to the major cities take too much time to respond within the golden hour following a crash. The cost of specialist services remains high and beyond the reach of many. The majority of the country's districts have just 2 or less ambulances thereby leaving the burden to the communities to look for unreliable, unsuitable and unsustainable alternative transport. The situation is worse in most of the resettlement areas where communities still walk long distances to the nearest health centre. According to the 2022 National Budget Estimates book, only 25% of the provincial hospitals are providing selected major surgeries, while there are no provincial hospitals offering selected specialist services. Only 20% of the hospitals are providing chemistry and haematology analysis services and only 10% of the health facilities are providing at least 80% of tracer medicines above minimal levels. There are no Village Health Workers that have been trained in the new Community Package of Care.

The country is experiencing rising incidence and burden of non-communicable diseases. Rapid unregulated urbanisation and changes in lifestyle are causing an increase in the risk factors that cause both communicable, non-communicable diseases (NCDs), traffic crash injuries, other conditions of public health importance such as prostitution, substance abuse. For instance, the prevalence of hypertension is estimated at about 30% of the total population, which is higher than HIV, tuberculosis and diabetes. Addressing the burden of non-communicable disease constitutes an integral part of achieving SDG 3, "Good Health and Well-Being". The target set out in SDG 3 is to reduce premature mortality from non-communicable diseases, through prevention and treatment, by one-third by 2030.

The cost of NCDs diagnosis and treatment remains very high and unaffordable for most people. For example, treatment of cancer costs on average between US$100-1000 per session. In most rural health centres, the only cancer services on offer are screening using VIAC and referrals for further tests, treatment and therapy at district or provincial level. Costs related to cancer screening and treatment are not easily accessible due to centralization

[6] https://africanarguments.org/2022/08/zimbabwe-struggles-to-provide-mental-health-support-amid-rising-demand/

to Harare and Bulawayo, and remain beyond the reach of many. Those without the means or else relatives who can facilitate their stay in the two cities while they get cancer treatment fall off with complications and death, and the elderly generally tend to ignore symptoms and have termed prostrate and penile cancers as "old man diseases" that are to be expected and ultimately result in one`s death. The low recovery rate of cancer patients has also increased the lack of confidence that communities have in the public health delivery system resulting in many diagnosed cancer patients seeking alternative treatment options.

The two public cancer treatment centres that offer chemotherapy and radiation treatment at subsidized prices in Bulawayo and Harare are oversubscribed and again poorly staffed and equipped such that the quality of service delivery is compromised. The medications needed for chemo and radiotherapy are also not always available at these two centres and in the private sector very expensive and many people cannot afford to go for more than one session and as a result progress quickly in the cancer staging and this results in a high number of avoidable deaths. The "poor" service delivery that public hospitals are known for has also resulted in a large exodus to mission hospitals such as Karanda in Mount Darwin, All Souls in Mutoko and Saint Alberts in Mazowe where people feel services are available, of high quality and at more affordable prices.

The high costs of cancer treatment, limited services on offer and general limited information at community level is also contributing to the high number of people seeking cancer prevention and treatment services from traditional and faith healers. There is need for the government to invest extensively in cancer research with focus on prevention, treatment, care including exploring the natural and traditional remedies and support mechanisms for comprehensive care and support to address this huge emerging health crisis. There is also need for collaboration between the health ministry and alternative health service providers to tap into existing knowledge systems and practices that can be adapted to assist in combating cancer. Zimbabwe is rated among the top five most burdened countries for cervical cancer in the world and once the health care system is back on its feet this statistic can be reversed.

Corruption and misuse of resources remain endemic in the health sector. Corruption diverts much-needed resources away from health care delivery and reduces patient access to services. Examples include medical staff who divert drugs and spend more time in private practice when they are supposed to be working in public hospitals. This has led to insufficient drugs in most healthcare centres in the country. Reports by the Comptroller and Auditor General have exposed poor corporate governance practices and financial irregularities owing to weaknesses in the internal control systems of the Ministry of Health and Child Care and parastatals under the Ministry. This needs to be corrected in line with the WHO building blocks for a string health system, Constitution, 2013 provisions in order to achieve national goals and targets.

Despite challenging economic conditions and dwindling allocations of the national budget to health, Zimbabwe has made significant progress in the health front owing largely to external financing from development agencies. These gains relate to significant declines in the HIV prevalence, child mortality, maternal mortality, scaling up of vaccinations of children and increase in life expectancy. Notwithstanding these milestones there is a need to close gaps in coverage and outcomes by eliminating huge income and urban/rural differentials in key health indicators. The revitalization of PHC for UHC is envisaged to assist in closing these gaps and making all Zimbabweans players and contributors to their health and well being enroute to achieving upper middle income economy status.

The COVID-19 pandemic has exerted a lot of pressure on the health sector and exacerbated the health crisis. Before COVID-19 pandemic the country in partnership with development partners had managed to score some notable achievements with respect to key health indicators. These achievements include: the significant reductions in mortality ratios. As shown in Table 10, the maternal mortality ratio (MMR) declined from 651 per 100,000 live births in 2015 to 462 in 2019 and 363 in 2022. The MMR was higher in rural areas (402 deaths per 100 000 live births) than in urban areas (298 per 100 000 live births). While this decline is positive and commendable, the ratio still remains unsustainably high. The high ratio is attributable to a number of factors that include: failure to access ante-natal services, a type of preventive health care whereby regular check-ups are provided to prevent potential complications throughout the course of pregnancy; delays in reaching health care facilities owing to poor public transport system in some areas; inadequate public health care financing; human resource challenges; and refusal to use modern medicine in some communities owing to religious and traditional attitudes. Zimbabwe has a long way to go to meet the UN SDG target of 70 deaths per 100,000 live births by 2030.

The infant mortality decreased from 50 per 1,000 live births in 2011 to 47 in 2019 and 24.2 in 2022. The under-5 mortality rate on the other hand decreased from 84 per 1,000 live births in 2011 to 65 in 2019 and 39.8 by 2022. In terms of the share of women with a live birth in the last 2 years whose most recent live birth was attended by skilled health personnel, there was an improvement from 80% in 2014 to 86% in 2019. Skilled birth attendance during delivery is vital in the reduction of maternal deaths.

**Table 10: Mortality Rates**

| | **2011** | **2014** | **2015** | **2017** | **2019** | **2022*** |
|---|---|---|---|---|---|---|
| Maternal Mortality Ratio | 960 | 614 | 651 | 525 | 462 | 363 |
| Under-5 Mortality Rate | 84 | 75 | 69 | 72 | 65 | 39.8 |
| Infant Mortality Rate | 57 | 55 | 50 | 52 | 47 | 24.2 |
| Neonatal Mortality Rate | 31 | 29 | 29 | - | 32 | 9.5 |

**Source:** 2019 MICS, 2017 ICDS, 2015 ZHDS, 2014 MICS, 2010-11 ZHDS.

*The 2022 statistics are from the 2022 Population and Housing Census Preliminary Report on Mortality and Orphanhood.

The macroeconomic challenges have taken a severe toll on the mental health of citizens. The COVID-19 pandemic exacerbated this. The mental health care system in the country is underfunded and understaffed. While the number of patients with mental health issues has ballooned, the number of psychiatrists has not increased in line with the increasing number of patients. It is estimated that in 2020, there were 18 psychiatrists — 94% of whom worked in Harare — and 917 psychiatric nurses. Parirenyatwa Annexe Psychiatric Unit, which can admit up to 80 patients, relies entirely on recurrent grants from the treasury because it does not have direct budget allocation[7]. The country has been experiencing an increase in cases of drug and substance abuse, resulting in an increase in the admissions at mental health institutions. For instance, about 60% of male patients admitted at Ingutsheni Central Hospital

[7] https://africanarguments.org/2022/08/zimbabwe-struggles-to-provide-mental-health-support-amid-rising-demand/

are as a result of drug and substance abuse by youths[8]. There is also poor rehabilitation services for abuse of alcohol and other substances

According to the 2019 Multiple Indicator Cluster Survey (MICS), the country has a high adolescent fertility rate of 108 births per 1,000 among young women aged 15 to 19 years. The adolescent fertility rate is much higher in rural areas at 136 when compared with 62 in urban areas. The high local fertility rate compares unfavourably with average fertility rate of 101 births per 1,000 young women aged between 15 and 19 in sub-Saharan Africa[9]. Poverty is a major driver of the high level of fertility among adolescents in the country. Pregnancy during adolescence increases the risk of morbidity, HIV infections and mortality for both mother and child. This could also lead to adverse social consequences such as limitations in educational and employment opportunities.

## 4.0 Conclusion

The country has been facing structural social and economic challenges, rising incidence of poverty, food insecurity, rising informality, increasing un and underemployment negatively affecting health outcomes. In particular, dealing with the following key determinants of health will significantly improve the performance of the health sector: rehabilitating and expanding key infrastructural facilities; improving access to potable clean water and sanitation; ensuring environmental sustainability in the use of natural resources; improving transparency and accountability in the use of public funds and other national resources. These factors and key determinants have to be addressed holistically and comprehensively with a deliberate implementation of a revitalized PHC in order to improve the conditions of health and development. It is particularly important to broaden the tax base by dealing with the problem of informality and to explore all possible avenues of domestic resources mobilization to close the persistent health financing gap to enable the country to achieve UHC and therefore the national development goals and the SDGs. The overall level of economic development is a key factor in determining the options for expanding health care coverage. The country must reaffirm and demonstrate its commitment to the values and principles of primary health care namely: equity, solidarity, social justice, universal access and community participation.

## 5.0 Key Recommendations

**5.1 Ensure sustainable financing for health care delivery and financial protection for the poor by implementing the comprehensive national health financing strategy.** Increasing health expenditure in tandem with the increased population, disease burden and new national development goals remains a challenge to the health sector. Similarly, the sector is confronted with ensuring that the poor and the vulnerable are also able to afford quality health services. The COVID-19 pandemic has highlighted the importance of strengthening the public health system and ensuring universal health coverage (UHC). No country can make significant progress towards universal health coverage (UHC) without relying on dominant share of public funds. Public funds and therefore strategic domestic resource mobilization for health and its determinants are essential for UHC and for achieving the

[8] https://newziana.co.zw/2022/09/30/drug-abuse-related-admissions-strain-mental-hospitals/?utm_source=rss&utm_medium=rss&utm_campaign=drug-abuse-related-admissions-strain-mental-hospitals

[9] https://www.voanews.com/a/covid-19-pandemic_zimbabwe-reports-major-rise-teen-pregnancies-during-pandemic/6204648.html

national goal of an empowered upper middle-income economy by 2030. These include the road levy, diaspora remittances, private and individual philanthropists, natural resource governance beyond the community share ownership trusts, while reviewing the AIDS levy, Health levy for improved effectiveness and efficiency of deployment. The current health financing model remains unsustainable as it heavily relies on external financing as well as Out of Pocket (OOP) financing. In line with regional and global best practices, Government should urgently explore a number of options and strategies for innovative mobilisation of resources. The WHO has been advocating for sin taxes including a sugar tax on sugar-sweetened beverages to fight the scourge of non-communicable diseases. The sugar tax, apart from reducing consumption of sugary drinks, also raises additional revenue for the treasury.

**5.2 Establish a National Health Insurance Fund** that is publicly funded through a combination of individual contributions from the formal and informal sectors, and establish a firm pre-payment system for health care provision at all levels of care, sin taxes as well as sugar taxes to ensure primary health care to every Zimbabwean. The WHO has been advocating for a sugar tax on sugar-sweetened beverages to fight the scourge of non-communicable diseases. The sugar tax, apart from reducing consumption of sugary drinks, also raises additional revenue for the treasury. Currently only about 7% of Zimbabweans have access to medical insurance and this number is insufficient to ensure decent public healthcare. No country can prosper without a healthy citizenry, and certainly no empowered upper middle economy can be achieved let alone the SDGs given the unfinished MDGs agenda and the current population health status.

**5.3 Enhance public financial management and accountability systems in the health sector.** As a move towards health financing, Zimbabwe is currently implementing the Health Levy Fund, where 5 cents for every dollar of airtime and mobile data goes to health, under the theme, 'Talk-Surf and Save a Life.' The Ministry of Health and Child Care is ring-fencing the financial resources mobilised through this levy for the purchase of drugs and equipment for public hospitals and clinics. There is however a need for greater accountability and transparency in the management of the Health Levy Fund to ensure that funds are being spent as they were promised. Furthermore, all levels of health care, that is clinic, district, provincial and central hospital must have timely and adequate disbursements to improve efficiency of operations, maintain staff motivation and patient satisfaction with the services. The road levy must also now be accessed for the introduction and full capacitation of emergency medical services and injury management in the areas most hit by road traffic crushes, including along the busy highways and transport routes.

**5.3 Strengthen public health infrastructure including referral, district and community centres.** Public health infrastructure has been referred to as 'the nerve centre of the public health system.' These are building blocks that underpin public health activities and practices and include: physical infrastructure; a capable and competent workforce; up-to-date data and information systems; and institutions with the capacity to address and respond to public health needs. Public health infrastructure provides the necessary foundation for undertaking the basic responsibilities of public health and of a strong resilient health system akin to that of Zimbabwe in the mid-80's to late 1990s. Government must allocate funds towards improving basic health infrastructure in the urban, resettlement, mining and rural areas. The public health infrastructure is old and mostly inherited from the colonial period when the population then was less than 2 million. Apart from the family health projects which provided district hospital infrastructure and some equipment, there has not been significant infrastructural upgrades, expansions nor new works, despite significant population and disease burden

increases, (population Censuses, 1982, 92, 2002, 2012, 2022 and Demographic and Health Surveys 1985, 90, 95, 00, 05/6, 10, 15, 2020; HMIS, National Cancer Registries).

Contrary to provisions of the Public Health, the large cities are neither preventing nor managing infectious and other diseases. Harare and Bulawayo have downgraded services at their infectious diseases hospitals, (Wilkins, Beatrice Road and Thornigrove infectious Diseases Hospitals) when they should have upgraded these facilities, built new ones as their urban populace and disease burden increased. Gweru and Mutare have non-functional infectious diseases hospitals, no laboratory facilities while Masvingo, Kadoma, Marondera, Kwekwe Chitungwiza have none. Given their large and underserved (water, sanitation, waste management, electricity) populations which give way to preventable diseases and conditions, this situation is not tenable and certainly not in favour of the country achieving any health and development goals.

**Priority must be on strengthening the referral, district and community health centres** to promote preventive health care as well as the curative and rehabilitative interventions, given the current population health status which is characterized by high morbidity and mortality, (DHS, MHIS, Census 2022). A significantly larger share of the budget should go to the district level, however the current situation demands resources to be urgently availed at all levels in order to restore normal services. For example, the central hospitals in both Harare and Bulawayo have downgraded their services to below district level capacity, which scheduled and some emergency surgeries and outpatient consultations being repeatedly cancelled, and patients being requested to provide all medicines and sundries for their care, those who can't being turned away. City of Harare closed 9 clinics and those left open restrict the number of patients seen daily and turn the rest away regardless of disease or condition. Currently there is a bias towards curative interventions and this is not sustainable and must be corrected through greater investments in preventive care. Government must increase funding for urban and rural councils and missions in order to strengthen primary level of health care and reduce unnecessary referrals to higher levels. Funding for mobile outreach services is required so that communities in remote areas and newly resettled and the expanding urban and peri-urban areas can access primary health care and referrals. A significant share of the national Budget should be allocated to the district level health system as the core or hub of health service provision, bridging the community health facility level and the referral levels of the system. Investing in district and community health systems should be a priority that can contribute towards universal health coverage and the achievement of the SDGs.

**5.5 Promote partnerships with the private sector.** Capacity of the private sector, including NGOs is not fully being mobilised for lack of clear guidelines and rules of engagement. As the country moves towards UHC and economic empowerment for development, It is important that the private sector be more involved in both supply of health services (including development hospital, clinics, diagnostic centres, education institutions, etc.) and demand for health services. The participation of the private sector in the health sector will help to bridge the huge resource deficit and provide state-of-the-art equipment at public health institutions, while also ensuring their improved involvement in the national health delivery system including reporting statistics on their individual and joint activities. There is however need for a strong regulatory and governance framework governing PPPS in the health sector.

**5.6 Address the human resources situation.** The Ministry of Health and Child Care used to be the favoured employer ahead of the city health departments, the WHO and others. Health care workers would leave employment from these and favour working for government, so the

current outward migration is the opposite of the situation in the 1990s. This is the time to ensure that Ministry is the employer of first choice for all health workers, if the national health strategy, national development goals and UHC are to be achieved. Review the staff establishment to reflect the current environment. There is a need for the absorption of all required health personnel, including the produced graduates by removing the moratorium on public health posts. As part of the process of expanding coverage to a larger proportion, it is imperative that Human Resources for Health (HRH) planning takes into account epidemiologic, demographic trends and developments. The revitalization of PHC for UHC will demands additional and well-trained staff to ensure the health system transformation as well as monitoring progress towards the country's desired 2030 goals. Appropriate incentives must be designed to ensure equitable distribution across urban and rural areas ensuring access to under-served populations.

**5.7 Address the essential drugs shortages.** To address the drugs shortages there is need to revisit and strengthen the essential medicines approach, explore better procurement and supply mechanisms to all levels in order to address local needs as well as build the capacity of local drugs manufacturers such as the National Pharmaceutical Company and CAPS. Pharmaceutical institutions must also be prioritised in terms of foreign currency allocation. Government should also reduce the high disease burden by prioritising public health interventions to clear backlogs in identified diseases and conditions, address the key determinants of health in sector ministries and in the population, and promoting primary and essential healthcare.

**5.8 Improve health information management systems including research in the health sector.** The health information system has continually performed well as it is founded on the primary health care principles which gave the country its previous health leadership prominence. In 1987 the system was awarded a SADC trophy for the best surveillance system. With the advent of technological advancements in HMIS, the system has been updated to migrate to the DHIS platform and now e-health and the electronic health record and telehealth. The latter need to urgently develop to provide the guidance, monitoring and evaluation not only now at the mid-point of SDGs reporting, but all the way to UHC, upper middle-income economy and the SDGs.

The Ministry of Health should improve its data analysis, processing and use, given that the country has sound and credible data sources. These include the population censuses conducted every 10 years since Independence, Demographic and Health Surveys also conducted every 5 years since Independence, the Multiple Indicator Cluster Surveys, other surveys, the central registry and vital statistics. This national data framework should therefore adequately inform where the country is at as regards the unfinished MDGs business and therefore inform on a regular basis the progress towards the health, social, economic development goals desired for 2030 and the SDGs.

Current research activity within the health sector is very minimal and often driven by outside interests as funding for health research is inadequate to incentivise innovation. With revitalization of primary health care and the move towards economic development and an empowered middle-income economy a local health/health determinants research agenda will be required to adequately inform the country and communities of progress or lack and therefore corrective actions before 2030.

**5.9 Enhance health service delivery through leveraging digital economy platforms such as telemedicine.** The country has benefited from the Ministry of #ICT, Postal and Courier Services and the national e-governance framework. A number of programmes within the

Ministry have embraced e-platforms for patient tracking, follow up and for health events reporting with some of the data getting reported in the DHIS. Working with the International Telecommunications Union, the World Health Organization and the Ministry of ICT progress has been made to usher in a deliberate e-Health Strategy to enable more efficiency and inter-operability. As the country makes bold steps towards the 2030 goals of socio-economic transformation, economic empowerment and development the digital platforms become critical to ensure universal and comprehensive health care and reporting and to ensure no-one is left behind. The e-Literacy must therefore be a priority in order to address the current e-chaos that has resulted in inefficient and sometimes non-use of some costly digital resources. Specific workforce will require to be trained for the various aspects of e-Health, while the in-service workforce must receive training and orientation on e-Health. Again, this calls for inter-sectoral collaboration between Ministries of Health and ICT and partnerships.

**5.10 Improve investments in mental health.** The mental health effects of the economic crisis and the COVID-19 pandemic can be counteracted through investments in social welfare and the implementation of other policy measures such as active labour market policies to help citizens to enter the labour market or to prevent already employed individuals from losing their jobs.

**5.11 Support adolescents to acquire skills and knowledge for healthy sexual development and behaviour.** Strengthening sex education is a primary strategy for achieving improved adolescent sexual health outcomes through improving sexual health literacy, building awareness, confidence and skills.