Zimbabwe Coalition on Debt and Development

ZIMCODD

*Investing in People*
*For Social and Economic Justice*

# Research Findings Report on Social and Economic Impacts of Public Private Partnership Agreements to the Realisation of the Right to Health:

## The Case of Chitungwiza Central Hospital

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# About ZIMCODD

ZIMCODD is a non profit Social and Economic Justice coalition established in February 2000. Its headquarters are in Harare with a Southern Region office in Bulawayo. ZIMCODD views indebtedness, the unfair local and global trade regime, tax injustices, unsustainable natural resource exploitation and lack of democratic, people–centred social economic and political governance as root causes of the socio–economic crises in Zimbabwe and the world at large. Drawing from community–based livelihood experiences of its membership, ZIMCODD implements programmes aimed at delivering the following objectives:

- To raise the level of economic literacy among ZIMCODD members and citizens to include views and participation of grassroots and marginalised communities.
- To facilitate research, lobbying and advocacy in order to raise the level of economic literacy of citizens.
- To formulate credible and sustainable economic and social policy alternatives
- To develop a national coalition and facilitate the building of a vibrant movement for social and economic justice.

## Our Vision

Sustainable socio-economic justice in Zimbabwe through a vibrant people based movement.

## Mission

To take action in redressing the debt burden, social and economic injustices through formulation and promotion of alternative policies to the neo-liberal agenda.

## Membership and Governance

ZIMCODD membership is based on the coalition model, bringing together various institutions and individuals who share the same vision. So far about 200 organizations subscribed and have shared the organization's mission and vision. These members are drawn from different thematic sectors and constitute the Annual General Meeting. A Board of Directors composed of representatives of specific sectors and regions is directly elected by the AGM in accordance with the constitution. The secretariat is responsible for the day to day programme management and administrative activities.

ZIMCODD is a member of regional and international networks working on Social and Economic Justice. In the SADC region, ZIMCODD is a member of the Southern African People's Solidarity Network (SAPSN), whose focus is to support the development of alternatives to neoliberal corporate led globalization, with a negative impact on national and regional policies. ZIMCODD hosted this vibrant regional network from 2003-2011 and continues to be a member of the SAPSN coordinating committee and the SAPSN Focal Point for Zimbabwe. Currently, ZIMCODD is host to the Zimbabwe Social Forum (ZSF) and through this platform, ZIMCODD aims to develop a vibrant space for reflective thinking, democratic debate, formulation and exchange of alternative ideas to the neoliberal agenda in Zimbabwe and beyond.

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# List of Abbreviations

| | |
|---|---|
| **CCH** | Chitungwiza Central Hospital |
| **CCHM** | Chitungwiza Community Health Monitoring Committee |
| **CHIRA** | Chitungwiza Residents Association |
| **FGDs** | Focus Group Discussions |
| **HTF** | Health Transition Fund |
| **ICESCR** | International Covenant on Economic, Social and Cultural Rights |
| **JVA** | Joint Venture Agreement |
| **JVP** | Joint Venture Partnership |
| **MOHCC** | Ministry of Health and Child Care |
| **NAC** | National Aids Council |
| **OIC** | Opportunistic Infections Clinic |
| **PPP** | Public Private Partnership |
| **PSI** | Public Services International |
| **SEJAs** | Social and Economic Justice Ambassadors |
| **UN** | United Nations |
| **VAT** | Value Added Tax |
| **WHO** | World Health Organisation |
| **ZIMCODD** | Zimbabwe Coalition on Debt and Development |

# 1. Executive Summary

The health sector in Zimbabwe has remained under funded with budgetary trends from 2012 to 2016 showing a downward trend of both the allocated and released funds to the sector. This has caused major public health service providers in the country, including Chitungwiza Central Hospital (CCH), to operate below capacity despite the increasing patient turnover rates at these hospitals.

CCH entered into a Public Private Partnership (PPP) Agreement with the corporate world in order to upgrade heath services at the hospital for high quality and availability of health services under one roof. However, the PPP model's intended benefits are not being realised because the poor people, who are the majority of the respondents to the research, have been discriminated as most services at the hospital now require upfront payment. CCH Chief Executive Officer (CEO), Dr. Obadiah Moyo, indicated that the project was no-longer called PPP but Joint Venture Partnership (JVP).

The research findings indicated that the majority of respondents have monthly household incomes below the Income Consumption Poverty Line which is about USD511.00 (ZimStat 2016). The majority of respondents with a monthly household income below USD250 rated the CCH health services as generally bad whilst those with incomes between USD250 and USD500 rated the hospital as generally good. The majority of respondents indicated that the right to health was being violated by CCH under the PPP model.

However, there are opportunities for the Government to adopt PPP models in sectors such as transport for the construction of roads, rails, and toll gates. Health, water, sanitation and energy sectors were not feasible to operate under PPP model as they result in the commoditisation of these basic public services, making PPPs no-more different from total privatisation.

The research recommends that CCH goes back to the drawing table with its corporate partners and consider conducting health care needs assessment; and carrying out a feasibility study; formulating the PPP guiding framework; adopting constitutionalism; transparency and accountability strategies as well as labour issues. The community should also mobilise, organise and demand constitutionalism from CCH in order to realise the right to health.

# 2. Introduction

This research was commissioned by the Zimbabwe Coalition on Debt and Development (ZIMCODD) to assess the social and economic impacts of privatisation under the Public Private Partnership (PPP) Agreement to the realisation of the right to health at Chitungwiza Central Hospital. The objectives of the research were:

- To examine the implementation of PPPs at Chitungwiza General Hospital;
- To analyse the social and economic impacts to the right to health resulting from the Chitungwiza Central Hospital's Public Private Partnership;
- To produce a detailed set of recommendations, based on views from the ground and experience from comparative national and international case studies, on how identified challenges can inform future health service provision under PPPs or be overcome and how to exploit opportunities.

PPPs are defined in this project as "a contract between a public sector institution and a party, in which the private party assumes substantial financial, technical and operational risk in the design, financing, building and operation of a project"[1].

## 2.1 Methodology

Quantitative and qualitative data collection methods were used during data collection. These included key informant interviews, general interviews, focus group discussion (FGDs), administered questionnaires and desktop review. Desktop review included the minutes from the two meetings conducted between the CCHM Committee and CCH representatives. The research intensively benefited from the ZIMCODD draft Paper on 'Zimbabwe Health Policy Analysis'. The questions asked were meant to address the key indicators and variables which have a bearing on social and economic impacts of PPPs in the health sector. Quantitative data was analysed using MS Excel while qualitative data was analysed thematically. Research respondents were residents of Chitungwiza Town.

Methods used to collect data amongst the research respondents were as follows:

| Data Collection Method | Male | Female | Sub-Total |
|---|---|---|---|
| Key Informant interviews | 2 | 1 | 3 |
| General Interviews | 8 | 12 | 20 |
| Focus Group Discussions | 12 | 18 | 30 |
| Questionnaires | 19 | 33 | 52 |
| **Total** | | | **105** |

[1] P. Farlam (2005), Working Together, Assessing Public-Private Partnerships in Africa.

### 2.1.1 Planning Meeting

The research methodology was compiled by the consultant with the help of ZIMCODD's Social and Economic Justice Ambassadors (SEJAs)[2], who are part of the organisation's Chitungwiza Community Health Monitoring (CCHM) Committee. The CCHM Committee is composed of members from Chitungwiza Residents Associations (CHIRA), Chitungwiza Disability Cluster and HIV/AIDS Cluster. Three (3) key informants of the research were from this Committee. The CCHM Committee made appointments with research respondents who are CHIRA members.

### 2.1.2 Key Informant Interviews

These interviews were conducted amongst the people who were involved somehow in CCH's PPP Agreement meetings and are well acquainted about the operation of the hospital under PPP Agreement. From the targeted 6 key informants, the research team managed to reach out to 3, who are members of the CCHM Committee. The CCHM Committee attended two meetings with the representatives from CCH, including the hospital's Chief Executive Officer, Dr. Obadiah Moyo and Public Relations Officer Mr. Gideon Mapokotera, to get clarity on how the hospital was operating under the PPP Agreement.

### 2.1.3 General Interviews

General interviews were conducted amongst 20 participants, who included 8 males and 12 females. General interviews' data added to that from key informant interviews and analysis was conducted thematically (household salary, health service provider, CCH rating, health service comparison before and after PPPs and realisation of the right to health). Amongst the 20 participants, 8 were youths of 35 years and below while 12 were adults of above 35years of age. Respondents were chosen randomly, through door to door visits, from the three main suburbs of Chitungwiza, Seke, St. Mary's and Zengeza.

### 2.1.4 Focus Group Discussions (FGDs)

Three FGDs were conducted, each with 10 participants totalling 30, of which 12 were males and 18 were females. The groups were categorised according to specialised clusters of CHIRA members, HIV/AIDS and Disability Clusters' members from across Chitungwiza. The FGDs were conducted in the form of open participatory discussions, following the FGDs questions' guidelines. In each group, a question was posed and participants brainstormed on the theme of the question and put forth responses.

[2]SEJAs are ZIMCODD members trained in the organisation's thematic areas to capacitate and build them as citizens who stand for their social and economic rights.

### 2.1.5 Questionnaires

The questionnaires were administered to extract data concerning the research's targeted thematic areas. A total of 52 respondents, 19 males (including 3 youths) and 33 females (including 5 youths), voluntarily completed the questionnaire during a CHIRA meeting on the 21st of May 2016. Questionnaires administered were 60 (30 in English and 30 in Shona language). 8 questionnaires were not returned by the respondents.

## 2.2 Research Limitations

From the 6 targeted key informants, only 3 (members of the CCHM Committee) were interviewed. Efforts to get response from CCH's Public Relations Officer were not fruitful due to the delays by the hospital in responding to request to conduct an interview with Dr. Obadiah Moyo and partner representatives who are part of the PPP Agreement. The research team relied on CCH management to refer them to their PPP corporate partners. As a result the research did not manage to come out with the specific partners from official sources.

Another limitation was the research's target population, which was limited to Chitungwiza Town (over 1.5 million people), a small area considering that CCH is a referral hospital for the whole of Mashonaland East province with the population of an estimated 4 million people[3], catering for patients from as far as Mudzi and Mutoko districts and also it services some of the very poor communities in the province, which include Epworth residential area.

To minimise the effects of the limitations, minutes from the two meetings conducted between CCHM Committee and the hospital's Public Relations Officer were analysed to pick some of the issues relating to the intended interviews. Some of the issues were picked from separate meetings conducted between the CCHM Committee and Dr. Obadiah Moyo.

[3]http://www.thestandard.co.zw/2012/10/07/the-genesis-of-chitungwiza-central-hospital/, Accessed 25 May 2016.

# 3. Historical Background for Chitungwiza Central Hospital

Chitungwiza Central Hospital was established in 1984 when it opened its doors to service the community as a public health care institution. Before the hospital started operating, Chitungwiza was being serviced by four Municipal Clinics run by Chitungwiza Town authorities, who referred patients to Harare Hospital or Parirenyatwa Hospital, which were very far thus compromising patients' health especially in cases of emergency. This was the reason the hospital was established as well as to provide quality and uncompromised health, which became the CCH's mandate[4].

CCH provides surgical, medical and dental care to the community as well as maternal and child health care programmes, specialised fields like radiology, clinical diagnostics, laboratory analysis and rehabilitation services. The hospital has a successful School of Nursing, with graduates in general nursing, state certified nursing, medical laboratory technicians, midwives and clinical officers. The milestones for CCH are summarised in the table below:

| Year | Achievement |
|---|---|
| 1985 | Started training State Certified Maternity Nurses |
| 1990 | Introduced training of Registered General Nurses (RGN) and State Certified Midwives (phasing out State Certified Maternity Nurses). |
| 1997 | Awarded the Baby Friendly Initiative Award which supports breast feeding of mothers in maternity and children's wards and community at large. |
| 2001 | Intensive Care Unit was opened to serve critically ill patients. |
| 2003 | Introduced the Prevention of Parent to Child Transmission of HIV. |
| 2004 | Opened the Opportunistic Infections Clinic (OIC) and started administering ARV drugs to HIV positive patients. |
| 2006 | Upgraded from a General Hospital to a Central Hospital |
| 2008 | Attained the ISO Certification of 9001:2000, becoming the first health institution in the country to attain such an achievement. |
| 2011 | Hosted the Bright Journey Eye camp (1,000 patients with cataracts and various eye problems benefited from the programme). |
| 2011 | Commissioned the Sally Mugabe Renal Institute to carter for patients with kidney or renal failure who need renal dialysis. |
| 2011 | Awarded one of the Best Run Laboratories Award in the country. |
| 2011 | Hosted the Alliance for Smiles programmes (over 100 children born with cleft lip and palate benefited from the programme). |

[4]http://www.thestandard.co.zw/2012/10/07/the-genesis-of-chitungwiza-central-hospital/, Accessed 25 May 2016.

| Year | Achievement |
|---|---|
| 2011 | Refurbishment of the hospital (casualty ward, main reception desk, tiling of the whole hospital and successful completion of the mortuary). |
| 2011 | Introduced computerisation programme (introduced an internet global village for research purposes and internet access to staff and patients). |
| 2011 | Introduced E-Government pilot programme. |
| 2011 | Introduced Private wards with state of the art equipment. |

*Compiled from the Source: http://www.thestandard.co.zw/2012/10/07/the-genesis-of-chitungwiza-central-hospital/*

## 3.1 Context

CCH suffers from professional staff shortages in various departments despite having about 1,300 staff members. This is due to a high patient turnover at the hospital. In 2012, the hospital had 18 locally trained doctors, 7 expatriate doctors and 11 junior resident medical officers. According to The Standard newspaper (2012/10/07), Dr. Obadiah Moyo said "We appeal to corporates to partner the hospital in this awesome cause. Efforts to develop a medical village, build a maternity hospital, OIC, Children wards and also partnering with other universities, medical research organisations locally, regionally, and internationally in training of other health sciences are at an advanced stage, we also endeavour to engage in Public Private Partnership (PPP) in the not so distant future".

Reports amongst the Chitungwiza residents indicate that the hospital adopted the PPP model when private hospitals were introduced in 2011, together with hospital refurbishments. Residents receiving health care from CCH reported that health care services have changed, with improvements in hospital machinery, equipment and availability of drugs and the general appearance of the hospital. However, residents were complaining that they are now paying for services which they were not paying before the hospital made such improvements and the hospital adopted a policy that no patient will be treated unless they have paid for the services first. Residents amongst themselves were convinced that the hospital was now privatised. Management and staff of the CCH did not communicate adequately the PPP model to their clients.

Open Society Initiative for Southern Africa (OSISA) conducted a meeting in South Africa where ZIMCODD's Executive Director, Ms. Patricia Kasiamhuru, attended. Dr. Obadiah Moyo was amongst the guests and he explained the adoption of the PPP model by CCH. He indicated that under the PPP model, CCH was in a partnership with the private companies, where the later were giving back to the community to make health services affordable to those who cannot afford. This reiteration was in contrast with what the CCHM Committee was reporting from the grievances raised amongst the residents. In an effort to understand the real situation taking place at the hospital, the CCHM Committee requested to meet representatives of the hospital to clarify the issue because they had not consulted the people. Due to lack of consultation on such critical processes, mistrust and

suspicion develops. For instance, the residents are not sure about the private partners that entered into agreements with hospital. Hence they suspect that players like Doves Morgan and Baines Emerging Group, among others are some of the private players. There also some sign posts belonging to certain corporate players pasted on the walls of hospital wards like the one for Mimosa Mining Company (See Figure 1). While this could be the company's social corporate responsibility, the CCHM Committee suspects that the company could be one of the players in the PPP Agreement. However, from the two meetings held between the CCHM Committee and the CCH Management, the explanation by the hospital management did not suffice as Dr. Obadiah Moyo reiterated what he had said during the OSISA meeting. This research therefore was meant to clarify the picture of CCH's operations under the PPP Agreement and assess impacts to access to the right to health by Chitungwiza residents.

*Figure : Mimosa Mining Company Sing Post*

## 3.2 Public Private Partnership Agreements

PPPs maybe in the form of "where the private party performs a function usually carried out by Government; or where the private party acquires the use of state property for its own commercial purposes or a hybrid of the two"[5]. Payment could involve the institution paying the private party for the delivery of the service; or the private party collecting user fees from clients; or a combination of these[6].

In Africa, successful PPPs were characterised by thorough planning, good communication and consultation of the public, strong commitment from both parties and effective monitoring, regulation and enforcement by government. The issue of pricing is crucial to avoid discrimination against the poor because the private partners enter into PPPs to make profits vs. the Government's efforts to be able to offer effective service delivery to the people. These two interests are contacting and it makes PPPs very difficult to manage. PPPs, like total privatisation and other forms of Government tendering, are vulnerable to graft and Government need to effectively tackle corruption before they can get such partnership right. This brings to question the CCH PPP Agreement, considering the rampant corruption levels in the country. One may not be surprised to learn that the PPPs were supported by individuals who knew that had personal gains from the undertaking, at the expense of marginalised groups, most of which have household incomes of less than the average Total Income Poverty Line of $511.00[7].

[5]P. Farlam (2005), Working Together, Assessing Public-Private Partnerships in Africa.
[6]P. Farlam (2005), Working Together, Assessing Public-Private Partnerships in Africa.
[7]Interim Poverty Reduction Strategy Paper by the Ministry of Finance, Zimbabwe, 2016.

PPPs under the right sectors such as transport, ports, prisons and telecommunications are usually successful compared to those of health, water and electricity due to pricing issues, which usually get higher under PPPs compared to the heavily subsidised prices under public service provision. Governments need to take thorough feasibility assessment and address the issue of affordability, value for money and risk transfer. Public complaints and suspicions need to be pre-emptied through public consultations corruption root-out and policy clarity. Many PPPs have run into controversy because the Government's public services division, which serves the poor communities, failed to set up a strong regulator to control prices and to require private partnering companies to extend services to the poor areas of the communities. P. Dwyer (2004) argues that PPPs and any other form of privatisation put profits before people and they are a way of commodifying basic commodities and entering into partnerships with the private sector if the same as borrowing from a loan shark. Organisations such as the Public Services International (PSI) argue that separating PPPs from Privatisation creates a distinction without a difference because the private sector always change previously agreed upon levels of service, price and/or employment[8]. This does not however dismiss the fact that African Governments have failed to provide adequate services to their people due to lack of funds and other resources to maintain and extend existing infrastructure.

Cases of PPPs in the water and sanitation sector in Nigeria resulted in improved services reliability and quality of water but higher water prices and bouts of public opposition led to the cancellation of the scheme.

## 3.3 Discussion on Privatisation

Privatisation is defined by policy makers in different ways. This research will outline the continuum on which the term can and has been used in order to compare it with PPP. According to G. Higgins (2011), the following spectrum of definitions applies to privatisation:

- Engaging the private sector to provide services or facilities that are usually regarded as public sector responsibilities.
- Shifting from publicly to privately produced goods and services.
- Transferring government functions or assets, or shifting government management and service delivery, to the private sector.
- Attempting to alleviate the disincentives toward efficiency in public organizations by subjecting them to the incentives of the private market.
- Using the private sector in government management and delivery of public services.

[8](Ibid).

### 3.3.1 Privatisation Methods

The following table outlines the different methods of privatisation:

| Method | Achievement |
|---|---|
| Public-Private Partnerships | The state relies on private sector resources for assistance in providing public services. Private firms may loan personnel, facilities, or equipment to state agencies. |
| Asset Sale | The state sells or cashes out its assets to private providers to enlarge the tax base. |
| Contracting Out | The state enters into agreements with private vendors to provide services. The state pays contractors to provide the services. |
| Deregulation | The state removes its regulations from the service previously monopolized by government in favour of private provision of the service and competition against government agencies. |
| Franchise | The state gives monopoly privileges to a private vendor to provide a service in a specific geographical area. |
| Grants & Subsidies | The state makes monetary contributions to help private vendors deliver a public service |
| Private Donation | The state relies on private sector resources for assistance in providing public services. Private firms may loan personnel, facilities, or equipment to state agencies |
| Service Shedding | The state drastically reduces the level of a service or stops providing a service so that the private sector can assume the function with private sources. |
| Volunteerism | The state uses volunteers to provide public services. |
| Vouchers | The state allows eligible clients to purchase services available in the open market from private providers. As with contracting, the government pays for the services. |

*Source: Practices: A Review of Privatization in State Government, CSG (2011).*

From the above methods of privatisation, it is clear that the PPP under which CCH is operating privatisation of a public service. This supports the worry among Civil Society Organisations about the privatisation of public services such as health, water and energy (electricity). In recent years, 2012 to date, the Government of Zimbabwe has embarked on public service privatisation projects through the installation of prepaid electricity vouchers and water meters. It is clear that the move is also targeting the privatisation of health services as witnessed at CCH, which was privatised through PPPs by the corporate world.

### 3.3.2 Arguments For and Against Privatisation

For Privatisation:-

- Helps governments save money in management and delivery of public services.
- Allows for speedy implementation of certain programs.
- Provides high-quality services in some areas.
- Becomes necessary when government lacks the expertise or personnel to carry out certain programs.
- Uses more innovative approaches and technology.
- Helps dissolve unnecessary government service monopolies.

- Offers services more effectively due to flexibility and reduced red tape.
- ·Slows the growth of government or downsizes government to improve its efficiency.
- ·Introduces competition between government employees and private service providers.
- ·Provides an alternative to traditional ways of improving government productivity.

Against Privatisation:-

- Does not save taxpayers' money.
- Does not guarantee market competition and can result in private monopolies.
- Leads to corruption.
- Causes policymakers and managers to lose control over privatized services.
- Diminishes accountability of government.
- Private gain and public good do not always correspond.
- Is unnecessary given other productivity approaches available to public service providers.
- Comprises quality because of private vendor profit motive.
- Lowers state employee morale and contributes to fear of displacement.
- Destabilizes economically marginal communities.
- A neoliberal agenda that favours the rich that the 'have nots' who cannot afford expensive services.

## 3.4 Joint Venture Partnership

The research team discovered that CCH management and staff have since abandoned the word PPP saying the model is now called Joint Venture Partnership (JVP). In a bid to come up with the definition for this model, two definitions for 'joint venture' and 'partnership' will be considered.

> **Joint Venture:** A business undertaking by two or more people engaged in a single defined project under the necessary elements of an express or implied agreement; a common purpose, shared profits and losses and equal voice in controlling the project.
>
> **Partnership:** A voluntary association of two or more people who jointly own and carry on a business for profit.

A joint venture and a partnership are two distinct interventions and the basis of calling a project a JVP is questionable to some extent. Joint ventures are generally distinguished from partnerships by being more limited in both scope and duration while a partnership engages in an ongoing business for an indefinite period of time.

This research will assess the link between the CCH's Joint Venture Partnership and the Joint Venture Act of Zimbabwe.

## 3.5 Joint Venture Act [Chapter 22:22]

The Joint Venture Act was gazetted on the 12th of February 2016 and will come into operation on a date to be proclaimed by the President in a Statutory Instrument. The Act is meant to provide for the implementation of joint venture agreements between contracting authorities and counterparties[9]. Contracting authority refers to any Ministry, Government department or public entity which has entered into or is considering entering into a joint venture agreement[10]. According to the Joint Venture Act [Ch 22:22], "Joint venture agreement means an agreement between a contracting authority and a counterparty approved under this Act, in terms of which:-

a) The counterparty undertakes to perform a contracting authority's function on behalf of the contracting authority for a specified period; and
b) The counterparty receives a benefit for performing the function by way of:-
    i) Compensation from funds appropriated by Parliament; or
    ii) Funds obtained by way of loan by the contracting authority; or
    iii) User levies; or
    iv) Revenue generated from the project; or
    v) Any combination of the foregoing;
c) The counterparty is liable for the risks arising from the performance of its function; and
d) Public resources may be transferred or made available to the counterparty".

The Act gives an outline of a Joint Venture Agreement (VJA) and it may be argued that the CCH's Joint Venture Partnership (JVP) falls in this category but to some extent limited by the 'Partnership' element which has connotations of an indefinite period of a project undertaking. The Act has specified that a JVA should have a specified time period. The JVA may be said to be supportive different forms of privatisation of public services, which leaves the community vulnerable to manipulation by the profit seeking corporates who are potentially the 'counterparties'.

## 3.6 Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIMASSET) – 2013-2018

The Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIMASSET) is a trajectory of accelerated economic growth and wealth creation through indigenisation, empowerment and employment creation, ZIMASSET (2013). The fourth (iv) assumption of the ZIMASSET Plan is "Increased investment in infrastructure such as energy and power development, roads, rail, aviation, telecommunication, water and sanitation, through acceleration in the implementation of Public Private Partnerships (PPPs) and other private sector driven initiatives"[11]. This assumption, has led to the privatisation of essential public services like health, water and sanitation as well as electricity, further marginalising the poor communities.

[9]Joint Venture Act [Chapter 22:22].
[10]Ibid.
[11]Zimbabwe Agenda for Sustainable Socio-Economic Transformation: Towards an Empowered Society and a Growing Economy", October 2013 – December 2018.

## 3.7 Health Situation in Zimbabwe

The health situation in Zimbabwe has been struggling for the last three decades. The spread of HIV/AIDS during the 1980s had a negative effect on the life expectancy and general health situation in Zimbabwe and was worsened by the economic problems in the 1990s and 2000s. Life expectancy declined from 59,2 years in 1980 to 37 years in 2006 (NAC: 2012). However, it has risen to 50 years for men and 47 years for women from 37 years following massive improvements in general healthcare and nutrition[12]. Life expectancy at birth is one of the most important demographic indicators. It shows the number of years a newborn infant would live assuming that birth and death rates will remain at the same level during the whole lifetime. The country's infant mortality rate: at 57/1,000 live births is one of the highest in the world. Infant mortality rate is the number of infants dying before reaching one year of age. The Zimbabwe Demographic Survey results released in 2014 shows that 84 children out of a 1000 are likely to die before they reach the age of five[13].

In 2008, the public sector provided 65% of health care services in Zimbabwe and the sector had problems securing medical staff due to brain drain. The severe social and economic challenges since that time have resulted in an unprecedented deterioration of health care infrastructure, loss of experienced health personnel and a drastic decline in the quality of health services available for the population (Human Resources for Health Profile, 2009)[14]. The lack of staff for medical education training and the high dropout rates in public sector health care posts resulted in vacancy rates of over 50 % for doctors, midwives, laboratory, and environmental health staff[15]. In 2010, there were 1.6 physicians and 7.2 nurses for every 10,000 people[16].

The problems in the health sector have particularly been negative for the health of pregnant women and children. For example, access to health is a large barrier for pregnant women and UNICEF estimated in 2011 that pregnant women had to pay between US$3 and US$50 to deliver in a government or municipal facility. In addition, as Zimbabwe lacks a functional and adequate ambulance system, pregnant women often need to pay for transportation which they cannot afford. In rural areas in particular, some respondents indicated that they travel more than five kilometers to access a clinic.

Cholera is one of the deadly diseases that has negatively exposed the country's health delivery system in recent years. History shows that cholera was first recorded in Zimbabwe in 1992/1993 with respectively 2048 and 5385 cases each of these years. The case fatality rate was high: 5.1% in 1992 and 6.1% in 1993. No cases were recorded between 1994 and 1997 (WHO: 2009). However, since mid-August 2008 and 30 July 2009, 98'592 cases including 4'288 deaths were reported from all the country's 10 provinces. This is the largest ever recorded outbreak of cholera in Zimbabwe[17]. At the moment there are no major threats of the disease although sporadic cases are recorded across the country.

[12] http://www.nac.org.zw/news/zimbabwes-life-expectancy
[13] https://www.newsday.co.zw/2015/01/27/six-horror-facts-zimbabwes-healthcare/
[14] http://www.who.int/workforcealliance/countries/zwe/en/
[15] Ibid
[16] Ibid
[17] http://www.who.int/cholera/countries/ZimbabweCountryProfileOct2009.pdf

The health system in Zimbabwe has been relying mainly on donor support. In 2011, Zimbabwe, in partnership with UNICEF and international donors, launched the Health Transition Fund (HTF). The HTF aimed to improve maternal, newborn and child survival by increasing poor women and children's access to health care, improve the quality of maternal and child health and nutrition services, and fund medicines, equipment and personnel, and assist in the development of health policy and planning.

## 3.8 Health Policies in Zimbabwe

In 2009, the Ministry of Health and Child Care (MoHCC) produced the 'National Health Strategy 2009 –2013: Equity and quality in health –A people's right'. The strategy raises universality, equity and quality as central principles: that everyone has access to defined health interventions and services based on health need, including those that promote health and prevent ill health[18]. To fulfil the aspirations of the strategy, the government needs resources. The MoHCC, therefore, has to raise public services funds through various means but mainly from the citizen's taxes and donations. Public funds consist of taxes, any revenue, donations or income received by the state or profits made by the state. Earmarked funds are defined as "those meant for a specific, identified use for the revenue that it generates. Various sources of tax revenue in Zimbabwe may be earmarked for revenue for health, as is the case with the National AIDS Trust Fund. Earmarking value added taxes (VAT), excise taxes or corporate taxes may also be considered[19]. The major concern of the health stakeholders has been the management of the resources raising transparency and accountability issues. It is critical thus to analyse the legal, policy and health budget frameworks in order to have an appreciation of their support to the enjoyment of the right to health by citizens. The obvious starting point is the country's Constitution.

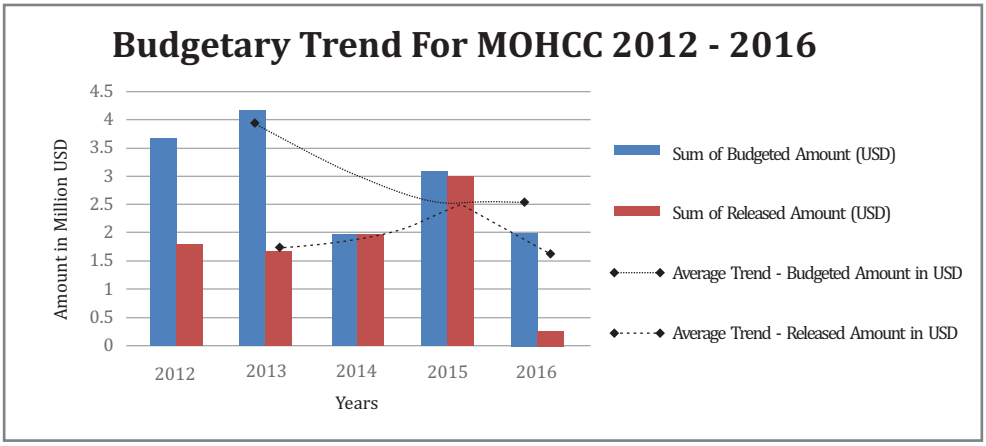


*Figure 2: M.HCC Budgetary Trend 2012-2016.*

[18]Bhala, B, (2013), Laws governing the management of public funds for health in Zimbabwe, Discussion Paper.
[19]Ibid

Zimbabwe has not been forthcoming in terms of aligning with the Abuja Declaration that 15% of the National Budget be allocated to the Health Sector. From 2012 to 2016, budget allocations to the Ministry of Health and Child Care have been decreasing[20] as shown in Figure 2 .

## 3.9 Constitutional Provisions

The Constitution's national objectives and directive principles for national policy obligate government to ensure civil society discourse, political action, public participation and administrative planning to develop public ownership of key public institutions including health institutions. It is therefore the most important legal document as enshrined in Chapter 1(2) of the Constitution. It establishes the following tools that have a direct implication on the health sector:

- Financial Management issues
- Consolidated Reserve Fund
- Anti Corruption Commission
- Oversight Role of Parliament
- Office of the Auditor General
- Human Rights issues e.g Access to information, health as a basic human rights issue

### 3.9.1 Constitution and Health Care in Zimbabwe

According to Chapter 1(2) the Constitution is the supreme law of Zimbabwe and any law, custom or conduct that conflicts with it is invalid. There are two relevant chapters when discussing health matters: Chapter 2 and 4. Chapter 2 lists national objectives that the state and institutions have to adhere to while chapter 4 is the bill of rights.

According to Chapter 2 (29), the state is obliged to take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe. The state must also take appropriate, fair and reasonable measures to ensure that no person is refused emergency medical treatment at any health institution and must take all preventive measures within the limits of the resources available to it against the spread of disease[21].

In chapter 4 of the Constitution, the most central article concerning health is section 76. It establishes that every citizen and permanent resident has the right to have access to basic health-care services. This includes reproductive health-care services. In addition, no one can be refused emergency medical treatment in any health-care institution. A person living with a chronic illness also has the right to have access to basic healthcare services for the illness[22].

[20] 2016-2018 Interim Poverty Reduction Strategy Paper, Zimbabwe.
[21] Constitution of Zimbabwe, Amendment Number 20, Act 2013
[22] Ibid

The last part of section 76 acknowledges that the state must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of the rights set out in Chapter 4[23].

### 3.9.2 The Right to Health

Zimbabwean courts have not yet had the opportunity to define this particular right. However, this right was thoroughly discussed in the judgment of the Constitutional Court of South Africa in Minister of Health vs Treatment Action Campaign[24]. However, the Constitution of Zimbabwe provides for the right to health care through section 76. In order to understand the scope and content of this right, one has to consider the interpretation of the right to healthcare as an international human right. The United Nations' (UN) General comments on the right to health provided for under article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) must be taken into consideration. Regard must also be given to article 16 of the African Charter on Human and People's Rights which is however drafted similarly to article 12 of the International Covenant on Economic, Social and Cultural Rights. However regard must be given to the fact that the right provided for under both the African Charter and the ICESCR is wider than what is provided for under the Constitution of Zimbabwe. As such, the scope and content of this right under the ICESCR or the African Charter is wider than what is contemplated under section 76 of the Constitution of Zimbabwe[25].

### 3.9.3 Monitoring the Right to Health[26]

There is need to capacitate the CCHM Committee to be able to monitor the progressive realisation of the right to health in Chitungwiza as enshrined in the country's Constitution. The following indicators should be focused on:

- Total state budget allocation towards improving access to health care.
- Number of new health care facilities such as clinics and hospitals established in particular areas of interest over a specific period.
- Increase or decrease in the number of medical doctors and other medical staff serving patients (doctor to patient ratio).
- Changes in the availability of basic medication and necessary equipment.
- Changes in the availability of medication and equipment for treating chronic illnesses such as HIV/AIDS, cancer, diabetes among others.
- Number of people who are denied treatment per month for failing to pay hospital fees
- Changes in the hospital fees.

[23]Ibid
[24]Monitoring the progressive realisation of social & economic rights in the Constitution of Zimbabwe(Amendment) Number 20, 2013), (2015), Paper developed by ZIMCODD
[25]Ibid
[26]ZIMCODD et al, (2016), Social, Economic and Cultural Rights, Awareness and Advocacy Training Manual based on the Constitution of Zimbabwe, 2013.

### 3.9.4 Public Health Act

The Zimbabwe's Public Health Act (Chapter) 15:09 is the principal law in the health sector. The Act creates the legal framework for the protection of public health in Zimbabwe. For this purpose, it provides for powers of the administration to regulate and control slaughter of animals, food production and handling, food and water supply, animal diseases, among others. It was enacted in 1924 and the date of commencement was 1st of January 1925. The Act was adopted as a transplant from the English Law on Public Health aiming at controlling public health challenges that were mainly defined as 'nuisances', or those conditions or premises that were harmful to health[27]. The Administration of this Act was assigned to the Ministry of Health and Child Welfare (now Ministry of Health and Child Care). The Act has a number of regulations providing for specific areas of Public Health interest. While the Act has been amended many times since 1924, it has played an important role in protecting public health in Zimbabwe for almost a century. However, it has to be aligned with other critical instruments like the country's Constitution and other international treaties that Zimbabwe is signatory to as well as to other situational context in the country.

[27]http://www.tarsc.org/publications/documents/PHact%20Tng%20Rep%20July2014.pdf

# 4 Research Findings

The research findings revealed various common trends and challenges concerning access to the right to health at CCH under the PPP Agreement. These common trends appeared the same both using quantitative and qualitative data. The research findings were grouped under the targeted research themes as follows:

## 4.1 Major Health Care Provider

From the 52 respondents that filled in the questionnaires, 92% indicated that their major health care provider is CCH while 6% said Municipal Clinics and 2% received health care from other health care providers as shown in Figure 3 below.

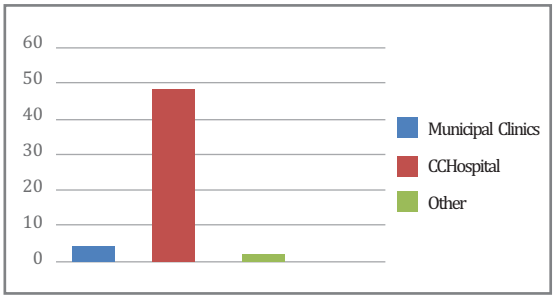


*Figure 3: Major Health Care Provider*

From the qualitative data, all 53 respondents indicated that their major health care provider was CCH. Some respondents indicated, however, that they also get service provision from local Municipal Clinics who in most cases refer patients to CCH. One outstanding respondent indicated that she used to get services from CCH but since the introduction of the PPP model, she prefers to go to Ruwa Municipality Clinic which charges affordable service fees because she cannot afford the high fees being charged by CCH. This indicates that CCH services the majority of the Chitungwiza residents.

## 4.2 Understanding of the PPP Model

67% of the 52 respondents who filled in questionnaires were not aware of the PPP model and how it works whilst 33% were aware of the model and how it works, as shown in Figure 4.

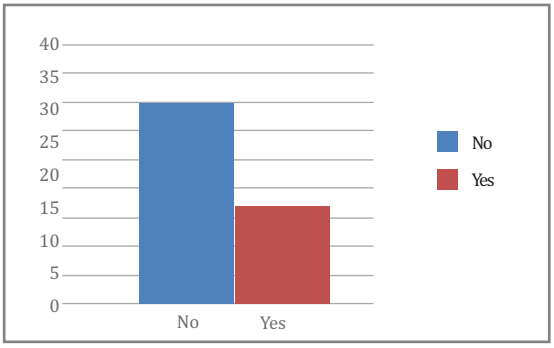


*Figure 4: Understanding of the PPP Model*

60% of respondents from interviews and FGDs indicated that they were aware that CCH was operating under the PPP Model but did not understand what it was all about. The key informants from the CCHM Committee indicated that during the meetings they had conducted with Dr. Obadiah Moyo, he notified them that the model has been changed from PPPs to Joint Venture Partnership (JVP). The definition of the JVP was, however, not different from the PPP Model which he had indicated before. This raises suspicion amongst interested stakeholders because the name JVP is polishing the outside appearance of PPPs to make them more friendly and appropriate to the patients or consumers of the health services. It may be suggested that the respondents were not aware of the PPPs and how they work because the hospital management did not make an effort in

sensitising the people. This shows lack of transparency and it is the root of community suspicions and mistrust of the whole project which might cause political and social uprisings against the hospital.

## 4.3 Source of Information

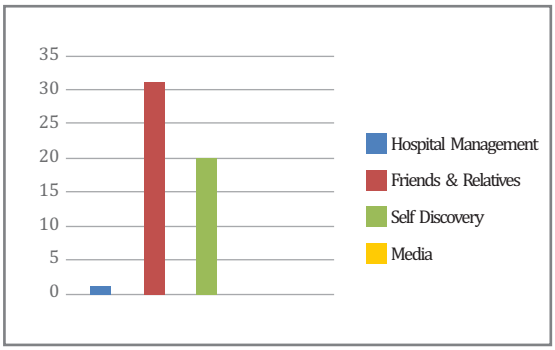

*Figure 5: Source of Information*

From the respondents who filled in the questionnaires, 60% knew about the PPP model through relatives and friends, 38% through self-discovery when they visited the hospital, 2% through Hospital Management whilst no one managed to get the information through media (see Figure 5). The 2% indicated that they got the information from Hospital Management during a meeting where CHIRA requested clarity on the PPP model, of which the hospital management are not the ones who initiated the engagement.

Interview and FGDs respondents indicated that the hospital did not make an effort to consult residents on the adoption of the PPP model. They indicated that there is lack of transparency and some political elites may be benefiting from the whole agreement at the expense of the poor communities who cannot afford highly priced health services. Most of the country's political elites are business people who might have seen an opportunity to make money out of the PPP Model. 80% of the 53 respondents from interviews and FGDs said that they thought that CCH management do not have the public at heart.

## 4.4 Household Monthly Income and Poverty Consumption Line

From the respondents who filled in the questionnaire, 52% had a household income below USD250 and 48% between USD250 and USD500 whilst none has a household income of over USD500 per month as illustrated in Figure 6.

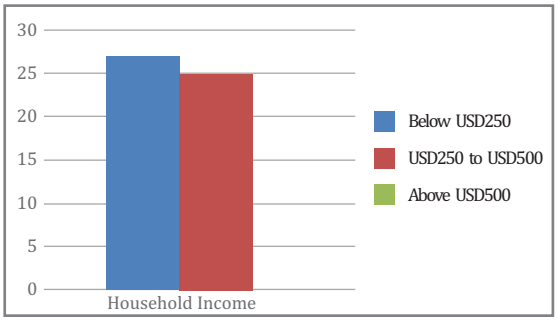

*Figure 6: Household Monthly Income and Poverty Consumption Line*

From the 53 respondents to interviews and FGDs, 60% had a household income below USD250, 40% between USD250 and USD500 per month. This is an indication that CCH serves poor communities as most of the respondents' household incomes were below the Poverty Consumption Line (PCL) estimated at an average of USD511 in May 2016. The issue of pricing therefore was supposed to have been considered by CCH management before the adoption of the PPPs model.

## 4.5 Household Monthly Income vs Hospital Performance Before and After PPP Adoption

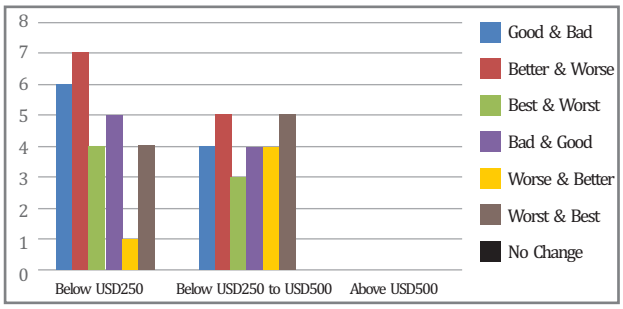


*Figure 7: Household Monthly Income vs Hospital Performance Before and After PPP Adoption*

From the questionnaire respondents under the group with a household income below USD250, 63% indicated that the hospital's operations were better before the PPPs and worse after the PPP model while 37% said the hospital's performance was generally good after the adoption of the PPP model. Under the USD250 to USD500 group, 52% said performance was generally good after the adoption of the PPP model whilst 48% said the hospital's performance was generally bad. A trend is showing that those with very low incomes see the performance of the hospital as bad under PPP whilst those with better incomes are saying the hospital is good under PPP than before. For more comparisons see Figure 7.

From interview and FGDs respondents, about 72% indicated that the hospital was nw very discriminatory against the poor because despite the availability of all treatments under one roof, it was unfair for the poor who would not afford the exorbitant charges an some resorted not to seek treatment, with some dying at home because they cannot afford the services. Most people in Chitungwiza were also being reported as going to *Mapostori*[28] for help as they shun the hospital's high prices and also the new policy which forbids treatment if the patient does not have money. On the other hand, 28% indicated that it was better because the hospital was now functioning because without the PPP model the hospital could have been shut down because there were no drugs, no mortuary and hospital equipment.

## 4.6 Health Service Rating vs. Monthly Household Income

From the questionnaire respondents, 79% of the below USD250 group rated the CCH between worst and bad whilst 21% rated the hospital between good and better. In the USD250-USD500 group, 74% rated the hospital between good and better whilst 26% rated between worse and bad, see Figure 8.

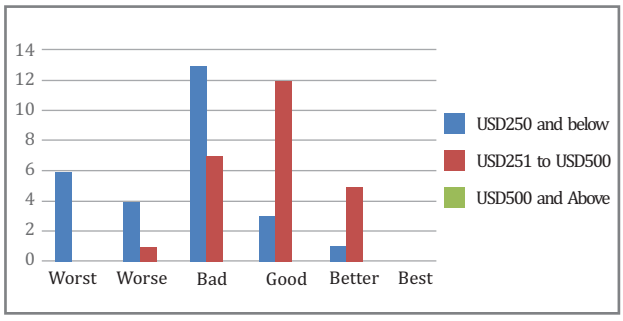


*Figure : Health Service Rating vs. Monthly Household Income*

From the interviews and FGDs respondents, the majority of respondents indicated that the hospital's health services were very bad citing that it was only good for the rich people. The poor were not allowed to access health services from CCH. It is interesting to note that even those with

[28]Mapositori are members of a certain religious sect who wear white garments and are well known for claiming to have healing powers.

USD250-USD500 income could not rate the hospital services as best but there were indications of the services being rated worst.

## 4.7 Social and Economic Rights Awareness

Respondents who filled in the questionnaires had 62% respondents aware of their social and economic rights whilst 38% did not know, *Figure 9.*

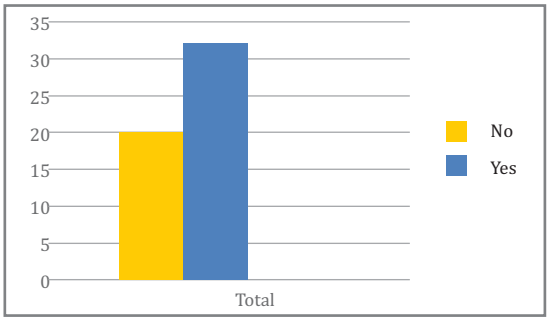

*Figure 9: Social and Economic Rights Awareness*

Interview and FGDs respondents had the majority who knew their social and economic rights. Knowing social and economic rights helps residents to identify their rights and also advocate and even demand duty bearers to commit towards the realisation of their rights.

## 4.8 Health Right Status as Offered by CCH

52% of the questionnaire respondents indicated that the right to health was being violated by CCH, 23% said it was threatened, 17% said the right to health was not being realised whilst 8% said it was being realised. None indicated that the right to health was being respected, indicating that CCH management might also not be aware of their patients' right to health as a Constitutional provision. *See Figure 10*.

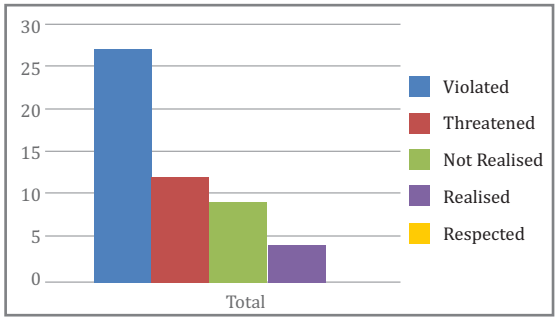

*Figure 10: Health Rights Status*

Respondents from interviews and FGDs also indicated that the right to health at CCH was suffering from violations and lack of realisation. Residents are mostly aware of their rights and they are able to identify the status of the right to health offered by CCH.

## 4.9 Social and Economic Impacts of PPP Model Adoption

The majority of respondents indicated that they were facing numerous challenges since the introduction of the PPP model at CCH, including:

- Un-affordable health services due to high prices;
- High prices discriminate against the poor thereby suppressing their health welfare;
- Poor community members will abandon other social and economic needs like education and

food security in trying to suffice their health budgets;

- Unfair treatment by management and staff if the patient does not have the required money. An example is one woman who delivered a baby in the hospital but did not have the money to pay-up and be discharged. She spent five (5) days at the hospital, sitting on the floor and not given food, as the husband was raising the money to pay arreas;
- Segregation and deepening inequality between the 'haves'and 'have nots'. Patients admitted in private wards were reported to be treated with maximum care whilst those in general wards were given little care and sometimes doctors were not available to attend to them;
- Most patients were dying at home fearing to go to the hospital due to the new policy saying 'no money, no treatment';
- The public pharmacy at the hospital was closed which was charging lower prices and the private pharmacy was opened which is very expensive even though a variety of drugs are always available;
- Other patients were risking lives by going to Mapostori in search for answers to their ills, where they spend their money without getting the treatment they require;
- There was corruption at the hospital and if one does not know anyone, that person will be charged higher health care fees at the reception. Corruption at national level might also be triggered as corporate pay bribes to win contracts.
- Some relative cannot afford mortuary services for their dead due to expensive fees charged at CCH, $15.00 per calendar day.
- Most people leave their relatives to get the pauper burial because they do not want to be associated with the huge hospital bills that person would have accrued during their stay at the hospital. If they come to claim their dead, the debt collectors will be sent to their homes promptly to collect property worth the arrears if they cannot pay the money;
- The hospital does not consider health as a right to citizens because they are now after profit making out of a public service; and
- Health services across the country will copy the model resulting in a national health inequality between the rich and poor.
- Economic destabilisation of communities.
- Morale for hospital staff maybe reduced due to fear of displacement.
- The quality of health services will be compromised due to private vendor profit motive.
- Government accountability will be diminished due to cover-ups by the private sector.
- National policy makers usually lose control over privatised services as they are governed by corporate institutions.

## 4.10 General Analysis

The CCH did not consult people from their catchment areas of Chitungwiza and Mashonaland East Province. Lack of communication has caused residents in Chitungwiza to be suspicious of the whole process and they are rejecting the move. Public consultations were going to make the residents part

of the process thereby coming up with a PPP regulatory framework that takes into account all stakeholders' interests. The current situation at CCH indicates that the marginalised communities who used to get services at the hospital are no-longer able to do so due to the new regulation that forbids patients to be treated unless they have paid up the required balance. This regulation is not favourable to the poor because illness is an emergency that can occur spontaneously, with or without money. Before the PPP model, patients were treated first and discharged then the hospital bill would be posted to the patient's address. If the patient does not pay-up during the agreed time, the hospital would send the debt collectors. Patients were not complaining under this model because the patient would have been part of the agreement through signing of the arrears statement. The patients would understand that they are the ones who have defaulted and need to pay-up the hospital.

The hospital under the PPP model has introduced some charges which were not there before as indicated in *Figure 11.*

| Fees Description | Before PPP Model | After PPP Model |
|---|---|---|
| Consultation | (USD)$10.00 | (USD)$10.00 |
| X-Ray | Free of Charge | $25.00 |
| Full Blood Count | Free of Charge | $10.00 |
| Lever Function Test | Free of Charge | $5.00 |
| Cretni | Free of Charge | $5.00 |
| Non-Refundable Admission Fee | Not there before | $30.00 |

*Figure: 11*

The introduction of new health care fees like the non-refundable admission fee is ripping off patients of their hard earned cash because it is not justified at all as the hospital has been operating for more than 25years without such a fee. The introduction of various charges on previously free health care services is not justified. All these new rules are meant to satisfy the corporate loan sharks who partnered with the hospital in offering health services. Considering that most of the respondents had household incomes below the poverty line, it will be very difficult for families to access their right to health. Health is a security service due to every citizen and the Health Sector should be treated as a security sector which cannot be commoditised. Once commoditisation of health services is allowed in the country, it will mean the violation of the Constitutional provision of the right to health. Whilst CCH management tried to explain how the PPP model is working for the good of the community, it is clear that the PPP is not different from other forms of privatisation, where profits come first before the people's interests.

## 4.11 Opportunities From The PPP Model

PPPs do not work for public service provision in the health, water and sanitation and power (electricity) sectors. These services cannot be commodified and still give equal access by all citizens. Commodification would mean that marginalised communities are suffering due to their low incomes. However, when it comes to the transport sector such as the construction of roads and railways, then the PPP model would work well under proper management and commitment by both parties to allow each part to benefit from the programme. Opportunities are there also for the Government to make policy reforms in the health, water, sanitation and energy sectors in order to protect citizens against these neo-liberal inspired projects that are discriminatory to the poor.

# 5 Conclusion and Recommendations

The research findings report has raised various challenges faced by Chitungwiza residents in trying to realise the right to health, including segregation against the poor, high health care fees and corruption by hospital staff and management. Most of these problems have been emanating from the adoption of the PPP model by the CCH which was not thoroughly considered before to see if the interests of all stakeholders were taken into account.

From the research findings, the following recommendations were drawn:

- **Health Care Needs Assessment**
  CCH needs to conduct a health care needs assessment in the catchment area it is servicing, that is, Chitungwiza and Mashonaland East Province. This will help the hospital to re-assess the policies and regulations it is working under so that they capture interests of the populace.

- **Carry out a Feasibility Study**
  CCH should have carried out a feasibility study before entering into the partnership in order to consider health care affordability, value for money and risk transfer.

- **Change the PPP Guiding Framework**
  CCH needs to re-formulate its PPP guiding framework in order to accommodate the poor and outline how their interests will be catered for under the PPP model.

- **Adopt Constitutionalism**
  CCH should align its PPP model with the Country's Constitution which is the supreme law of the country. This will help the hospital's operations to be without interruption due to demonstrations by unhappy residents.

- **Transparency and Accountability**
  The project needs to be transparent in order to avoid cases of corruption where the elite will benefit at the expense of the poor majority. Accountability is also equally important for the public to know who is getting what, from who, how and why. This is the best way to root out corruption in Government projects like PPPs and other tenders. This will pre-empt complaints and suspicion. For instance, the residents continue to speculate about the private partners who are in agreements with the hospital. To avoid this mistrust among stakeholders, future projects need to be conducted after thorough consultations.

- **Stakeholder Engagement and Dialogue**
  In a situation like the CCH PP model, where the Agreement was signed already, it is very unlikely to see the parties to the agreement changing their operational guidelines for the sake of accommodating the poor who cannot access the health services. This calls for the citizens themselves to mobilise, organise and participate in dialogue engagements with the parties involved for their voices to be heard.

- **Consider Labour Issues**
  Labour issues need to be considered by both CCH staff and management. PPPs are more skewed to profit making rather than service provision. If it happens that the wage bill is too high for them, they will lay off some of the staff, especially the general hand, further destabilising household incomes, which are already below the poverty datum line.

- **Amendment of the Joint Ventures Act [Ch 22:22]**
  The Act supports privatisation of public services by Government departments or Ministries failing to provide services and goods adequately through partnerships with counterparties who may be the corporate world seeking profits at the expense of citizens' social and economic rights enjoyment. The Act needs to be reconsidered to address issues to do with violations of the Constitution during implementation of joint venture projects. The amendments may be in the form of Joint Venture Project Guidelines, specifically targeting the protection of citizens who are usually consumers and customers of the contracting parties. The amendments will target public services like health, water and sanitation and electricity where privatisation does not work out.

# Annex 1: Community Voices on the CCH's PPP Model

The following community voices were captured during the research:-

**1. The CCHM Committee addressed to the following situations**

In June 2016, an elderly woman of 70 years died at home around 11pm. The body was taken to CCH Mortuary. The following day around 1pm, the relatives went to collect the body and they were told that a US$30.00 storage fee was needed by Doves Morgan which offered the service. The relatives reported the issue to CCHM Committee. The Committee asked hospital officials about the US$30.00 and they indicated that it is US$15.00 per calendar day and not per 24Hr day (11pm storage as day 1 and 1pm collection day as day 2). The Committee then highlighted the age of the dead which was above 65 years and qualifying for senior citizenship to be accorded free services. The issue was taken to the office of the hospital's CEO where the mortuary attendants were ordered to release the body.

On another incident in June 2016, a 33 year old man went to CCH seeking health care due to the serious state of sickness (meningitis) he was in (almost a coma). The relatives paid the consultation fees of US$10.00. Afterwards, they were asked to pay US$100.00 for hospital admission and US$350.00 for C.T. Scan. The money was no available and they were sent back home. Left with no option, the relatives went back home to seek advice from CCHM Committee. The Committee went to the office of the hospital's CEO and presented their issue on the basis that the hospital, on public platforms, says 'No one is sent home without treatment under whatever circumstance', yet a dying man had been returned home due to lack of admission and service fees. The office of the CEO then ordered the admissions department to admit the man. That is when the sick man was brought back and admitted to the hospital. Unfortunately he died after 5 days of admission and the C.T. Scan had not been conducted.

**2. One of the interviewees, Mary Mandishona had this to say about the PPP Model:-**

"I was registered with a local clinic for prenatal services whilst I was pregnant. I went to the clinic when I was due for delivery but there were complications during the process and I was referred to CCH. At CCH I delivered my baby and when it was time to be discharged, after 2 days, hospital officials told me that I owed the hospital $380.00. I told them that I had paid up my maternity fees with the local clinic but they had nothing to do with that. I then called my husband about the issue, knowing he was not going to get the money from anywhere because we are all unemployed, living on the little vending proceeds we make. My husband failed to get the money and I stayed in the hospital for five days, sitting on the floor and feeding on good Samaritans' food, because the bad had already been given to another patient. Finally, my husband managed to get $75.00, which they received after we had signed an affidavit that we will pay up the balance in a month's time".

**3. Another interviewee Sharon Munjoma said:**

"The hospital is now very expensive. People have to think twice before going to the hospital. There are a lot of embarrassments these days because no one seems to understand the kind of operations at the hospital. Every time one goes to the hospital, there are new rules and user fees demanded which you can't even understand. *Tichafira mudzimba mazuvano nokuti kana usina mari hapana anombokutarisa pachipatara paya!"* (We will die at home because no-one looks at you at that hospital if you don't have money

**4. Sherry Nyika said:**

*"Mazuva ano zvaanani kuchipatara nokuti mishonga, ma doctor nema scans zvaakuwanikwa pachipatara. Kare kwaive kusina".* (These days things are better at the hospital because drugs, doctors and scans are now available. Before there was nothing).

**5. Muchaneta Tito had this to say:**

"I think there is no change at all, whether after or before privatisation because despite the available drugs and other services, if I can't afford them, I will still die."

*Investing in People*
*For Social and Economic Justice*

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