Investing in People
For Social and Economic Justice

Baseline Survey on the Social and Economic impacts of PUBLIC HEALTH CARE provision under the Public Private Partnership Agreement to the Realisation of the Right to Health:

The Case of Murehwa and Marondera

Supported by
FRIEDRICH EBERT STIFTUNG

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LIST OF ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
AU:	African Union
BoT:	Buy Outs (Management/Employee)
CCH:	Chitungwiza Central Hospital
CHWG:	Community Health Working Group
CSOs:	Civil Society Organisations
DMO:	District Medical Officer
ESAP:	Economic Structural Adjustment Programmes
FES:	Friedrich Ebert Stiftung
GDP:	Gross Domestic Product
GNU:	Government of National Unit
GoZ:	Government of Zimbabwe
HDI:	Human Development Index
HIPCs:	Highly Indebted Poor Countries
HIV:	Human Immune Virus
HTF:	Health Transition Fund
IFIs:	International Financial Institutions
ICESCR:	International Covenant on Economic, Social and Cultural Rights
IMF:	International Monetary Fund
IMR:	Infant Mortality Rate
MDGs:	Millennium Development Goals
MHCC:	Ministry of Health and Child Care
MPRA:	Marondera Progressive Residents Association
NGOs:	Non-Governmental Organisations
NHS:	National Health Strategy
PGHs:	Parirenyatwa Group of Hospitals
PPPs:	Public Private Partnerships
SAPs:	Structural Adjustment Programmes
SDFs:	Social Dimension Funds
SDGs:	Sustainable Development Goals
TB:	Tuberculosis
UDHR:	Universal Declaration of Human Rights
UN:	United Nations
UNECOSOC:	United Nations Economic and Social Council
WHO:	World Health Organisation
WB:	World Bank
WCoZ:	Women's Coalition of Zimbabwe
ZIMCODD:	Zimbabwe Coalition on Debt and Development

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ABSTRACT

The post-independence Government of Zimbabwe (GoZ) introduced a host of policies and programmes towards social services delivery such as in health and education sectors from 1980 to the early 1990S. These programmes mainly included free education in the government run primary schools and free health in government hospitals. Towards the late 80s, the government fiscus began to be overburdened and the Bretton Woods Institutions (BWIs) advised the government to introduce structural adjustment programmes (SAPs) to reduce government expenditure towards social services delivery. The GoZ was advised to introduce user fees in social services delivery in health and education. This led to the citizens not being able to afford social services resulting in the deterioration of Zimbabwe's health-care services. These fees, which are often applied in an ad hoc way and so vary from provider to provider, act as a barrier to basic health services for many of the most vulnerable people especially women in Zimbabwe.

In Zimbabwe, the public health system is the largest provider of health-care services, complemented by private hospitals, local council clinics, mission hospitals and health care delivered by non-governmental organizations (NGOs). In recent years, economic and social decline have led to a reduction in health-care budgets, affecting provision at all levels. In the past two decades, the country's poorest have suffered the most, with a 40 per cent drop in health- care coverage.

The country's health sector faces numerous challenges such as a shortage of skilled professionals and health-care professionals due to brain drain as they seek greener pastures in neighboring countries and in the West due to poor working conditions; an eroded infrastructure with ill-equipped hospitals, many lacking functional laundry machines; and a lack of essential medicines and commodities. The introduction of user fees in the health sector soon after the adoption of SAPs, resulted in a few people being able to access and afford health care services, the poor opting for the apostolic sect, witch doctors and herbal medicine while others are dying at home and women giving birth in their homes.

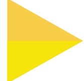
To deal with these challenges, the government introduced Public Private Partnerships (PPPs) seeking support from the private sector in 2009 and this is a funding model for a public service delivery such as health, a new telecommunications system, airport or power plant. This research managed to highlight a number of issues that led to the introduction of PPPs and commercialisation of social services delivery such as in the health sector. These include

pressures from the BWIs, GoZ's own failures to fund and provide basic health services to its own citizens as enshrined in the country's Constitution, regional and continental protocols as well as international treaties. The research found out that there are no PPPs in Marondera and Murehwa although there are plans to introduce the concepts such as at Chitungwiza Central Hospital (CCH) and Parirenyatwa Group of Hospitals (PGHs).

1.0 INTRODUCTION

This report records the findings from the Research on the Cost of Health Care under Public Private Partnerships (PPPs): the Case of Marondera and Murehwa in Mashonaland East Province. This research on the Social and Economic Impacts of Public Health Care Provision under the PPP s Agreement to the Realisation of the Right to Health is part of the broader research project the Zimbabwe Coalition on Debt and Development (ZIMCODD) started in 2016.

The post-independence Government of Zimbabwe (GoZ) introduced a host of policies and programmes towards social services delivery such as in health and education sectors from 1980 to the early 1990S. These programmes mainly included free education in the primary schools owned by the government and free health in government hospitals. Towards the late 80s the government fiscus began to be overburdened and the Bretton Woods Institutions (BWIs) advised the government to introduce structural adjustment programmes (SAPs) to reduce government expenditure towards social services delivery. The GoZ was advised to introduce user fees in social services delivery in health and education. This led to the citizens not being able to afford social services and the deterioration in Zimbabwe's health-care services coincided with a fall in demand for services, following the introduction of user fees. These fees, which are often applied in an ad hoc way and so vary from provider to provider, act as a barrier to basic health services for many of the most vulnerable people in Zimbabwe



2.0 BACKGROUND TO THE RESEARCH

In 2017 ZIMCODD proposed to conduct 2 consultative engagements with the hospitals in Murehwa and Marondera to have an appreciation of the social and economic impact of public health care provision under the PPPs towards the realisation of the right to health care. The survey is part of the broader research project ZIMCODD has been undertaking with the support of FES. It emanated from the understanding that Chitungwiza Hospital was elevated from Mashonaland East Provincial Hospital to a central hospital in 2005.

The introduction of the PPP model in 2009 meant that the hospital was no-longer a public health care provider due to the privatisation element attached to the operations of the hospital. The research carried out by ZIMCODD in 2016, revealed that whilst the services at the hospital had improved (availability of hospital machinery, equipment and drugs), affordability of health care services was the new challenge as most residents who receive health care from the hospital have their incomes below the Total Consumption Poverty Line(TCPL), which ranges from $439.00 to $583.00 for a family of five (Average TCPL is $511.00). The health budgetary trends from 2012 to 2016 show that the budget allocated to the Ministry of Health and Child Care has been falling every year and they do not tally with the 15% allocation of national budget the Health sector as specified in the Abuja Declaration[1].

The hospital now receives cases from Mashonaland East Province covering areas such as Mudzi, Mutoko, Hwedza, Marondera, Murehwa and Chihota just to mention a few. In 2016, ZIMCODD conducted a research which focused on Chitungwiza urban area only. The engagements will contribute to advancing the right to health by catalyzing citizen participation in health rights advocacy. It will also be based on whether the introduction of the PPPs is a threat or an opportunity to the people from Mashonaland East. Through the engagement processes, ZIMCODD will strengthen the capacity of grass root groups to monitor and self-advocate against health rights violations if any. In this regard, ZIMCODD sought to undertake this research to understand the social and economic impacts of public health care provision under the PPPs for the peoples of Marondera and Murehwa.

[1] *http://www.who.int/healthsystems/publications/abuja_declaration/en/.*

2.1 Objectives of The Survey

The research sought to achieve the following specific objectives:

- To conduct localised field research meant to unearth the trends, opportunities and challenges of accessing health care at Chitungwiza Central Hospital under PPPs;
- To produce a detailed picture of the right to health in Mashonaland East Province considering that all public health institutions are referring patients to CCH which is operating under PPPs;
- From the two case studies, look into various trends such as gender, returning patients, success cases of helped patients at CCH, common diseases referred to CCH, etc.
- To analyze opportunities and challenges of PPPs and other institutional challenges affecting the right to health;
- To produce a detailed set of recommendations on how identified challenges can be overcome and opportunities can be exploited.

2.2 Methodology

Data was collected through interviews, focus group discussions (FGDs), desk research, observations and questionnaires. Participants were mainly drawn from villagers/residents from Marondera with the support of Marondera Progressive Residents Association (MPRA) and Women's Coalition of Zimbabwe (WCoZ) in Marondera and in Murehwa, a key focal person was identified to mobilise villagers to participate in the survey. A total of 15(11 males, 4 females including 3 youths) among them, 2 local councilors being key informants participated in Marondera while in Murehwa, 31 (13 males and 18 females including 3 youths) among them, one village head being key informants participated in the survey.

Desk research was intended to provide information on legal and policy frameworks as well as best practices governing public health service provision under the PPPs. Desk research would also draw case studies from other regional and international examples of PPPs in health care provision. The researcher used internet, newspaper articles, journals and discussion papers to gather information. Questionnaires were not administered to patients at the General Hospitals (Murehwa and Marondera) because the researcher was advised to seek clearance from the Permanent Secretary from the MHCW in order to undertake the research at hospitals.

2.3 Background of Research Areas

Murehwa is a township (and district) in Mashonaland East province, Zimbabwe, 75 kilometers northeast from the capital city of Harare, along the road to Tete (Mozambique). It is situated almost 1400m above sea level. It is dominated by traditional African tribe of the Shona people. The population is estimated to be around 195 085 (93 367 males and 101 718 females)[2]. Murehwa district is served by Murehwa district hospital and Musami Mission Hospital as well as other smaller clinics such as Goromonzi clinic though it is far, Kowo/35 miles, Chipfumbi/John Reiner, Munamba for dental health only paying US$5 for treatment as compared to Musami where patients pay about US$40, Somerset, Shamba and Nyamutumbu clinics. All these smaller clinics charge less user fees as compared to Marondera hospital and Musami Mission and patients prefer to travel long distances to access low cost and quality health care services.It was noted that though there are higher costs of accessing health care services at Musami Mission, the people prefer to go there because of the quality of services provided there as compared to Murehwa District hospital owned by government irrespective of the lower costs, but the quality of services is poor. Any complications are mostly referred to Harare Central Hospital and PGHs with a few cases to CCH.

Marondera (known as Marandellas until 1982) is a town in Mashonaland East, Zimbabwe, located about 72 km east of Harare. The population was estimated at 62 120 (28 988 males and 33 132 females in Marondera urban while 116 427 with 56 558 males 57 871 females)[3]. Marondera is one of the earliest centres of white settlement in the former colony of Southern Rhodesia Marondera was one of the centres of Zimbabwe's large forestry and farming district and markets timber, tobacco, corn (maize), beef, and dairy products until the seizure of white-owned farms and redistribution of land began in 2000. Health care provision is provided by Marondera General Hospital, Dombotombo Clinic, Rushinga clinic, Ruvimbo Clinic, Premier Services Medical Society a private hospital while complications from the government owned health providers are referred to Chitungwiza Central Hospital (CCH).

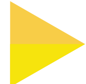
2.4 Limitations of the Survey

The study was limited by a number of challenges such as language that was used especially

[2] *P. Central Statistics; 2012 Census Report*
[3] *Central Statistics Office: Census Report 2012*

English though ZIMCODD tried to translate the face-to-face interview guide into Shona. Only a few respondents understood the process and issues to do with PPPs especially in Murehwa thus there is need for civic education in Murehwa and maybe other parts of the country on PPPs. Most participants were old aged who commented about the health provision by the government soon after the country gained independence whereby they could access free health care as compared to the current situation whereby they are paying health user fees but not understanding the concepts PPPs.

Mobilisation of residents to participate in Marondera was also a limitation as there was a breakdown in communication for logistical purposes and only 15 out of the 30 targeted sample size participated. The other limitation was on engaging district health officials especially in Marondera who expressed ignorance to the processes and sought clearance from the Ministry of Health and Child Welfare before the Clinical Superintend could respond and nurses were not in a position to answer. In Murehwa, the District Health Administrator advised that there were no PPPs at Murehwa hospital and referred further questions to the district medical officer who was not available at the time of interviews. The other limitation was the issue of the budget as the research was undertaken under a minimum budget thus the research could not reach out to a wider selection of the people of Marondera and Murehwa.



3.0 CONTEXTUAL BACKGROUND

In Zimbabwe, the public health system is the largest provider of health-care services, complemented by private hospitals, local council clinics, mission hospitals and health care delivered by non-governmental organizations (NGOs). In recent years, economic and social decline have led to a reduction in health-care budgets, affecting provision at all levels. In the past two decades, the country's poorest have suffered the most, with a 40 per cent drop in health- care coverage. Chronic malnutrition limits the life prospects of more than one third of the country's children. Zimbabweans continue to experience a heavy burden of disease dominated by preventable diseases such as, malaria, tuberculosis and other vaccine-preventable diseases, diarrheal diseases and health issues affecting pregnant women and neonates though there have been a decline in HIV infections at 15% for the past 10 years. Every year, one in every 11 children in Zimbabwe dies before his or her fifth birthday. In other words, 35,500 Zimbabwean children under the age of five die every year.[4]

3.1 Historical Background of Public Private Partnerships

3.1.1 Definition of PPPs

PPPs are agreements through which private financiers essentially replace governments as providers and funders of traditional public services like schools, hospitals and roads[5]. The AFRODAD report on, ***What lies beneath?: A critical assessment of public private partnerships and their impact on sustainable development*** examines the nature and impact of PPPs in Tanzania, Peru in Latin America. The report notes that most governments in developing countries are turning to PPPs for development and bridging the infrastructure gaps in their countries without much knowledge of the true costs and risks of PPPs. PPPs in most circumstances do not have positive development outcomes but rather are profit oriented from the point of view of the private partners who drive them. There is a lot of secrecy in the negotiations of PPPs by the public sector, who often takes most of the risks associated with PPP projects[6].

[4] *www.zimhealth.org*
[5] *Rachel Jenkins (etal); Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review; PLoS Med, June 2012*
[6] *www.afrodad.org/A critical assessment of public private partnerships and their impact on sustainable development*

The report shows that in Tanzania and Peru, successful PPPs are noted and have improved access to services for the people. However, in other sectors such as water, PPPs have terribly gone wrong like the experience of Tanzania where the water project in Dar es Salaam had to be cancelled. The Lesotho health PPPs is another typical example that has resulted in the PPPs cost going up to US$ 67 million per year, three times what the old hospital would have cost today and in the process consuming more than half of the government's health budget. Overall, the new report by AFRODAD found out that:

- PPPs are, in most cases, the most expensive method of financing, significantly increasing the cost to the public purse.
- PPPs are typically very complex to negotiate and implement and all too often entail higher construction and transaction costs than public works.
- PPPs are all too often a risky way of financing for public institutions.
- The evidence of impact of PPPs on efficiency is very limited and weak.
- PPPs face important challenges when it comes to reducing poverty and inequality, while avoiding negative impacts on the environment.
- Implementing PPPs poses important capacity constraints to the public sector, and particularly in developing countries.
- PPPs suffer from low transparency and limited public scrutiny, which undermines democratic accountability.

The major challenge that PPPs face include low transparency and limited public scrutiny which has the effect of undermining accountability. In some cases, PPP projects have resulted in public discontent due to higher costs and corruption allegations. Governments and financial institutions should focus on developing the right tools at country level to identify whether and under what circumstances – it is desirable to use PPPs.

The report by AFRODAD recommends that governments should stop hiding the true cost of PPPs and that decision-making about PPPs be more transparent and accountable. It also recommends that development outcomes are at the forefront of any project and that developing countries are in the driving seat when principles and criteria to assess and implement PPPs are developed. Governments often hide the true costs of PPPs because they can keep the project and its contingent liabilities (or future potential debt) 'off balance sheet'. Examples of PPPs:

1. The case of The Queen 'Mamohato Memorial Hospital in Lesotho. The hospital was built to replace Lesotho's old main public hospital under a public–private partnership (PPP) – the first of its kind in a low-income country. The Ministry of Health in one of the

poorest and most unequal countries in the world is locked into an 18-year contract that is already using more than half of its health budget (51 per cent), while providing high returns (25 per cent) to the private partner. [7]

2. Kazakhstan and Krgyszstan in Central Asia are two interesting case studies as these States have the greatest experience in reforming their health sectors. The reform consists principally of four elements: introduction of health insurance schemes, cost reduction, separating service provision from financing and rationalization of health services. The partnership work closely together with government health services and participate in direct service provision, health status monitoring and reporting[8]. The core of the reforms was the introduction of a mandatory health insurance fund, a capacitated health provider system, thereby improving the development of a basic benefit package in selected sections[9]. The outcomes of this partnership was not as expected as there was no improvement in delivery of health services as the costs increased thereby affecting more people.

3. Riders for Health (The Gambia): Reliable transport is one critical success factor to health care delivery, affecting many key inputs including health workers, ambulances, supply stock outs and lab services. The Gambia partnered with Riders for Health, a not-for-profit, to provide transport management and, eventually, full fleet management for all trucks, cars, motorcycles and ambulances. Contracts may also include vehicle leasing for renewal. Capital funding, when required, was provided through local and regional banks.[10]

The above examples highlight some of the PPPs in the world that are entered by governments and the private sector to improve on social and economic delivery for the benefit of their citizenry. The reality on the ground leaves a lot to be desired as citizens finds it difficult to access and afford these services. The Lesotho example is a classic one, the government of Lesotho wanted to replace an old hospital but it found itself trapped with a huge budget expenditure of 51% while the private sector was getting more profits of about 25%. A further analysis also reveals the same in Gambia whereby government expenditure also increased in the acquisition of the transport and leaving management to the Riders for Health NGO with none improvement in service delivery in the coming years.

[7] *https://www.oxfam.org/sites/www.oxfam.org/files/bn-dangerous-diversion-lesotho-health-ppp-070414-en.pdf*
[8] *http://www.phrproject.com/publicat/si/sir19sum.htm/ Report of the Partnership for Health Reform Project (PHR),*
[9] *www.afrodad.org/A critical assessment of public private partnerships and their impact on sustainable development; 2017*
[10] *African Health Forum: Public Private Partnerships for Health: PPPs are Here and Growing; 2013.*

3.1.2 Evolution of PPPs in Zimbabwe

The post-independence Zimbabwe era introduced a host of socio-economic policies such as the First Five Year Development Plans of 1980-1985-1986-1990 and other economic policies in the 1990s. The overall objective was to improve socio-economic lives of her citizens. One of the major policy instruments was to do with free education and health for citizens especially after independence. By the mid-1980s, the GoZ started to experience fiscus constraints and reverted to the BWIs (IMF and WB) for financial advice and balance of payments support and infrastructural development financing. The BWIs advised the GoZ that they had to implement SAPs for support and reduce huge government expenditure[11]. To ensure a continued inflow of funds, the GoZ already devastated by debt obligations had little choice but to adhere to conditions mandated by the BWIs. Most donor countries from the West, condition their bilateral assistance upon a country's adoption of SAPs[12].

3.1.3 What are SAPs Designed to Do?

SAPs are designed to improve a country's foreign investment climate by eliminating trade and investment regulations, to boost foreign exchange earnings by promoting exports, and to reduce government deficits through cuts in spending[13]. Although SAPs differ somewhat from country to country, they typically include:

- **a)** Abolishing food and agricultural subsidies to reduce government expenditures;
- **b)** Deep cuts to social programmes usually in the areas of health, education and housing and massive layoffs in the civil service;
- **c)** Privatization of government-held enterprises.

3.1.4 Socio-Economic Costs of SAPs

Zimbabwe's Economic Structural Adjustment Programme (ESAP), launched in 1990, was meant to herald a new era of modernised, competitive, export-led industrialisation. Despite a high-performing economy in its first decade of independence, the country appeared firmly lodged in a quagmire of mounting debt and erratic growth in the wake of five years of ESAP-mandated reforms[14]. It entailed the reduction of government expenditure by retrenching 25 percent of the civil service establishment, withdrawing subsidies, commercializing and privatizing some state owned companies, introducing user fees in the health and education sectors, among others[15].

[11] *Mlambo A; (1997); The Economic Structural Adjustment Programme: The Case of Zimbabwe; Harare, UZ Publication*
[12] *Mlambo A; (1997); The Economic Structural Adjustment Programme: The Case of Zimbabwe; Harare, UZ Publication*
[13] *Johannes Jütting Public-private partnerships in the health sector: Experiences from developing countries; Extension of Social Security Paper No. 10; Social Security Policy and Development Branch International Labour Office; 2002*
[14] *Emmanuel R Marabuka; What are the effects of ESAP in the Zimbabwean context; 1998*
[15] *Dhliwayo R (2001); he Impact of Public Expenditure Management Under ESAP on Basic Social Services, Health and*

Mlambo (1997) asserts that Economic Structural Adjustment Programs were formerly introduced in Zimbabwe in October 1990. Its framework was spelled out in the January 1991 document (Zimbabwe; a framework for Economic Recovery 1991–1995)[16].

In a short time, ESAP's WB-inspired reforms had ripped into the existing economic and social infrastructure, shifting the focus of many mass-oriented development social programs away from redistribution towards management of defined and limited, even declining, public resources[17]. These SAPs proved to be disastrous and harmful causing socio economic effects to the government and the mass population[18]. Mlambo (1997) states that during ESAP, government resources had decreased so that real expenditure on health declined because of a combination of rising costs, inflation, declining value of the Zimbabwean dollar, emerging diseases such as TB and AIDS. According to Makoni (2000), poorer communities and families ended up receiving an inferior education, while some children eventually dropped out of school due to inability of parents to pay user fees[19].

Of particular note was the rapid deterioration in the country's acclaimed health and education sectors[20]. One of the leading causes of mortality of children aged five years old and below in Zimbabwe, HIV and AIDS account for more than 20 per cent of the deaths in this age group[21]. Tuberculosis remains a leading cause of morbidity and mortality with prevalence in 2009 of 431 per 100,000 population. The under-five mortality rate was 94 per 1 000 live births, up from 78 in 1990. These statistics reveal that on average, pregnancy-related complications lead to the deaths of eight women per day and about 100 children died every day from common and preventable diseases. During the decade 2000 – 2010[22], state investment in health varied from 4.2% of the state budget in 2001 to 8.5% in 2009 and 2010. However, as acknowledged to Parliament in the 2012 Budget address, budget performance below the 15 per cent threshold stipulated by the Abuja Declaration of 2000 (which says the health budget must be 15% of total expenditure) compromising the speed at which the country could attain its Millennium Development Goals (MDGs) targets especially on health delivery system across the country[23].

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[16] *Mlambo A; (1997); The Economic Structural Adjustment Programme: The Case of Zimbabwe; Harare, UZ Publication*

[17] *Emmanuel R Marabuka; What are the effects of ESAP in the Zimbabwean context; 1998*

[18] *Dhliwayo R (2001); he Impact of Public Expenditure Management Under ESAP on Basic Social Services, Health and Education, Harare, UZ Publications.*

[19] *Makoni R.D (2000);The Effects of the Structural Adjustment Programme (1991-1993) on the Participation of Secondary School Girls in Zimbabwe, Department of Educational Administration, UZ, Harare*

[20] *Dhliwayo R (2001); he Impact of Public Expenditure Management Under ESAP on Basic Social Services, Health and Education, Harare, UZ Publications.*

[21] *National Child Survival Strategy for Zimbabwe 2010 – 2015*

[22] *www.ZimHealth.org*

[23] *Ibid; zimhealth*

3.1.5 The Link Between SAPs, PPPs and Privatization Including Commercialisation

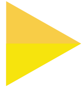
As noted earlier, SAPs are designed to deregulate the economy and bring in more players and reduce government expenditure. The concept of PPPs is a broad term that can be applied to anything from a simple, short term management contract (with or without investment requirements) to a long-term contract that includes funding, planning, building, operation, maintenance and divestiture. Privatization is the process of transferring ownership of a business, enterprise, agency, public service, or public property from the public sector (a government) to the private sector, either to a business that operates for profit or to a nonprofit organization[24]. Commercialisation is defined as the reorganisation of enterprises wholly or partly owned by the government in which such commercialized enterprises shall operate as profit making commercial ventures without any subvention from the government[25].

It can be noted that SAPs are policy processes while PPPs and privatization are the means to achieve the policy processes contained in SAPs. It can be noted that the concept of PPPs is comprehensively related to commercialization such as CCH and PGHs. To offset any negative impact of ESAP on poorer Zimbabwean households and retrenched public sector workers, government introduced the Social Development Fund (SDF) and social protection mechanisms to assist poor households with school fees, health fees and food money subsidies[26].

[24] *Compare Bel, Germà (2006). "Retrospectives: The Coining of 'Privatisation' and Germany's National Socialist Party". Journal of Economic Perspectives*

[25] *Deregulating the public sector. Privatization and commercialization in Nigeria By Rainer Rohdewohld, First published: July 1993*

[26] *Dhliwayo R (2001); The Impact of Public Expenditure Management Under ESAP on Basic Social Services, Health and Education, Harare, UZ Publications.*



4.0 LEGAL AND POLICY FRAMEWORK IN HEALTH DELIVERY SYSTEMS IN ZIMBABWE

Zimbabwe's health delivery system is governed by a host of national policies such as the national Constitution, Zimbabwe's National Health Strategy, and Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset), regional protocols such as the Southern Africa Development Community (SADC) Health Protocol of 1999, continental declarations such as the African Union (AU) Health Strategy and international treaties such as the UN Charter and the United Nations Declaration of Human Rights (UNDHR).

4.1 The Zimbabwe Constitution

The Constitution of Zimbabwe 2013 is the supreme law governing Zimbabwe and Chapter 2 Section 29 of the Constitution state the following:

1. The State must take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe.
2. The State must take appropriate, fair and reasonable measures to ensure that no person is refused emergency medical treatment at any health institution.
3. The State must take all preventive measures within the limits of the resources available to it, including education and public awareness programmes, against the spread of diseases.

Section 30 of the Constitution states that the State must take all practical measures, within the limits of the resources available to it, to provide social security and social care to those who are in need. It is alleged that the GoZ has always been saying that there are not enough resources to meet its obligations as government but it is known fact that there are huge mineral deposits such as diamonds, gold, platinum and other precious minerals that the government can leverage to meet the social and economic rights of its citizens. Section 76 of the constitution confirms the right of every citizen and permanent resident of Zimbabwe to have access to basic healthcare services, including reproductive health[27]. What is disheartening is that the Constitutional provisions have been violated with regards to provision of basic health care provision at CCH,

[27] *Zimbabwe Constitution Act 2013*

Marondera district hospital and Musami Mission hospital. Patients who can afford health care costs at these hospitals are told to go to district hospitals and clinics that are still owned by the government and district councils but with poor quality service. This is due to a privatization element attached to PPPs though Marondera and Murehwa Hospitals are not yet to be put under PPPs. Patients are chased away while others are detained and have to deal with debt collectors for non-payment of hospital fees.

4.2 The National Health Strategy for Zimbabwe, 2009-2013

The Government of Zimbabwe desires to have the highest possible level of health and quality of life for all its citizens, attained through the combined efforts of individuals, communities, organizations and the government, which will allow them to participate fully in the socioeconomic development of the country. This vision would be attained through guaranteeing every Zimbabwean access to comprehensive and effective health services.

As part of its mandate to give strategic direction in health sector development, the MoHCW has developed this National Health Strategy, 2009 – 2013, 'Equity and Quality in Health - A People's Right. This document is a successor to the National Health Strategy (NHS), 1997 – 2007 'Working for Quality and Equity in Health', whose major thrust was to improve the quality of life of Zimbabweans and set the agenda for launching the health sector into the new millennium. The main thrust of the 2009-2013 NHS was therefore firstly to provide a framework for immediate resuscitation of the health sector (Health System Strengthening), and secondly, to put Zimbabwe back on track towards achieving the Millennium Development Goals MDGs by 2015 though the time was too short and now Sustainable Development Goals (SGDs)[28].

4.3 Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset)

Over the past two decades soon after SAPs, Zimbabwe experienced an endless corrosion of existing public infrastructure, decayed in social delivery such as health and education due to the unrelenting economic downturn. While the government has taken a policy position of adopting PPPs and partnering with the private sector to deliver infrastructure, government and local

[28] *Zimbabwe National Health Strategy 2008-2013*

capacity for the planning and execution of projects remains low. The ZIMASSET of October 2013-December 2018 was crafted to achieve sustainable development and social equity anchored on indigenization, empowerment and employment creation[29].

The main thrust of the Social Services and Poverty Eradication cluster is to enable the Government of Zimbabwe to improve the living standards of the citizenry for an empowered society and a growing economy. With regards to health service delivery, this cluster has the following key areas; namely access to basic health services, access to water and sanitation; infrastructure and gender mainstreaming because research has shown that there are inequalities in health care provision with women and other marginalized groups finding it difficult to access and afford health services. This is due to the fact that women have other extra health care needs such as maternal and sexual reproductive health needs.

The PPPs are typically implemented through the Ministry of Finance's appointed minister for infrastructure as well as relevant line departments. Even though ZIMASSET establishes the development of PPP legislation as a key strategy, there is currently no PPP legislation in place in the country. The government planned to develop guidelines aimed at expediting and supporting the economic reform process and Zimbabwe's PPP bill is currently before Parliament[30]. ZIMASSET recognised that accelerated funding of public projects shall be achieved through the hastening of PPPs, where the Office of the President and Cabinet was mandated to monitor and evaluate the plan and its implementation. The joint Ventures Act of 2016 was adopted with the objective was to provide for the implementation of joint venture agreements between contracting authorities and counterparties; and to provide for matters connected with or incidental to the foregoing. It was alleged that the Act was just old wine in a new bottle as it failed to meet its mandate and that there is too much regulatory role and corruption by the government though giving contracting parties freedom on labor regulations and costing aspects thereby giving the party more room to exploit workers and consumers[31]. It sought to promote private sector participation just like under PPPs and commercialisation.

4.4 The SADC Health Protocol of 1999

A healthy population is a pre–requisite for sustainable human development and increased

[29] *Nyasha Chizu; ZimAsset is anchored on effective implementation of PPPs; www.newsday.co.zw ; March 6, 2017 in Business*
[30] *Nyasha Chizu; ZimAsset is anchored on effective implementation of PPPs; www.newsday.co.zw ; March 6, 2017 in Business*
[31] *https://www.theindependent.co.zw/2016/02/19/joint-venture-act-new-barrier-to-investment/; by Taurayi Mangudhla*

productivity in a country. SADC recognizes that close co-operation in the area of health is essential for the effective control of communicable and non-communicable diseases for addressing common concerns within the region. To this end, SADC Member States signed the Protocol on Health on the 18th of August 1999 to coordinate regional efforts on epidemic preparedness, mapping prevention, control and where possible the eradication of communicable and non- communicable diseases. Education and training, efficient laboratory services and common strategies to address the health needs of women, children and vulnerable groups are discussed within the Protocol. The Protocol encourages the establishment of institutional mechanisms within the health sector of the region to effectively implement the Protocol. What is on the ground is saddening as only countries such as Mauritius, Botswana, Seychelles and South Africa have such mechanisms while the rest of SADC member states are still grappling with funding constraints.

4.5 The African Union (AU) Health Strategy (2007)

The African Union Health Strategy was adopted in 2007 by the African Union (AU) in response to the large burden of diseases, which were identified as a major barrier to socio-economic development in Africa. The strategy committed the AU, Regional Economic Communities (RECs), African governments and development partners to the strengthening of health systems through improved resources, policies and management in order for the health systems in Africa to reach the poor and those most in need of health care.

4.6 Africa Union- Africa Health Strategy and Plan (2016 – 2030)

In 2015 the meeting of the 1st African Union Specialized Technical Committee on Health, Population and Drug Control (STC-HPDC) recommended that a revised Africa Health Strategy be developed for the period 2016 -2030 based on an assessment of the previous strategy of 2007, the relevant AU health policy instruments and integrating research and innovation for health. The policy framework was premised the Agenda 2063: The Africa We Want" and 2030 Agenda for Sustainable Development, including its SDGs. Other policy frameworks from which AHS 2016 -2030 reinforces include the Sexual and Reproductive Health and Rights Continental Policy Framework and its extended Maputo Plan of Action (2016-2030), African Regional Nutrition Strategy 2015 - 2025 (ARNS), the various AU Abuja commitments, calls, declarations aimed at combating AIDS, tuberculosis and malaria in Africa, the Catalytic Framework to end AIDS, TB and

Eliminate Malaria in Africa By 2030 as well as the Global Strategy for Women's, Children's and Adolescent Health 2016 - 2030[32].

It is important to emphasize that the AHS 2016 - 2030 is an over-riding document inspired by other continental and global commitments which does not seek to replace nor duplicate but is intended to enhance further the commitments reflected in the global and continental instruments in Africa in the context of "Agenda 2063: The Africa We Want" and the Sustainable Development Goals (SDGs). This goal will be people driven with a particular focus on the most productive segments of society as well as on women, youth, adolescents, children and other vulnerable groups[33].

4.7 The United Nations (UN) Charter

Article 55 of the UN Charter states that 'with a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote:

a) higher standards of living, full employment, and conditions of economic and social progress and development;
b) solutions of international economic, social, health, and related problems; and international cultural and educational cooperation;

4.8 The Universal Declaration of Human Rights

The Universal Declaration of Human Rights (UDHR) is a milestone document in the history of human rights. It sets out, for the first time, fundamental human rights to be universally protected. UDHR Article 22 states that everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality. Article 25:

[32] *NAfrican Union Health Strategy*
[33] *NAfrican Union Health Strategy*

- **Sub-section (1)** notes that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
- **Sub-section (2)** notes that motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

But what is happening in Zimbabwe and the survey areas under this study leave a lot to be desired as this has not yet been achieved.

4.9 International Covenant on Economic, Social and Cultural Rights

The UN International Covenant on Economic, Social and Cultural Rights was adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 and entered into force on 3 January 1976. Article 12 of the International Covenant on Economic, Social and Cultural Rights states the following:

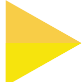
1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

   a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

   b) The improvement of all aspects of environmental and industrial hygiene;

   c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

   d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.



5.0 CHALLENGES IN ZIMBABWE'S HEALTH CARE PROVISION

The country's health sector continues to face numerous challenges such as a shortage of skilled professionals and health-care staff due to brain drain as professionals seek greener pastures in neighboring countries and in the West due to poor working conditions in the sector; an eroded infrastructure with ill-equipped hospitals, many lacking functional laundry machines, kitchen equipment and boilers; and a lack of essential medicines and commodities. The system breakdown has been exacerbated by humanitarian crises such as the cholera and measles epidemics between 2008 and 2010, by poor maternal and child health services and high numbers of people living with HIV[34].

This study ZIMCODD undertook revealed that the introduction of user fees in the health sector soon after SAPs resulted in a few people being able to access and afford health care services, the poor opting for the apostolic sect, witch doctors and herbal medicine while others die at home and women giving birth in their homes. One of the leading causes of mortality of children aged five years old and below in Zimbabwe, HIV and AIDS account for more than 20 per cent of the deaths in this age group[35]. Tuberculosis remains a leading cause of morbidity and mortality with prevalence in 2009 of 431 per 100,000 population[36].

5.1 Access to Health Care

The deterioration in Zimbabwe's health-care services coincided with a fall in demand for services, following the introduction of user fees in the 1990s due to the adoption of the SAPs. These fees, which are often applied in an ad hoc way and so vary from provider to provider, act as a barrier to basic health services for many of the most vulnerable people especially women in Zimbabwe[37]. The GoZ policy is to provide free-of-charge health services for pregnant and lactating mothers, children under five and those aged 60 years and over, but the policy has

[34] *Dhliwayo R (2001); he Impact of Public Expenditure Management Under ESAP on Basic Social Services, Health and Education, Harare, UZ Publications.*
[35] *National Child Survival Strategy for Zimbabwe 2010 – 2015*
[36] *http://www.unicef.org/infobycountry/zimbabwe_statistics.html*
[37] *Health Transition Fund, A Multi-donor Pooled Transition Fund for Health in Zimbabwe, December 2011*

proved to be difficult to implement. Currently, in the absence of substantial government financial support, user fees provide the main income for many health care facilities, enabling them to provide at least the minimum service.

The research found out that giving birth in a government or municipal facility costs between US$3 and US$50. These costs are often prohibitive, leaving some women to give birth outside the health system. It is estimated that more than 39 per cent of women are delivering at home[38]. The under-five mortality rate was 94 per 1 000 live births, up from 78 in 1990. These statistics reveal that on average, pregnancy-related complications lead to the deaths of eight women per day and about 100 children die every day from common and preventable diseases[39]. The GoZ, UNICEF and international donors formulated a five-year plan titled the Health Transition Fund (HTF) to reduce high maternal and child mortality rates. Abolishing health-care user fees was one of the key goals in 2011 but this never came to be.

5.2 Investing In Health Services Provision

Following the formation of the Government of National Unity (GNU) in February 2009, the government developed the National Health Strategy (NHS) for Zimbabwe. A health-sector recovery plan sought to reverse the decline in the performance of the country's health delivery system, especially as it impacted on universal access to primary health care by vulnerable populations. The goals of the plan included tackling levels of health financing and thus improving access to basic medical equipment and essential medicines; taking steps to attract and retain health workers in the public health sector; and laying the foundations for an investment policy to fund the rehabilitation and development of the health-services infrastructure.

In the 2012 Budget, it was recognised that further investment was required; the government allocated US$63.4 million for infrastructure rehabilitation, equipment, the purchase of ambulances and service vehicles[40]. In line with the NHS, it was stated that primary health-care needs would be prioritised. The support of the Government's partners in the HTF was also acknowledged. The fund, for its next phase from 2011 to 2015, had received pledges of US$435 million to reduce high maternal and child mortality rates, to strengthen health systems and abolish health-care user fees. This was not achieved as the possible funders questioned the lack

[38] *http://www.unicef.org/infobycountry/zimbabwe_statistics.html*
[39] *Health Transition Fund, A Multi-donor Pooled Transition Fund for Health in Zimbabwe, December 2011*
[40] *2012 National Budget Speech by Minister of Finance, Hon Tendai Biti*

of transparency and accountability in public resources management by policy makers thereby worsening the already dilapidating health delivery system.

5.3 Strategy for Recovery

In the period since the formation of the GNU in 2009 and the MHCW's NHS, the MHCW instituted further policy developments, targeted financing and introduced programmes to address inequity in the health-care system. During the decade 2000 – 2010, state investment in health varied from 4.2% of the state budget in 2001 to 8.5% in 2009 and 2010[41]. However, as acknowledged to Parliament in the 2012 Budget address, budget performance below the 15 per cent threshold stipulated by the Abuja Declaration of 2000 (which says the health budget must be 15 per cent of total expenditure) compromising the speed at which the country could attain its Millennium Development Goals (MDGs) targets.

An assessment of progress towards the realisation of MDGs 4 and 5, on child survival and maternal survival respectively, were among the goals that Zimbabwe had made least progress towards achievement, as Zimbabwe's Deputy Prime Minister, Thokozani Khupe, points out in her foreword to a Situational Analysis on the Status of Women's and Children's Rights in Zimbabwe, 2005 – 2010: A call for Reducing Disparities and Improving Equity[42]. “As the world turns to 2015 when all countries will be evaluated against their progress on the Millennium Development Goals, it is increasingly clear that women and children are central to the achievement of the majority of these goals'' she added.

5.4 Public Private Partnerships (PPPs) as a Recovery Model

The government introduced PPPs to get the support of the private sector in health service delivery in 2009. Governments everywhere are grappling with rising healthcare costs and increased demand for healthcare services in the face of ongoing budget constraints.

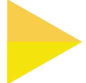
As governments struggle to stretch their healthcare funding and produce better results, many

[38] *www.ZimHealth.org*
[38] *www.ZimHealth.org*

are increasingly turning to PPPs with the private sector. There are four key factors driving governments worldwide to use the PPP model for health sector improvements:

- Desire to improve operation of public health services and facilities and to expand access to higher quality services;
- Opportunity to leverage private investment for the benefit of public services;
- Desire to formalize arrangements with non-profit partners who deliver an important share of public services and;
- More potential partners for governments as private healthcare sector matures.

The potential benefits of public funding and private delivery of health facilities and services are well-known, but the path from publicly-run hospitals to publicly funded and privately-provided hospital services is not so well known and can be challenging. PPP arrangements are useful for large projects that require highly-skilled workers and a significant cash outlay to get started. They are also useful in countries that require the state to legally own any infrastructure that serves the public. Different models of PPP funding are characterized by which partner is responsible for owning and maintaining assets at different stages of the project such as a mortuary service at Marondera hospital.



6.0 RESEARCH FINDINGS FROM MUREHWA AND MARONDERA

The research managed to highlight a number of issues that led to the introduction of PPPs and commercialisation of social services delivery such as in the health sector. These include pressures from the BWIs, GoZ's own failures to fund and provide basic health services to its own citizens as enshrined in the Constitution, regional and continental protocols as well as international treaties. To understand the impact of PPPs on health service delivery in Murehwa and Marondera, a set of interview guides and FGD questionnaires were drafted and used to gather peoples' voices.

6.1 Personal Interviews

Interview Question	Murehwa		Marondera	
	Respondents	Total	Respondents	Total
What is your; a) Name? (Optional) b) Sex?	13 males and 18 females including 3 youths	31	4 females and 11 males including 3 youths	15
How old are you? (Optional)	28 participants were above 35 years while 3 were below 35 years	31	4 participants were below 35 years while 11 were above 35 years	15
Who are your regular health service providers?	28 participants all confirmed going to Musami only. 1 goes only to Murehwa hospital 1 goes to community health workers 1 goes to Musami and Murehwa	31	1 goes to PSMAS only 1 goes to Marondera and Ruvimbo Clinic 1 goes to Marondera and CCH 1 goes to Marondera and Dombotombo Clinic 1 goes to Marondera and PSMAS 10 respondents go to Marondera only	15
Do you receive health services from Chitungwiza General Hospital?	6 respondents have been referred to CCG, 6 have been to PGHs and Harare central, while 1 has been to a private surgery. 5 people were referred to Marondera and 9 rely on Murehwa and Musami hospitals. 4 respondents did not answer.	31	4 participants confirmed receiving health services at CCH while 11 said they did not.	15

Interview Question	Murehwa		Marondera	
	Respondents	Total	Respondents	Total
If yes, rate the services	Those referred to CCG said they could not rate the services. 2 respondents referred to PGHs and Harare central hospital said they were well taken care of and 1 who went to a private doctor rated the services as good. Some respondents said they avoided going to CCG because the fees are unaffordable. Respondents who opted for Musami said they were well taken care of especially with maternity services being better as compared to Murehwa hospital.	31	3 participants who received health care said that service has improved while one argued that there is shortage of staff	15
Are you aware of the privatisation of the hospital under the current PPP Model used by CGH? If yes: **a)** Were you consulted during the decision making process? **b)** Do you understand how the model works?	3 participants did not answer this question. 7 participants were aware of PPPs while 21 did not know them. Participants who were aware of PPPs said they were not consulted and only knew about them through media.	31	4 participants have knowledge of PPPs and they got the information from media while 11 do not know. Though they got information from media they do not have adequate information on how PPPs operate. All respondents confirmed that they were not consulted.	15
Compare the effectiveness of health service provision by CGH before and after the adoption of the PPP Model	15 participants did not answer the question. 1 person said PPS had not helped control diseases. 5 participants said the situation was now worse as they are paying for treatment and drugs when the poor, elderly, children and expectant mothers had previously received free care. 10 respondents said services have not yet improved with patients not receiving medication and some being told to buy medication at private pharmacies.	31	2participantsdid not answer the question. 1 respondent said that there is no change due to economic challenges 3 rated the hospital operations as the best, getting new drugs, new machines in the hospital where it had previously been like a death trap 3 said they only know about Marondera Hospital which is government owned but with shortages of staff and drugs, and outdated machinery. 4 said that the situation is now worse than before; marred by long ques, with patients spending the whole day in waiting to be served. Patients are paying exorbitant fees and staff take their time to attend to patients.	13

Interview Question	Murehwa		Marondera	
	Respondents	Total	Respondents	Total
What are the major health services provided by CGH?	14 said that they get free HIV and Aids treatment, condoms and information on how to use drugs. They also get information on how to take care of patients. They are given clean drinking water, allowed to pay a part of the fees they can afford. The hospital provides mosquito nets for malaria control. 17 participants did not answer the questions.	31	12 respondents agreed that there are modernized machines for diagnosis, surgical services, basic health, operations, maternity, cesarean, rehabilitation, male circumcision, x-rays, VCTs, OI, eye and dental surgeries while 3 did not respond.	15
Are you aware of the social and economic rights outlined in the country's Constitution?	14 participants said they did not know about the social and economic rights in the constitution. 4 did not answer. 13 respondents said they knew about the right to health for everyone, free treatment for HIV and AIDs including TB patients as well as information on health related matters.	31	4 said they were not aware of the constitutional provision. 1 participant did not answer the question and 10 agreed that there are aware of their rights especially the right to health and a healthy living, access to treatment and non discrimination.	15
Is the hospital in violation of the Constitution?	All agreed that the hospitals were violating the Constitution by chasing away people without treatment, detaining patients who fail to pay for services and sending debt collectors. This never used not to happen before the introduction of health fees.	31	The same as in Murehwa	15
In the past, how much did you pay for health services in your area?	1 participant said in Murehwa it was $5. 7 did not answer, 4 said they did not pay fees when government was in control of the hospitals. 19 participants said they pay from $20 up to $50 which can be more if referred to bigger hospitals.	31	5 participants did not answer the questions. 10 people said that it ranges from $12 in Marondera and increases depending with your disease and can go up to as much as $20 or $200 for complications at CCH.	15
How affordable are the health services now compared to the previous years?	4 participants did not answer. 4 said they could afford consultations only while 23 participants said they could not afford the fees with the elderly and the rural folk being most affected as they depend on minor economic activities for survival.	31	1 participant said it is a bit affordable, 4 did not answer and 10 participants said that was unaffordable due to the harsh economic conditions prevailing in the country.	15

6.2 Focus Group Discussion Questions

In this section Focus Group Discussions were conducted with residents in Marondera and Murehwa. Participants in the FGDs were drawn randomly from the communities. Each FGD consisted of 10 people (men, women and youths) in Murehwa and a group of 7 in Marondera. Observations were done at the two Hospitals (Murehwa and Marondera) to capture voices and visuals which characterise the quality of health care provision at the institutions..

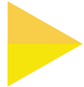
Interview Question	Murehwa	Marondera
	State and/or trends of the health sector	
What can you say about health care provision in Zimbabwe?	Health service is expensive wit patients paying higher fees. HIV/Aids, diabetic and hypertension patients should receive free treatment and testing such as in South Africa. Cancer treatment is very expensive for patients with no medical aid. In some cases medical aid is rejected for shortfalls which adds up to no money no treatment. A 75 year old man from Murehwa with eye problems was told to pay fees to receive treatment but he is unemployed with no source of income. People are dying at home with women delivering in their homes. Doctors are advising patients that there are no drugs at government hospitals with patients having to buy drugs at private surgeries. PGHs, CCG and Harare hospitals are at the forefront are rejecting patients, and not releasing patients due to failure to pay and sometimes sending debt collectors. An example of woman who was detained at Harare Hospital but met a relative working there and was discharged later after a month.	Health service provision is of poor quality though expensive. At CCH fees are too high; patients are detained until they are able to pay at least half of the fees thereby violating the right to health as enshrined in the Constitution. Children are not given birth records before paying for services. Attention is given to patients at council clinics while at government hospitals staff takes time to attend to patients and can be harsh even to the elderly. There is negligence of patients even expecting mothers. In Harare 5 staff members attend to an expecting mother while at Marondera there can be one or none especially during evening shifts. There is a provision of water for the expecting mothers to clean up and charges are around $16 and above at both Marondera and CCH. Patients are dying in Marondera due to the non-availability of specialist doctors. It is worrying to note that government officials are not treated in Zimbabwe hereby exporting the scarce forex available for treatment outside Zimbabwe. This is in stark contrast with South Africa and Botswana where government officials use their own local hospitals.
Which Central Hospital are you referred to from your district hospital?	Musami, PGHs, CCH and Harare Hospital.	CCH, PGHs and even South Africa. There is one anesthetic specialist in Marondera thus patients are referred to CCH.
What can you say about health care provision by the Central Hospital?	The service has improved though expensive especially in incidences where patients develop complications. Expecting mothers at PGHs, CCH and Harare Hospital are taken good care of by hospital staff but at Musami and Murehwa hospitals patients are at times left attended.	The services at Marondera are not above average quality though the government has not yet put the hospital under PPPs as compared to CCH. Recruitment procedures for nursing staff are not transparent and there are allegations of nepotism and corruption. There is need to check the criteria for recruitment as some medical staff do not have the welfare of patients at heart. Health service should be affordable to the ordinary citizens, health is a right in the constitution thus NO to exorbitant fees being charged. Donated drugs are sometimes allegedly charged to patients; and this is unacceptable. Blood donations are for free but when a relative is in need, residents are told to pay higher fees. Nurses and doctors need to be passionate about their work. Nurse aids are taking over the duties of registered nurses who opt to work at private surgeries or have gone abroad for greener pastures. Apostolic sects are now threatened by diseases which hospitals should be treating. People are also dying at accidents scents due to the non-availability of emergency ambulances.

Interview Question	Murehwa	Marondera
	Institutional Policies	
Are you aware of any institutional policies governing health care provision by the Central Hospital?	Residents said they were not aware of any new policies but they do get other information from the media.	Residents are not well versed with institutional policies at the hospital but they are aware of the right to health as enshrined in the Constitution with non-discrimination irrespective of one having paid fees or not. User fees are affecting the right to health of residents.
Does the hospital consult residents whenever health care policies are crafted?	Residents are not consulted. They can make reports to the Matron or clinical superintendent. Unfortunately in some cases such reports can result in patients being treated badly by other hospital staff. At Musami Hospital there is awareness raising for patients in the morning about the operations of the Hospital.	There are no consultations on policies.
Are you aware of any constitutional provisions on the rights to health and life?	A few residents are aware of the Constitutional provisions (13 out of 31 respondents).	Residents agreed that they are aware of the constitutional provisions. There is need to amend the Health Act and include the right of every citizen to access health services regardless of having fees or not. Health must be affordable and accessible to all citizens.
Are you aware of the PPPs under which the Central Hospital is being operated?	7 residents reported that they were aware of PPPs especially at PGHs, CCH and Harare Hospital but the concept was not yet operational at Murehwa hospital. Musami is a mission hospital that is complementing government efforts and is not affected by PPPs.	At least 4 respondents are aware of PPPs. PGHs, CCH and Harare hospitals are all referral hospitals for people from Marondera, with most patients being referred to CCH.
Were you consulted during the decision making process when the PPP Model was put under consideration?	Residents were not consulted.	Residents were not consulted and they only received information via media. There is need for a massive consultation in the whole country to ascertain the impact of PPPs on peoples' livelihoods.
What do you have to say about the PPP Model in health service provision?	With the current model hospital fees are expensive. People are dying in hospitals as they are unable to pay for drugs. The government used to offer free treatment for everyone during the first years of independence; outpatients' fees were covered but now only consultations are free.	PPPs are unconstitutional as they have led to the introduction of user fees thus ensuring that those who cannot afford are denied their right to health. Privatisation of hospitals in the form of PPPs needs to be analyzed as to whether it is to help government's efforts or to make profits. GoZ need to analyze the partnerships and donor investments and see if they improve people's livelihoods.
What differences in health service provision are there before and after the PPP Model?	At Musami Hospital consultation fees is $5 while in Murehwa it is $4, $6 is charged for bed only with no treatment. Maternal care is $30 at Musami. Patients can be admitted for 3 days while hospital staff takes care of the mother and baby. At Murehwa hospital the mother and baby are released soon after giving birth.	Patients are now paying user fees as compared to a time when the GoZ was in total control. Mortuary at Marondera hospital is now operated by Doves funeral services.
Are there any reports of health and life rights violations and/or threats?	The people's rights are being violated. Murehwa Hospital is mandated to open at 08:00 but patients only receive service from around 10:00am at a slow pace even in critical cases. Some patients are chased away if they do not have fees thus violating their right to health.	Patients are being detained in hospitals due to nonpayment of fees. Debt collectors are being sent to defaulters and in some instances they confiscate assets.

Interview Question	Murehwa	Marondera
	Other Public Health Institutions	
Are there any public health care institutions (e.g. clinics) in the area?	Goromonzi clinic is available though it is far, Kowo is 35 miles away while Chipfumbi/John Reiner, Munamba are available for health care with patients paying US$5 for treatment as compared to Musami where patients pay about US$40. Somerset, Shamba and Nyamutumbu clinics are also available	Dombotombo and Nyameni clinic in Marondera urban, PSMAS, Rushinga Clinic, Mahusekwa, KushingPhikelella and Madamombe hospital Mahusekwa is a state of the art hospital which is unfortunately short staffed.
How do these institutions treat you?	These clinics treat patients very well and take good care of patients.	These clinics and hospitals treat patients very well as long as they have the money to pay.
Are they helpful	They are helpful because they charge less as compared to Musami and Murehwa hospitals and they are reachable with people using scotch carts to go there. Residents can receive free treatment at Reimer clinic and can pay $1 for treatment as compared to district hospitals.	They are helpful as they are completing Marondera hospital initiatives.
	Health Care Fees	
Do you pay any fees to access health care from public health institutions?	Residents agreed that they pay user fees starting from $5 but medication can be expensive depending with the disease that has been diagnosed Nowadays it is not affordable to rural people but can get free treatment at council clinics mentioned above.	Residents confirmed paying health fees and some cannot afford if referred to Harare and CCH.
If yes, where and how much?	$5 at Musami, $4 at Murehwa and $1 at Reimer clinic. Services are for free at most council clinics.	Residents confirmed paying at least $5 for consultation at Marondera and this can be more if referred to CCH and for patients with complications.
How do you compare these fees before and after the adoption of the PPP Model?	These fees are expensive and unaffordable to most rural people as compared to a time when the government used to provide free health services.	As in Murehwa it is now expensive and unaffordable to access health services.
How do the current fees affect residents' access to health care?	These fees are affecting residents as people cannot afford treatment and some people are dying at home with some expecting mothers also delivering at home. The role of health workers is not being recognized as they give information to residents at clinics on the spread of diseases but are told to pay when they visit hospitals. There are no initiatives in the village such as water treatment and mosquito control.	People are no longer able to access and afford health care. A sizeable number of people are dying in their homes just like Murehwa.
What are your recommendations on health care fees?	There is need for the reduction of admittance fees. Hospitals should stop selling cards for $1 and encourage patients not to buy small notebooks for 20 cents. The elderly should be treated for free just like the golden days when the government was in total control. More staff needed for night duties. Need for sanitary wear at low costs for women and girls.	Increase budgets for health care and reduce user fees. Adequate staff needed, government needs to increase budgets so that there is an improvement on doctor/nurse to patient rations. Need to increase nursing schools and infrastructural development by GoZ and not rely on PPPs that are expensive. , need to deal with corruption in hospitals, offer free medication to TB, HIV/Aids, cancer and diabetic patients.

Interview Question	Murehwa	Marondera
	Relations With Technical Partners	
Do you have any technical partners promoting access to health care in your district?	There are relations with organisations such as CRS, Commutec, DAC, ZICHIRE, FACT, ZWAP, MHCW, ZACH, Silveria House, Helpage, St Johns Ambulance and PSI.	Cordaid, Community Working Group n Health, ZICHIRE, ZNNP+
If yes, how do you relate to them?	Residents work with partners very well. Commutec provided bicycles for community care givers, CRS provides medicines once per week but this facility is open to abuse by corrupt officials since drugs are administered by hospitals. St John's Ambulance provided assistance for home based care while ZACH helps with peer education.	Residents relate to partners such as Cordaid who provide free care to expecting mothers at Marondera, Nyameni and Dombotombo. Services are characterized by delays due to large numbers of people waiting for free services.
	Challenges	
What problems are you facing in the health sector?	Drinking water is scarce and there are water shortages at hospitals during the dry season, toilets need to be rehabilitated as they were damaged by the rains and this can cause disease outbreaks e.g. cholera. There is no ambulance to pick patients from their homes to referral hospitals. People still depend on donors to access treatment. The changes in staff are also affecting operations especially between community care givers and new staff.	There is an unavailability of ambulance services; exorbitant fees also affect service delivery. There are water shortages and no electricity at clinic's which affects service. There is abuse of donor drugs, and nepotism in recruitment processes. Staff attendance to patients is also poor.
How have you attempted to solve these problems?	No effort has been made to rectify the situation at the moment but efforts are being made to mold bricks for the rehabilitation of toilets and wells.	No efforts were made to solve problems.
Who do you communicate your problems to?	Residents use suggestion boxes with no evidence of these suggestions being considered. Community care givers can take issues to hospitals and local councilors and MPs.	Residents use suggestion boxes in cases where reports to clinical superintendent and staff are not taken into consideration..
Do they make any efforts to address your challenges?	There is no direct person to give grievances. Suggestion boxes are not opened thereby no efforts are made to address the challenges being faced in the hospitals.	There have been no tangible efforts to address the challenges.
	Opportunities	
What are the opportunities arising from the adoption of PPPs in the health sector? (to individuals, Government, CGH, private companies and rights to health and life among others).	New clinics to be built in the local areas so that patients do not travel long distances. HIV/Aids patients to receive free treatment so that they are not made to pay $1 for a card. Creation of new jobs for local people. New machinery being brought by private companies. Expecting mothers used to die while giving birth but the situation has since has improved.	It was noted that opportunities were outweighed by the negatives impacts of PPPs. PPPs have improved service delivery at CCH though access to health has become expensive. Results are not yet visible to a larger extent as the process is bureaucratic with staff shortage leading to people dying in ques and at times there is one doctor on call.

Interview Question	Murehwa	Marondera
	Opportunities	
Is the Constitution promoting these opportunities?	Respondents were not yet aware.	One respondent said the constitution was promoting opportunities and cited a case when his father with prostate cancer was referred to CCH, he got quality services showing how the Constitution promotes opportunities through PPPs.
What are your recommendations for the full utilization of the opportunities?	To remove the $1 charged for HIV/Aids treatment, free medication to diabetic, hypertension and cancer patients. Ambulance services should be provided for free, rehabilitation of blair toilets.	To remove health fees and conduct civic education on the health rights of citizens. Sensitization on PPPs. More supervision of health staff so that Doctors are discouraged from concentrating on their own surgeries.
	Recommendations	
What do you recommend as the main policy and/or legal steps needed for the health sector to reach its full potential under PPPs?	To reduce or do away with user fees. Maternity care and registration should be free because expecting mothers are giving birth in a home which is not safe for both mother and baby. Family planning should be free. There is need for a comprehensive policy that addresses the rights of rural and marginalized communities as well as the elderly including women.	Need to analyze the tendering processes in PPPs. Need to clarify policies on PPPs assess the benefits and not the problems from PPPs. Need for wider consultations on the impact of PPPs with more time being given to citizens to understand the policies being introduced. Need for policy to address health needs of the elderly and women. GoZ needs to be accountable to its citizens.
What are your recommendations to Government, local authorities, residents, Ministry of Health and Child Care, private companies involved in the PPP Agreement and other stakeholders involved?	To electrify more hospitals and community health centers so as to improve the storage of drugs. Need to do road rehabilitation. Malaria control needs to be reintroduced. Residents can do food for work to maintain roads, cutting of grass to deal with malaria, assist with scotch carts to transport patients, women helping in community health programmes, brick molding for toilets, dig wells, and be self-sufficient in food and nutrition systems and not rely on donors. Other stakeholders can contribute to agriculture to improve on food security and nutrition and help communities to adequately equip health centers. They can also contribute towards the rehabilitation of toilets and assist with construction of new clinics.	To put in place accountability measures to act as check and balances. Need to improve on hospital systems. Hospitals need to be transparent on drug stocks as patients cannot find drugs in government hospitals which are readily available in private hospitals. There is need to know the number of doctors and nurses at any given hospital and their working conditions. Need to understand joint ventures and budgets should be clear and public participation is very crucial in health budgets. Citizens should be afforded the opportunity to reject unfavorable health budgets. There is need to do away with passive participation by citizens. A new health policy is needed that addresses the income gaps among citizens. Need to revise recruitment processes and not fast track recruitment so that suitable candidates are chosen. Other stakeholders need to chip in with their technical and financial resources. Need for transformational leadership in hospitals and reformation of staff behavior so that they put the needs of patients at the forefront.



7.0 DATA ANALYSIS

From the research findings, data was analyzed and put in a summary in the following charts and tables. Number of respondents: A total of 31 participants were interviewed in Murehwa women being 58% while 15 in Marondera and women being 36% of the respondents:

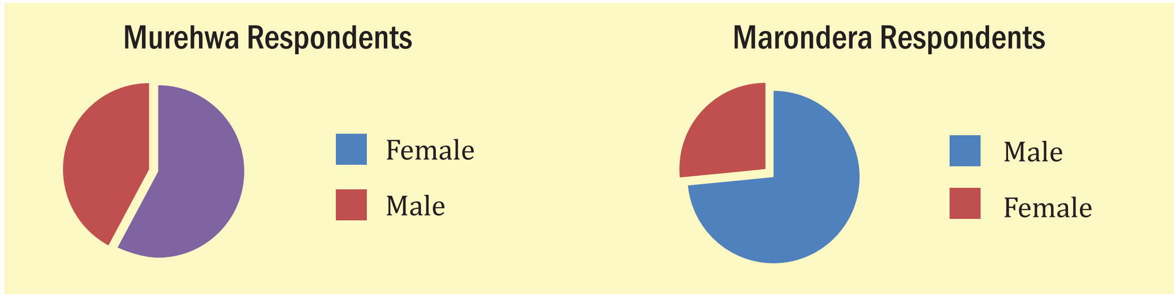


Fig. 1

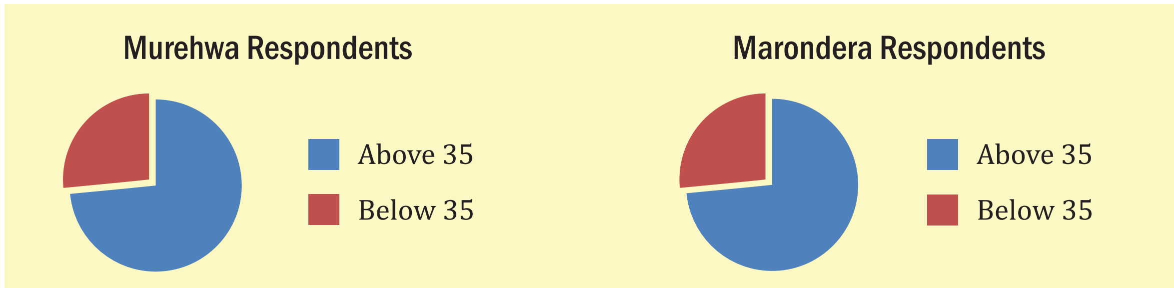


Fig. 2

The sample size was characterized by low turnout of youths in the two areas.

Regular Health Providers in Murehwa and Marondera

Murehwa Respondents

Murehwa Only
Community Health
Murehwa & Musami
Musami Only

Marondera Respondents

Marondera Only
PSMAS
Marondera & Ruvimbo
Marondera & CCH
Marondera & Dombotombo
Marondera & PSMAS

Fig. 3

From the pie charts above, it shows that residents have more confidence in Musami Mission hospital though it is a bit expensive as compared to Murehwa. In Marondera residents prefer Marondera Hospital due to its proximity and affordability as compared to PSMAS and CCH.

Number of Patients Receiving Health Services and CCH

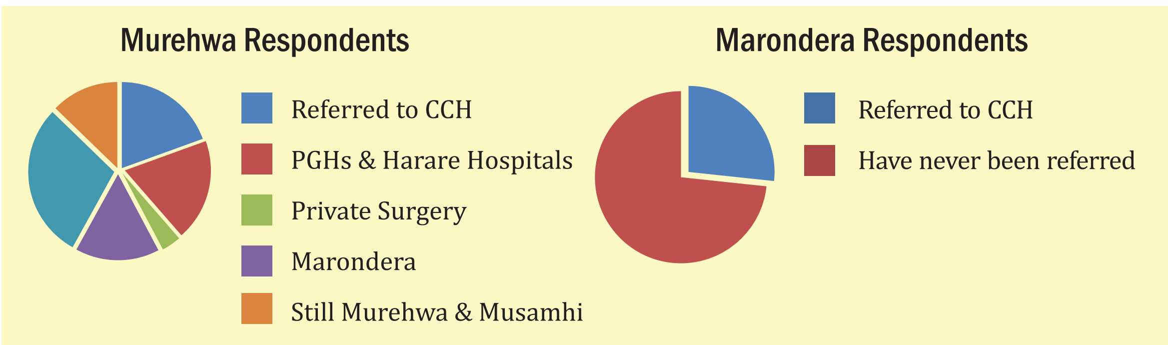
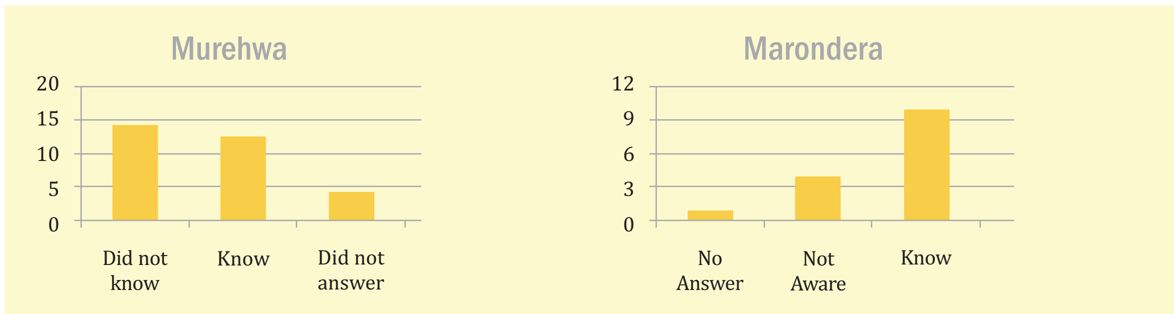


Fig. 4

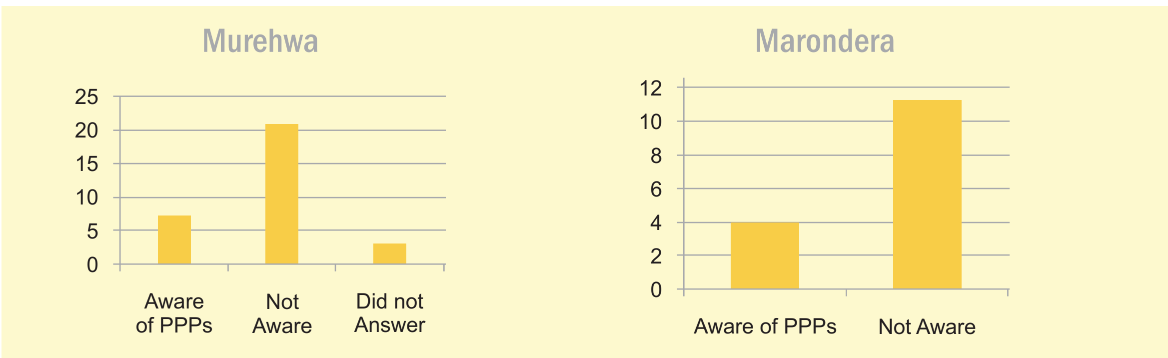
In Murehwa those referred to CCG did not rate the services, 2 respondents referred to PGHs and Harare central hospital said they were handled well and 1 who went to a private doctor rated the services as good. Some said they cannot go to CCG because they cannot afford the costs. Those who opted for Musami said they were well taken care of especially maternity services as compared to Murehwa hospital. In Marondera, 3 of those who received hospital care said that service has improved while one argued that there is a shortage of staff.

Knowledge on Constitutional Provisions on Health Services



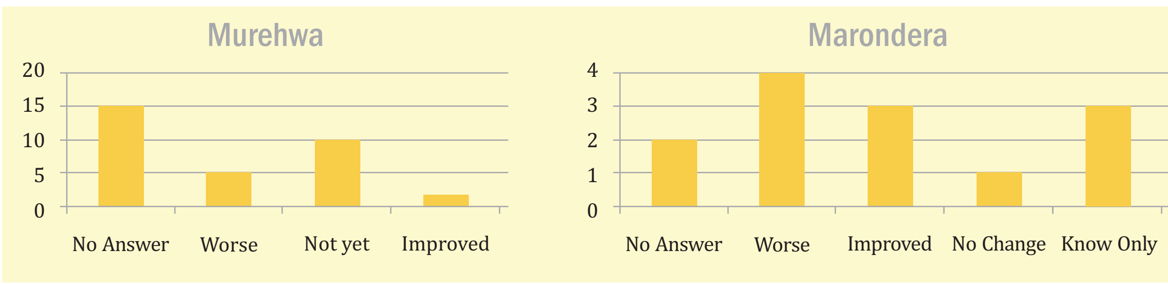
Residents noted that they know about the right to health for everyone, free treatment for HIV and AIDs including TB patients as well as information of health related matters including the right to a healthy living, access to treatment and nondiscrimination.

Awareness on PPPs

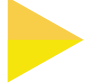


Those who said they were aware of PPPs said they were not consulted and only knew about them through the media in Murehwa. All respondents confirmed that they were not consulted and only got information from the media.

Changes in Quality of Health After PPPs



In Murehwa 15 respondents did not answer, 1 said diseases have been controlled due to PPPs, 5 said things are now bad as they are paying for treatment and drugs while previously the poor, the elderly and children including maternal care were for free. 10 respondents said services are poor and have not improved, there is no medication and they were told to buy medicines at private pharmacies. In Marondera, 2 respondents did not answer, 1 respondent said that there is no change due to economic challenges, 3 rated the hospital operations as the best, getting new drugs, new machines in the hospital whereas it had been like a death trap. 3 said they only know about Marondera Hospital that is still government owned but with shortages of staff and drugs and, outdated machinery . 4 respondents said that the situation is now worse than before marred by long ques, spending the whole day waiting to be served, with patients paying exorbitant fees and staff taking their time to attend to patients. This is highlighted in the graphs above.



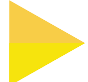
8.0 CONCLUSION AND RECOMMENDATIONS

From the above research findings and data analysis it can be noted that most residents in peri-urban and rural areas are not aware of PPPs and what the constitution and even national policies say with regards to health delivery services in Zimbabwe and their own localities. It was noted in the research that residents have been complaining about the deterioration in quality health care as this has become expensive to rural marginalized communities especially the elderly and women. In this regard, there is need to come up with a holistic new health policy that takes into account the needs of the elderly and women and the poor marginalized rural communities. As part of the recommendations, the government and other stakeholders can pursue the following:

1. Leverage national resources to fund health provision and remove user fees as the citizens were proposing.
2. Need to analyze tendering processes in PPPs and clarify policies on PPPs and need to see benefits and not problems from PPPs.
3. Need for more consultations on impact of PPPs, more time should be given to citizens to understand the policies to be put in place instead of being given a short notice to be consulted while at the same time consulting a few people.
4. Need for policy to address health needs of the elderly and women.
5. The GoZ need to be accountable to its citizens and to know the number of doctors and nurses at any given hospital and their working conditions.
6. To put in place accountability measures to act as checks and balances. There need to improve on hospital systems to deal with leakages and be transparency on drug stocks as patients cannot find drugs in government hospitals but private hospitals.
7. There is need to understand joint ventures and budgets should be clear and public participation is very crucial in health budgets. Citizens can reject unfavorable health budgets. There is need to do away with passive participation by citizens.
8. New health policy is needed that addresses the income gap among citizens.
9. There is need to revise recruitment processes and put in place health care professionals who have the importance of humanity at heart.
10. ZIMCODD and other civil society organisations (CSOs) can expand their civic participation

in economic development (CPED) programme to these areas so as to sensitize and raise awareness on the Constitutional provisions on health and the impact of privatisation under PPPs on people's livelihoods.

11. ZIMCODD can capture and amplify rural communities' voices on the impact of PPPs people's livelihoods and use this as a lobby and advocacy strategy to influence health policies reforms in Zimbabwe.



9.0 CONCLUSION AND RECOMMENDATIONS

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Investing in People
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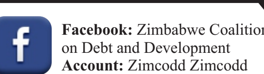
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