SAPRI / ZIMBABWE

The Impact of Public Expenditure Management Under ESAP on Basic Social Services: Health and Education

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1.0 Background

The goal of ESAP as regards fiscal operations was to reduce government expenditure through removal of subsidies, cost recovery, civil service rationalisation and parastatal reform. Since 1991, the government embarked on a process of expenditure control, which encompassed removal of subsidies on basic commodities, health and education sectors, user fees in the provision of basic social services, reduction of the civil service and parastatal reforms. The belief by mainly government and the IMF/World Bank was that public expenditure reforms would lead to price stability and an improvement in the cost-effectiveness of the provision of social services.

According to civil society however, the removal of subsidies and cost recovery in education and health sectors, has resulted in swelling numbers of children out of school, people dying of curable diseases in their homes and women giving birth at home or in scotch carts on their way to health centres. Civil society also contends that several health indicators have deteriorated. Participation in prenatal services has declined; maternal death and mortality rates of babies born before arrival (BBAs) have increased. Declining wages of health personnel since 1990 has resulted in a mass exodus of qualified staff, low morale and general discontent.[1] Not only are the hospitals facing critical drugs and equipment shortages, they are facing congestion at casualty departments and mortuaries. The quality of health care has deteriorated at most hospitals. Clayton Shambare of Kuwadzana Extension has a vivid expression of his sordid sojourn at Parirenyatwa Hospital. He said, *"It's not as if I have improved,"* he explained with emotion, *"I have to leave to allow others to come in as well, I will die but somewhere else."* (Daily News, 8 November 2000:17).

1.1 Purpose of the Study

The purpose of this study is to assess the situation of basic services in particular health and education under ESAP, and examine the impact on various sectors of the population, particularly low-income groups, children and the poor from the resulting changes in social welfare.

1.2 Methodology

To address the issues at hand, two approaches are adopted: review of available literature on structural adjustment programmes; studies on the impact of public expenditure on health and education; data on performance of aggregate public spending and social spending in Zimbabwe during the period under review was analysed. The other was to conduct participatory focused workshops involving ordinary Zimbabweans from each of the country's eight provinces. Fifteen such workshops were held.

Qualitative responses from the workshops provided a wide range of responses on provision of social services. These responses were tailored to discern key issues.

[1] This has generally been reflected in strikes, rudeness of nurses and general practitioners spending more time in their private practice than the public institutions.

2.0 The Process of Implementation of ESAP

To reduce socio-economic disparities, the government that came to power at independence in 1980, invested heavily in education and health, and through parastatals, in rural development and productive sectors. This lead to an increase in public expenditures, which for the most of the 1980s made up 45% of GDP. Although social indicators improved, particularly in health and education, per capita income stagnated. Huge government spending crowded out private sector investment and fuelled inflation, while shortages of imported goods constrained investment and growth. Population grew faster than job creation, widening the income disparities. In 1991, the government proposed a policy agenda that formed the basis for the Economic Structural Adjustment Program (ESAP). The ESAP package contained the standard features of the IMF/World Bank economic reform strategies, including, inter alia, reduction of the budget deficit, through a combination of reduction of parastatal deficits and rationalisation of the civil service; trade liberalisation, including price decontrol, and deregulation of foreign trade, investment and production; phased removal of subsidies; devaluation of the local currency; and enforcement/introduction of cost recovery in health and education sectors.

A key component of ESAP was a strategy to tackle the Social Dimensions of Adjustment (SDA). The strategy was adopted by the government in November 1991 in a report entitled "SDA: A Programme of Action to Mitigate the Social Costs of Adjustment." The objectives of SDA were effectively to target and design programmes for disadvantaged groups over the economic reform period, while minimising the costs to the fiscus by maximising participation and support from third parties, notably NGOs, employee organisations, employer organisations and local authorities.

The major areas targeted for action were employment and training, targeting of food subsidies, cost recovery, social services, monitoring and evaluation. To coordinate the first three activities, a Social Dimensions Fund (SDF) was established to operate two main programmes, namely the Employment and Training Programme (ETP) and the Social Welfare Programme (SWP). Both programmes were to be coordinated by the Social Welfare Department of the Ministry of Labour, Public Service and Social Welfare. The SWP manly involved the targeting of subsidies in areas of food, health and education.

ESAP's successor Zimbabwe Programme for Economic Transformation (ZIMPREST) 1996 – 2000, continued the same thrust of macroeconomic policies with more focus on social dimensions, empowerment, indigenisation of the economy and land reform.

2.1 General Observations on the Implementation of ESAP

The economy has not performed well since the introduction of ESAP. For example, the economy grew at an average of 1% in real terms during the ESAP period (1991-95) compared to 4% during the pre ESAP period (1985-90). While economic growth

improved in 1996, registering a real growth rate of 7%; this was reversed to a real growth rate of 2% in 1997. Throughout ESAP, the budget deficit exceeded the targeted 5% of GDP, performance of parastatals worsened and the quantitative reduction of the civil service was not met.

A major important exercise is to identify the fundamental causes of this poor performance. In the early days of ESAP, it was possible to attribute the poor performance to exogenous factors, in particular the drought of 1991-92. However, subsequent events have made it crystal clear that domestic mismanagement is the fundamental cause of the poor performance. "*There is no doubt that the fiscal area has been mismanaged to the extent that it is responsible for many of the other problems in the economy.*" (Dhlodhlo and Mabugu 2000:9).

3 Brief Overview of the Literature on Public Expenditure and Provision of Social Services

Public finance should set basic education and primary health care as top priorities to boost productivity, economic growth, external competitiveness, promote equity and reduce poverty. The justification of higher spending on basic education is based on the individuals' lifetime income (i.e., social rate of return) and changes life style. Studies have found that that the social rate of return to primary education is higher than for secondary/higher education (Psacharopoulos 1985); besides, in most developing countries, rarely do the poor manage to graduate beyond primary school. Hence, it would be both allocatively efficient and equitable to meet the resource needs of primary education from the government budget on a priority basis.

The notion of changes life style can be clearly be understood by examining the life cycle of an educated girl.

> *An educated girl is likely to marry later, have few children and provide better care to herself and her children than a girl without education. As more women become educated, there is a cumulative effect on more households with respect to fertility. As more households become smaller the provision of care improves for more children. Taken together, the benefits of greater education among women adds up to a virtuous circle of social development*. (Mehrotra 2000:16).

Similarly, it is both equitable and efficient in the health sector to allocate resources to the lower or primary levels of service. Prevention is better than cure – hence it is cost effective to allocate sufficient resources in the health sector to primary levels of care in order to prevent potential cases reaching hospitals. Such cases are dealt with more cheaply - for both the patient and the provider - at the primary health care centre (PHC); the human cost is also lower, as care can be delivered easily due to the physical proximity of PHC. It is equitable because a large proportion of the population are likely to use a PHC than a hospital.

Mehrotra (2000) contends that the high achievers (i.e., East Asian countries) in education and health emphasised education and health systems building and a comprehensive (not selective) approach to lower or primary level of service. In education, the expansion of physical facilities, proximity to schools, and increase in number of female teachers laid the basis for the participation of girls.[2] Similarly, the emphasis on primary health care achieved major reductions in the mortality and child health – thus applying the principles of the Alma Ata Declaration on Health (1978) long before the principles were written.[3] Almost all children were born under medical attention, supported by a good health referral system. This was followed by household visits by the first-level health worker. High levels of immunisation of children – provided mainly by PHC – ensured that communicable diseases did not lead to high morbidity or mortality of mother and child.

The foregoing suggests that expenditure allocation within social sectors matters for education attainment and health status. For expenditure allocation to boost economic growth and the well being of the poor, attention should be paid to the allocation within the social sectors – both size and allocative efficiency.

4.0 Public Expenditure Management and Provision of Social Services

In the 1980s, Zimbabwe recorded remarkable achievements in important social indicators such as crude death rate, infant mortality, life expectancy and adult literacy. This was achieved via increased budget allocations to the health and education sectors in line with the Growth and Equity Policy Statement (1981); which emphasised the provision of social services to the majority of Zimbabweans. Some of the salient trends with regard to public expenditure on social spending are summarised in Tables 1 to 4. The following features of public expenditure and social spending can be inferred from tables 1 to 4:

- Expenditures in heath and education rose throughout the 1980s;
- Expenditures in health and education fell throughout the 1990s;
- Wages have fallen in the health and education sectors; and
- Relative to the overall Consumer Price Index (CPI), the medicare price index rose by 2106.3 percent while the education price index rose by 857.2 percent between 1990 and 2000. This is particularly important in assessing the impact of rising social expenditures as it implies that the cost of health and education services rose by 2106.3 percent and 857.2 percent, respectively, relative to average prices.

[2] Female teachers give parents of girl-children a sense of security as well as providing a role model for girls in the community.

[3] At a major conference held in 1978 in Alma Ata, the Kazakhastan capital, an important practice already in practice in many countries was internationally recognised that the organisation of health in developing countries be based on primary health care. The principle responded to the nature of the disease burden in developing countries.

An aggregate analysis of government expenditure when compared with the Sachs "norms" of government expenditure appropriate for Sub-Saharan Africa shows that the country is underspending on health and infrastructure while is it overspending on interest defence and general administration (see Table 5).

4.1 Public Expenditure in the Health Sector

The Community Working Group for Health (1998) and Parliamentary Committee on Health (2000) identified the following features of public spending in the health sector:

- The public health budget is not enough to meet heath needs, the per capita budget has fallen since 1991 to a level where it does not even pay for prevention, clinics and district hospital costs per capita. In 1990 health allocation constituted 3.1 percent of GDP (US$22 per capita), it dropped to 2.1 percent of GDP (US$11 per capita) in 1996.

- Decreases in health care spending has resulted in reduced maintenance, delayed upgrades of deteriorating health facilities, shortages of essential drugs and the high rate of staff attrition to the private sector and abroad.

- There are too few doctors and nurses in the public sector, particularly at the clinic and district hospital level where the majority of patients go.

- The cost of health has risen sharply, especially for the urban poor. Rural health facilities are more affordable but poor quality care means that people still have to spend money travelling to higher level or urban facilities and pay for services there.

- The medicare price index has increased faster than any other item in the Consumer Price Index. Many people drop out of health services, report late when illness is more severe, use self-help or traditional health care. This in itself leads to the increased spread of disease in the community.

- There has been deterioration in access, as well as availability and quality of health services.

- The health sector is best by shortages of drugs and equipment and overwhelming demand for services as a result of the HIV/AIDS pandemic.

- Private health facilities are booming.

- The government is failing to provide basic minimum health facilities.

The Community Working Group for Health (1998) and Parliamentary Committee on Health (2000) advocate the following strategies:

- The public sector should allocate a minimum per capita allocation to preventive health, monitor more closely the activities of local authorities and other public and private sectors in terms of their prevention of health risks, mobilise more responsible health practice and organise people to prevent illness. Prevention should be the core of the public health system.

- There should be a national and local investment plans and programmes for improvements of most important inputs to health. These include, for example, ensuring household food security, generally and particularly in terms of adequate energy for vulnerable groups such as young children, reducing density of accommodation and improved housing quality, ensuring access to adequate water supplies and ensuring access to education, particularly female education.

- Greater finances and health care resources (including drugs and staff) should be directed to the primary care clinics and district hospitals where the majority (80%) of people seek health care, but which currently receive less than 49% of the public health budget.

- The shortage in human resources cannot be met by recruitment and training. There is need to look into factors that make people leave the public heath sector and address them.

- Private enterprise should be encouraged to play a meaningful role in health, and current subsidies to the private sector should be redirected as tax and other incentives for private investment in areas of wider national need, in training of health personnel and in supporting public health.

4.2 Public Expenditure in the Education Sector

Independent studies have identified the following features vis-à-vis public spending in the education sector:

- The total education vote declined gradually as a percentage of GDP from a high of 6.29% in 1986/87 t0 4.82% in 1999 (Makamure and Muzuwa 2000).

- Per capita allocation to the Ministry of Education fell in real terms from Z$37.83 in 1990 to Z$30.44 in 2000 (Kadenge 2000).

- Recurrent government expenditure on primary education fell by more than 30% between 1990 and 1994, while higher education increased by 1% between fiscal years 1990/91 and 1994/95 (Chisvo and Munro 1994).

- Ninety percent of government expenditure to primary education goes to salaries and wages leaving only 10% for maintenance of infrastructure, acquisition of

furniture, textbooks, didactic materials monitoring and continuous upgrading of teachers.

- Cost recovery measures have impacted negatively on enrolments and females (Myambo and Dombo 1999).

- Teachers' real wages have fallen (Chisvo and Munro 1994).

The independent studies cited above make the following recommendations vis-à-vis public expenditure in the education sector:

- More resources should be allocated to primary education in order to ensure equity and the reduction of poverty.

- The boy and girl child should be treated equally vis-à-vis access to education.

- More resources should be allocated towards the acquisition of textbooks and didactic materials.

4.3 Inferences from Selected Statistics on Provision of Education and Health Services

This section presents statistics from which inferences can be made on the provision and performance of the heath and education sectors during the ESAP period.

4.3.1 Health Services

Table 1 shows that government expenditure on health increased throughout the 1980s as government embarked on an expansion of health care to rural areas and the urban poor. During the 1980s, infant mortality fell (IMR) fell from 86 to 61 per 1000 births, immunisation increased from 25% to 80%, the crude death rate dropped from 10.1 in 1982 to 6.1 in 1987. Life expectancy increased from 55 years to 59 years. More health infrastructure was constructed and there was greater access to health (Chibanda 1996). More nurses with better qualifications entered the system and much emphasis was placed on preventive and simple curative care such as immunisation campaigns, and health information in the areas of family panning, mother-child health care, environmental health and treatment of communicable diseases (TB, STIs).

However, since 1990 real government allocations to the Ministry of Health and Child Welfare (MoHCW) has decreased from 6 percent of total government expenditure to about 4 percent. A similar picture is also captured by health expenditures as a percentage of GDP and per capita health expenditures. Health expenditure as a share of GDP (in real terms) increased from 2 percent in 1980 to a peak of 3 percent in 1990. In 1995, it had

declined to 2.2 percent of GDP (Zimbabwe Human Development Report 1998). On a per capita basis, health expenditure declined from US$22 in 1990 to US$11 in 1996 (Auditor Generals Report 1996). The government also reduced grants to church related and local authority hospitals.

Fiscal austerity has reversed all the gains in the health sector as shown by the following (see Table 6 for instance):

- Decline in prenatal services;
- Shortages of drugs and equipment;
- Mass exodus of qualified staff, low morale and general discontent;
- High nutritional deficiency;
- Reduction in admissions in public hospitals (see Table 7);
- Congestion at casualty and mortuaries;
- Less outpatient attendance;
- Decline in the number of district hospitals from 37 in 1995 to 34in 1998 (Quarterly Digest of Statistics, June 1999);
- Decrease in immunisation coverage (see Table 8);
- Fall in the relative and per capita allocation to prevention (see Table 9); and
- A fall in the number of government clinics from 37 in 1995 t0 35 in 1998 (QDS June 1999).

The HIV/AIDS pandemic has added to the crisis, and hospitals are having problems coping up with demand for services.[4] Over 3 000 victims die every week. This has important implications for both the health sector and the whole economy as a whole by lowering worker productivity, raising dependency ratios in rural areas (where patients end up due to the absence of hospital care facilities, and raising the cost of health services World Bank, 1996). By 2000 it was estimated to result in one million deaths of adults and children and to 600, 000 orphans; putting additional burden on already strained social services (Loewenson and Chisvo, 1997).

[4] On this one the health information officer for Harare Central Hospital has this to say, "We have had to adjust the way we operate because of these economic difficulties. Because we operate on a specific budget we can no longer admit more patients than we can afford to. It simply doesn't make economic sense." (Daily News, 8 November 2000:17)

The reversal of earlier gains in health was noted by a 1993 UNICEF study which noted that the quality of Zimbabwe's health services had fallen by a colossal 30% and that twice as many women were dying in childbirth in Harare hospitals than before 1990 and that fewer people were visiting clinics and hospitals because they could not afford hospital fees. It further noted that bed occupancy at Harare hospital fell from 5 766 in December 1990 to 4 795 in December 1991. These observations are supported by a recent study by Biljmakers et al (1998), which focused on Chitungwiza and Murehwa. Its findings are:

- There are high levels of wasting and stunting in children less than five years of age in Zimbabwe;

- Malnutrition was highest in Murehwa in 1992 and 1993 when 9% to 11% of all children who reported for growth monitoring were underweight; and

- In Chitungwiza, the percentage of underweight never exceeded 3.5% at any time.

4.3.2 Impact of Health Service User Fees

In 1991, the government began to systematically enforce the system of user fees for heath services. Those earning more than Z$150 per month were made to pay for health services. Unemployed people and those earning less than Z$150 were entitled for free treatment. A letter from the local councillor or from the Social Development Officer could serve as proof of eligibility for free treatment. This cost recovery measure was put in place just as the worst drought of the century hit the country in 1991-1992. The 1991-1992 drought reduced disposable income for discretionary expenditure drastically. In November 1992, the fee exemption income was increased to Z$400.[5] In January 1993, the government abolished fees at rural health centres and most rural hospitals, in order to alleviate the effects of the 1991-92 drought on rural populations. It should be noted, though, that most council and mission clinics continued charging fees. In June 1993, user fees were reintroduced at rural government facilities.

In January 1994, the system of user fees for health services was again revised, with substantial increases in all services. These new guidelines were intended to rationalise user charges across institutions as well as cost recovery. The MoHCW had recognised the large variations of fee level between the health institutions belonging to the ministry itself, local governments (rural district councils and municipalities) and missions. All fees were standardised.

It is evident that some of the increases were dramatic, exceeding 1000 percent and had serious impact on the utilisation of health services in both rural and urban areas. Immediately after fees were raised in 1991 and 1993/94, declines were noted in out

[5] In principle, the exemption system was costly to implement and it did not guarantee access to health services by the poor (Moyo and Zwizwai 1998).

patient and antenatal attendance, prescriptions dispensed, admissions, X rays, lab, and dental services (Hongoro and Chandiwana 1994). Most people sought early discharge or absconded to save, money (ibid).

The scenario of the health sector after 1990 can aptly be depicted by a macabre imagery of a reporter visiting Zimbabwe's hospitals, who described them as a "death trap." (Daily News, 8 November 2000:16). He apply summed it when he wrote,

> *Not only do these hospitals face a critical drug, equipment and staff shortages, they are becoming extremely expensive for the ordinary worker who is battling to make ends meet due to the high cost of basic commodities. Consultation and admission fees are pegged at Z$169 for adults and Z$84 for children and are now demanded upfront. The exemption certificate from the Social Development Office for low-income earners is now only worthy the paper it is written on. In the context where the HIV/AIDS pandemic is claiming 1 700 people a week over and above a host of many other fatal diseases, then the deplorable sate of the health delivery system could be seen as a bombshell of seismic proportions.* (Daily News, 8 November 2000:16).

It is not surprising that therefore, that a group of participants at one SAPRI workshop interpreted the acronym ESAP to mean "Elimination of Social Assistance of the People."

4.3.4 Education

Education also suffered from fiscal austerity. Available statistical evidence shows that women (both teachers and young girls) are concentrated in primary then followed by secondary education. Eight percent of all females undergoing formal education are in primary schools, 19 percent in secondary education, 0.8% in vocational, industrial and teacher training and 0.2% in universities.

Recurrent expenditure on primary and secondary education (where women are concentrated) has been allowed to decline by more than 30% during ESAP, while that of Higher Education grew up by 1% in 1994/95 fiscal year above its 1990/1 level (Chisvo and Munro, 1997). Because of this, it can be inferred that ESAP has affected the quality (and quantity of women education).

Despite education dominating the budget allocation, the allocation to education as a percentage of total recurrent expenditure fell from 39% in 1999 to 21% in the 2000 budget. Per capita allocation to Ministry of Education fell in real terms from Z$37.83 in 1990 to Z$30.44 in the 2000 budget. The decrease in per capita allocation has resulted in a fall in real wages (see Table 3). Resource supplies – didactic materials such as books, chalk, etc., the Ministry's own enhancing activities – monitoring, continuous upgrading of teachers, etc., school services (including repair and maintenance), furniture and equipment, and grants to private schools fell drastically. This adversely affected the quality of education.

4.3. 4 Impact Cost Recovery in Education

The government abolished primary school fees at independence in 1980, but reintroduced them in urban and all secondary schools in 1992. An exemption system was established for children from households earning less than Z$400 per month. The Z$400 limit, which corresponded to the threshold for the payment of personal income tax, was way below the poverty datum line equivalent of Z$593 for a family of six in July 1991 (Kanji and Jazdowska 1993, Loewenson et al 1991).

Available statistics show that the dropout rates increased with the introduction of school fees (see Table 10). The results of the study by Myambo and Dombo (1999), which covered four districts in Harare and Kadoma district found out that most of the respondents, indicated that school fees were not affordable because of low wages and salaries. It should also be noted that apart from school fees households also pay school levies, purchase books and uniforms. What is striking about the cost structure of education is that more than half the costs (especially in rural areas) are absorbed by uniforms, an item, which has no impact on educational quality. It appears uniform costs are clearly acting as a price barrier to education. [6]

As shown in table 10, and as noted in the Zimbabwe Human Development Report 1999, the dropouts are highest in grade 1. In grades with the highest dropouts, the rates are highest among girls relative to boys. This result confirms that although parents prefer to send both a male child and female child to school, if parents are forced to withdraw children the girl child may lose out. The transition from Grade 7 to from one fell by 70 percent of all those who completed Grade 7 by the end of the decade (Zimbabwe Human Development Report 1999). Dropout rates in secondary schools reached a peak at Form 4, averaging 92, and 98.4 percent for males and females over the period 1990-1997, respectively (Kanyenze 1999).

The foregoing suggests that, large increases in school fees necessitated by cost recovery in education have impacted negatively on females. The results of the Third Round of SDA monitoring survey found that the reasons for not being at school "because it was too expensive," was frequently in all age groups for girls than boys.

5. 0 People's Views Based on the Workshops Results

This section summarises the qualitative information collected from the participatory focused workshops.

5.1 Equitable Access and Quality

Introduction of higher and ever increasing fees in the health and education sectors has resulted in many dropping out of health service and some pupils failing to acquire even primary education. Health staff have negative attitudes to their clients. This may partly be

[6] One step to address this problem is to do way with uniforms.

caused by stress due to poor working conditions, but seems also to indicate lack of respect for clients.

5.2 Public Finance Management

The general perception is that there is poor control and management of public finances as epitomised by lack of accountability, poor monitoring mechanisms, increase in abuse of public finances, corruption and lack of prioritisation in budget allocations. Regarding corruption, one participant at the SAPRI workshop remarked, *"We have read so much about Zim-looters, but what is painful is that nothing happens to them. The courts may find them guilty, but before they serve for any reasonable time they are pardoned."* A Chitungwiza SAPRI participant added, *"Some problems blamed on ESAP are in fact perpetuated by mismanagement of public finances."*

5.3 Audit

There are no proper controls for public finances. There is a need to put in place a structure that is independent to conduct annual audits for all government ministries so that corrupt and fraudulent leaders are swiftly brought to book.

5.4 Role of Local Authorities

Local authorities felt totally marginalized in the sense that they are never consulted by central government. During SAPRI workshops, a Manicaland councillor regretted that he did not understand ESAP because the local leadership was neither consulted nor enlightened on it. The councillor added that the only time there was consultation was during the constitutional date. He lamented that there should be more consultation. There is an urgent need to clearly define the role of local authorities in education, health and governance issues.

5.5 State and Governance

The general perception is that central government does not consult, the President has too much power and that there is no rule of law. The general consensus was that the government should consult widely on both economic and political matters. Policy options should be more transparent and public consultation is a way to improve monitoring and accountability. A consultative process similar to the constitutional debate should be applied vis-à-vis economic policies. Broader consultation helps build a broader sense of ownership of the country's strategy.

6.0 Summary

Macroeconomic policies are the major determinant of heath and education sectors performance. The health and education sectors performance were impeccable in the 1980s due to supportive macroeconomic policies. However, the introduction of ESAP in the 1990s has resulted in these social sectors operating under severe stress. Budget cuts,

decline in real wages, increases in poverty levels, cost recovery, and increases in HIV/AIDS have resulted in a decline in social indicators.

7.0 Recommendations

i) The health budget should be increased in real terms and the bulk of the expenditure must be channelled towards primary health care. The Community Working Group for Health recommends that at least 2.5 % of GDP should be allocated to the health sector.

ii) Greater finances and health care resources (including drugs and staff) should be directed to primary care clinics and district hospitals where the majority of the people seek health care.

iii) Maternal health care services deserve more attention to enhance access of majority.

iv) More resources should be channelled towards HIV/AIDS campaign.

v) More resources should be allocated to primary education to ensure equity and the reduction of poverty.

vi) There should be more provision in the primary education allocation for the purchase of textbooks, furniture, maintenance, construction of classrooms and schools.

vii) Boys and girls should be given equal access to education.

viii) Staffing at facility levels (schools and hospitals) should be given attention and constraints addressed to enhance effectiveness of complimentary inputs already provided.

ix) Overall allocation and management of resources in the two sectors should be given attention for efficient use. Corruption in particular should be arrested via proper legislation that includes, inter alia, strict punitive measures.

x) Well-designed safety nets and poverty reduction strategies should be put in place.

xi) The government should encourage the private sector to provide education and health care.

xii) The budget formulation process should be democratised. Civil society should be involved in the budget formulation process. Strong networks of poor people's organisation and strong civil society are required for effective governance at the local and national level.

xiii) Transparency and accountability should be a constitutional requirement with regard to the national budgetary process.

xiv) The government should stop directing more resources to defence because it has no direct effect on social welfare. Participatory workshops evidence condemned the army's involvement the DRC.

xv) Introduction of a maximally publicised national audit of public finances at specified intervals.

xvi) The role of local authorities in education, health and education sectors should be clearly articulated.

References

Basset, M., Bijmakers, L. and Sanders, D., (1998) "Socio Economic Stress, Health and Child Nutritional Status at a Time of Structural Adjustment," Research Report 105, Scandinavian Institute of African Studies, Uppsala.

Central Statistical Office, Quarterly Digest of Statistics, various issues.

Chebundo, B., (2000) " The Position of Parliament on the Health Budget," Community Working Group for Health Meeting, 17 November.

Chibanda, S., (1996) "Adjustment and Woman's Health in Zimbabwe: The Current Financial Crisis," A Report Prepared for the Woman Action Group.

Chibanda, S., (1996) "Financing the Health Services: A Budget Analysis," A Report Prepared for the Woman Action Group.

Chisvo, M., and Munro, L., (1994) A Review of the Social Dimensions of Adjustment, UNICEF, Harare.

Chuma, W., (2000) "Zimbabwe's Ailing Health Institutions Now A Death Trap," Daily News, 8 November 2000.

Community Working Group for Health (1998) Health in Zimbabwe: Report on a Meeting of Community Based Organisations.

Dhloldhlo, R. and Mabugu, R. (2000) Macroeconomic Reforms, Tourism and Sustainable Development, ZERO Regional Environmental Organisation, Harare.

Gibbons, P., (1995) Structural Adjustment and the Working Poor, Scandinavian Institute of African Studies, Uppsala.

Government of Zimbabwe (1991) Zimbabwe: A Framework for Economic Reform, Government Printers, Harare.

Government of Zimbabwe (1991) Social Dimensions of Adjustment: A Programme of Action to Mitigate the Social Costs of Adjustment, Government Printers, Harare.

Hongoro, C. and Chandiwana, S., (1994) "Effects of User Fees and Health Care in Zimbabwe," Blair Research Institute, Harare.

Kadenge, P. G., (2000) "Situational Analysis of the Impact of the Budget Allocations to the Social Ministries on Women, with Specific Emphasis on the Ministry of Health and Child Welfare," Paper Prepared for Woman Action Group, Harare.

Kanji, N., and Jazdowska, N., (1993) "Structural Adjustment and Women in Zimbabwe," Review of African Political Economy, 56:11-26.

Kanyenze, G., (1999) "The Implications of Globalisation on the Zimbabwe Economy," Paper Prepared for the Poverty Reduction Forum, Harare.

Loewenson, R. and Chisvo, M., (1997) "Rapid Transformation Despite Economic Transformation and Slow Growth: the Experience of Zimbabwe, in S. Mehrotra and R Jolly (eds.) (1997) Development with a Human Face: Experiences in Social Achievement and Economic Growth, Clarendon Press, Oxford.

Loewenson, R., (2000) "2001 Health Budget: Enough to Make You Sick," Daily News, 21 November 2000.

Makamure, J. and Muzuwa H., (2000) "A Child Friendly National Budget," A Study Funded By Save the Children Norway (Red Barna Zimbabwe) for NANGO.

Mehrotta S., 2000. "Integrating Economic and Social Practices: Good Practices for High Achieving Countries," Innocenti Working Paper No 80.

Ministry of Health and Child Welfare (1998) National Health Strategy for Health 1997-2007, Working for Quality and Equity in Health.

Myambo, S. and Dombo, F., (1999) "The Impact of the Escalating Costs of Education in Zimbabwe," Friedrich Ebert Foundation Working Paper # 29.

Nyathi T, and Makoni, K., (2000) ESAP and Ordinary People, SAPRI.

Ojoo, A., (2001) "The Impact of Public Expenditure Management Under SAPs on Basic Social Services, Education and Health," Uganda National NGO Forum, SAPRI

Poverty Reduction Forum (1998) Human Development Report/ Zimbabwe 1998.

Poverty Reduction Forum (1999) Human Development Report/ Zimbabwe 1999.

Psacharopoulos, G., (1985) "Returns to Education: A Further Update and Implications," Journal of Human Resources, 20/4.

World Bank (1996) Understanding Poverty and Human Resources in Zimbabwe: Changes in the 1990s and Directions for the Future, World Bank, Washington DC.

World Bank (1996) Zimbabwe, Fiscal Management Review, World Bank, Washington DC.

Table 1: Real Recurrent Health Expenditure (at 1990 prices), Ministry of Health and Child Welfare

	Total Real Exp. (Z$ millions)	Per capita Real Exp.	Health as % of GDP	Health Exp. As % of Gov. I
1980/81	256.24	35.62	2.0	5.3
1981/82	306.60	41.44	2.2	5.6
1982/83	300.10	39.44	2.1	4.8
1983/84	289.61	36.74	2.2	4.8
1984/85	291.97	53.92	2.2	4.9
1985/86	331.00	39.48	2.3	5.3
1987/87	355.64	41.14	2.5	5.1
1987/88	384.10	43.08	2.8	5.5
1988/89	412.18	44.82	2.8	5.4
1989/90	478.88	50.50	2.6	5.9
1990/91	564.49	57.72	2.8	6.2
1991/92	511.97	50.76	3.0	5.1
1992/93	458.18	44.00	2.5	5.3
1993/94	412.88	38.45	2.4	5.1
1994/95	424.33	38.31	2.2	4.5
1995/96	409.71	35.86	2.2	4.2

Source: Chandiwana S., et al, 1997.

Table 2: Education Expenditure

	Education exp. as % of GDP	Education exp. As % of total gov. exp.
1980	1.8	10.3
1985	3.1	15.8
1990	1.9	16.9
1995	0.7	16.3
1996	0.5	15.8

Source : Report of the Comptroller and Auditor General (various years)

Table 3: Annual Earnings Per Employee (in US Dollars) in Health and Education

	Health	Education
1990	4,321	4,934
1991	3,641	4,415
1992	2,742	3,259
1993	2,330	2,725
1994	2,183	2,386
1995	2,546	2,516
1996	2,408	2,249

Source: Central Statistical Office, 1985-1996 National Accounts

Table 4: Consumer, Medicare and Education Price Indices

	Consumer Price Index	Medicare Price Index	Education Price Index
1990	100.0	100.0	100.0
1991	123.3	116.3	127.6
1992	175.2	144.4	191.6
1993	223.6	169.3	211.4
1994	273.4	419.9	229.1
1995	335.1	496.0	258.5
1996	406.9	632.9	295.7
1997	483.6	734.0	392.3
1998	636.9	818.7	508.3
1999	1,009.6	1,107.7	678.0
2000	1,573.6	2,206.3	957.2

Source: Central Statistical Office.

Table 5: Spending Patterns as % of GDP*

	Sach's norms	Zimbabwe (1996-2000)
Education	5	7.3
Health	4	2.3
Defence and public order	2	4.5
Infrastructure	4	2.2
General administration(1)	1	7.0
Sub total Interest	16	23.3
Interest	6	9.0
Total	22	32.3

* Average for Sub-Saharan Africa, excluding South Africa.
(1) Including housing and social welfare.

Table 6: Zimbabwe Infant Mortality Rate (IMR) and Child and Mortality Rate (CMR), 1978-1997

	Rural IMR	Urban IMR	Total IMR	Rural CMR	Urban CMR	Total CMR
1978	88	64	83	40	25	57
1981	85	59	79	38	22	34
1984	77	50	69	33	17	28
1986	72	47	64	30	15	25
1988	69	46	61	28	15	23
1990	71	55	66	30	20	26
1997	89	63	80			36

Source: MoHCW National Health Strategy for Zimbabwe 1997-2007.

Table 7: Number of Admission, 1997- 1999

	Total Hospital Admissions
1997	477,530.00
1998	454,927.00
1999	396,511.00

Source QDS, CSO, June/December 1999.

Table 8: Immunisation Coverage of Children Under One Year

	Pop. Under 1 year	BCG	Polio	DPT3	Measles	PCC
1998	416,373.00	71.3%	75.4%	78.8%	69.7%	65.2%
1999	729,752.00	71.2%	68.4%	46.0%	66.5%	63.4%

Source: Quarterly Digest of Statistics, CSO, and December 1999.

Table 9: Public Budget Allocation to Prevention 1993-2000

	Health Vote (Z$ million)	Prevention Vote	Prevention as % of Total Vote
1993	689	109	15.8
1994	923	114	12.4
1995	1067	130	12.1
1996	1355	156	11.5
1997	1810	187	10.3
1998	3818	427	11.1
1999	3668	342	9.3
2000	6189	659	10.6

Source: Government Estimates of Expenditure (various years), Ministry of Finance.

Table 10: Dropout Rates by Grade and Gender, 1990-97

	Grade 1		Grade 2		Grade 3		Grade 4		Grade 5
	M	F	M	F	M	F	M	F	M
1990	4.5	7.1	0.9	0.1	2.1	0.5	2.8	1.4	6.2
1991	14.3	10.3	5.5	3.9	6	4	5.4	2.7	3.2
1992	10.3	11	3.5	4.2	3.7	3.3	2.8	3.1	0.4
1993	14	14.3	6.7	5.8	6.3	5.6	5.3	6.1	3.7
1994	8.5	8.9	2	0.5	0.8	0.3	1.2	1.1	4.2
1995	11.5	12.3	4.9	4.6	4.3	3.8	3.1	1.7	1
1996	12.2	12.6	5.2	3.3	4.8	3.5	3.4	2.6	0.6
1997	12.1	13.2	4.4	3.3	3.4	3.7	1.9	2.5	0.2

Source: Adapted from Human Development Report Zimbawe/1999.