

Resource mobilisation for health under the Zimbabwe Investment Case 2010-2012

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Executive summary

Following a decade of economic crisis in Zimbabwe, and given the limited resources available to resuscitate the health sector, the 2009 Government of National Unity developed a Health Sector Investment Case to support the revival of the country's health system. The Investment Case, which was launched in October 2010, was an effort by the Ministry of Health and Child Welfare (MoHCW) to mobilise US\$700 million from its partners to fund priority areas of health sector delivery for three years from 2010-2012. Money raised from this effort was meant to scale up interventions in priority areas over and above what would be financed from the traditional budget.

This review was implemented through Training and Research Support Centre (TARSC), with mentoring from the University of Cape Town Health Economics Unit as part of its work on health financing in the Regional Network for Equity in Health in East and Southern Africa (EQUINET). The review assesses the resource mobilisation and allocation performance and challenges faced by the MoHCW in meeting the target set out in its Investment Case. As the Investment Case was meant to complement the annual government budget and resource mobilisation efforts by other players, the review took these resources into account in assessing the level and direction of funding.

The review specifically looked at the response from funders of the health sector to the Investment Case, in terms of what resources were raised and the successes and challenges associated with raising the intended resources. It assesses the resources raised and some of the health outputs from these resources. The study included interviews with key informants in the Ministry, review of policy documents and analysis of financial data from government and external funders.

A few funders responded either directly or indirectly to the request for funds for the Investment Case. For instance, the Health Transition Fund (HTF) launched a comprehensive programme worth US\$436 million to support the health system to deliver services, focusing on: maternal and child health (provided free of cost), medical products, vaccines and technologies, health workers and support to health policy, and planning and financing. The European Union provided US\$5.2 million to the HTF basket fund, and the United Kingdom, through the Department for International Development (DFID), provided more than US\$80 million. HIV and AIDS received US\$256 million for 2010-2011, although these funds were not a direct response to the Investment Case.

It was, however, difficult to quantify the actual amount of funds that flowed into the country's health sector because of the diverse channels through which funds flowed and were used. It was thus possible that some health sector funds were not accounted for or were counted twice

The continued polarised political environment, suspicion of public funding channels and lack of human resource capacity led most external funders to channel their funds off budget. If the funds had gone through the normal national budget support framework, it would have been easier to quantify and associate funding with achievements against targets set. Equally, overheads for funding that went to external funders may have been more available for strengthening management capacities within the state. Private sector and household contributions to the Investment Case also remain largely unaccounted for because of the lack of information on their activities.

Apart from the Health Transition Fund, which explicitly stated that it was a response to the Investment Case, other external funders bringing resources into the health sector were not as clearly tied to the Investment Case. Further, the national health budget, while complementary to Investment Case resources, did not in the period appear to follow the Investment Case in terms of resource allocation to the targets and goals set out in the document.

The impact of the Investment Case was possibly weakened because it did not set any mechanism for raising and spending resources, did not stipulate how it was going to operationalise the resource mobilisation effort, nor how it was going to track and account for the resources. It had neither a secretariat nor a management committee to implement and oversee the mobilisation effort. This obstacle to resource mobilisation was somewhat remedied later through the formation of the Health Transition Fund, a pooled public sector fund. The Fund has a steering committee, management structure and secretariat and also monitors resource flows and health service outcomes in its four strategic areas (maternal nutrition and child health, commodities, human resources for health and policy and planning).

Improvements were found in service outputs and coverage in 2009-2011. These improvements could not be attributed directly to the resources raised in the Investment Case, given the difficulties in distinguishing between it and other funder and private contributions to health outcomes. Nevertheless, these improved outcomes were associated with overall improvements in resources flowing to the sector.

It would appear that the Investment Case was used to highlight the gaps and ambitions of the MoHCW in terms of financial needs and coverage targets. While it provided an indication of resource needs, the absence of a clear plan for its implementation and a mechanism for pooling, managing, allocating and accounting for the resources possibly weakened its impact.

1. Introduction

Zimbabwe experienced a fiscal crisis and decline in economic activity in all sectors of the economy post 2000. Hyperinflation, company closures and unemployment all made resource mobilisation difficult for government as a whole, let alone for the health sector. However, the introduction of a multicurrency system (using US dollars and South African Rands) in 2009 brought some economic confidence and predictability. The positive economic growth experienced since 2009 provides a more positive context for the resuscitation of the health sector.

There are various signs of improving economic performance. The real Gross Domestic Product (GDP) in Zimbabwe grew from 6% in 2009 to 9% in 2010. Off-budget donor grants accounted for 8.6% of GDP in 2010 (IMF, 2011). Year-on-year inflation stabilised after 2009 at around 4.5%. The country's industrial capacity utilisation grew from 10% in 2008 to an average of 50% in 2010 (Ministry of Finance, 2011). The removal of price and exchange rate distortions in both the labour and goods market supported a growth in household disposable incomes. With the growth in capacity utilisation and increased employment, the country's revenue mobilisation capacity increased from less than 10% in 2008 to 29% of GDP by 2010 (IMF, 2011). The traditional revenue categories such as taxes on income and profits improved, although Value Added Tax (VAT) and Pay As You Earn (PAYE) remain the most important contributors to domestic revenue in the country. High unemployment levels (above 70%) and low terms of domestic trade, however, have resulted in a very thin PAYE tax base, whose contribution is not sufficient to cover revenue for government obligations.

While the fiscal discipline brought about by the cash budgeting system introduced in 2009 led to economic stabilisation, it also restricted government's fiscal space, making it difficult to resource critical social sectors such as health and education. The absence of deficit financing for central government activities coupled with an unsustainable external debt (US\$8.823 billion or 118% of GDP by end 2010) has made it difficult for the country to borrow from the international community to fund health and education sectors. Hence, in 2011 the MoHCW only accessed 57.5% of the estimated US\$256 million set in the 2011 budget allocation (Ministry of Finance, 2012).

The civil service wage bill of 17.3% of GDP is double the sub-Saharan Africa average of 7.6% due mainly to low overall revenue rather than real wage levels, and is 59% of government budget, compared with a sub-Saharan average of 18.4% (IMF, 2011). Capital expenditures are below 20% of total government expenditure, leading to under-investment in the economy. While this pattern reflects an imbalance between recurrent and capital expenditure, real wages are very low compared to regional counterparts. There are also high wage differentials (100:1) between top executives and lowest paid workers (TARSC, MoHCW, 2011) and a high level of brain drain. To curb the brain drain, international partners such as the UK Department for International Development (DFID) through the Crown Agency; and Global Fund for AIDS Tuberculosis and Malaria (GFATM) have assisted government in paying retention allowances to health sector personnel.

Faced with the under performance of the health system, lack of financing and deterioration in health indicators (*Table 1*), the 2009 Government of National Unity prepared a Health Sector Investment Case to revive the country's health system. The

Investment Case, which was launched in October 2010, was an effort by the Ministry of Health and Child Welfare to mobilise US\$700 million from its partners to fund priority health areas for three years from 2010-2012 (MoHCW, 2010). Money raised from this effort was intended to scale up interventions in priority areas over and above what would be financed from the traditional budget.

Table 1: Selected health indicators, mid-1990-2009

Indicator	Mid-1990	1999	2005	2009
Infant mortality rate (per 1000 live births)	53	65	60	63
Under-five mortality rate (per 1000 live births)	77	102	82	119
Maternal mortality ratio (per 100,000 population)	283	695	612	725
HIV and AIDS prevalence (adults aged 15-49)	29.3	28	18.1	13.7
Crude death rate (deaths per 1000 population)	9.5	17.2	-	20
Life expectancy at birth	61	45	43	43

Source: MoHCW, 2010; ZIMSTAT and ICF International, 2012; ZIMSTAT, 2011.

2. Objectives

This review was implemented through Training and Research Support Centre, with mentoring from University of Cape Town Health Economics Unit as part of its work on health financing in the Regional Network for Equity in Health in East and Southern Africa (EQUINET). The review aimed to assess the resource mobilisation and allocation performance and challenges faced by the MoHCW in meeting the target of US\$700 million over three years as set out in its Investment Case. As the Investment Case was meant to complement the annual government budget and resource mobilisation efforts by other players, the evaluation took these resources into account in assessing the level and direction of funding.

The study sought to:

- i. Assess the extent to which the Investment Case achieved its stated objectives, namely: to raise US\$700 million by 2012; to reduce infant mortality; to strengthen community, clinic and hospital services; and to realign the resource allocation criteria;
- ii. Assess the success and challenges of the Investment Case as a resource mobilisation strategy.

The review looked at the response to the Investment Case in terms of what has been raised; the successes and challenges associated with raising the intended resources; and explored the health outputs achieved with these resources.

3. Methods and limitations

The study included interviews with key informants in the MoHCW, review of public domain policy documents and analysis of financial data from government and external funders.

There were various limitations. The relationship between the resources raised and the disease burden could not be evaluated given the difficulties in clearly distinguishing

between the impact of the Investment Case and that of other funding strategies in mobilising contributions to the health sector. In interviews, MoHCW officials indicated that the Investment Case was a call for resources, but without a clear mechanism. It was also noted that depressed investor confidence and caution over the political situation negatively affected the mobilization effort, and led to reluctance amongst international partners to provide direct budget support to the MoHCW.

Hence, the exercise became an assignment to assess the value of resources raised within the stipulated time in the Investment Case. The assessed value of resources was used as an indicator of the response to the Investment Case on the assumption that any resources raised in this period were directly or indirectly related to the call made by government and the Investment Case.

4. Budget and resource allocation

The MoHCW has in place a comprehensive National Health Strategy (NHS) for the period 2009–2013, focused to meet its goal of providing affordable and quality health care to the people of Zimbabwe. The Ministry faces a severe lack of resources (financial, human and material) to accomplish its objectives. In 2009, the MoHCW accessed only 35% of the national budget because of the limited funds realised from tax collections.

In 2010, out of an initial budget allocation of around US\$156 million, the total health expenditure by the MoHCW was about US\$35 million (excluding salaries), or around US\$3 per capita. Nevertheless, 25% of the allocated funds were disbursed by September 2010, an improvement from the 10% in 2009 for the same period. Given the challenges faced by the health sector noted earlier, these disbursements are far too low. The Ministry's development partners met almost 98% of total drug purchases in 2009 and 2010. While this is welcome in a time of resource constraints, the high ratio of aid relative to government financing raises questions about predictability and sustainability of financing (Shamu and Loewenson, 2011).

While health services in Zimbabwe have been largely funded by contributions from external funders (EU, DFID, USAID, WHO, UNICEF, UNFPA, GFATM and others), the Ministry of Finance reports that the Vote of Credit of US\$810 million from development partners has "not performed to expectations, with only about US\$360.2 million having been received by end of October 2010". Ministry of Finance noted that "The US\$360.2 million, however, remained outside the budget framework", making it difficult to prioritise resources in line with the needs of the different ministries (Ministry of Finance, 2011). As noted above, political uncertainty in the country negatively affected the mobilisation and coordination through the budget of funds that were directed towards the health system.

In terms of the Social Determinants of Health (SDH), in 2011 external funders pledged US\$618.3 million to support the following areas: health, agriculture, water and sanitation, social protection, technical assistance and governance. As of June 2011, however, only US\$142.5 million had been disbursed, indicating difficulties in turning pledges into real support.

Table 2 shows the allocation levels to the different activities in the Ministry of Health as well as the allocation per capita for the years 2011 and 2012. Within the government budget, the MoHCW allocates more resources towards curative services and significantly

less to preventive services. Historically, the allocation of resources has been 'hospital based'. Resource allocation in the health sector is still skewed towards curative care and is hospital based, although MoHCW argues that about 40% of the budget that goes to curative care caters for prevention (MoHCW, 2011). The expenditure per capita is still below the WHO minimum per capita expenditure of US\$34. In the absence of the per capita expenditure figures, this evidence is based on per capita allocation figures as a proxy for expenditures. As the ministry only managed to access 35% of the funds in the previous year, actual per capita expenditure is far lower than per capita allocation, and spending patterns may also differ as a result.

Table 2: Government health budget allocation and expenditure, 2011 and 2012

	Revised budget 2011 (US\$)	Actual expenditure 2011 (US\$) (i)	Actual expenditure as % budget allocated 2011	Budget estimate 2012 (US\$)	% allocation 2012
Administration	35 996 000	15 008 432	41.7	50 989 000	14.8
Medical care services	189 749 000	116 472 186	61.4	255 499 000	73.9
Preventive services	25 331 000	11 994 740	47.4	30 750 000	8.9
Research	5 122 000	3 935 503	76.8	8 450 000	2.4
Total	256 198 000	147 410 861	56.8	345 688 000	100.0
Ministry of Health budget as a % of total national budget excluding direct budget support from donors (Abuja target = 15%)					9.5%
Per capita budget allocation for 2011 (ii) (iii)					\$20.79
Per capita budget allocation 2012					\$27.78

Source: Ministry of Finance (2012)

- i. Salaries and allowances for health sector personnel are embedded within the expenditure heads shown in the table above.
- ii. The actual per capita expenditure for 2010 and 2011 was on average below US\$10.
- iii. WHO minimum per capita expenditure: US\$34 for core interventions; US\$60 for system funding

4.1 Targets and assumptions of the Investment Case

An assessment of primary health care undertaken in 2009 recommended the need for the MoHCW to draw up a national primary health care package with clear entitlements and the estimated resources needed to meet the objectives at the community and primary levels (TARSC and CWGH, 2009). MoHCW, in consultation with development partners and technical partners, civil society and private sector, then developed a three-year Health Sector Investment Case for 2010-2012 meant to mobilise additional resources to finance the objectives of the primary health care package.

The Investment Case also proposed measurable parameters that could be tracked over time, with one of the fundamental parameters being the allocation mechanism at community and national levels. It proposed that relative shares to community: rural health centre: secondary hospital: management levels be 7:2:12:1. Fundamentally, this was argued to be the basis to be followed in allocation of resources by the MoHCW and its partners. While *Table 3* shows the infant and maternal mortality reduction targets by different levels, as well as the additional costs associated with targets, it was not made

clear how the funding for this would be achieved. Most funds in the Investment Case were to be sourced from external funders, raising the need to track how these funds have been used, although the mechanism for this was not made clear. Current budget allocations are not broken down by level (primary or secondary) or geographical location (district or provincial), although the public management system reports allocations and expenditures by institution (TARSC, MoHCW, 2011).

The Investment Case focused primarily on what was identified as high impact priorities. It set financial and health goals to achieve during the period.

The first goal was to raise enough resources over and above the government's estimated annual budget envelope, which was set at the minimum level of US\$156 million for the base year 2010, to scale up all activities identified as high priority. *Table 3* shows the summary of estimated yearly financial needs for the scale up of all the priority interventions and annual needs for the different management and technical levels that support implementation.

Table 3: Total budget for a comprehensive investment option (000 US\$)

Service delivery modes	2010	2011	2012	Total
Community health services	74,356.93	75,568.37	78,207.88	228,133.18
Clinic-level services	17,148.95	20,991.74	24,825.86	62,966.54
Hospital services	99,154.23	123,509.18	153,394.82	376,058.22
District management	608.39	753.29	898.19	2,259.87
Provincial management	514.24	684.96	855.67	2,054.88
National programme management and technical support	4,709.28	9,390.66	14,072.05	28,171.99
Total	196,492.02	230,898.20	272,254.46	699,644.68
Per capita	15.68	18.42	21.72	18.61

Source: MoHCW, 2010.

The table also shows the minimum levels of per capita requirements from US\$15.68 to US\$21.72 by 2012 over and above the national budget. Most of the funds were earmarked towards support for hospital services (US\$376 million against a total of US\$291 million), reinforcing the historical budget allocation towards curative over preventive services noted earlier.

Several core assumptions were made in the Investment Case that proved not to be met:

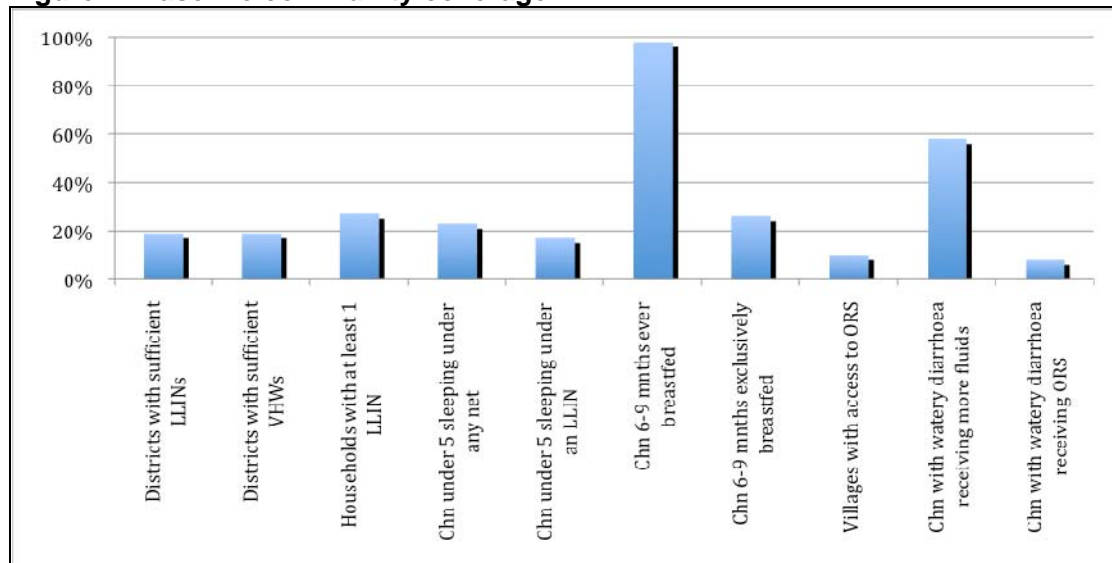
- A base line budget allocation of US\$156 million in the 2010 budget and projected increase in government funding. However, the minimum budget baseline of US\$156 million was not realised in 2011 as the government could only allocate US\$100 million.
- An estimated annual external funding of US\$100 million (estimated external funder contribution per year is currently at US\$80 million, which falls short of the average estimated support for the Investment Case).
- The disbursement of the Global Fund Round 8 Phase 1 grants estimated at US\$166 million (UNDP 2011). According to the Country's Coordinating Mechanism (CCM) secretariat, Phase 2 Round 8 and Phase 1 Round 10 estimated at US\$236 million were only released in April 2012 for the period 2012–2014. (Zimbabwe CCM, 2011).

Direct budget support from development partners did not materialise as expected, with US\$306.2 million being released in 2010 against an expected allocation of US\$810 million.

4.2 Priority services in the Investment Case

At each level of health care, that is primary, secondary and tertiary levels, the Investment Case identified the priority intervention areas (community, health centres and hospitals) noting the current levels in terms of performance and the desired levels to be attained after the scale up. Baseline community coverage indicators showed less than 20% coverage for the priority areas of access to village health workers, access and ownership of mosquito nets, breast feeding and access to oral rehydration solution for the under five year olds (*Figure 1*).

Figure 1: Baseline community coverage



Source: MoHCW, 2010.

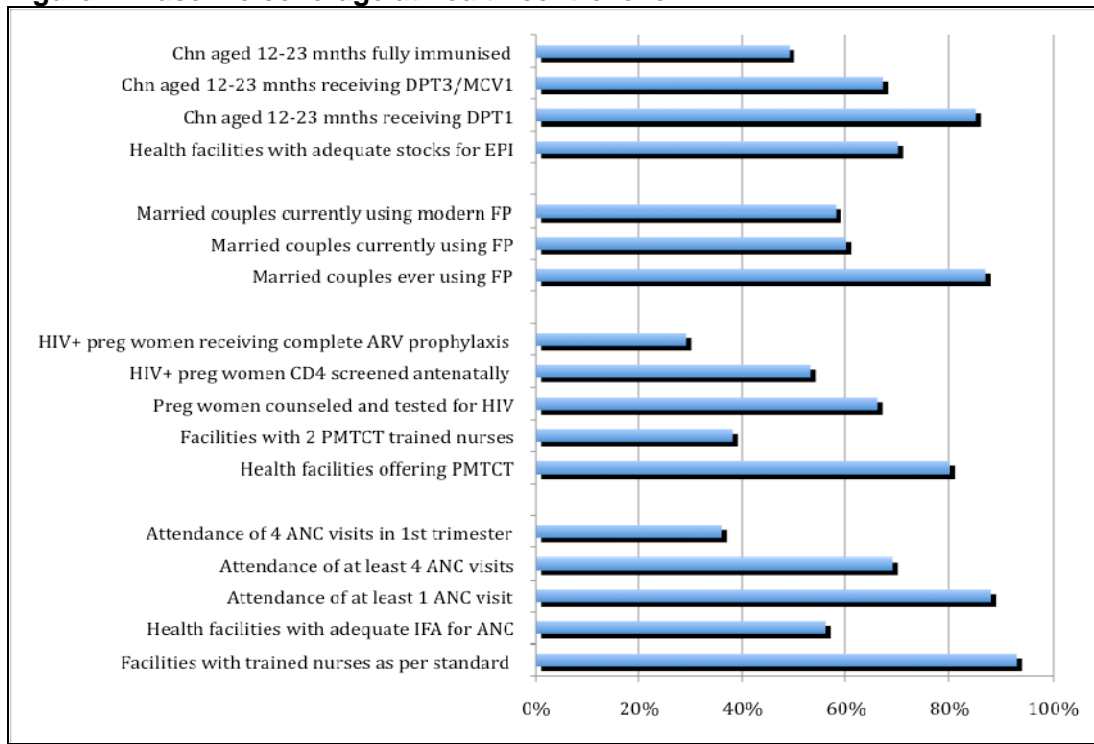
Baseline coverage at health centre level (*Figure 2*) at the time showed that most of the interventions were below 80% coverage, although most were supposed to be provided free of charge at public health facilities. Many priority interventions at clinic-hospital level were at less than 60% coverage. Less than 20% of clinics had adequate midwives, skilled birth attendance in clinics that met national standards was found to be less than 10% coverage, and various child health interventions had less than 40% coverage (*Figure 3*).

The second goal of the Investment Case was to reduce the disease burden by increasing coverage and access to essential health care services. The targets included:

- Increasing skilled attendance at delivery from 60% to 85% by the end of 2012;
- Scaling up the provision of comprehensive HIV and AIDS care and treatment to reach at least 80% of adults, pregnant women and children in need of ART by 2012; and
- Increasing the TB case detection rate from 27% to 70% and treatment cure rate from 60% to 85% by the end of 2012.

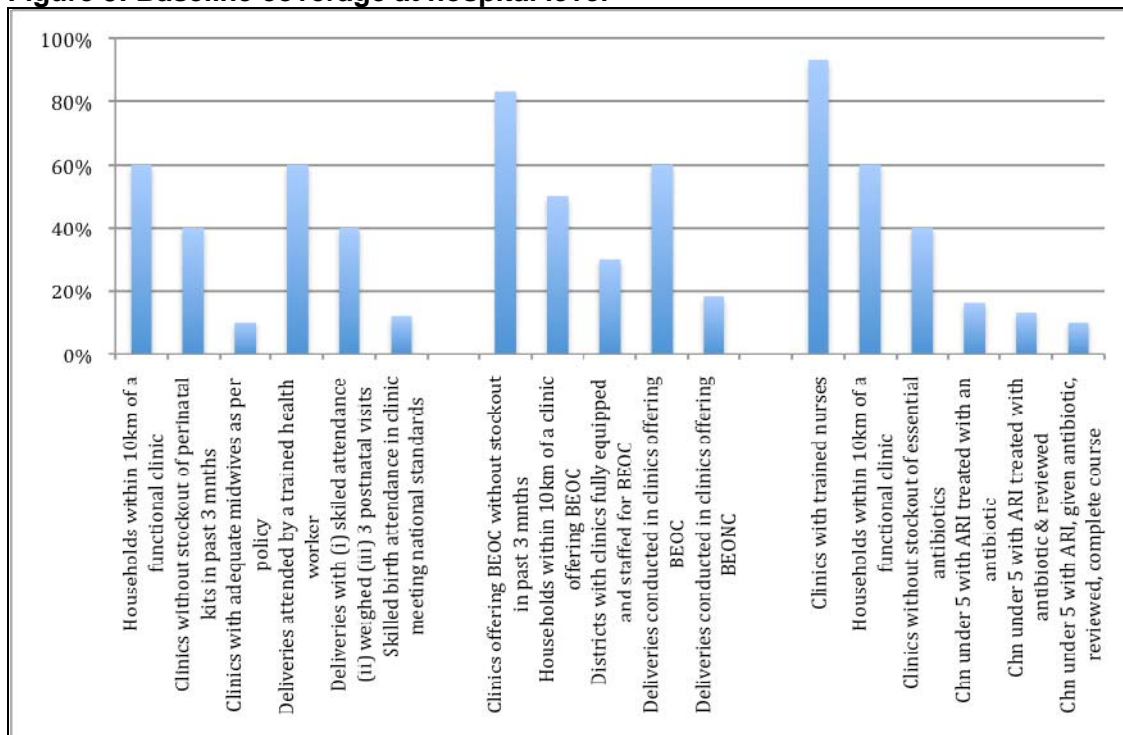
The projected mortality reductions for the priority areas for the three-year period at the three levels of care and the cost per person needed to achieve the reductions were calculated and are shown in *Table 4*.

Figure 2: Baseline coverage at health centre level



Source: MoHCW, 2010.

Figure 3: Baseline coverage at hospital level



Source: MoHCW, 2010.

Table 4: Percentage reduction in maternal and child mortality by 2012

Service delivery mode	Mortality reduction			Additional annual cost per capita, US\$
	Neonatal	Under five	Maternal	
	Comprehensive option			
Community-level package of interventions	0.4%	10.1%	0.8%	6.07
Rural health centre or clinic package of services	1.0%	11.7%	3.3%	1.67
Package of hospital services	9.4%	16.3%	13.3%	10.00
Management and technical support				0.86
Total	10.8%	38.1%	17.4%	18.61

Source: MoHCW, 2010.

5. Funders' response to the Investment Case

The next sections provide an overview of a subset of funders and financing mechanisms in different disease and programme areas, some in response to the Investment Case mobilisation call and others in response to other mobilisation calls. Because of the interrelationships between the funders and programmes, assessing accurately the actual contribution and shares by the various funders was a difficult task.

5.1 Health Transition Fund

The Health Transition Fund (HTF) was set up to mobilise funds and resources in support of critical interventions for maternal and child health for the period 2011 to 2015 to the amount of US\$436 million. It was set up to resource goals set in the Zimbabwe National Health Strategy and the Health Sector Investment Case to reduce maternal and under-five mortality, among other goals. According to UNICEF 2011, "The HTF is responding to the findings in the Health Sector Investment Case with a comprehensive programme that aims to build back better health system". The HTF focuses on four areas, namely: maternal and child health care (which will be provided for free); medical products, vaccines and technologies; human resources; and health policy and planning and finance.

Table 5 shows the HTF contribution to the urban and rural facilities that provide free maternal and child health care. The HTF will be co-financed by the government and its external partners, with the government committing US\$10 million in the 2012 national budget. DFID has also committed £74 million (US\$120 million) for the next four years, with US\$80 million going to the HTF and US\$30 million going towards payment of antiretroviral drugs. The EU donated US\$5.2 million towards the HTF. Support to some of the thematic areas such as human resources will be phased out gradually and will be synchronised with improved government contributions. The HTF therefore ranks as the first explicit response to the call in the Investment Case, although its timeframes for achieving its objectives and targets are not synchronised with the targets of the Investment Case.

Table 5: Expected HTF contribution to maternal and child health*

Type of facility	Number of facilities	Monthly contribution per facility	Year 1 (6 months) contribution US\$)	Year 2 contribution US\$	Year 3 contribution US\$	Year 4 contribution US\$	Year 5 contribution US\$
Clinic/rural centres**	1252	750	5 634 000	11 268 000	11 268 000	11 268 000	11 268 000
District and mission hospitals	181	1500***	1 629 000	3 258 000	3 258 000	3 258 000	3 258 000
District health executives (DHEs) office	62	1500	558 000	1 116 000	1 116 000	1 116 000	1 116 000
Total required for health services (funded by HTF)	1495		7 821 000	15 642 000	15 642 000	15 642 000	15 642 000

Source: UNICEF, 2011.

Figures shown in *Table 5* cover only direct administrative needs of the institutions and do not include payments for health workers through retention allowances, salary support to critical staff, policy and planning component and medicines.

**Includes Local government primary health care facilities.

*** this figure has since shifted off-budget as current estimates use the Results Based Financing pilot funding at US\$8000 monthly (US\$25 000 per quarter).

Other support has come outside the Investment Case framework, even whilst stating the same goals and objectives. Some of these programmes were in place before the launch of the Investment Case, which also took into consideration the aims and objectives of those programmes. *Tables 6,7,8,9* and *10* in subsection 5.2 to 5.5 give a summary of funds invested by donor partners covering the period before and after the launch of the Investment Case.

The support shown could be a response to the Investment Case or to other strategic plans from the MoHCW. There is also a possibility of double counting of the funds given the intricate distribution of funds by the various external funders. Further, this is not an exhaustive list of the agencies and financial and material support, as some support, such as that of United States Agency for International Development (USAID), could not be ascertained at the time of compiling this document.

5.2 External funder support for HIV and AIDS

Given that the Investment Case was not very clear on how it would mobilise, use and account for the resources it raised from partners, the assumption made was that money channeled to MoHCW or the health sector was broadly a response to government policy and the Investment Case, while noting that this may oversimplify the situation.

For the financial years 2010–2011 the estimated total support to the HIV and AIDS effort was US\$256 million. These funds included those channeled through the Expanded Support Programme (CIDA, DFID, IRISH AID, SIDA, NORWAY), which was already operational before the launch of the Investment Case. Both the ESP and GFATM

supported health systems strengthening other than the usual support to procurement and provision of medicines (*Table 6*).

Table 6: HIV and AIDS support to Zimbabwe 2010-2011

External Funder	Amount (US\$)
Global Fund for AIDS, TB and Malaria (GFATM)* Round 8 Phase 1	166 688 977
CIDA	1 225 913
DFID	20 234 310
IRISH AID	2 565 274
NORWAY	1 720 068
SIDA	7 590 895
USAID PEPFAR	56 000 000
TOTAL	256 025 437

Source: UNDP, 2011.

*The GFATM, which includes Tuberculosis and Malaria funds, receives contributions from most of the funders listed in the table. European Union and European Commission members provide about 50% of the GFATM budget. In April 2012, Round 8 Phase 2 and Round 10 Phase 1 a total of US\$236 million in funds were released to Zimbabwe.

Support from the GFATM shown in *Table 7* included support to maternal and child health in the areas of prevention of mother-to-child transmission (PMTCT) and health system strengthening, some of the core objective areas of the Investment Case. While in theory the application for funds for the GFATM was made before the conceptualization of the Investment Case, the study assumes that release of funds in 2010 and 2012 was also in support of the objectives of the case.

Table 7: GFATM support to programmes, 2010-2011

Component	Phase 1 Budget Round 8 (US\$)
HIV and AIDS	84 641 215
Tuberculosis	28 236 112
Malaria	32 810 290
Health systems support	34 271 524

Source: Zimbabwe CCM, 2011.

Since dollarization there have been improved funding flows to the National AIDS Trust, a national institution funded from levies on tax. The funds collected have grown from US\$5.7 million in 2009 to US\$26.5 million in 2011. Over this period, the National AIDS Council received a total of US\$52.7million. This improved revenue mobilization was not a response to the Investment Case, but rather a function of more stable values in the funds collected from companies and workers and some improvement in their earnings (NAC 2012).

5.3 European Union Support

In direct response to the Investment Case, the European Union provided US\$5.2 million to the HTF. Other EU support came before the Investment Case but still aligned to the objectives of addressing the priorities identified in the Investment Case (*Table 8*). Support by EU to Zimbabwe's health sector is mostly channeled through United Nations agencies, the GFATM, Crown Agency and other non-governmental organisations.

Table 8: Most recent European Union support to Zimbabwe's health sector

Programme	€million	US\$ million(i)	Status
Vital Health Service Support Programme (VHSSP) I and II (vital and essential medicines)	22	28.6	Ended in 2010
Midwifery Accelerated Training	1.5	1.95	Ongoing
Environmental Health Assistant (EHA) training	1.0	1.3	Ongoing
Provision of Safe Blood and Medical Gases	2.0	2.6	Ongoing
Support to the Health Service Fund	4.0	5.2	Pipeline
Support to provision of essential medicines and supplies	10.0	14.0	Ongoing
Support to the Health Transition Fund (ii)	12.0	15.6	Pipeline
Total	52.5	68.25	

Source: European Union, 2012 (i) Using an exchange rate of 1€ = 1.3 US\$.

(ii) €4 million (US\$5.2 million) had already been given to the Ministry.

5.4 DFID Support

DFID is one of the largest donors to Zimbabwe, contributing on average £70 million between 2010-2011. DFID responded directly to the Investment Case by committing US\$120 million to the HTF, as indicated earlier. Since 2004, DFID has supported Zimbabwe's health sector in several other areas as shown in *Table 10*. Since 2002, DFID has been providing support outside the national budget framework.

In 2010-2011, DFID provided support of £70 million to Zimbabwe's health sector (US\$109.9 million). In 2011-2012 it increased its support to £80 million (US\$126.5 million) and in 2012-2013 to an estimated £84 million (US\$131.88 million) (DFID, 2011). In 2010-2011, DFID allocated 40% of its total support to the health sector and is expected in the following years to maintain an average of 35% expenditure in the health sector. In terms of distribution, DFID has channeled its funds through United Nations agencies (more than 40% of its total country support) and non-governmental organisations (more than 60% of total country support) and collaborates with other donors (more than 70% of its total support) for effective implementation and monitoring of resources.

Table 9: DFID support to the health sector, 2010-2011

Support area	Total spent (£ millions)	US\$ millions (i)	Duration
HIV/AIDS Expanded Support Programme	35	54.95	2004-11
HIV prevention and behaviour change	21	32.97	2006-11
Maternal and newborn health	25	39.25	2006-11
Emergency medicines	16.5	25.91	2008-11
Emergency hospital rehabilitation	2.3	3.61	2009-11
Sanitation and hygiene	3.0	4.7	2010-11
Demographic and health survey	0.3	0.47	2010-11
Nutrition surveillance	0.2	0.31	2010
Total	103.3	162.17	

Source: DFID, 2011. (i) Using a conversion rate of 1 UK pound = US\$1.57

5.5 World Bank

In 2011, the World Bank introduced Results-based Financing in the amount of US\$15.5 million to increase the availability and accessibility of health services and help reduce maternal and child mortality in targeted rural areas for 2011-2014: 70% of the funds are meant for health and 30% are meant for public administration (World Bank, 2011). The funds will target the following three thematic areas: health systems, accounting for 40%;

reproductive health, 40%; and participation and civic engagement, 20%. Since 2009 the Global Alliance for Vaccines and Immunisation (GAVI) has also supported MoHCW with more than US\$10 million worth of immunisation drugs and supplies. GAVI has always supported the Government of Zimbabwe, but it is again difficult to conclude that any of the support subsequent to 2009 was in response to the Investment Case.

Table 10: GAVI support to Zimbabwe 2009-2011

	2009	2010	2011
US\$	3 526 664	6 441 214	316 492

5.6 Drug procurement and management

Beset by a host of viability problems, the National Pharmaceutical Company of Zimbabwe (Natpharm) still relies on donor support for procurement and management of essential drugs, vaccines and other medical supplies. By 2008, NatPharm could only provide about 30% of the country's requirements for essential drugs. In 2009 a number of external funders (DFID, EU, Irish Aid, Canadian International Development Agency and UNICEF) pooled resources to facilitate the procurement and supply of a Primary Health Care (PHC) package of 45 basic medicines and medical supplies. The programme is known as the Vital Medicines Support Programme (VMSP) and is coordinated by a number of donors to address critical shortages of vital and essential medicines in Zimbabwe (CCORE, 2011).

UNICEF procures drugs on behalf of external partners, while NatPharm implements the management, storage and distribution. The PHC package mainly focused on rural health facilities and provided district hospitals intermittently. Since 2010 it widened its focus to include local authorities. The European Union has been providing a third of all medicines and about 60% of the vital drugs for the whole country, while WHO, Global Fund and other UN agencies have been facilitating the purchase and provision of ARVs, malaria and TB drugs to the public sector. EU has provided US\$25.5 million of the overall donor contribution of US\$52 million for essential medicines (UNICEF and MoHCW, 2011).

Multi-donor support of VMSP funds 75% of the country's essential medicines and surgical needs for primary and secondary level facilities. The programme runs in parallel to the family Planning and PMTCT supply programmes and makes use of the Delivery Team Top Up (DTTU, which is a project run by Crown Agents and is funded by DFID and USAID). It provides PMTCT and reproductive health commodities to facilities across Zimbabwe (CCORE, 2011). It supplies specific reproductive health products to about 1,300 health centres across Zimbabwe. The VMSP support programmes have been included in the Health Transition Fund, thus guaranteeing continued support.

A number of external partners have supported local government authorities, in particular Harare City Health, which received an estimated US\$3.3 million from the International Committee of the Red Cross (ICRC) for 2009-2011. WHO has supported Harare City Health with vaccines for the immunisation programmes, while its ART programme has been getting support from external partners such as UN agencies, Global Fund and bilateral donors through the Expanded Support Programme. The ICRC has directly provided essential drugs, medical equipment, furniture and training assistance. This support is important since local governments are still charging user fees for maternity services, defeating the objectives of the Investment Case and the HTF. HTF has agreed in principle to reimburse local government facilities for any maternal and child health services as shown in *Table 5*.

Help Germany assisted Harare City Health with drugs in 2009 and 2010 and together with the ICRC and UNICEF have provided the bulk of non-HIV and AIDS and non-TB drugs to Harare City Health clinics and hospitals. The Global Fund and TB Reach have provided the bulk of ART and TB commodities.

ICRC procures directly from its sources outside the country and supplies directly to Harare City Health, unlike other donors who distribute their commodities through NatPharm. This exposes some anomaly in the drug procurement and distribution system in the country as NatPharm was supposed to act as the central distribution point to guarantee affordable and consistent supply. Although a Health Commodities Coordination Committee was set up to facilitate coordination amongst players in the sector, there is no clear harmonisation framework to monitor all players in the procurement and management of drugs to ensure that commodities are supplied in time, used appropriately and distributed to where they are critically needed. There is a need therefore to strengthen the capacity of the central distribution centre or alternatively to decentralise drug management, but at the same linking the facilities electronically to the central pharmacy for easier accountability.

5.7 Private Sector

There is no information in the public domain on the private sector response to the Investment Case. The MoHCW health information system has failed to capture the contribution of the private sector and the national health accounts that are supposed to provide that information are not done on an annual basis, so that information assessing private and household contributions to the health sector is not readily available. Information from WHO on health expenditure in 2000-2007 by various players shows that the private sector and households are major contributors (*Figure 4 overleaf*).

5.8 Administrative overheads

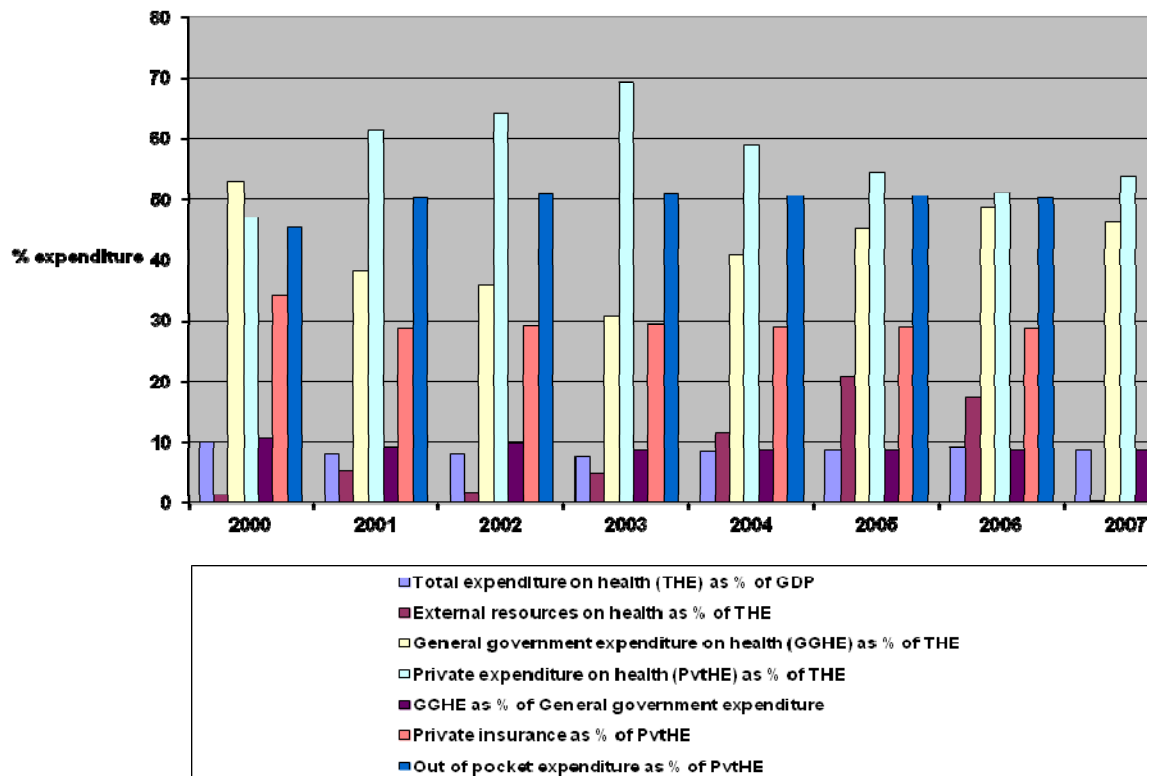
Implementing partners of external funds have charged overhead fees for the funding of about 10-13% of total funds (*Table 11*). A question arises on whether a clearer pooled fund at the outset would have allowed for some of these resources to be used to strengthen critical areas of capacity in the state.

Table 11: Overhead charges of implementing partners

Organisation	Overhead
UN agencies (general)	11-12%
UN agencies (specialised)	13%
PSI	12%
Elizabeth Glasier Foundation	12%
Crown Agents	4.25%

Source: ICAI Review Team in DFID, 2011.

Figure 4: Health expenditure in Zimbabwe 2000-2007



Source: WHO, 2011

6. Health system performance

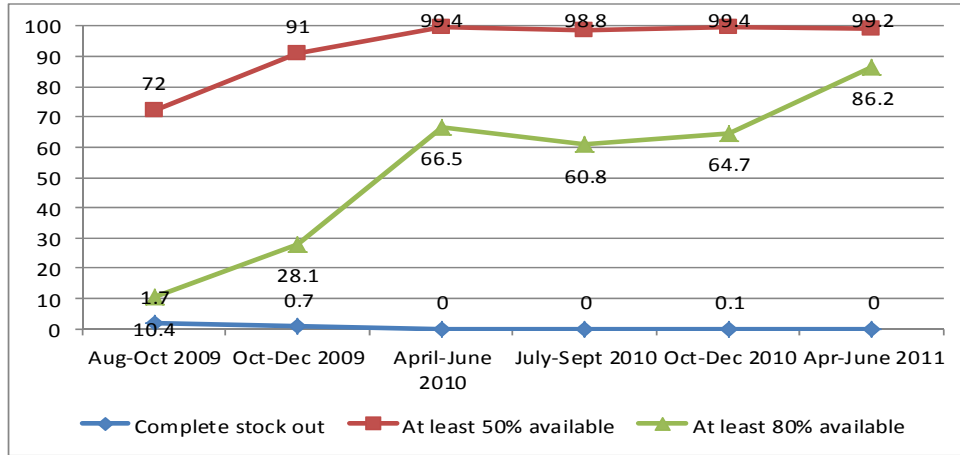
The Investment Case does not set facility performance targets. It does mention health coverage indicators, such as antenatal care coverage. Resource flows should support improved access and coverage and this section assesses performance in terms of availability of essential medicines, child health cards and maternity services.

In terms of health indicators, UNICEF surveys implemented since 2009 provide most of the updated information on service performance since the launch of the Investment Case. The Vital Medicines and Health Services Survey (VMAHS) that UNICEF has been carrying out since 2009 is a credible source of performance on indicators associated with the Investment Case. No direct association can be made between the Investment Case and the performance of these health indicators and attribution is made with great caution. This is also the same scenario with the resources mobilised, where there is also no direct association between the funds raised during the period and the investment. One can only infer that need and urgency expressed in the Investment Case gave an extra impetus to the MoHCW partners to translate their commitments into real disbursements and increase their resource mobilisation efforts. There could thus be some positive association between the Investment Case and the improvement in the health service indicators shown in the following figures.

Access to essential and vital medicines improved from the first survey carried out in 2009 up to 2011.

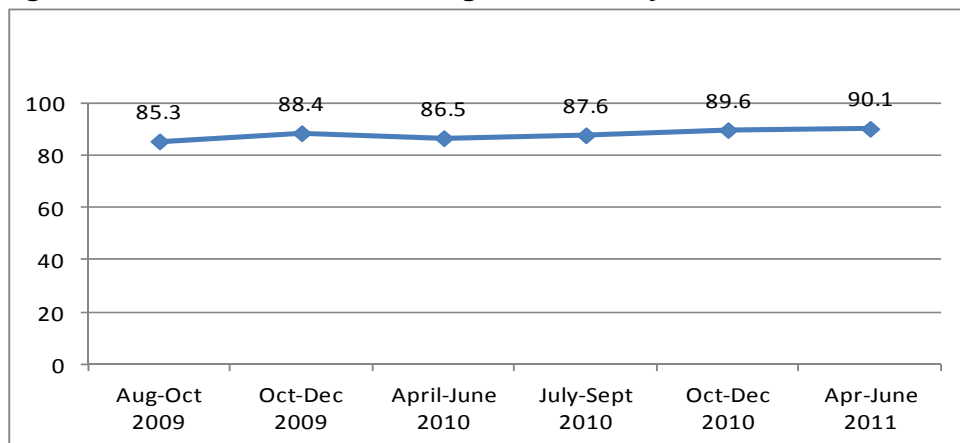
The selected health service indicators shown in *Figures 5-10* suggest some improvements were made after 2009 in the performance of the health system.

Figure 5: Availability of essential medicines



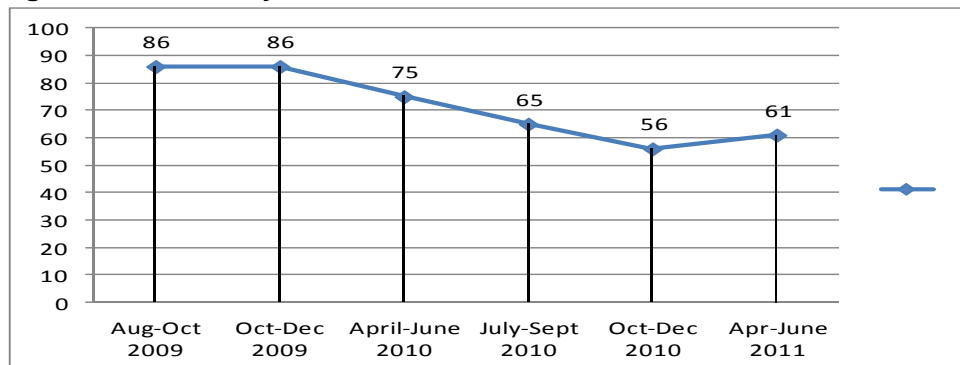
Source: UNICEF, 2011.

Figure 6: Share of facilities offering full maternity services, 2009-2011



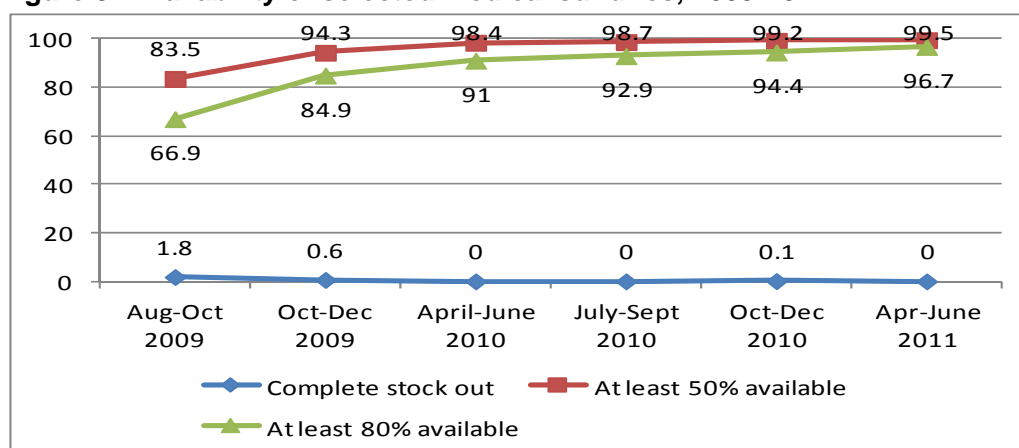
Source: UNICEF, 2011.

Figure 7: Availability of child cards in stock, 2009-2011



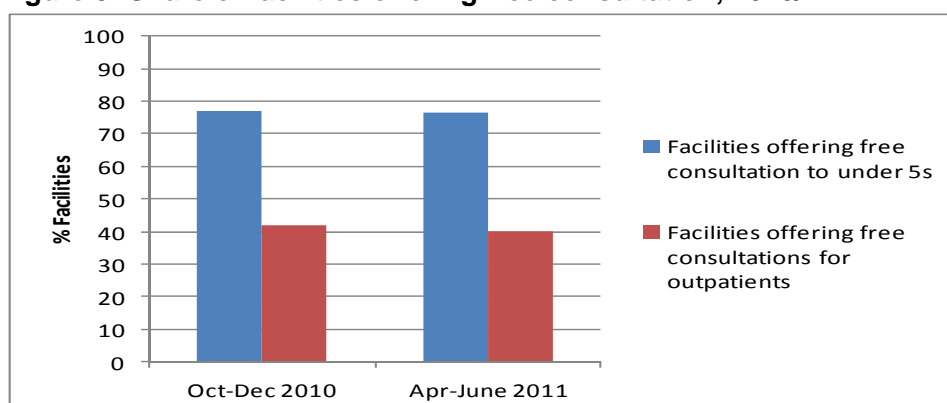
Source: UNICEF, 2011.

Figure 8: Availability of selected medical sundries, 2009-2011



Source: UNICEF, 2011.

Figure 9: Share of facilities offering free consultation, 2010/11



Source: UNICEF, 2011

The Investment Case using the modest scenario had a target of reducing neonatal, under- five and maternal mortality by 2.2%, 8.7% and 4.6% respectively by 2012. The evidence in *Table 11* suggests that this has not been achieved. However, it is difficult to judge from this data as the neonatal and under-five year mortality estimates have wide confidence intervals and the maternal mortality rate reflects mortality in the past *seven* years, beyond the time frame of the Investment Case. It would be important to identify coverage and health outcome indicators that are more responsive to immediate resources to reinforce 'willingness to contribute'.

Table 11: Maternal and child mortality, 1988-2011

ZDHS Surveys	Neo-natal mortality	Under-5 mortality	Maternal mortality
2010-2011	31	84	960 (i)
2005-2006	24	82	612
1999	29	102	695
1994	24	77	283
1988	27	71	-

Source: ZIMSTAT and ICF International, 2012

(i) Measures mortality for the past 7 years, i.e. 2003-2010

7 Discussion

The projected per capita of US\$18.61 for achieving the Investment Case goals were ambitious; almost at the end of the period, the amount raised is far short of this. The shortfall in domestic financing has been raised as an issue, and options to improve domestic revenues over and above the traditional budget allocation have been proposed. These include: increasing further the duties / taxes on cigarettes, alcohol; adding new earmarked taxes, such as on road tolls, VAT on luxury goods; using these taxes to contribute to a health promotion fund for improved public health; sustaining the AIDS Levy Fund; extending tax concessions for private sector contributions to the health system to contributions to primary care and public health programmes (MoHCW, TARSC, EQUINET, 2012).

Government did not follow the Investment Case targets in terms of the resource allocation mechanisms and shares in the national budget: The Investment Case set a ratio of community health care versus rural health centres of 7:2 and a ratio of 12:1 for secondary hospitals and management services, but these ratios were not reflected in the 2011 and 2012 budget allocations; budget proposals were not explicitly aligned to the priorities set in the national Investment Case. It would have been expected that the resource allocation formula would have shown some shifts to align to funding targets set out in the Investment Case.

External resources complemented government funds in meeting these targets. While evidence on these funding flows is presented, it is difficult to quantify the external funds that flowed into the country's health sector because of the various channels through which the funds flowed. Apart from the HTF, which clearly stated that it was acting in response to the Investment Case, other external funds coming into the health sector were not explicitly tied to the Investment Case.

Tracking the allocations of *all* resources against the targets set is complicated by the absence of pooled funding and reporting. It is thus likely that some funds coming into the health sector were not accounted for while other funds may be double counted. If the funds had gone through the normal national budget support framework, it would have been easier to quantify and associate funding with the achievements of targets set in the Investment Case. The continued polarised political environment, suspicion of public funding channels and lack of human resource capacity led most external funders to channel their funds off budget. This has raised problems of tracking and linking funding to the targets set. The significant resources used for overheads by external funders for managing these parallel funding channels may have been available to strengthen the management capacities within the state if these funds were channeled through the budget.

The private sector and household contributions to the Investment Case also remain largely unaccounted for because of the lack of information on their activities. According to an interview with the MoHCW finance department, the Investment Case was a mobilisation call and not necessarily a concrete mechanism for resource mobilisation. As a result, private sector players were not fully committed. This lack of private sector information exposes the gaps in the country's health management information system.

It appears that the Investment Case acted as a document to broadly highlight the gaps and ambitions of the MoHCW in terms of financial needs and coverage targets. It acted

as a motivation for resources. That it did not set any mechanism for raising and spending resources, did not stipulate how it was going to operationalise the resource mobilisation effort, nor how it was going track and account for the resources weakened the possibilities of implementation. The Case had neither a secretariat nor a management committee to implement and oversee the mobilisation effort.

This obstacle to resource mobilisation through a pooled public sector fund was somewhat remedied later through the formation of the Health Transition Fund. The HTF has a management structure that has the MoHCW driving the strategy policy and planning. It has a secretariat and an HTF coordinator housed at the MoHCW within the department of policy and planning. It has a steering committee co-chaired by the MoHCW Permanent Secretary and a representative of the external funding partners. Other members of the steering committee include funding partners, WHO, UNFPA and UNICEF. UNICEF has two roles and acts as fund holder and programme manager. The HTF offers technical support and monitoring of its four strategic areas (maternal nutrition and child health, commodities, human resources for health and policy and planning) and it is developing a detailed operations manual (UNICEF, 2011). Although time has not allowed it to track the performance of the HTF against the targets of the Investment Case, measures are being put in place to report on expenditures, so that this can and should be done in the future.

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral
CIDA	Canadian International Development Agency
CWGH	Community Working Group on Health
DFID	Department for International Development
DHE	District Health Executive
EC	European Commission
EHA	Environmental Health Assistant
ESP	Expanded Support Programme
EU	European Union
GDP	Gross Domestic Product
GF	Global Fund
HIV	Human Immune Virus
HTF	Health Transition Fund
ICRC	International Committee of the Red Cross
MoHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
NatPharm	National Pharmaceutical Company of Zimbabwe
NHS	National Health Strategy
PAYE	Pay As You Earn
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission
SDH	Social Determinants of Health
SIDA	Swedish International Development Cooperation Agency
TARSC	Training and Research Support Centre
TB	Tuberculosis
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAT	Value Added Tax
VHSP	Vital Health Support Programme
VMAHS	Vital Medicines and Health Services
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic and Health Survey

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Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity-oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

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- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair financing of health systems
- Valuing and retaining health workers
- Organising participatory, people-centred health systems
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

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