DOMESTIC RESOURCE MOBILISATION AND HEALTH FINANCING IN ZIMBABWE

Situation Analysis

PITCH Partnership to Inspire, Transform and Connect the HIV response

aidsfonds

FRONTLINE AIDS

Ministry of Foreign Affairs

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1. BACKGROUND AND PURPOSE

The Partnership to Inspire, Transform and Connect the HIV response (PITCH) is a strategic partnership between Aidsfonds, Frontline AIDS and the Dutch Ministry of Foreign Affairs working with those most affected by HIV (sex workers, people who use drugs, men who have sex with men, lesbians and transgender people, and adolescent girls and young women) in enabling these groups to transform national HIV responses by strengthening their advocacy skills and capacities and promoting innovative evidence-informed practice. This will durably enable these groups to advocate for a more effective response to ensure all people have equal access to sexual and reproductive health services, including HIV-related services. PITCH's Budget Advocacy Project aims to enhance the knowledge and technical expertise of PITCH partners on domestic financing for HIV and budget advocacy. The objective is to ensure that PITCH partners have the right skills, tools and evidence for credible and effective advocacy. With this project, PITCH will contribute to ensuring meaningful engagement of and advocacy by key and vulnerable populations for financing for HIV, influencing government budgets, ensuring equitable access to quality health services and financial protection for all. To achieve this, the project seeks to strengthen the capacity of civil society organisations in domestic health financing advocacy in a way that promotes coherence and constructive multi-stakeholder collaboration in efforts to hold governments to account for the level and use of funds allocated to health.

To inform the CSO advocacy capacity strengthening process, a situation analysis of the Zimbabwe health financing landscape and CSO operating environment was conducted to generate evidence to support the advocacy work of CSOs on domestic resource mobilisation and healthcare financing.

2. CIVIL SOCIETY ORGANISATIONS: SITUATION ANALYSIS

2.1 Introduction

As part of the Budget Advocacy and Domestic Healthcare Financing capacity building process for Civic Society Organisations (CSOs) under the Partnership to Inspire, Transform and Connect the HIV response (PITCH) consortium in Zimbabwe, a scan of laws with implications on the registration, operation, funding and participation of CSOs and on healthcare investment, resource mobilisation and resource allocation in Zimbabwe was conducted. The purpose for this situation analysis was to identify legal provisions that act as constraints to the independence and functionality of CSOs as well as their participation in domestic health financing processes. Once identified, these legal constraints would then be a focus for advocacy and lobbying actions by the CSOs to enable the CSOs to meaningfully engage in and influence domestic healthcare financing and budgetary processes in Zimbabwe.

2.2 Legal Framework Regulating CSOs in Zimbabwe

Zimbabwe's CSOs have mainly adopted three organisational and legal forms namely: Private Voluntary Organizations (PVOs); Trusts; and Unincorporated Associations also known as Universities (Mugabe, 2015). The main pieces of legislation that regulate the registration and operations of CSOs include the following:

- The Constitution of Zimbabwe (2013)
- The Private Voluntary Organisations Act (PVO) of 2002
- Deeds Registries Act (Chapter 20:05)
- Unlawful Organizations Act of 2001 (Chapter 11:13)
- Maintenance of Peace and Order Act [Chapter 11:23]
- Freedom of Information Act (Chapter 10.33) No.1/2020

2.2.1 The Constitution of Zimbabwe

The Constitution of Zimbabwe is the supreme law of the land and any law, practice, custom or conduct inconsistent with it is invalid to the extent of the inconsistency (Government of Zimbabwe 2013: Section 3, 16). The constitution provides an enabling environment for CSO participation and healthcare financing in Zimbabwe through the provision of basic legal rights.

The new Constitution of Zimbabwe, which was adopted in May 2013, contains a number of new provisions that could potentially enlarge the operational space for civil society in the country. Amongst them, the respect for the rule of law and fundamental rights and freedoms: the freedom to assembly and association, conscience, expression and freedom of the media, freedom to demonstrate, and petition and access to information. Moreover, there is a duty by the State to respect the rights set out in the Constitution. It includes the duty to respect, promote, protect and fulfil the rights and freedoms as they are set out in the declaration. The right to freedom of assembly and association is provided in Section 58 of the new Constitution and it provides that everyone has the right to assembly and association and the right not to be compelled to belong to an association or attend a meeting or gathering. Section 59 provides that every person has the right to demonstrate and to present petitions, but these rights must be exercised peacefully. The freedom of expression has been expanded in the new Constitution to include the freedom of the media (Section 61). Under this section every person has the right to freedom of expression, which includes freedom to seek, receive and communicate ideas and other information.

Section 62 of the constitution guarantees the right to information. Every Zimbabwean citizen or permanent resident, including juristic persons and the Zimbabwean media, has the right of access to any information held by the State or by any institution or agency of government at every level, in so far as the information is required in the interests of public accountability. Freedom of movement is guaranteed in Section 66 of the constitution while political rights are provided for in Section 67. Under this section every Zimbabwean citizen has the right to form, join and participate in the activities of a political party or organisation of their choice; to campaign freely and peacefully for a political party or cause; to participate, individually or collectively, in gatherings or groups or in any other manner, in peaceful activities to influence, challenge or support the policies of the Government or any political or whatever cause.

Section 76 of the constitution provides for the right to health care and obligates the state to provide health services in relation to health need. CSOs focusing on HIV support the realisation of this right by providing HIV services in different locations across the country to complement national efforts in fighting the pandemic.

The rights provided for and guaranteed in the Constitution create a conducive legal environment for CSOs to carry out their activities, including those that are aimed at holding the Government to account. These rights are likely to provide a better protection for CSOs if the provisions of the Constitution are applied. It has to be noted however that the enjoyment of the rights espoused in the Constitution is only possible if the constitutional provisions are implemented in letter and spirit. The Government should also show political commitment and will to implement the constitution in order for a conducive environment to be created for CSOs.

2.2.2 Private Voluntary Organisations (PVO) Act

The Private Voluntary Organisations (PVO) Act is the main piece of legislation that govern the registration and operations of CSOs. Prior to Zimbabwe's independence in 1980, the piece of legislation that governed CSO operations was the Welfare Organizations Act of 1967. This Act's main purpose was to control organizations with apparent connections to the liberation movement or suspected of documenting human rights abuses in the former Southern Rhodesia (Kagoro 2005; Masunungure 2011; Mugabe 2015). Consequently, organizations with such missions operated guise of church-related bodies and training and

education institutions. Concurrently, the Unlawful Organization Act [Chapter 11:13] of 1971 was also used to proscribe African political and other colonial resistance movements (Mugabe 2015). The PVO Act of 1976 repealed the Welfare Organizations Act of 1967. An amended version of this Act has since governed the operations of CSOs in post-independent Zimbabwe with the most recent version being the PVO Act of 2002. Additional amendments to this Act were published in 2007, following a proposed 2004 NGO bill approved by the Zimbabwe Parliament. In response to widespread criticism of this bill from both internal and external NGO/CSO communities, the bill did not receive the President's assent, and therefore, failed to pass.

The PVO Act defines and governs CSO operations. It also spells out the process by which CSOs can register their organizations. The PVO Act of 2002, Section Two, defines PVOs as organizations with a public benefit, that is, "anybody or association of persons, corporate or unincorporated, or any institution, the objects of which include or are one or more of the following – (a) the provision of all or any of the material, mental, physical or social needs of persons or families; (b) the rendering of charity to persons or families in distress; (c) the prevention of social distress or destitution of persons or families; (d) the provision of assistance in, or promotion of, activities aimed at uplifting the standard of living of persons or families; (e) the provision of funds for legal aid; (f) the prevention of cruelty to, or the promotion of the welfare of, animals; (g) such other objects as may be prescribed; (h) the collection of contributions for any of the foregoing". Such organizations register with the Registrar and the PVO Board. The Minister of Labour and Social Services administers the PVO Act, for the registration and de-registration of PVOs.

A number of organisations are not considered PVOs under the PVO ACT. These include Trusts, which according to Section 2(1)(h) of the PVO Act (2002), "any trust established directly by any enactment or registered with the High Court" (iii); or "any educational trust approved by the Minister" (iv) (GoZ 2002, 86), is not considered a PVO and can only be dissolved by a Court order. Religious bodies such as churches, health institutions registered under the Health Professions Act, bodies or associations carrying out activities for the benefit of a hospital or nursing home approved by the Ministry of Health, and mutual and membership benefit groups such as burial societies that exclusively benefit their own members, are not considered PVOs (GoZ 2002). Instead, they are considered Universitas as per the Supreme Court of Zimbabwe ruling on Zimbabwe Lawyers for Human Rights and Anor vs. The President of the Republic of Zimbabwe (Mugabe 2015; NANGO 2013). Political organizations and the Zimbabwe Red Cross, which was established by the Zimbabwe Red Cross Society Act, are also not considered PVOs.

Registration under the PVO Act provides CSOs with a legal status that enables them to operate legally in Zimbabwe and to solicit for financial assistance for their work. It also enables the government to have an oversight over the operations of these CSOs for accountability purposes. Operating and receiving funding without registration is considered a criminal act punishable by imprisonment and/or a fine. An unregistered PVO is not entitled to government grants.

The legal framework applicable to PVO contains several legal barriers relating to establishment and registration. The PVO Act provides for an overly complex registration process. Based on the General Notice 99 of 2007 of the PVO Act [Chapter 17:05] "Code of Procedure for the Registration and Operations" (GoZ 2007), local NGOs and international organizations follow different registration procedures. Local NGOs register with the Registrar. However, their application must go through the District Social Services Office in the area where they are headquartered (GoZ 2007). Following a review, interviews, and approval by the District Service Officer (DSO), the registration application is forwarded to the Head Office through the Provincial Social Services Officers (PSSO). The PSSO then forwards the NGO's application packet

(which includes application form, proof of advertisement, a copy of the NGO's constitution, the curriculum vitae of the members of the NGO's executive committee, and proof of notification to local authorities of intent to register for consideration by the PVO Board (GoZ 2007).

CSOs in Zimbabwe have expressed concerns over the registration requirements and procedures. Zimbabwean CSOs claim that, in the absence of an established criterion for the evaluation of applicants, the process becomes a subjective evaluation. Those CSOs whose focus areas are perceived to be sensitive and likely to destabilise the status quo are unlikely to be registered or will find the registration process difficult. Another concern relates to the waiting period for registration, which in some cases can stretch to over a year. As NANGO noted, there is no fixed period for government review of PVO registration applications. This lack of a fixed registration period might be used as an excuse to frustrate registration of applicants that are not perceived in favour by the authorities. Although the process of registration is decentralized, some view the process as a bureaucratic hurdle and effectively a barrier to entry for CSOs (e.g., Elone 2010).

The PVO intending to register is required, at its own expense, to publish in a local paper where it is headquartered, its intention to register. The publication of this intention to register allows any person to object to the organization's registration and the evidence for grounds of objection must also be submitted (Government of Zimbabwe, 2002, Section 9 (3), 88). On the other hand, the PVO Act makes specific reference to and enunciates reservations about foreign funding to civic groups, with the latest amendment to the Act banning all foreign funding to civic organisations particularly those focusing on voter education.

Foreign civil society organizations that seek to operate in Zimbabwe, in particular by undertaking work of a humanitarian nature or whose objectives are covered under the PVO Act, are required to register as such. These foreign CSOs are required to have a direct memorandum of understanding (MoU) or cooperation with the relevant Government Ministry, both at national and local level. The application documents must include, among other requirements, curriculum vitae and an Interpol or local police clearance certificate for the country representative. Both local and foreign PVOs are required to notify the local authorities in their geographical areas, of their intended operations, prior to commencing operations, presumably for security reasons. Once registered, these PVOs cannot alter their geographical areas of operation or "digress into programs that are not specified in the MOU" (Government of Zimbabwe, 2007, Section 4(d), 2), without the approval and facilitation of the relevant ministries. This implies that, if circumstances change that demand that the CSOs to change focus, they will need to go through the bureaucratic process of seeking approval from the relevant authorities. In addition the PVO Act provides vague grounds for denial of PVO registration, including where the applicant "appears unable to abide by the objectives" stated in its application.

The PVO Board performs functions conferred to it by the PVO Act. It comprises five representatives from PVOs, or organizations the Minister of Public Service, Labour and Social Welfare considers representative of the sectors. It also includes ten PVO representatives from organizations headquartered in Zimbabwe's 10 provinces. Additional members include a representative from each of the following Ministries responsible for Public Service, Labour and Social Welfare, Health and Child Care, Justice, Finance, Cooperatives, and Foreign Affairs, as well as the Registrar – whoever is the current Director of Public Service, Labour and Social Welfare. The main challenge however is that all representatives, including those from PVOs, are appointed by the Minister of Public Service, Labour and Social Welfare. The Minister can decline to appoint a person recommended by the PVO associations.

Appointed members serve three-year terms. The Registrar, in consultation with the PVO Board, has the prerogative to grant temporary authority to collect contributions; especially when delays in the registration process would “prejudice the objects for which such contributions are to be collected” (GoZ 2007, Section 8, 88).

The stated purposes of registering PVOs with the Registrar’s Office is “to enable both the supervision of the developmental impact of programs under implementation and the monitoring of organizations’ corporate governance” (GoZ 2007, Section 7(a), 2). In principle, registration is important to enable the government to rationalise the implementation of development interventions while ensuring that CSOs are accountable and are sticking to the mandates for which they were set up. The threat however exist in the fact that the Registrar of PVOs can easily deregister an organisation that is deemed not to be sticking to its mandate and when its activities are classified as being “not in the public interest”. Section 9: 5b (a) states that the PVO board can deregister a PVO if it appears to the Board that the organization is not bona fide operating in furtherance of the objects mentioned in its application for registration. Under Section 10 of the PVO Act, a PVO can be deregistered if the Board considers that the objects in respect of which the organization was registered are merely ancillary or incidental to the other objects of the organization. CSOs have argued that these are vague grounds for deregistration which can be used to target those PVOs that would wade into uncomfortable political spaces for the government.

The PVO Act (Section 20) gives the Minister authority to (a) inspect any aspect of the affairs or activities of any private voluntary organization and examine all documents relating thereto; (b) examine the books, accounts and other documents relating to the financial affairs of any private voluntary organization. Based on information available to him through these inspections the Minister may suspend any or all members of the PVO’s executive committee where “it is necessary or desirable to do so in the public interest.” CSOs argue that these provisions in the PVO Act gives the Minister the powers to interfere in the internal affairs, management and activities of PVOs. The PVOs will therefore remain registered at the discretion of the Minister.

CSOs have also complained that although they are not required to submit letters of notification of intent to hold meetings in public spaces (unlike political parties), in practice police have continuously banned CSO activities, and interpreted “notification” to mean actual application even though CSOs are not required to do neither. The CSOs further complain that there has been selective application of law by governmental authorities resulting is some CSOs being targeted.

CSOs are required to sign memorandum of Understanding (MOUs) with relevant ministries in provinces and districts they wish to operate in. CSOs in the health sector, and in particular those CSOs supporting the rights of key populations such as LGBTI and sex workers have found it difficult to establish MoUs with local authorities and relevant ministries because some of the key population groups that they target are criminalised.

The PVO Act is currently under review and there are concerns by CSOs that provisions of the 2004 NGO Bill that was passed by parliament but was not assented to by the President to become law, will find their way into the amended PVO Act. The expressed intentions and aims of the 2004 NGO bill were to “provide for the registration of non-governmental organizations; provide for an enabling environment for operations,

monitoring and regulation of nongovernmental organizations; and to repeal the Private Voluntary Organization Act" (GoZ 2004).

In spite of the bill's proposed good intentions, there were strong reservations related to some of the bill's provisions by UNDP, NANGO and CSOs. There were concerns particularly with regard to Section 9(4) of the bill which stipulated that "No foreign Non-governmental organization shall be registered if its sole or principal objective involve or include issues of governance," and Section 17 which stated that "No local Non-governmental organisation shall receive foreign funding or donation to carry out activities involving or including issues of governance" (GoZ 2004). CSOs argued that the NGO bill violated the Constitution of Zimbabwe as the provisions essentially served to hinder the exercise of the rights to association and assembly (e.g., NANGO 2004; Kagoro 2005). They also argued that governance includes the "promotion and protection of human rights and political governance issues" (GoZ 2004). NANGO further argued that the funding restrictions of the bill would have resulted in the closure of the majority of its members who largely depended on foreign funding for their activities (NANGO, 2004).

It remains to be seen if the provisions of the NGO bill will find their way into the revision of the PVO Act which is currently on going.

2.2.3 Deeds Registries Act (Chapter 20:05)

Trusts, which typically have unlimited objectives, are regulated under the Deeds Registries Act [Chapter 20:05] and therefore register with the Registrar of Deeds. Trusts are often intended to benefit an identifiable constituency. The trust form, however, has also been used as a way of registering organizations that have faced difficulties in registering under the PVO Act. The PVO Act excludes trusts in its definition of what constitutes a PVO [PVO Act, Section 2(1)(h)(iii)]. Consequently, Trusts are regulated under the Deeds Registries Act, which allows the Registrar of Deeds to register notarial deeds in donation or in trust.

Registration through the Deeds Office defines Trusts as a type of ownership of property held by one party for the benefit of another (NANGO, 2013). Section 2(1)(h) of the PVO Act states that "any trust established directly by any enactment or registered with the High Court" (iii); or "any educational trust approved by the Minister" (iv) (GoZ 2002, 86), is not considered a PVO and can only be dissolved by a Court order. In light of Trusts' unlimited objectives, organizations that have faced difficulties registering as PVOs have often adopted the Trust form (Mugabe 2015). CSOs can be registered as Trusts in terms of the Deeds Registries Act [Chapter20:05], which allows the Registrar of Deeds to register notarial deeds in donation or in trust. Some of the CSOs opt to register as Trusts and not PVOs since it takes less time and is less restrictive in terms of the objectives that the Trust can pursue. The Trust format, being a private arrangement, provides limited room for government interference in the internal affairs of the CSO.

CSOs that register as Trusts however face a number of huddles. These include lack of access to government grants as the Trusts are not considered PVOs. Some of the international development partners have insisted that CSOs that become recipients of their funding support should be registered as PVOs instead of Trusts, for example, the United Nations Spotlight Initiative Programme required that all applicants be registered as PVOs thereby excluding those registered as Trusts. The rationale is that there

is more accountability when a CSO is registered as a PVO as the regulating act allows for inspection and examination of the organisation's operations and accounts and any malpractices identified can lead to the deregistration of the CSO. The PVO act also allows for government oversight to ensure that the CSO is delivering according to their mandate. With the Trust format, the arrangement is private which can only be dissolved by a court order. Accountability oversight over a trust arrangement is thus a challenge and hence some donors embrace more CSOs that are registered as PVOs.

Registering as a Trust is expensive because of the legal fees and costs required by the Notary Public to prepare the deed. In 2009, the Ministry of Justice and Ministry of Labor issued the "Joint Memorandum re: Amendment to the PVO Act and the Deeds Registries Act" (2009). The Memo proposed that trusts, which are registered with the Deeds Registry, and fall within the definition of a PVO, be expressly included within the embrace of the PVO Act and therefore be obliged to register as a PVO before commencing activities. This would have subjected trusts to a burdensome two-tiered registration process, and to broad control by the Registrar and PVO Board.

CSOs that are registered as trusts and are working with key populations such as sex workers and LGBTI face operational huddles as some of these KP groups are criminalised. It is difficult for these CSOs to be registered as PVOs given that they are working with criminalised groups and hence many opt to be registered as trusts or universitas organisations. Several of CSOs supporting sex workers and LGBTI, for example GALZ, have been arrested and taken to court for being "unlawful' organisations.

2.2.4 Universitas

Universitas are a product of the common law and are not regulated by statute. A universitas exists when there is an entity which has a constitution and a membership that agree to achieve a common objective out of activities that are entirely for the benefit of its members. This is the easiest way of forming an institution where two or three partners come together and make an understanding through an agreed constitution, which establishes the modus operandi. Although it is an easy and straight forward option few NGOs operate under this form of establishment. The National Constitution Assembly and church related NGOs like Catholic Commission for Justice and Peace (CCJP) are not officially registered but operate under the common law universitas, which is lawfully acceptable in Zimbabwe. A Common Law Universitas can be viewed as a common law persona; this form was recognized by the Zimbabwean Supreme Court in ***Zimbabwe Lawyers for Human Rights & Anor v. The President of the Republic of Zimbabwe & Anor*** SC 12/03. Such an entity is excluded from registering under the PVO Act and is therefore not viewed as a PVO, but as the corporate form "UNIVERSITAS" or with a corporate form legal personality.

2.2.5 Unlawful Organisations Act [Chapter 11:13] Of 1971

In addition to the registration requirements set up by the PVO Act and the Deeds Act, Zimbabwean CSOs are subjected to a whole spectrum of legislation that, once applied, can seriously affect their operating environment. One such piece of legislation is the Unlawful Organization Act [Chapter 11:13] of 1971. The Act was used to proscribe African political and other colonial resistance movements by the colonial regime (Mugabe, 2015). The act was enacted *" to make provision, in the interests of defence, public safety or public order, for certain organizations to be unlawful organizations"*. The Act defines an organisation as *" any association of persons, whether incorporated or unincorporated, and whether it has been established*

or registered under any enactment" . By this definition it implies that CSOs in any organisational form (PVO, Trust or Universitas) can be declared an unlawful organisation. Under Section Three of the Act, the President, through a proclamation, can declare any organization to be an unlawful organization if it appears to the President that the activities of that organization or of any of the members of that organization are likely to endanger, disturb or interfere with defence, public safety or public order in Zimbabwe. That proclamation shall not be open to question in any court of law but is subject to confirmation by parliament, failure which the proclamation lapses within 21 days.

The Act makes CSOs vulnerable to being labelled unlawful if their activities are perceived to be a threat to public safety or public order. The Act provides the government with an easy way of dealing with CSOs or membership that is regarded as anti-government. The provision that the proclamation is not subject to questioning in a court of law goes against the tenets of justice and violates Section 69(3) of the Constitution which guarantees the right of access to the courts for the resolution of disputes.

2.2.6 Maintenance of Peace and Order Act [Chapter 11:23]

The Maintenance of Peace and Order Act – (Act 9/2019) was gazetted in a Government Gazette Extraordinary dated 15th November 2019. The Act repeals the Public Order and Security Act (POSA) [Chapter 11:17], which for a long time was considered by CSOs as a draconian piece of legislation curtailing the freedoms of association and assembly enshrined in the country's constitution. POSA itself was enacted in 2002 during the ascendency of MDC as an opposition party which posed the first serious challenge to ZANU PF's grip on power. POSA was thus viewed as an Act meant to curtail the functionality of the MDC and CSOs demanding a more democratic space and an even playing field for political players. POSA repealed the Law and Order Maintenance Act [Chapter 11:07] (LOMA), a colonial and draconian law by the government's own admission. However, ironically POSA incorporated many provisions of LOMA and introduced even more repressive provisions. The repeal of POSA, given its background as a repressive piece of legislation, was seen as a priority for the new government after the fall of the Mugabe government.

The Maintenance of Peace and Order Act (MPOA) has been described by CSOs and human rights critics as a reincarnation of POSA under a different name. The new act still contains several clauses with adverse implications for the operation of CSOs.

Sections 5 to 8 of MPOA regulate gatherings in public places. These clauses require organisers of public gatherings to notify regulating authorities before the gatherings are held (five days' notice in the case of public meetings, seven days in the case of demonstrations and processions). Organisers will also be obliged to negotiate with regulating authorities about arrangements for the gatherings and to comply with directives the regulating authorities may give them. Even though MPOA refers to police notification, the procedure thereafter is actually one of seeking approval. It is the regulating authority who indicates if the meeting or demonstration can proceed or is subject to further consultations, amendments and/or eventual prohibition. Conveners must be invited for consultations prior to any prohibition order, but their submissions are not binding on the regulating authority and such meetings are often held as a procedural requirement towards prohibition. If a regulating authority believes that a gathering will cause serious disruption, injuries or property damage the authority will be able to prohibit the gathering. Any person who knowingly opposes or fails to comply with a prohibition notice or any directions or conditions under which a procession, public demonstration or public meeting is authorised, shall be guilty of an offence and liable to a fine not exceeding level 14 or to imprisonment for a period not exceeding one year or to both such fine

and such imprisonment. The South African Constitutional Court recently struck down the offence of failure to give notice, finding that the right of assembly is too important to be restricted by a law which even criminalizes 'peaceful and unarmed assemblies.' The threat of imprisonment is clearly meant to curtail freedom of expression and association.

Sections 9, 22 and the Schedule

Section 9 of MPOA lists gatherings exempt from the application of the notification requirement. The gatherings are listed in a schedule and they mainly exempt gatherings which are not of a political nature. The Minister can amend the schedule by way of statutory instrument through section 22 of the Act. It is only when the Minister is reducing the number of gatherings which are exempt from the notification requirement that parliamentary approval is required to activate the changes. Thus, the Minister can add gatherings to the schedule without the need for any parliament approval. This clause can have serious implications for the activities of CSOs whose work can be labelled as political.

Section 10 of the Act deals with Gatherings in vicinity of Parliament. This clause prohibits public gatherings in the vicinity of Parliament, courts or places declared to be protected places under the Protected Places and Areas Act. Parliament is a public institution open to members of the public and the clause unreasonably limit their right to petition Parliament which is guaranteed by section 149 of the Constitution. Even though the clause will allow demonstrations near Parliament if the Speaker gives written permission for them, the constitutional right to petition Parliament cannot be made dependent on permission from the Speaker or a police officer. This provision also alienates voters from their elected representatives and judicial officers.

Section 12 spells out the civil liabilities of organisers of gatherings. Under this clause organisers of gatherings who fail to notify regulating authorities of their gatherings or to follow directives issued by regulating authorities will be liable to compensate persons who suffer injury or loss from public violence or breaches of the peace caused by or arising out of or occurring at the gatherings. Organisers will be liable regardless of whether they incite or permit the violence or disturbance which causes injury or loss, and regardless of any measures they may have taken to prevent it. This provision ensures conveners suffer double jeopardy and are held liable in both civil and criminal forums for the actions at or arising out of such gatherings. It is a strong deterrent against the exercise of constitutional rights and undermines democratic participation. Under Section 13 there are however no criminal or civil consequences if a police officer uses weapons or excessive force likely to cause serious bodily injury or death.

Section 15 of the MPOA empowers the police to cordon areas to contain public disorder or violence or protect them from it. Section 16 contains the power to set up road blocks. Both provisions empower the police to limit movement of persons and conduct searches without warrant. The freedoms of speech, movement and association have been curtailed notably by sections 15-16 of MPOA just as was the case with POSA. This has continued to make the work of CSOs difficult, particularly for those working to promote civil liberties, democratic participation and government accountability.

2.2.7 Freedom of Information Act (Chapter 10.33) No.1/2020

The Freedom of Information Act (FIA) (Chapter 10.33) came into effect on 02 July 2020. The Act repealed the Access to Information and Protection of Privacy Act (AIPPA) [Chapter 10:27], which CSOs have long complained about its restrictive clauses that prohibit citizens from accessing and sharing information that could be used to inform citizens and hold government to account.

AIPPA was a legal instrument that enabled the government to monitor and control the flow of information in the country. AIPPA aimed to control the free flow of information as the government had been empowered to determine what type of information eventually reaches citizens. Under the Act, the disclosure of information regarding to national finances, heritage sites, economic interests, public interests and governmental relations was subject to the public office's discretion. This implied that CSOs would find it difficult to access public information that they could use to hold government to account.

Media freedom and independent newspapers were under threat as many of their staff were arraigned before the courts of law for publishing information that the state viewed as prejudicial to state security, which under sections 23-30 of AIPPA was a criminal offence. The provisions of AIPPA were largely viewed as unconstitutional as the Constitution (Sections 61 and 62) guaranteed Freedom of expression and freedom of the media as well as Access to information. Under AIPPA, CSOs were also not allowed to be involved in the politics of the country or to make political statements or to leak any information outside the country, thus, limiting the operating environment for CSOs. In line with the need to align all legislation to the new Constitution, AIPPA was repealed and replaced with FIA in July 2020.

FIA's main objective is to "additionally provide for the constitutional rights of expression, and freedom of the media; to provide further for the right of access to information held by entities in the interest of public accountability or for the exercise or protection of a right". FIA is aligned to Section 61 (Freedom of expression and freedom of the media) and Section 62 (Access to information) of the national constitution. Section 62(1) of the Constitution states that: *"Every Zimbabwean citizen or permanent resident, including juristic persons and the Zimbabwean media, has the right of access to any information held by the State or by any institution or agency of government at every level, in so far as the information is required in the interests of public accountability"* . These constitutional provisions enable CSOs to access information that they can use to hold government and other public institutions to account. This includes budget information on domestic healthcare financing.

FIA has progressive clauses compared to its predecessor AIPPA. However, there are still concerns regarding some of its clauses. According to the Act, it is not clear to what extent information from private bodies can be accessed by the public and other interested parties such as CSOs. Private bodies can hold information that is vital and of public interest. Part III of the Bill deals only with access to information held by public bodies, not private ones, but clauses 22 and 24 set out circumstances in which private entities can refuse to allow access to their information.

The FIA has no provision requiring public bodies to publish information proactively beyond a vague statement in clause 5 that public bodies must have written "information disclosure policies". This means

that CSOs requiring information from public bodies will have to go through a lengthy official process to access the information. The African Commission on Human and Peoples' Rights in 2002 adopted the Declaration of Principles on Freedom of Expression in Africa which stated that public bodies shall be required, even in the absence of a request, to actively publish important information of significant public interest. The Act also imposes duties of disclosure on "holders of statutory office" but does not define what that term means.

Although the repeal of AIPPA by FIA is generally progressive and makes it easier for CSOs to access information, there are a few clauses that would need to be addressed to improve the operating environment for CSOs.

2.3 Operating Environment for CSOs: Challenges and Opportunities

The table below provides a summary of the operating environment challenges and opportunities for CSOs in Zimbabwe.

Table 1: *Operating environment challenges and opportunities for CSOs in Zimbabwe*

	Challenges	Opportunities
Overall	• General mistrust by government of CSOs as advocates of regime change agenda • Some CSOs viewed as political • Threat of deregistration through several pieces of legislation • Police harassment of some CSOs deemed to be operating illegally	• The current review of the PVO ACT provides a window for CSOs to provide an input into the act • Constitutional provisions and supportive legislation such as the Freedom of Information Act
CSOs registered as Private Voluntary Organisations	• Registration process cumbersome and can take up to a year • Registration and deregistration at the discretion of the Registrar and Board • PVO Act allows for government monitoring of the finances and activities of the CSO which can lead to interference • Limited objectives that a CSO can pursue	• Access to government funding and international donor funding • Improved accountability can enable the PVO registered CSOs to have increased access to funding
Trusts and Unversitas	• Harassment by police of those CSOs supporting KPs that are criminalised such as LGBTI and sex workers • Cannot access government funding and funding from some international donors who require the CSOs to be registered as PVOs	• Limited state interference in the operations of the CSOs as under the trust law, the trusts are considered private entities

3. HEALTH FINANCING IN ZIMBABWE: SITUATION ANALYSIS

3.1 Introduction

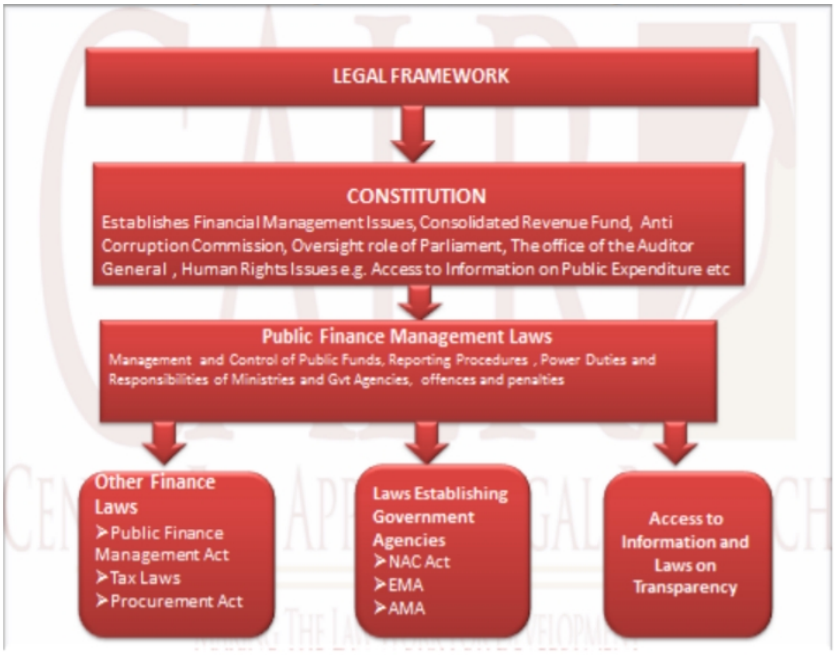
Stable and sustainable health care financing (HCF) is considered an essential component for achieving a country's health goals. Appropriately arranged health care financing helps governments mobilize adequate financial resources for health, allocate them rationally, and use them equitably and effectively. Equitable and pro-poor health financing policies promote universal health access. It also contributes to social protection and strengthens the social safety nets in rapidly changing socioeconomic environments. In such broad context, HCF contributes to the overall social and economic development process.

Zimbabwe is currently in the process of building the foundation for a long-term system for Universal Health Coverage (UHC), considering equity in access and coverage as set out in the National Health Strategy (NHS). In this regard, this Situation Analysis of health financing is intended to provide an overview of the Healthcare Financing landscape in Zimbabwe, mapping the different financing mechanisms and models that are currently being used in the country to support the healthcare system. The situational analysis also identifies existing gaps in the healthcare financing system that act as barriers to the attainment of UHC. Opportunities for CSO participation in the healthcare financing mechanisms are also identified.

3.2 Legal Framework for Healthcare Financing In Zimbabwe

Several pieces of legislation govern the various components of healthcare financing and the delivery of healthcare in Zimbabwe. These pieces of legislation include the National Constitution, the Health Services Act (2002), the Public Health Act (2002), the Public Finance Management Act (2010), the Medical Services Act (year), the Mental Health Act (year), and the Health Professions Act (2000). Other acts and policies that govern specific components of the health system draw from these major pieces of legislation. The various pieces of legislation also create various bodies and institutions that oversee enforcement of these laws and regulations. Figure 1 below shows the legal framework that is used to manage public funds (including healthcare funds) in Zimbabwe.

Figure 1: *Legal Frameworks for management of public funds*



Source: *R Chari in MoHCW, TARSC, KIT (2013)*

3.2.1 National Constitution

The Constitution of Zimbabwe Section 76 clearly states that:

(1) Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services.

(2) Every person living with a chronic illness has the right to have access to basic health-care services for the illness.

(3) No person may be refused emergency medical treatment in any health-care institution.

(4) The State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of the rights set out in this section.

In Section 29, the constitution obligates the State to: take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe; take appropriate, fair and reasonable measures to ensure that no person is refused emergency medical treatment at any health institution; and take all preventive measures within the limits of the resources available to it, including education and public awareness programmes, against the spread of disease.

The Constitution contains a Declaration of Rights that has implications for the equitable allocation of available resources. The right to health care (section 76) obligates the state to provide health services in relation to health need. Section 301 of the Constitution further provides for the allocation of revenues across provincial and local tiers of government. The Constitution is the yardstick for the laws that enable the establishment of funds for health as part of the progressive realisation of the right to health. The establishment of funds through the budget process is governed by a budget policy process in which Cabinet identifies national priorities that benefit the entire nation. This is to lay a foundation for ministerial planning and budgeting (Bhala, B: 2013).

Although the rights of citizens to health are clearly spelt out in the constitution, the caveat that the State must take measures to ensure that the rights are realised "*within the limits of resources available to it'* provides a clawback clause that makes the realisation of those rights precarious. The State can easily blame the non-attainment of some of those rights on "lack of resources".

Public Money: The Consolidated Revenue Fund (CRF) is the principal source of funding for government. A budget appropriation procedure provides for parliamentary authorisation of public revenues in the CRF. Section 2 of the Public Finance Management Act [Chapter 22:19] (PFMA) defines "public money" as revenues and all other money received and held, whether temporarily or otherwise, by a public officer in his or her official capacity. A public officer is defined as any person who is in the employment of the state or a designated corporate body. Section 302 of the Constitution of Zimbabwe defines public money as that which is held in the Consolidated Revenue Fund (CRF). In section 308 on stewardship over public resources, this definition is broadened to include "any money owned or held by the State or any institution or agency of government, including provincial and local tiers of government, statutory bodies and government-controlled entities". Section 302 identifies the CRF as the national account into which must be paid all fees, taxes and borrowings and all other revenues of the government, whatever their source, unless they are required by law to be paid into a separate fund or to be retained by the authority that receives them. The Constitution and PFMA's definition of public money therefore covers revenues within the national accounts, except for public money that Parliament authorises to be used for a purpose that is specified by legislation. Expenditures are provided for in an Appropriation Act.

The legislative power to establish and define statutory funds for a particular purpose in the definition of public money has been used in the past to allow the Minister of Health to submit legislative proposals to Parliament to raise public revenue through taxation and to earmark the revenue raised to pursue a particular objective mandated by legislation.

The power to raise revenue through taxation is exercised by the Minister of Finance in terms of the Finance Act [Chapter 23; 04] and by the Zimbabwe Revenue Authority established in terms of the Revenue Authority Act [Chapter 23:11]. This power to tax is exercised subject to Section 298 (2) of the Constitution which states that no taxes may be levied, except under the specific authority of the Constitution or an act of Parliament. Parliament consents to the use of public funds through enabling legislation for specific policy implementation. Parliament permits the use of public revenues each year by approving Estimates of National Expenditure (ENE) before the beginning of the government's financial year. At the close of each financial year, Parliament expects a clear account of the use of the public funds that it would have authorised through the appropriations process regulated in terms of the Constitution in sections 302, 303, 305, 307 and 308 and the PFMA under section 6.

Funds that are set up by legislation, extra-budgetary funds and other funds which are sourced outside the CRF are subject to the accountability requirements of the public finance management system by virtue of the definition of public money in section 302 and 308 of the Constitution as discussed earlier. When such funds are collected for state agencies outside the CRF and directly into their own coffers (such as international donations to the National AIDS Council) they should then be accounted for in terms of the enabling legislation for that particular body. In most instances, the enabling legislation requires accounting for such funds in accordance with the PFMA. Entirely private funds and funding from foreign funders to non-state actors that takes place directly without involvement of the state or any institution or agency of government are not included under public funds or governed by the PFMA.

Section 194 (1) of the 2013 Constitution provides that public administration in all tiers of government, including institutions and agencies of the state and government-controlled entities and other public enterprises, must be governed by the following democratic values and principles:

- a high standard of professional ethics;
- efficient and economical use of resources;
- development-oriented public administration;
- impartial, fair, equitably provided services, provided without bias;
- people's needs responded to within a reasonable time, and the public encouraged to participate in policymaking;
- public administration accountable to Parliament and the people;
- co-operation between institutions and agencies of government at all levels;
- transparency, such as by providing timely, accessible and accurate information to the public;
- good human-resource management and career development practices, to maximise human potential;
- a public administration that is broadly representative of Zimbabwe's diverse communities; and
- employment, training and advancement practices based on merit, ability, objectivity, fairness, the equality of men and women and the inclusion of persons with disabilities.

Chapter 14 of the Constitution creates an obligation for the state to devolve power and responsibilities to lower tiers of government to ensure democratic participation in government by all citizens and communities of Zimbabwe, equitable allocation of national resources and the participation of local communities in the determination of development priorities within their areas.

The constitution thus provides a framework for accountability by putting mechanisms in place to ensure that government ministries and institutions promote public participation in policy making and have access to information that the public can use to hold government accountable.

3.2.2 The Public Finance Management Act [Chapter 22:19] (PFMA)

The PFMA provides for a framework of accountability and transparency in managing public funds. The objective of the Act is to secure transparency, accountability and sound management of the revenues, expenditure, assets and liabilities of (a) Government Ministries; (b) designated corporate bodies and public entities; (c) constitutional entities; (d) statutory funds, and (e) Office of the President and Cabinet. Under Section 6, the Act bestows the power to manage and control public resources on Treasury through managing the Consolidated Revenue Fund; determining the manner in which public resources shall be accounted for; and exercising a general direction and control over public resources.

The national budgeting process requires the Minister of Finance to submit to the National Assembly, the annual budget for the forthcoming financial year, before or not later than thirty days after the start of the forthcoming financial year, stating— (a) estimates of the revenues, expenditure and financing requirements for the Government of Zimbabwe for that year; (b) for each vote of expenditure a statement of the classes of outputs expected to be provided from that vote during the year and the performance criteria to be met in providing those outputs (Section 28). The votes of expenditure contained in the estimates other than statutory expenditure shall be included in a Bill to be known as an Appropriation Bill which shall be introduced into the National Assembly to provide for the issue from the Consolidated Revenue Fund of the sums necessary to meet the expenditure and the appropriation of those sums to the purposes specified therein. If in respect of any financial year it is found that the amount appropriated by an Appropriation Act is insufficient or that a need has arisen for expenditure for a purpose to which no amount has been appropriated by that Act, a supplementary estimate, showing the amount required, shall be laid before the National Assembly and the votes of expenditure shall be included in a Supplementary Appropriation Bill to be introduced to the National Assembly to provide for the appropriation of those sums.

The Act provides scope for public participation in the budget formulation process. Section 28 (5) states that the Minister may through the appropriate portfolio committee of Parliament seek the views of Parliament in the preparation and formulation of the annual budget, for which purpose the appropriate portfolio committee shall conduct public hearings to elicit the opinions of as many stakeholders in the national budget as possible. The Act does not however make it mandatory for the Minister to seek the views of the appropriate portfolio committee of Parliament, and by extension the public, as the Act states that the Minister “may” and not “shall”. This leaves public participation in the budgeting process at the discretion of the Minister.

Part II of the Act (Sections 6-27) outlines legislative measures for the *Control and Management of Public Resources.* Part IV of the Act outlines the obligations of each Government Ministry in preparing monthly, quarterly and annual financial statements. For annual statements (Section 32), each ministry is required to submit to the Accountant-General within thirty days of the year concerned. The Auditor-General or any independent auditor shall audit the annual financial statements and return the audited statements to the accounting officer within sixty days of receipt thereof. The annual report and audited financial statements shall— (a) contain a report on the activities, outputs and outcomes of the Ministry; (b) fairly present the state of affairs of the Ministry, reporting unit, constitutional entity or public entity for which the Ministry is responsible; (c) include, where appropriate— (i) particulars relating to losses arising through criminal activities, and criminal and disciplinary action taken; (ii) instances of unauthorised expenditure; (iii)

instances of irregular expenditure; (iv) instances of fruitless and wasteful expenditure; (v) recoveries and write-offs of public resources; (vi) any other matters as may be prescribed.

Sections 33 and 35 provide legal guidelines for the preparation of quarterly and monthly financial statements by each Ministry. Each ministry will submit financial statements within 14 days of the end of each quarter or month to the Accountant-General. The Minister will submit the financial statements and reports to the appropriate Parliamentary Portfolio Committee, within sixty days of the end of the respective quarter. The Accountant-General shall prepare consolidated quarterly or monthly financial statements and shall submit such statements to the Secretary, for presentation by the Minister to the National Assembly and to the appropriate Parliamentary Portfolio Committee, within sixty days of the end of the respective quarter or within thirty days of the respective month. The Accountant-General shall prepare consolidated quarterly financial statements and shall submit such statements to the Secretary, for presentation by the Minister to the National Assembly and to the appropriate Parliamentary Portfolio Committee, within sixty days of the end of the respective quarter. For the monthly financial statements and reports, the Accountant-General shall prepare consolidated monthly financial statements and shall submit such statements to the Secretary, who shall publish such statements or cause them to be published in the Gazette, within thirty days of the next succeeding month.

In Section 35, every Minister shall, within ninety days of the end of the financial year, submit to the National Assembly the unaudited consolidated annual financial statements. Each Minister is required, within thirty days of the tabling of the Report of the Auditor-General thereon before the National Assembly, to submit to the respective Parliamentary Portfolio Committee the audited annual financial statements of his or her respective Ministry. The Minister shall submit to the National Assembly, audited consolidated annual financial statements within one hundred and eighty days of the end of the financial year.

Section 36 outlines what must be contained in the financial statements. Every financial statement shall state the following amounts and compare such amounts in each case with the corresponding budgeted amount in respect of the relevant period— (a) the actual revenue for the relevant period and for the financial period concerned to the end of that period; and (b) the actual expenditure for each vote, distinguishing between capital and recurrent expenditure for that period. The financial statements will be published in the Government Gazette.

CSOs needing information on healthcare financing and expenditure can get access to these quarterly and monthly financial statements and reports from the Ministry of Health. The CSOs can also attend financial statements presentations to the Parliamentary Portfolio Committee and the National Assembly by the Ministry of Health to access information on healthcare funding. There is however limited scope for public participation in the budget because the Act does not mandate the Minister to consult the appropriate portfolio committee, stakeholders and members of the public.

CSOs interviewed reported that some of them do not know at what stage of the budget formulation process they should participate to influence the budgeting process. Some do not know where to go, who to lobby and how to lobby and advocate to influence the budgeting process. This remains a gap within the CSO sector.

3.2.3 Health Services Act [Chapter 15:16]

Under the Health Services Act, a Health Services Board (HSB) is established which is body corporate capable of suing and being sued in its own name and, subject to this Act, of doing anything that a body corporate may do by law. The HSB has the following functions:

(1) The functions of the Board shall be -

(a) To appoint persons to offices, posts and grades in the Health Service;

(b) To create grades in the Health Service and fix conditions of service for its members;

(c) To supervise and monitor health policy planning and public health;

(d) To inquire into and deal with complaints made by members of the Health Service;

(e) To supervise, advise and monitor the technical performance of hospital management boards and State-aided hospitals;

(f) To set financial objectives and the framework for hospital management boards and State-aided hospitals;

(g) To handle appeals in relation to disciplinary powers exercised by hospital management boards over members of the Health Service employed in any Government hospital;

(h) To assist in resource mobilisation for the Health Service;

(i) To exercise any other functions that may be imposed or conferred upon the Board in terms of this Act or any other enactment.

The Board shall exercise its functions under this Act to ensure the well-being and good administration of the Health Service and its maintenance in a high state of efficiency.

Section 18 of the Act establishes Hospital Management Boards (HMBs) for each government central, provincial, district or general hospital. HMBs are also body corporates capable of suing and being sued in their own name and, subject to this act, performing all acts that bodies corporate may by law perform. They are the responsible authority for the hospital concerned. The following are the functions of the HMBs:

(a) To provide for the care and treatment of the patients at the hospital for which the board is the responsible authority (hereinafter referred to as "the hospital"); and

(b) To hire and fire staff; and

(c) In the case of a teaching hospital, to provide facilities for the teaching and training of medical practitioners, medical student nurses and other personnel; and

(d) Conduct negotiations with the Ministry responsible for health with respect to the provision and terms of any grants appropriated or to be appropriated by Act of Parliament or otherwise obtained for the benefit of the hospital or Government and State-aided hospitals generally; and

(e) Ensure the best use of the resources available to the hospital in the interests of the patients; and

(f) Implement Government health policy as communicated to the hospital management board from time to time by the Board; and

(g) Devise means of financing the operations of the hospital on a continuing and sustainable basis; and

(h) Maintain or improve the hospital.

In exercising these functions as a government hospital, the HMB has a duty to regard the social obligations of the hospital to provide for the health needs of the public and to assist in the implementation of national health policies and the formulation of institutional health management arrangements. Every hospital management board shall, before the commencement of each year to which the plan relates, devise an annual plan setting out the manner in which it proposes to spend the funds at its disposal and to fulfil its functions during that year. In line with section 18 of the PFMA, the HMB is the responsible authority for administering the health services fund established for the hospital, and it should apply the funds to enable the HMB to fulfil the functions above. The health services fund established for each central, provincial, district or general hospital consists of such moneys as may be appropriated by an act of Parliament for the hospital concerned; the fees and charges payable for services and facilities provided at the hospital; any donation or grant permitted by the minister to be accepted by the hospital management board and paid into the fund; and any income derived from the investment of the surplus moneys of the fund.

Section 22 of the Act states that each hospital management board shall keep proper books of accounts in relation to the health services fund and other records relating thereto and, as soon as possible after the end of each financial year, shall prepare audited accounts reflecting the operations of the hospital concerned during the financial year and the financial condition of the hospital at the end of the financial year. Each hospital management board shall furnish to the Board one copy of the audited accounts prepared in terms of PFMA together with the report of the hospital management board within three months after the end of the financial year to which the accounts and the report relate.

Section 23 on audit of accounts provides that the accounts of a HMB be audited by the Comptroller and Auditor-General, in terms of the Audit and Exchequer Act [Chapter 22:03] (now replaced by sections 6 and 7 of the Audit Office Act [Chapter 22:18]). Any member of the HMB or health service who fails or refuses to provide the Comptroller and Auditor-General with any explanation or information required by him or her for the purpose of an audit or hinders or obstructs the Comptroller and Auditor-General in the conduct of an audit is guilty of an offence and liable to a fine not exceeding level five and/ or to imprisonment for a period not exceeding three months. The Comptroller and Auditor-General may appoint a suitably qualified person to audit the accounts of a HMB with the same authorities as the Auditor-General and any expenses incurred by the person appointed in carrying out his or her audit shall be met from the health services fund.

3.2.4 Mental Health Act [Chapter 15:12]

The Mental Health Act Section 68 provides for the establishment of a Mental Hospital Board by the Minister of Health, for every institution, special institution or other place in which patients are detained. A mental hospital board shall have power to control and administer any funds and other property that may accrue to it from any source whatsoever, but such funds and property shall be used only for the specific

purpose, if any, for which the donor has given the funds or property. If no purpose has been specified by the donor the funds will be used for the benefit of patients at any institution, special institution or other place for which the board has been established, including the provision of legal assistance for such patients. The chairman of a mental hospital board shall be responsible for keeping proper accounts of the board's funds and property, and such accounts shall be audited annually by the Comptroller and Auditor-General.

3.2.5 The National Aids Council of Zimbabwe Act [Chapter 15:14)

The National Aids Council of Zimbabwe Act [Chapter 15:14] establishes the National AIDS Council (NAC). The Council is body corporate capable of suing and being sued in its corporate name and, subject to this Act, of doing anything that bodies corporate may do by law. The following are the powers and functions of the Council provided in Section 4 of the Act.

(a) to ensure the development of strategies - (i) to combat HIV and AIDS; and (ii) to control and ameliorate the effects of the HIV and AIDS epidemic; and to promote and co-ordinate the application of such strategies and policies;

(b) mobilise and manage resources, whether financial or otherwise, in support of a national response to HIV and AIDS;

(c) to enhance the capacity of the various sectors of the community to respond to the HIV and AIDS epidemic and to co-ordinate their responses;

(d) to encourage the provision of facilities to treat and care for persons infected with HIV and AIDS and their dependants;

(e) to monitor and evaluate the effectiveness of the strategies and policies

(f) to promote and co-ordinate research into HIV and AIDS and to ensure the effective dissemination and application of the results of such research;

(g) to disseminate, and to encourage the dissemination of, information on all aspects of HIV and AIDS;

(h) to submit regular reports to the President, through the Minister, concerning the HIV and AIDS epidemic;

(i) to exercise any other function that may be conferred on the Council by or in terms of this Act or any other enactment; and

Section 25 provides that NAC's funds shall consist of any moneys payable to the council from moneys appropriated for the purpose by Parliament. Other funding may come from: fees and charges raised for services and facilities provided and other things done by the council; donations, which may be accepted with the approval of the minister; loans, which may be raised with the approval of the minister and the Minister of Finance; and any other moneys that may vest in or accrue to the council, whether in the course of its operations or otherwise.

Section 26 provides that moneys not immediately required by NAC may be invested in such manner as the minister, acting on the advice of the Minister of Finance, may approve. Section 28 provides that the NAC board ensure that proper accounts and other records relating to such accounts are kept in respect of all

the council's activities, funds and property, including such particular accounts and records as the minister may direct. As soon as possible after the end of each financial year, the board is to prepare and submit to the minister a statement of accounts in respect of that financial year or in respect of such other period as the minister may direct.

Section 29 provides for the audit of the council's accounts. Subject to the Audit and Exchequer Act [Chapter 22:03] (repealed by the Audit Office Act and the PFMA), NAC shall appoint as auditors one or more persons approved by the minister who are registered as public auditors under the Public Accountants and Auditors Act [Chapter 27:12] or where required to do so the Comptroller and Auditor-General. The auditor shall be entitled at all reasonable times to require council or its agents to produce all accounts and other records relating to such accounts. Any member of the board or employee or agent of the council may be required to provide such information and explanation as in the auditor's opinion are necessary for the purpose of the audit. Any member of the board or employee or agent of the council who fails without just cause to comply with a requirement of an auditor shall be guilty of an offence and liable to a fine not exceeding level four and/ or to imprisonment for a period not exceeding three months. After examination of the board's accounts, the auditor's report to the board and to the minister stating whether the statement of accounts gives a true and fair view of the council's financial affairs. In addition to these reports, the minister may require the board to obtain from the auditors such other reports, statements or explanations in connection with the council's activities, funds and property as the minister considers expedient, and the board shall comply with any such requirement. If, in the opinion of the auditors, they have not obtained any information or explanation they require, or the board has not properly kept any accounts or records, or the council has not complied with its enabling act, the auditors will include this in their report.

3.2.6 Other Relevant Legislation

The following are public health entities permitted by an act of parliament to retain public money to meet expenses:

Medicines and Allied Substances Control Act (15.03) (MASCA)

Section 3 of the Act allows the Medicines Control Authority of Zimbabwe to retain fees payable in terms of regulation made under Section 72.

Zimbabwe National Family Planning Council Act (15:11)

Section 11 of the Act allows the council to collect fees or levies as determined by the Board from time to time, to support the functions of ZNFPC with approval from the Minister Health and Minister of Finance.

3.3 HEALTHCARE FINANCING POLICY IN ZIMBABWE

3.3.1 Background

Zimbabwe launched its first National Health Financing Policy and strategy on 6 June 2018, becoming the 17th country in the WHO AFRO Region to launch a national healthcare financing policy. The policy and strategy was informed by World Health Organisation (WHO) guidelines on healthcare financing. The approach is embedded in the health systems framework, recognising health financing as one of the Health Systems Strengthening building blocks. The policy and strategy acknowledge that the way funds are raised and allocated and the way services are paid for influences how services are accessed by the population.

The policy was motivated by the global call for UHC, the increasing disease burden in the country and the need to harmonise all health financing functions. The policy and strategy provide a "resourcing pathway to UHC" and promotes equity and quality in health, ensuring that no one is left behind. The policy ensures that all citizens have access to quality health services they need without suffering financial hardships. The healthcare financing policy is aligned to the National Health Strategy (2016-2020) and ensures that the National Health Strategy is well financed and implemented.

The healthcare financing policy and strategy was launched in the context of a myriad of socio-economic challenges facing the country, which were having significant negative impacts on the health sector. The country is still behind in meeting the Abuja Declaration target of allocating 15% of the Government's budget towards health. Health insurance covered less than 10% of the population, leading to an out of pocket expenditure of over 39% by 2010. This resulted in the financial impoverishment for many Zimbabweans, challenges in the purchase of health services and in equity in accessing health services.

3.3.2 Policy Vision, Goal, Mission and Objectives

The following are the Vision, Goal, Mission and Objectives of the Healthcare Financing Policy:

Vision: The whole population of Zimbabwe has access to the highest possible level of health and quality of life regardless of income levels, social status, or residency.

Mission: To provide, administer, coordinate, promote and advocate for the provision of equitable, appropriate, accessible, affordable and acceptable quality health services and care to all Zimbabweans while maximizing the use of available resources, in line with the Primary Health Care Approach.

Goal: The goal of the Health Financing Policy is to guide Zimbabwe's health system to move towards Universal Health Coverage (UHC) including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all by 2030.

Policy Objectives

The National Health Financing Policy has the following specific objectives:

- Mobilizing adequate resources for predictable sustainable funding of the health sector;
- Ensuring effective, equitable, efficient and evidence-based allocation and utilization of health resources;
- Enhancing the adequacy of health financing and financial protection of households and ensure that no-one is impoverished through spending on health by promoting risk pooling and income cross subsidies in the health sector;
- Ensuring that purchasing arrangements and provider payment methods emphasize incentivizing provision of quality, equitable and efficient health care services
- Strengthening institutional framework and administrative arrangements to ensure effective, efficient, and accountable links between revenue generation and collection, pooling and purchasing of health services.

Guiding Principles and Values

The health financing policy is guided by the following principles and values:

- Social solidarity
- Equity in health and health care
- Gender equality
- Healthcare as a right and shared responsibility
- Essential quality services integrating comprehensive primary health care
- Cost benefit and value for money
- Efficiency
- Appropriateness
- Affordability
- Public participation and user and provider satisfaction
- Transparency and accountability
- Ownership and
- Partnership in health

3.3.3 Policy Pillars and Direction

The National Health Financing Policy is anchored on four pillars with specific policy directions. The following are the key pillars of the policy:

(a) Sustainable Resource Mobilisation and Revenue

Under this pillar, the policy seeks to foster equitable, transparent and accountable revenue collection mechanisms and to progressively increase the share of domestic government financing relative to external financing and out of pocket (OOP) expenditure to create an ideal balance. The policy aims at creating mechanisms for mobilising resources for sustainable funding of the health sector and to coordinate the use of the resources across sectors. It also seeks to improve targeting for budget allocations. To achieve these objectives, the Government will adopt the following policy directions:

1. The GoZ will seek to strengthen domestic health financing and abide by the Abuja Declaration on Health where not less than 15% of budget shall be allocated to health.
2. The GoZ will spend not less than $60 per capita per year to ensure the minimum comprehensive benefit package is financed.
3. The GoZ will explore options for progressive earmarked taxes and levies to raise additional resources for health.
4. Current mechanism to raise additional revenue to the health sector that has been successful and sustainable will be maintained and expanded where feasible. Examples include the National AIDS Levy, Health Services Fund, Workman's Compensation Fund, Assisted Medical Treatment Order, and Accident Victims Compensation Fund on Motor Vehicle Insurance.
5. The government will encourage various forms of mandatory prepayment mechanisms such as social health insurance (SHI), community based health insurance (CBHI), national health insurance (NHI) especially for the informal sector and rural areas as a means of achieving universal health coverage.
6. Private health insurance will continue to be available as a voluntary prepayment mechanism for services not covered in the minimum benefits package.
7. Special revenue generation provisions will be requested for diseases of high national public health concern/significance as and when they emerge.
8. All external aid for health will be harmonized, coordinated, monitored and evaluated in line with health priorities and plans of the government of Zimbabwe.
9. The GoZ will continue to encourage and expand involvement of local philanthropy and charities for special health initiatives at all levels of care.
10. The GoZ will explore, ensuring consistency with its key policy principles and goals, innovative partnership mechanism with the private sector to increase resources to health such as joint ventures and outsourcing guided by a strong regulatory framework.

(b) Risk Pooling and Cross-subsidisation

Risk pooling will ensure income and risk crosses subsidies between the healthy and sick and the rich and poor. Risk pooling and cross subsidies will ensure that no one is left behind in accessing adequate and quality health services, including poor and vulnerable households. The following policy directions will be adopted:

1. The government of Zimbabwe will explore new mechanisms while at the same time strengthening existing mechanisms for promoting equity, risk equalization and reduce fragmentation with a special emphasis on ensuring that health spending does not lead to or deepen impoverishment especially in the poor and indigent population.
2. A national mandatory prepayment scheme will be introduced and expanded as a key form of pooling risk to reduce out of pocket payments.
3. There will be clear separation of functions and roles between pooling and purchasing of healthcare services.

(c) Purchasing/Provider Payments Mechanisms

The policy objective under this pillar is to ensure that purchasing arrangements and provider payment methods emphasize incentivizing provision of quality, equitable and efficient health care services. The policy seeks to improve efficiency in the allocation of health sector budgets and identifying priority areas through evidence based and transparent costing of benefits that will be purchased from pooled funding. Low cost and evidence based impact interventions will be prioritised to improve technical efficiency. Priority will also be given for the active and consultative monitoring and performance review of the purchasing mechanisms and deficit areas will be timely attended to.

The following are the key policy directions under this pillar:

1. Priority will be given to the purchase of cost effective services and those essential for achieving universal health care, that is, the Essential Health Benefit package at all levels of care (primary, secondary, tertiary, and quaternary)
2. A framework for regular evaluation of benefits and cost interventions will be put in place to ensure optimal choices.
3. Services will be purchased from all registered and accredited providers (private, public and traditional practitioners).
4. There will be separation of purchasing and provision functions for health care services.
5. Health care resources will be allocated using needs based formula to achieve equity.
6. There will be strengthening of current purchasing mechanisms and developing others that ensure those who cannot afford to pay can still access services without facing impoverishment.
7. There will be use of a mix of provider payment mechanisms that promote optimal provider performance while containing costs.
8. There will be quality assurance for services purchased irrespective of funding mechanisms and level of care.

(d) Governance

Under the governance pillar, the policy aims at strengthening institutional framework and administrative arrangements to ensure effective and efficient links between revenue generation and collection, pooling and purchasing of health services. The governance system will ensure the protection of all actors as well as the promotion of high quality service provision to all citizens. The governance pillar will be anchored on principles of transparency and accountability; fairness in the delivery of services, social participation and consultation in decision making; collaboration and consultation with all stakeholders; and routine monitoring of implementation.

Below are the key policy directions under the governance pillar:

1. Establishment of a Health Financing Coordinating body within the MOHCC to coordinate the various pillars of this policy (i.e., funds collection, pooling and purchasing functions within the GoZ).
2. Financial management will be decentralized to operational levels to effectively perform various health financing functions within the confines of the Public Finance Management Acts.
3. The role of performance based financing in current and future schemes to be clearly defined where it strengthens the purchaser's function.
4. Planning, budgeting and resource allocation will be harmonized along the results based management principles in consultation with all stakeholders.
5. The GoZ will strengthen existing mechanisms and/or establish new structures and systems for coordination and harmonization of funding at all levels of health care financing

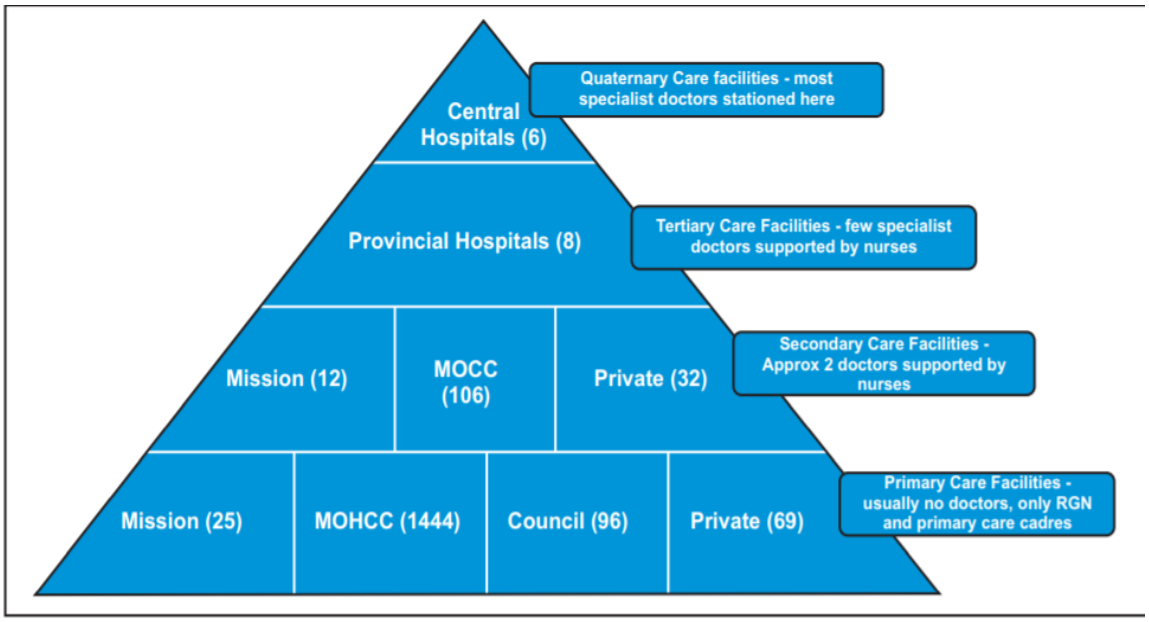
3.4 Structure of the Zimbabwe Health System

The Zimbabwe health system is guided by the national governance frameworks, namely the Constitution and the National Economic Plan. The National Economic Plan then feeds into the National Health Policy and the National Health Strategy, which are directly responsible for the governance of the health sector. Implementation of all ministries' activities within Zimbabwe is guided by the Results Based Management (RBM) system, which was adopted in 2013 to ensure improved public sector performance and accountability. From the RBM framework, every year the MOHCC develops operational plans to coordinate all stakeholder activities required to meet the objectives outlined in the National Economic Plan and the National Health Strategy.

Over 180 organisations are involved in health service provision in Zimbabwe. These organisations play different roles ranging from revenue generation, pooling, purchasing and service provision. Health services in Zimbabwe are accessed through 1,848 facilities, most of which are public health care facilities. These include public facilities, non-profit run facilities, religious/mission organizations, and the private sector (for-profit facilities). The public sector is the major provider of health services in Zimbabwe and is comprised of the Ministry of Health and Child Care; Ministry of Defence; Ministry of Justice and Legal Affairs (Prisons); Ministry of Local Government, Public Works and National Housing; and Mission Health Services. According to 2017 Poverty Income Consumption and Expenditure Survey (PICES), about 57 percent of poor people who were ill-used public health facilities for treatment while 48 percent of the non-poor went to such facilities. Extremely poor people seemingly cannot afford visiting private clinics. Around one third of people in all wealth categories did not seek treatment when they were ill mainly because of financial constraints.

Figure 2 below shows the health service structure in Zimbabwe.

Figure 2: *Health service structure in Zimbabwe*



Source: SARA, 2015

Health centres at the lowest level comprising mission hospitals, government, council and private facilities are the entry points into the health system and they provide primary health care. There are usually no doctors at these primary health care centres and service is provided in most cases by Registered General Nurses (RGN) and primary care cadres. In principle, if the primary care centres cannot handle a health condition, there is a referral pathway to secondary care facilities comprising Mission hospitals, government district hospitals and private hospitals. These facilities have on average two doctors supported by nurses. The next referral level comprises government provincial hospitals where a few specialist doctors are stationed and lastly the central hospitals where most of the specialist doctors are stationed. The referral pathway is however no longer as systematic as originally structured as people are making choices on the basis of quality of services and affordability. Those who can afford can go straight to central or private hospitals without going through the referral ladder.

Other government agencies directly involved in health care delivery include the following:

- **National Pharmaceutical Company of Zimbabwe (NatPharm):** This is a government owned company that is established to procure, store and distribute health commodities for Zimbabwe's public health facilities (including mission facilities)
- **Medicines Control Authority of Zimbabwe (MCAZ):** This is a statutory body which is the primary regulatory agency for the pharmaceutical industry. It regulates the registration of pharmaceuticals to be used in Zimbabwe, including the licensing of pharmaceutical manufacturers, wholesalers, community pharmacies and other organizations and individuals that procure, distribute and/or sell pharmaceuticals.

- **Medical Research Council of Zimbabwe**: This organization is tasked with coordinating and regulating health research including monitoring ethical practices in research.
- **Zimbabwe National Family Planning Council**: It is mandated to coordinate the provision of Family Planning services in Zimbabwe. Its operations include the procurement and distribution of contraceptives, Sexual Reproductive Health service provision, training and research.
- **National Aids Council (NAC):** NAC is mandated to coordinate the multi-sectoral response to HIV&AIDS. This is funded through an earmarked AIDS Levy

3.5 General Health Indicators

Table 2 below shows general National Health Accounts indicators for the period 2015-2018.

Table 2: *General National Health Accounts Indicators*

NHA indicators	2015	2016	2017	2018
Total population	13 943 242	14 262 236	14 588 528	14 922 285
Total nominal GDP (US dollar)	14 007 108 087	20 548 678 073	22 466 000 000	24 311 560 544
Total government expenditure	3 937 497 855	4 779 811 474	6 568 065 601	7 552 803 626
Total government health expenditure	309 699 620	321 314 576	437 690 000	762 840 000
Total Health Expenditure	1 447 785 504	1 386 239 947	1 324 694 390	1 729 670 220
The per capita	103.8	97.2	90.8	115.9
The as a % of nominal GDP	10.3%	6.7	5.9	7.1
Government health expenditure as % total government expenditure	8.7%	6.7	6.7	10.1

Source: National Health accounts 2017-2018

Total Government Health Expenditure increased by 29% from 2015 to 2017 and by 43% from 2017 to 2018. Total Government Health Expenditure as a percentage of Total Health Expenditure increased from 21.4% in 2015 to 33% in 2017 and 44% in 2018. The above table shows that Total Health Expenditure as a percentage of GDP was 10.3% in 2015 and declined to 5.9% in 2017 then slightly increased to 7.1% in 2018. Per capita, Government Health Expenditure increased from $22.21 in 2015 to $30 in 2017 and to $51.12 in 2018. Total per capita health expenditure declined from $103.80 in 2015 to $90.80 in 2017 and slightly increased to $115.90 in 2018. Government Health Expenditure as a percentage of total government expenditure declined from 8.7% in 2015 to 6.7% in 2017 and then increased to 10.1% in 2018.

3.6 Revenue Raising

To explore opportunities for CSO and citizen participation in the national budgeting process, it is important to understand the legal and institutional provisions for the national budgeting process.

3.6.1 Legal and Institutional Framework for National Budget

The national budget is the main fiscal policy tool that guides and prioritises a country's development processes. The national budget process in Zimbabwe is enshrined in the national Constitution. Section 298 of the Constitution provides principles that guide all aspects of public finance in Zimbabwe. This is further complimented by Section 7 (1)(a) of the Public Finance Management Act (PFMA) which identifies the duty of the Minister of Finance and Economic Development as that of developing and implementing macroeconomic policies as well as to supervise, monitor and coordinate the finances of Zimbabwe. The whole budget process, including dates and key activities of a budget process are set in Section 10(1) of the Public Finance Management (General) Regulations, 2019. The budget calendar starts with the preparation of the Budget Strategy Paper and ends with annual performance reports production.

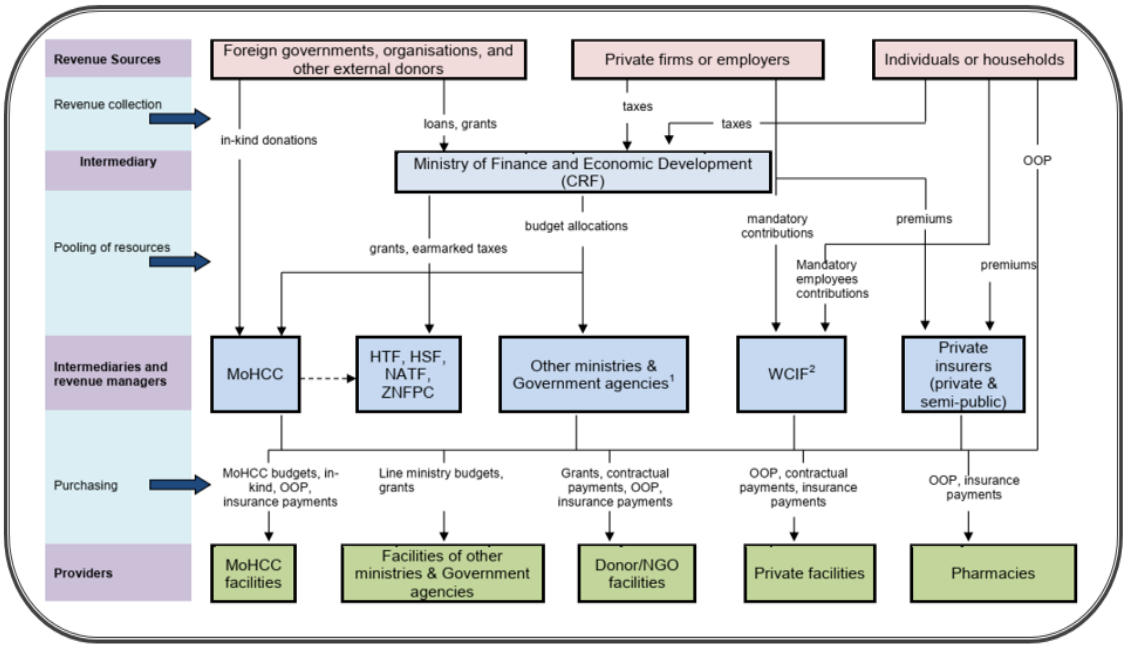
3.6.2 Sources of Healthcare Funding

Zimbabwe relies on a disaggregated mixture of health financing including domestic funding and external funding. Domestic funding comprises (a) central government and local government funding and (b) private expenditure from individual households, NGOs (including religious organizations and local philanthropies), and private companies[1]. External funding comprises donor funds from development partners such as Global Fund, PEPFAR, USAID, DFID, UN agencies, SIDA etc.

Figure 3 below shows the architecture of healthcare funding in Zimbabwe.

1 National Health Policy (2016)

Figure 3: Healthcare funding architecture in Zimbabwe



(a) Government funding

Government funding to health has primarily been raised through taxes such as value-added tax (VAT) and income taxes collected through the Consolidated Revenue Fund and allocated to health in the national budget. In addition to allocations through the national budget, a special financing provision for AIDS, the AIDS Levy, contributes significant earmarked funds towards health. In addition to central government allocations to health, sub-national government through rural and urban councils also commits significant resources to health. Zimbabwe has 32 urban councils and 60 rural district councils. Though individual budget allocations to health differ from one council to the other, urban councils allocate higher sums to health than their rural counterparts whose health institutions are mostly funded through Ministry of Health and Child Care. Local authorities generate their revenues through various means including rates and levies on residents, charges and other fees such as licensing as well as user fees when accessing various services like health and water. However, allocations are higher than disbursements as the economic environment has significantly affected revenue collection in local authorities.

(b) Private sector funding

Private sector funding comprises individual households out of pocket funding (OOP), Private Not for Profit NGOs and Other Philanthropic Funding and Private for Profit Funding.

Individual households

Individual households in Zimbabwe contribute significant resources to the health sector annually. Besides contributions made to various medical aid schemes, households also pay directly to access various health services. Within government public health facilities, household payments are managed under the Health Services Fund which allows facilities to hold these funds at facility level as well as give them autonomy for their use. Individuals also contribute through insurance premium payments to private insurance. Though some employers contribute premiums for their employees, those who are not formally employed also contribute their own premiums.

Private Not for Profit NGOs and Other Philanthropic Funding

Zimbabwe's external funding is primarily channelled through various NGOs that implement health activities. In addition to external donor funding, some of the NGOs have various sources of domestic funding; the level of domestic funding is however insignificant compared to external funding. In addition to various NGOs, church owned facilities also play a crucial role in financing and providing healthcare. Using a mixture of domestic and external charitable funds, churches own and operate various facilities from health centres to district hospital levels. Church related facilities are coordinated by Zimbabwe Association of Church Hospitals (ZACH), an independent affiliate body. Other local philanthropic organizations also channel funds towards significant health concern areas (such as disabled needs, cancer etc.) that are usually not adequately financed by mainline sources of funding[2].

Private for Profit Funding

The private sector contributes to health financing in various ways such as: 1) Paying a portion of their employees premiums to health insurance; 2) Reimbursing costs of health care incurred by their employees; 3) Providing on-site health services in their premises and other health programmes financed by the company's resources; and 4) Engaging in corporate social responsibility activities for public use. Zimbabwe has a fragmented private insurance industry with over 30 health insurance companies that cover various sectors but mostly the formally employed.

(c) External Resources for Health

External donor funds have been an important source of healthcare funding in Zimbabwe since independence. Donor funding however increased significantly from 2008, when the country experienced an economic crisis. Main funding partners for the health sector include the Global Fund, PEPFAR, DFID, SIDA, UN agencies and international NGOs among others.

3.6.3 Contributions to Healthcare Funding by Source of Funding

Table 3 below shows sources of healthcare funding in Zimbabwe. As has already been discussed in the preceding sections, the main sources of healthcare funding in Zimbabwe are: Government (including local government); private sector (including individual households out of Pocket (OOP) payments and private companies); and external donor partners.

2 National Health Financing Policy

Table 3: Sources of Healthcare Funding in Zimbabwe

	FY2015		FY2017		FY2018	
FINANCING SOURCES	**Amount ($US) Million**	**Share (%)**	**Amount ($US Million)**	**Share (%)**	**Amount ($US Million)**	**Share (%)**
Government	309.7	21.4	437.69	33.0%	762.84	44.1%
Corporations	411.54	28.4	228.72	17.3%	274.04	15.8%
Households	365.7	25.3	205.23	15.5%	230.60	13.3%
Rest of the world	360.85	24.9	453.05	34.2%	462.20	26.7%
TOTAL	**1447.79**	**100.0**	**1,324.69**	**100.0%**	**1,729.67**	**100.0%**

Source: *National Health Accounts assessment report (2017-2018)*

In terms of domestic funding, Government funding gradually increased from 21.4% in 2015 to 33% in 2017 and 44.1% in 2018 in the wake of decreased funding from individual households OOP financing and funding from the corporate sector.

Corporate funding of healthcare expenses decreased gradually from 28.4% in 2015 to 17.3% in 2017 and to 15.8% in 2018. This represents a 12.6% decrease in corporate funding over the four year period, a reflection of the economic challenges that the corporates are going through in the country.

Household OOP funding of healthcare has significantly decreased over the past decade. In 2010, OOP payments contributed 39% of the total healthcare funding, before dropping to 25.3% in 2015 and further declining to 15.5% in 2017. The 2017 Poverty, Income, Consumption and Expenditure Survey (PICES) report shows that OOP spending has further declined to 13.3%. This represents a 25.7% decrease in the households OOP contributions to healthcare expenditure over the 8 years. The decrease in household OOP funding can be attributed to failure by individual households to fund their healthcare needs resulting in these households failing to access health services as the economic situation in the country deteriorated over the years.

In 2015, 7.6 percent of households in Zimbabwe incurred catastrophic health expenditure (CHE). Catastrophic health expenditure (CHE) means that the medical spending of a household exceeds a certain level of capacity to pay. Health expenditure is considered to be catastrophic when OOP health expenditures exceed 40% of household's capacity to pay subsistence expenditures. Incidences of CHE were highest amongst the poorest (13.4%), followed by less poor (8.7%), middle (8.4%) and was lowest among the rich (2.8%).

According to 2017 PICES report, 34.5% of people in all wealth categories did not seek treatment when they were ill. Almost 28% across all wealth categories did not seek treatment because they did not afford while 38% resorted to home remedies.

Table 4: *Reasons for not seeking medical treatment for people who were ill but did not treat their illness*

Poverty Status	Facility to far	Cannot afford	Home Treatment	Religion	Not Necessary	lack of Medicine	Other	Total
Non Poor	6.6	25.9	42.9	1.5	12.2	0.5	10.5	100
Poor	8.2	28.8	37.1	6.8	10.3	0.5	8.3	100
Extremely Poor	9.2	29.1	33.3	7.3	9.9	1.3	9.3	100

Source: PICES 2017

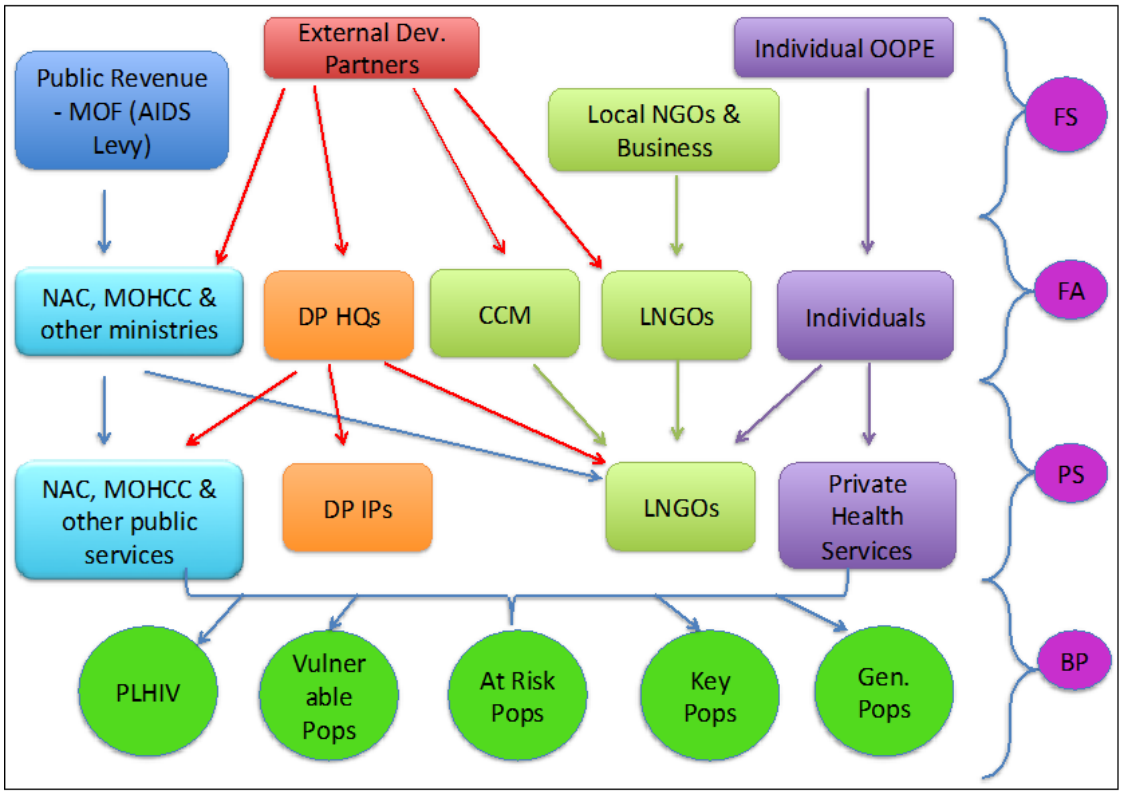
The sharp drop in the contributions of household OOP to health funding can largely be attributed to lack of affordable health services by individual households. As a result, most of the households ended up not reporting their illness, hence resorting to self-managing of illness and employing various coping strategies to illness such as home treatment. According to PICES 2017, 42.9% of the non-poor preferred home treatment followed by the poor with 37.1% and the extremely poor with 33.3%.

HIV Funding

The HIV and AIDS response in Zimbabwe is funded through local sources (National AIDS Trust Fund[3], national budget, private sector companies, individuals, non- profit and charity organisations); and external sources (Bilateral and Multi-lateral funding partners, International NGO's, charitable foundations, and Government aid agencies) and multilateral funding mechanisms such as the Global Fund on HIV, TB and Malaria (GFTAM) as shown in figure 4 below.

3 *This is a 3% taxation levy on personal and most corporate income*

Figure 4: *HIV Funding Flows in Zimbabwe*



Source: NASA Report, 2017

Domestic financing for HIV has largely been through the AIDS levy which accounts for approximately 10-15% of total AIDS spending. The remainder comes from external partners. Table 5 below shows HIV and AIDS spending by source of funding for 2014-2015 (Zimbabwe National AIDS Spending Assessment Report) and 2018-2019 (GAM Indicator Report).

Table 5: *Actual Spending (USD$ millions) on HIV by Source (2014- 2015) and (2018- 2019)*

Amount (USD) 2014	%	Amount (USD) 2015	%	Amount (USD) 2018	%	Amount (USD) 2019	%
39,828,236	0.12	41,943,497.00	0.1	49,701,222.00	13	45,231,793.00	11.4
5,627,254	0.02	9,626,561.00	0.02	2,105,325.00	0.5	2,105,325.00	0.5
33,804,850	0.1	37,060,557.00	0.09	76,057,872.00	19.9	30,423,149.00	7.7
140,749,058	0.41	101,336,534.00	0.26	PEPFAR 138,872,548	36.3	PEPFAR 152,967,248	38.6
29,522,046	0.09	14,195,255.00	0.04	Global Fund 91,423,175	23.9	Global Fund 140,507,189	35.5
91,520,232	0.27	192,213,931.00	0.49	All other International 24,842,179	6.5	All other International 24,842,179	6.3
341,051,676	1	396,376,335.00	1	383,002,321.00	100	396,076,883.00	100

Source: *Zimbabwe National AIDS Spending Assessment Report (2014-2015) and GAM Indicator (2018-2019)*

From 2014, HIV and AIDS funding has largely depended on external funding as table 4 above shows. In 2014, domestic resources accounted for 23.2% of total HIV and AIDS funding, decreased to 21.9% in 2015 before increasing to 33.4% in 2018 and declined to 19.6% in 2019. The decline in domestic funding in 2019 reflects the economic challenges that the country is going through which has left government, the private sector and individual households unable to meet expenditure related to HIV and AIDS. During the same period, external funding of HIV and AIDS increased from 76.8% in 2014 to 78.1% in 2015, before decreasing to 66.6% in 2018 and again increasing to 80.4% in 2019. International donor partners have had to fill in the funding gap created by declining capacity of domestic sources of funding.

Over the four years, government contribution to HIV and AIDS expenditure averaged 11.6%. It reached a high of 13% in 2018 and a low of 10.2% in 2015. Local government revenue expenditure on HIV and AIDS drastically reduced from US$50,634 in 2014 to US$500 in 2015. The National Health Accounts assessment of 2018/2019 did not collect expenditure data from local government sources due to non-availability of data.

The private/corporate sector contribution over the four years has averaged 1.3%. The contribution declined from 1.6% in 2014 to 0.5% in 2019. The decline is attributed to the difficult economic environment which has seen private companies folding up or reducing their productive capacity.

Individual household OOP contributions to HIV and AIDS expenditure averaged 11.7% over the four years. It reached a high of 19.9% in 2018 and a low of 7.7% in 2019. The decrease in OOP implies that households are increasingly finding it difficult to access HIV and AIDS services due to the tough economic environment, leaving them largely dependent on external donor funding for the services.

The main sources of external funding were bilateral donors whose contribution to HIV and AIDS expenditure averaged 35.5% over the four years. Bilateral contributions reached a high of 41.3% in 2014, declined to 25.6% in 2015 before increasing to 36.3% in 2018 and to 36.6% in 2019. The leading contributor among the bilateral agents has been the USA government through PEPFAR support. The Global Fund has been the second largest contributor. The Fund contributed 23.9% in 2018 and 35.5% in 2019 to the national HIV and AIDS expenditure. The UN family contributed 8.7% in 2015 and 4% in 2015 while all other international NGOs contributed 6.5% in 2018 and 6.3% in 2019.

3.6.4 Arrangement of Government's Financial Year

The budget calendar starts with the preparation of the Budget Strategy Paper and ends with annual performance reports production as shown in Table 6 below.

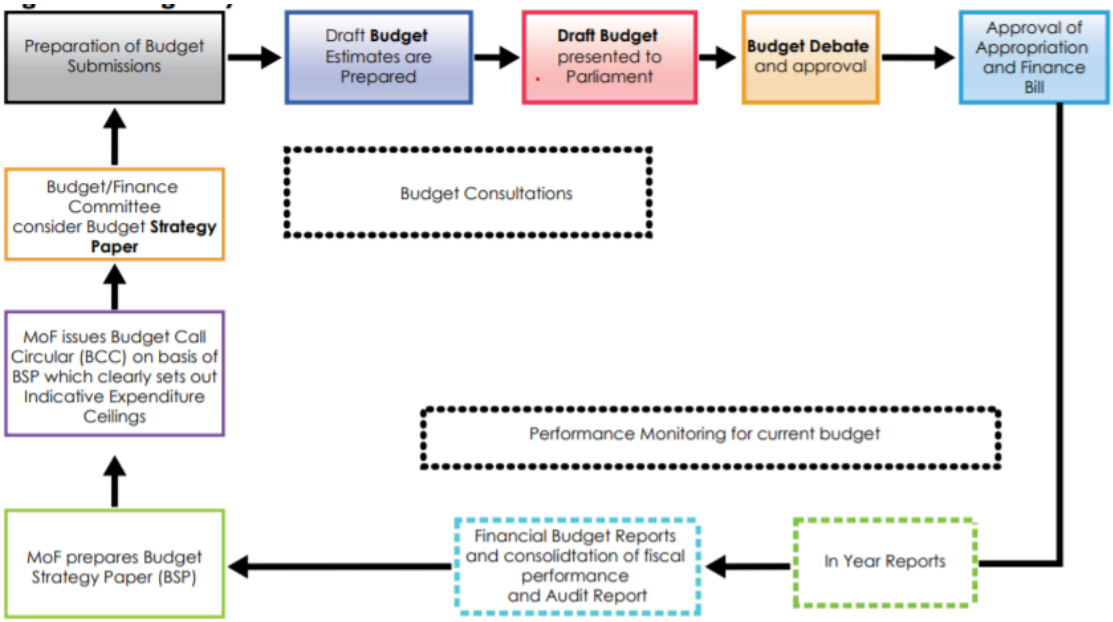
Table 6: *Budget Calendar*

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Ministries input into the Budget Strategy Paper		■										
Ministry of Finance sends the Budget Strategy Paper to Cabinet			■									
Ministry of Finance submits the Budget Strategy Paper to Parliament				■								
Cabinet approval of the Budget Strategy Paper				■								
Ministry of Finance issues Budget Call Circular				■								
Submission of Mid-Year Fiscal Review to Cabinet					■							
Ministries provide budget submissions to ministry of finance					■							
Ministry of Finance updates the macroeconomic and fiscal information and submits to cabinet						■						
Ministry of Finance completes review of budget submissions						■						
Ministry of Finance and other ministries hold budget discussions						■	■					
Ministry of Finance provides draft budget estimates to Cabinet							■					
Presentation of annual Budget to parliament								■				
Budget debate and approval /Publication of enacted budget								■	■	■		
Periodic Performance reports			■		■							

Source: Public Finance Management (General) Regulations, 2019

The national budget process starts with the development of a Budget Strategy Paper (BSP) in May and the submission of the paper to cabinet in June. The BSP is then submitted to parliament for debate before it is send back to cabinet for approval in July. After approval by cabinet, the Minister of Finance then issues a Budget Call Circular (BCC) also in July. In August, the Minister of Finance submits a Mid-Year Fiscal review Report to cabinet. In the same month ministries provide budgetary submissions to Ministry of Finance. The following month in September the Ministry of Finance updates the macro-economic and fiscal information and submits to government and the Ministry of Finance also completes the review of budget submissions. In October the Ministry of Finance and other ministries hold budget discussions before submitting draft budget estimates to cabinet the same month. Once approved by cabinet, the Minister of Finance will present the annual budget to parliament. From November to January the following year, parliament will debate and approve the budget. Performance review reports will be released in May and July. The national budget cycle is presented in Figure 5 below.

Figure 5: *Budget Cycle*



Source: *ZIMCOD, 2019*

The Minister is also required by legislation to provide constant implementation progress updates of the national budget. Section 9 of the Regulations requires the Minister to produce half-year Budget Situation Analysis Report by 15th August of each year. Historically, a national Budget Review Statement has been produced routinely by the Ministry of Finance by July and this is currently being presented with the mid-term budget review. The Budget Review realigns expenditure allocations with developments particularly revenue performance that would have taken place over the course of the implementation of the budget over the first half of the year.

3.7 Revenue Allocation

3.7.1 Allocation of Health Funding

Resource allocations for the health sector are guided by priorities in the National Health Strategy and the Zimbabwe National HIV/AIDS Strategic Plan. In principle the MoHCC accepts the use of a needs based resource allocation formula for allocating its budget vote. A Program Based Budgeting (PBB) to complement the needs based resource allocation framework has been adopted by the government and MoHCC. However, the NHA (2017-2018) analysis concluded that there is no resource allocation formula for the distribution of resources in the health sector. The budget allocation is not linked to population needs, and the needs-based resource allocation formula developed in 2013 for the MoHCC is still not fully functional. Ideally there should be an equitable distribution of resources that follows disease burden and the most affected population groups. Health financing is highly fragmented, making it difficult to have a generic allocative formula for healthcare resources.

The current allocation system is based on bids consolidated from the districts and provinces, although the final allocation rests with the MoFED. Over the last five years the budget bids have always been at least twice what is eventually allocated. The Ministry is now moving away from the line item budgeting towards Programme Based Budgeting (PBB). Although the line item budgeting enabled fiscal authorities to monitor expenditures, they could not link money spent to eventual health outcomes. With PBB, fiscal authorities should have detailed and disaggregated expenditures which are much easier to monitor and tie to results.

Several studies have identified allocative inefficiencies as a result of a lack of an allocative formula for health resources. The inefficiencies have led to the following[4]:

- The burden of disease in Zimbabwe is largely dominated by communicable diseases that can be addressed at low cost at the lowest level of care but resources are more directed to curative care rather than to prevention. Targeted investments on preventive care can pay off and avoid expensive curative care.
- Although most of the disease burden, such as Diarrhoea, lower respiratory, and other common infectious diseases as well as HIV/AIDS can be addressed through primary level care, public spending is however largely geared towards hospitals
- Resource allocation on health in Zimbabwe is not pro-poor. MoFED and MoHCC budgeting has historically been a line item based budgeting framework categorically divorced from the realities on the ground. Apart from Harare and Bulawayo, the other eight provinces have been allocated almost the same amounts despite differences in population numbers and disease burden. A vast majority of the public spending on health is geared towards urban areas, at the expense of the rural.

4 Analysing Fiscal Space Options for Health in Zimbabwe, World Bank and ZIMREF, 2017

Table 7 below shows total expenditure patterns by disease/healthcare condition for 2017 and 2018.

Table 7: Total Consumption Expenditure by Disease/Condition

DISEASE / HEALTHCARE CONDITIONS	FY2017		FY2018	
	Amount (US$ Million)	Share	Amount (US$ Million)	Share
HIV/AIDS and Other Sexually Transmitted Diseases (STDs)	278.34	21.3%	272.32	16.3%
Tuberculosis (TB)	46.59	3.6%	40.99	2.5%
Malaria	95.37	7.3%	102.22	6.1%
Respiratory infections	0.43	0.03%	0.35	0.02%
Diarrheal diseases	60.38	4.6%	92.92	5.6%
Vaccine preventable diseases	2.57	0.2%	7.86	0.5%
Other and unspecified infectious and parasitic diseases	146.87	11.2%	213.06	12.8%
Reproductive health	195.35	14.9%	284.30	17.1%
Nutritional deficiencies	7.86	0.6%	11.99	0.7%
Non-communicable diseases	276.18	21.1%	375.48	22.5%
Injuries	70.24	5.4%	87.67	5.3%
Non-disease specific	128.92	9.8%	176.70	10.6%

For 2017, HIV and AIDS and other Sexually Transmitted Diseases had the highest expenditure (21.3%) but this declined to 16.3% in 2018. NCDs had the second largest expenditure (21.1%) in 2017 and the budget share increased to 22.5% in 2018, more than the expenditure for HIV and AIDS for the same year.

Government expenditures for the year 2017 was highest in NCDs (26.7%), Reproductive Health (22.9%), and other unspecified infectious and parasitic disease (17.8%). There was no government expenditure towards Respiratory infectious diseases for both years. Share of Government expenditure was the least on Nutritional Deficiencies (0.2%), vaccine preventable diseases (0.1%). For HIV and AIDS and other STDs, government expenditure was low at 2% for both years.

For HIV, the GAM indicator report shows that of the USD 347,010,987 AIDS levy collected from 2009 to 2019, the biggest proportion was allocated for treatment care and support (47.3%), followed by programme logistics and support (19.8%) and Prevention at 12.2%. creating an enabling environment received 0.37% of the budget while planning, coordination and monitoring received 0.58% of the budget.

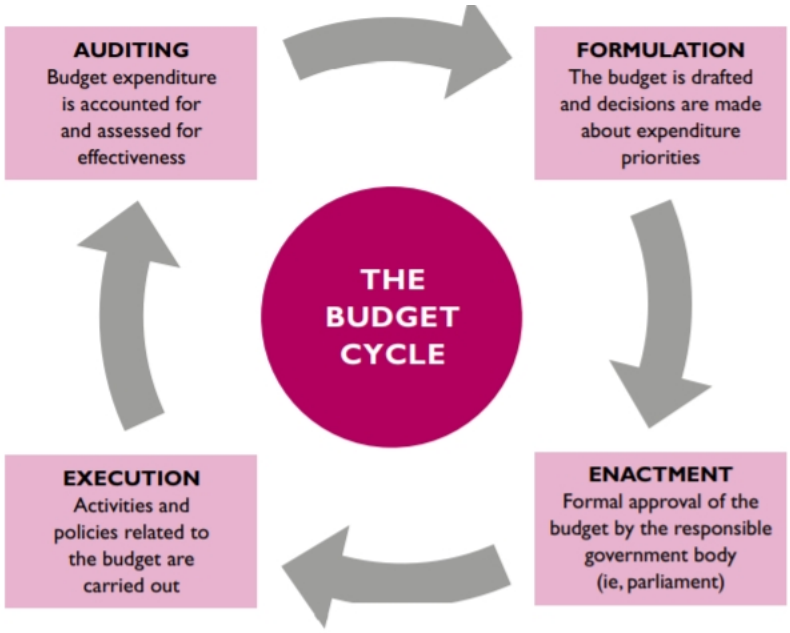
3.7.2 The National Budgeting Process/Cycle

In Zimbabwe, the framework for budgeting is defined in the country's Constitution, Section 298 (1) which establishes the principles of Public Financial Management as well as the Public Finance Management Act (Chapter 22:19) Section 7(2) which highlights the need to ensure transparency, accountability and sound management of revenue, expenditure, assets and liability of Government Ministries, designated corporate bodies and public entities.

Stages in the budgeting process and opportunities for citizen participation: (Please see figure 6 below)

The National Budget is produced by the Minister of Finance in terms of Section 305 of the Constitution and Section 28(1) read together with Section 7(2) (a) of the Public Finance Management Act (PFMA). It covers the period 1st January to 31st December. The budget cycle goes through the following stages.

Figure 6: *The budget cycle*



Stage 1: *Budget Formulation Stage*

Institutionally, the Minister of Finance and Economic Development, is mandated by law to craft the country's national budget. The Ministry of Finance is the main institution at the executive level that is responsible for initiating and managing the budget process. In crafting the national budget, the Ministry makes use of a top-down approach, initiated through the issuance of a pre-budget strategy paper that sets out the formal budget framework to be followed in the preparation of budget proposals by line ministries. However, all government Ministries also play a role in submitting requirements and sending any comments which they would see fit concerning the issues covered in the Budget Strategy Paper.

Section 8 (1) of the Public Finance Management (General) Regulations, 2019 has provisions guiding the preparation of the Budget Strategy Paper (BSP). The BST includes a medium-term macroeconomic forecast setting out actual, estimated and projected values of different economic variables for a period of not less than the previous two years, the current year and the next three years.

At the pre-budget stage, Portfolio Committees consider Ministries' draft bids or sector priorities and **hold public hearings,** receive written submissions and make recommendations. The Parliament of Zimbabwe conducts national budget public consultations to ensure that the Executive is crafting a national budget that meets the priorities and needs of the citizens. Parliament plays a more pronounced role during the pre-budget process. The involvement of Parliament and, by extension, the generality of Zimbabweans at the formulation stage of the National Budget, has helped in the promotion of a participatory and transparent budget process as envisaged in Section 141 of the Constitution. When the budget is announced, Parliament invites Ministries to comment on the adequacy of the resources as well as possible suggestions which Parliament can use as the basis for rejecting or approving the budget subject to some modifications.

The Parliament of Zimbabwe carries out budget consultations in all the provincial capitals and other selected areas based on resource availability. Thus, at least 20 venues are visited of which 10 are provincial capitals whilst the other ten are districts (one in each province) that are selected under the criteria that the venues chosen would not have been visited in the last 2-3 years.

Stage 2: *Budget Enactment/ Approval*

Section 305 of the Constitution and Section 28(1) of the PFMA requires the Minister of Finance to present the National Budget to Parliament not later than thirty days after the start of the Financial Year. The national budget process is also described under the Public Finance Management (General) Regulations, 2019 (Statutory Instrument 135 of 2019). Section 11(2) of the Public Finance Management (General) Regulations. The budget will be debated in parliament and through post-budget seminars with stakeholders. Parliament will approve the budget and the Minister of Finance is required to publish the Annual Budget documents on the internet on the same day when Annual Budget documents are presented to Parliament and also make available the documents to the public in printed format as soon as possible.

Stage 3*: Budget Execution*

After budget approval by parliament, the budget execution stage entails implementing expenditure according to plan and accounting for and reporting on actual expenditure and service delivery. The Ministry of Finance will release funds to the spending units and these units are mandated to report to parliament on spending status. The Ministry of Finance will also handle supplementary budget requests from spending units.

Stage 4*: Auditing and Evaluation*

Section 309 of the constitution provides for the establishment and functions of an Office of the Auditor General whose main duty is to audit the accounts, financial systems and financial management of all departments, institutions and agencies of the government in order to safeguard public funds and public

entities. The functions of the Auditor-General are also stated in Section 83 of Public Finance Management Act, which requires annual reports and audited financial statements of Ministries, public entity, constitutional entity or statutory fund to be produced. These reports should show the activities, outputs and outcomes of the Ministry; particularly relating to losses arising through instances of unauthorized expenditure; irregular expenditure; fruitless and wasteful expenditure; as well as recoveries and write-offs. Furthermore, section 46 of the Regulations, requires all Accounting Officers of Ministries, Public Entities and Constitutional Entities to retain all financial information relating to one financial year for three years in their original form after the audit report for that financial year has been tabled in Parliament.

Through the relevant Portfolio Committees, Parliament monitors government spending on a periodic basis by requesting for periodic performance update reports from Ministries as enshrined in the Public Finance Management Act. The reports are prepared using the guidelines, which provide indicators that Portfolio Committees can use to assess public expenditures and the achievements of specific public policy objectives. The Portfolio Committees can also embark on field visits to ascertain progress on the ground.

3.7.3 Stakeholder Participation in the National Budgeting Process

Within the national budgeting legal and institutional framework, there is scope for stakeholder participation. Stakeholders include citizens, Civic Society Organisations and any other entities interested in the budgeting process. Citizen engagement is provided for in all the phases of the budget process, namely the budget consultation; in-year performance reporting; and the post budget period (auditing of performance). Interested groups such as CSOs and Key populations can also participate in all the stages of the budget process to ensure that their budget concerns and interests are represented in the consultations.

Civil society organizations play a critical role of providing independent research and opinions on various policy aspects of the National Budget. This includes analysing the impacts of the budget on various interest groups such as women, children and socially excluded groups like key populations. Civil society organizations are also involved in civic education on the importance of participation in budget outreach, as well as synthesizing the budget into simple language for easier understanding by ordinary citizens.

The media has an important role to play in ensuring that the central issues in budgetary debates are widely understood. The media also covers discussions by Parliamentary Portfolio Committees during budget consultations as well as post budget review processes, especially submissions from Ministries to various Portfolio Committees during the period following the announcement of the national budget.

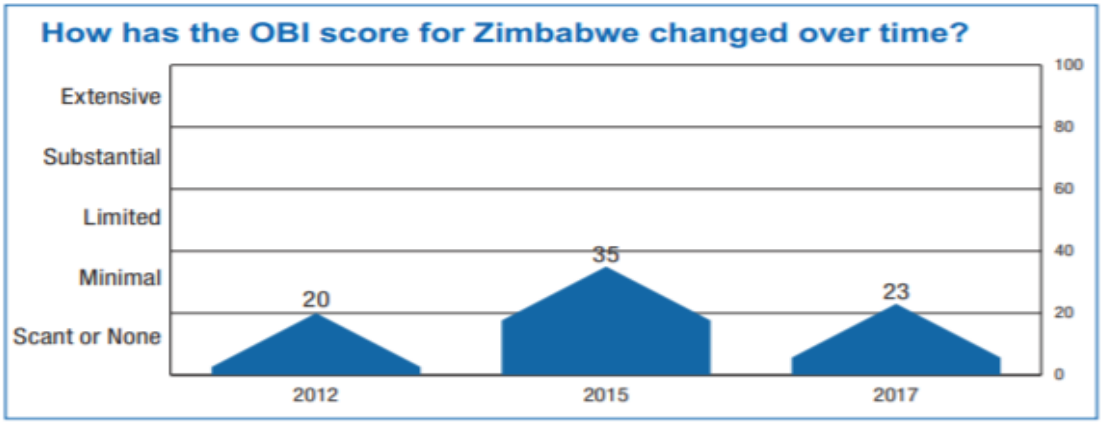
Cognizant of the importance and need to promote transparent and inclusive government budget processes, the International Budget Partnership (IBP) established the Open Budget Survey (OBS) in 2006. The open budget initiative is a global research and advocacy program aimed at promoting public access to budget information and the adoption of accountable budget systems. It is an objective, comprehensive, independent, global survey, currently carried out in 115 countries, that analyses and evaluates whether governments give the public adequate access to budget information and opportunities to participate in the national budgeting process.

OBS is a biennial measure, anchored on 3 pillars: **budget transparency** - public access to key national budget information, **public participation** - opportunities for public participation in budget processes and **budget oversight,** the role of formal oversight institutions. It is based on international good practices developed by the International Monetarily Fund (IMF), Organization for Economic Corporation and Development (OECD), International Organization of Supreme Audit Institutions (INTOSAI), and the Global Initiative for Fiscal Transparency (GIFT). Zimbabwe has participated in the survey and the results show the need for improved budget transparency, public participation and budget oversight. Zimbabwe Coalition on Debt and Development (ZIMCODD) also conducted an Open Budget Survey (OBS) between May and July 2019 and the study also show the need for improved budget transparency, public participation and budget oversight. The study sought to understand national and local authority budgeting processes and suggest ways of increasing the participation of citizens in the budget cycle.

In the 2017 OBS, Zimbabwe was ranked 87 out of 115 countries on the OBS scale. The country is classified among countries that provide minimum budget information, with minimum opportunities for civil society and citizens' participation in budgeting process, as well as weak budget oversight. Accordingly, the budget transparency and accountability systems are deemed deficient, which seriously undermines the effective management of funds, creates openings for corruption and ultimately results in poor social and economic outcomes for citizens.

Under the OBS system, each country receives a composite score (out of 100) used to determine its ranking. Figure 6 below shows Zimbabwe's OBS scores over time.

Figure 7: *OBS Score for Zimbabwe over time*



Source: OBS report, 2017

Zimbabwe had a score of 20 in 2012 which increased to 35 in 2015 and declined to 23 in 2017 which generally indicates poor performance of the country in terms of open budget.

The following are the specific results of the OBS:

Budget Transparency

Budget Transparency assesses whether the government makes eight key budget documents available to the public on online platforms in a timely manner and whether these documents present budget information in a comprehensive and useful way. Table 8 below summaries findings on availability of budget documents in Zimbabwe for years 2012, 2015 and 2017.

__Table 8:__ Public availability of budget documents

Public availability of budget documents from 2012 to 2017

Document	2012	2015	2017
Pre-Budget Statement	●	●	●
Executive's Budget Proposal	●	●	●
Enacted Budget	●	●	●
Citizens Budget	●	●	●
In-Year Reports	●	●	●
Mid-Year Review	●	●	●
Year-End Report	●	●	●
Audit Report	●	●	●

● Available to the Public ● Not Produced
● Published Late, or Not Published Online, or Produced for Internal Use Only

The pre-budget statement as well as the Executive's Budget Proposal were made available throughout the years. However the enacted budget in 2015 and 2017 was either published late or not published on line. Year-End reports were not published for all the three years while the audit report was only available on time in 2017 and was not published in 2012.

The ZIMCOD OBS survey (2019) revealed that only 1.7% of the respondents indicated that they have had access to the pre-budget strategy paper published by the Ministry of Finance before participating in the budget consultation. Reasons for limited access included document being too technical for the ordinary person to understand; discussions on the budget strategy paper usually being communicated within government circles and membership organisations, with little extension to the citizens; little or no awareness about the budget strategy paper except through the ministry of finance website. Only 3.8% of the respondents had knowledge of the budget presentation period, especially the time and period in which the national budget is presented.

At local government level the ZIMCOD OBS revealed that residents did not have knowledge about the BSP as it is only presented to Cabinet and Parliament and ministries will then be expected to develop budget guidelines from the BSP. About 98.3% of the survey respondents indicated that they had not seen a BSP whereas less than 5% confirmed to have seen the BSP through the internet. A further 93.7% had not seen the Ministry of Local Government, Public Works and National Housing (MLGPWNH) budget guidelines. Ninety percent of the chairpersons of the finance committees of local authorities lacked knowledge of the BSP, whereas only 10% who were aware of the BSP did not understand its utility to local

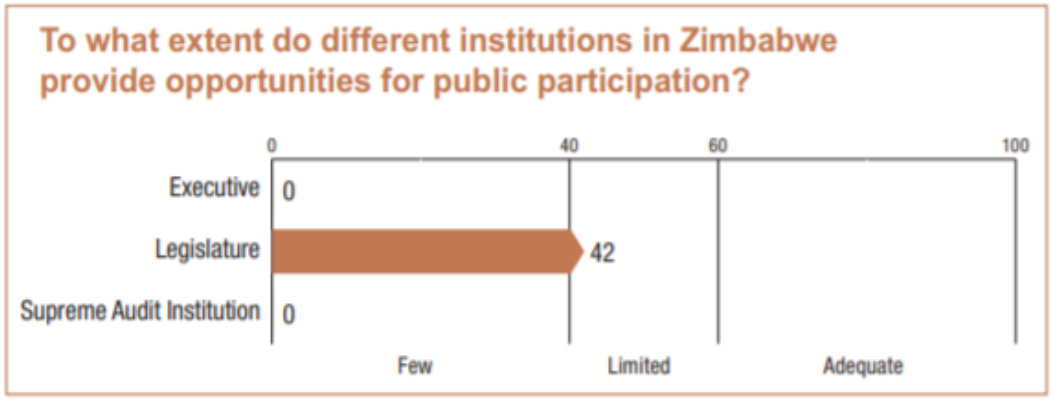
government budgeting process. Over 72% of the local authority respondents did not understand the local authority budget process. Of the 28% with knowledge on the budget process, 18% felt that the consultation process lacks genuine and open engagement and are only meant to legitimise a council budget by meeting a statutory requirement which makes consultation obligatory. More than 72% of respondents have not accessed any council budget. None of the 10 studied local authorities has a citizen version of the budget.

Public participation:

Public participation in budgeting is vital to realize the positive outcomes associated with greater budget transparency. To measure public participation, the OBS assesses the degree to which the government provides opportunities for the public to engage in budget processes. Such opportunities should be provided throughout the budget cycle by the executive, the legislature, and the supreme audit institution.

In the 2017 OBS, Zimbabwe scored 9 out of 100 in terms of public participation in the budget process. This indicates that the country provides few opportunities for the public to engage in the budget process. This is significantly lower than the global average score of 12. The 2017 OBS survey also sought to establish the extent to which the executive, the legislature and the audit institutions provide opportunities for the public to engage in budget processes.

Figure 8: *Provision of opportunities for public participation*



Source: *OBS report, 2017*

The 2017 OBS only gave the legislature a score of 42 while the executive and the audit institution were noted not to be providing opportunities for public participation within the budget cycle. Through public hearings, it is only parliament that provides that window of opportunity for public participation.

The ZOMCOD 2019 survey established that 57.3% of the citizens have never participated in pre-budget consultations. While more than 40% have participated, most of them did so without having accessed the Budget Strategy Paper or having known about the timelines in advance. The majority of the respondents (56.1%) surveyed did not believe that their contributions during the pre-budget consultations sessions will be adopted in anyway by the central government.

At local government level the survey results showed that over 70% of the residents are not active in local government budgeting. Over 95% of the disabled are technically excluded from budget consultation meetings. Physical barriers are a major factor for limited participation in the budget making process. Less than 5% of the youth and about 15% of the middle aged have attended the meetings which are usually dominated by the elderly. The reasons for such low attendance are varied from lack of interest (15%), lack of information on such meetings (25%), lack of appreciation of the importance of such meeting (30%), inconvenient venues and times for the meetings (11%). Over 75% of the survey respondents stressed that budget consultation meetings have had a marginal influence on the final budget.

Budget Oversight:

Budget Oversight examines the role that legislatures, supreme audit institutions, and independent fiscal institutions play in the budget process and the extent to which they can provide effective oversight of the budget. In the OBS 2017, Zimbabwe scored 44 out of 100 in terms of budget oversight. This implies that Zimbabwe's budget oversight is significantly limited, hence more needs to be done to strengthen the oversight institutions and their mandate in the budgeting process.

The ZIMCOD 2019 OB survey revealed that during budget implementation stage, there is generally limited scope for citizen engagement. The scope generally lies in feedback, especially citizens being informed about the performance of the budget in relation to plans. The study establishes that only 25.8% of citizens had access to budgetary performance reports. At post budget processes, survey results show that only 2.4% of respondents have access to the Auditor General's report. This generally shows that the majority of the citizens do not have much knowledge about the status of the budget implementation process.

At local government level, 75, 6% of the respondents indicated that they have not had access to a council budget. Of the 24.4% who had accessed the budgets, the media they used to access such budgets were council websites (29%), local newspapers (45%), buying a printed copy at council (17%) and other media (9%). Only 3.5% of the respondents accessed financial statements from council. Over 80% of the respondents in this research had never accessed any audit reports of local authorities and this compromises citizen's ability to hold the local authorities accountable. Fifteen percent had accessed audit reports on the internet usually as excerpts of the Auditor General's reports. Five percent accessed the report through informal networks with council employees.

3.7.4 Resource Allocation for Key Populations

Most of government resources for HIV and AIDS come from the National Aids Trust Fund. The national budget, under the health sector budget does not have specific budget allocations for KPs. This is largely because of legal and policy issues around KPs such as LGBTIQ and sex workers which makes it difficult for specific budget allocations to be made for these KPs. Budget support for KPs therefore mainly comes from external donor partners.

The National AIDS Spending Assessment (NASA) classifies HIV and AIDS related activities into eight (8) thematic areas, i.e. AIDS Spending Categories (ASCs). The classification system is standard[5] and has been applied over the years. The eight categories, are further sub-divided into several sub-categories; in total almost 200. This allows for great flexibility to represent the country's response.

KP related activities fall under three main categories namely:

(a) Enabling Environment which focuses on advocacy, human rights protection, gender-based violence (GBV) prevention, institutional development;

(b) Treatment which focuses mainly on ART, home-based care (HBC), palliative care, out- & in-patient costs for opportunistic infections (OIs) & Sexually Transmitted Infections (STIs), TB treatment; and (c) Prevention – e.g. behavioural change communication (BCC), youth programmes, voluntary medical male circumcision (VMMC), elimination of mother-to-child transmission (eMTCT), post-exposure prophylaxis (PEP), HIV counselling and testing (HCT), interventions for vulnerable populations including most-at-risk populations (MARP), condoms etc. The most at risk populations include KPs such as LGBTIQ and sex workers.

Based on the NASA classifications, there are six broad categories of beneficiary populations of HIV and AIDS services and these include **Key Populations** who are defined as sex workers (SW), people who inject drugs (PWID) and men who have sex with men (MSM). Other key populations such as lesbians, trans-gender and intersex are not specifically mentioned under the KP category.

The NASA report (2014-15) shows that spending on the HIV and AIDS budget was targeted at a total of 18 beneficiary population groups. Among these targeted groups were Most at Risk Populations (MARPs) who include sex workers and LGBTI groups. Out of the USD 341,051,676 spent on these targeted population groups, 2.9% of the budget (or USD 9,845,509) was spend on MARPS in 2014 while 0.23% (or USD 896,780) out of a budget of USD 396,376,335 was spend on the same group in 2015. There was a decline in funding support to MARPs between the years.

5 UNAIDS 2009

Table 9 below shows expenditure for key population groups for 2018 and 2019.

Table 9: *Expenditure for Key Populations 2018-2019*

Modular Approach - Modules	Modular Approach - Interventions	Year 1 Actual Exp (Jan to Dec 2018)	Year 2 Actual Exp (Jan to Dec 2019)	Cumulative Year 1 - Year 2 Actual Expenditure
Comprehensive prevention programs for sex workers and their clients	Other intervention(s) for sex workers and their clients	656,694.00	2,314,891.00	2,971,586.00
Comprehensive prevention programs for MSM	Community empowerment for MSM	65,003.00	377,468.00	442,471.00
Comprehensive prevention programs for sex workers and their clients	Harm reduction interventions for sex workers who inject drugs	13,362.00	60,839.00	74,200.00
Comprehensive prevention programs for sex workers and their clients	Community empowerment for sex workers	186,719.00	555,472.00	742,190.00
Comprehensive prevention programs for MSM	Other intervention(s) for MSM	60,528.00	203,533.00	264,061.00
Comprehensive prevention programs for MSM	Addressing stigma, discrimination and violence against MSM	15,246.00	19,694.00	34,940.00
Comprehensive prevention programs for MSM	Condoms and lubricant programming for MSM	0.00	711.00	711.00
Comprehensive prevention programs for MSM	Behavioural interventions for MSM	700.00	1,461.00	2,162.00
Comprehensive prevention programs for sex workers and their clients	Condoms and lubricant programming for sex workers	323.00	134,216.00	134,539.00
Comprehensive prevention programs for sex workers and their clients	Pre-exposure prophylaxis (PrEP) for sex workers	0.00	857,566.00	857,566.00
Total for Key Populations		998,575.00	4,522,851.00	5, 524,426
% of total budget of all targeted population groups		0.01	0.03	0.02
Grand Total for All targeted population groups		**91,423,175.00**	**140,507,189.00**	**231,930,364.00**

Source: *GAM Indicator 2019*

Most of the funding for key population programmes in 2018-2019 was provided by the Global Fund. The above table shows that there was an increase in funding of key population programmes from USD 896,780 (or 0.23% of the budget) in 2015 to USD 998,575 (or 1.1% of the budget) in 2018. There was a substantial increase in funding in 2019 to USD 4,522,851or 3.2% of the total budget of the targeted population groups in the HIV and AIDS national response. Most of the targeted key populations were sex workers and their clients and MSM. Programmes implemented included Pre-exposure prophylaxis (PrEP) for sex workers, condoms and lubricant programming for sex workers, behavioural interventions for MSM, Condoms and lubricant programming for MSM, addressing stigma, discrimination and violence against MSM, harm reduction interventions for sex workers who inject drugs and community empowerment for MSM and sex workers among other programmes.

3.8 Accountability for Health Funds

3.8.1 Accountability Systems for Healthcare Funding

The Auditor-General has been producing reports for appropriation and fund accounts, state owned enterprises and local authorities. However, the reports for most years have not being produced in time. Moreover, what has been mainly lacking prior to 2017 were the follow up actions on the report. In 2019, there was increased pressure from citizens and parliament for the findings to be followed through to the letter and spirit.

The Analysing Fiscal Space Options for Health in Zimbabwe report (2017) pointed out some weaknesses in the MoHCC resource accountability system. The weaknesses included the following:

- **The MoHCC had weak budget control procedures.** The AG 2015 report noted anomalies in MoHCC budget control procedures, including unauthorized budget expenditures and virement of funds between budget lines without prior MoFED authorization.
- The MoHCC had improper accounting procedures, especially with regards to the Health Services Fund. In some instances, ministries did not keep proper records via receipts, payment vouchers, goods-received vouchers, cashbooks and ledgers.
- Weak internal budget controls and management systems
- Weak procurement systems increased the MoHCC's transaction costs and promoted corruption. For example unsupported payments were made to workers who had already left employment.

The findings of the 2017 Fiscal Space Options Analysis are still relevant to the current situation in the MoHCC. Recently in September 2020, the government has had to restructure the MoHCC because of inefficiencies, lack of accountability and alleged corruption within the ministry. Some senior staff were dismissed because of alleged corrupt activities, particularly during the COVID 19 outbreak where there were procurement irregularities that caused a public outcry.

In 2018, ZIMCODD in its analysis of the Auditor General's report, recommended that consistent with the follow up reports from the Auditor General's report, that legislature should develop a comprehensive programme for monitoring and reviewing actions taken on the recommendations outlining clear timelines

considering that some of the recommendations date back to 2014. If unchecked the government departments will be reluctant to address them. It is expected that going forward, there will be more visible follow up action aimed at addressing the flaws identified by the Auditor-General's reports. The implication from the legislative framework review is that citizen engagement is provided for in all the three phases of the budget process, namely the budget consultation; in-year performance reporting; and the post budget period (auditing of performance). This forms the basis upon which citizen participation in the process would be assessed.

Accountability mechanisms for HIV and AIDs Funding

The Global Fund, for instance, gives all the responsibility to the CCM, which then selects institutions to access funds through performing capacity assessment. Some of the main funders invite organisations to take part in the formulation of a concept note and proposal which is then consolidated to form the basis of the country's proposal to the Global Fund. Some funders provide funds in line with specific national and sector specific plans and strategies. For instance, those who partner with the MoPSE indicated that that they support specific activities based on the Education Strategy and information obtained during planning meetings with the ministry. Another avenue for funding activities is by directly meeting expenses, for example UNESCO pays directly to hotels for conference packages. Some of the funders initiate calls for proposals based on their funding priorities and they contract organisations that have the capacity to meet the call objectives. Although, rapport has been established over the years with most institutions, most funders still request for proposals. Twenty-five percent (25%) of the funders request organisations to submit proposals and 16.7% of the service providers write proposals responding to tender adverts in the newspapers[6].

Different pre-conditions are considered by funders before they disburse funds to recipients. Foremost, findings revealed that the service providers should have the capacity to implement HIV and AIDS activities. This is in terms of human resources and equipment. The service provider/implementer should have personnel to handle funds such as a coordinator and a finance administrator. In addition, the recipients of funds should have a clear record of previous financial audited reports to access funds easily form the sources of funds. The recipients of funds must also be registered for them to access funds. There are other terms considered by the sources of funds for example, the institution should have been identified as an implementer after a capacity assessment exercise has taken place. The assessment looks at systems and structures and the ability of the institution to fully implement activities in terms of coverage and fulfilment of specified objectives.

There are different reporting requirements that are given to service providers when they access funds. These vary among the funders. However, funders expect all recipients to report back, submitting both financial and narrative reports on activities implemented during the reporting period. Reporting is usually on a monthly, quarterly and annual bases but frequency varies among the funders.

A Number of challenges have been experienced in the accountability mechanisms for HIV and AIDS funding. These include:

- Inability to meet donor requirements timeously
- Late disbursement of funds by some donors

6 NASA Report, 2017

- Limited capacity to absorb funds by some implementing partners
- Inability to work within the budgets by some implementing partners

3.8.2 Efficiency in Healthcare Expenditures

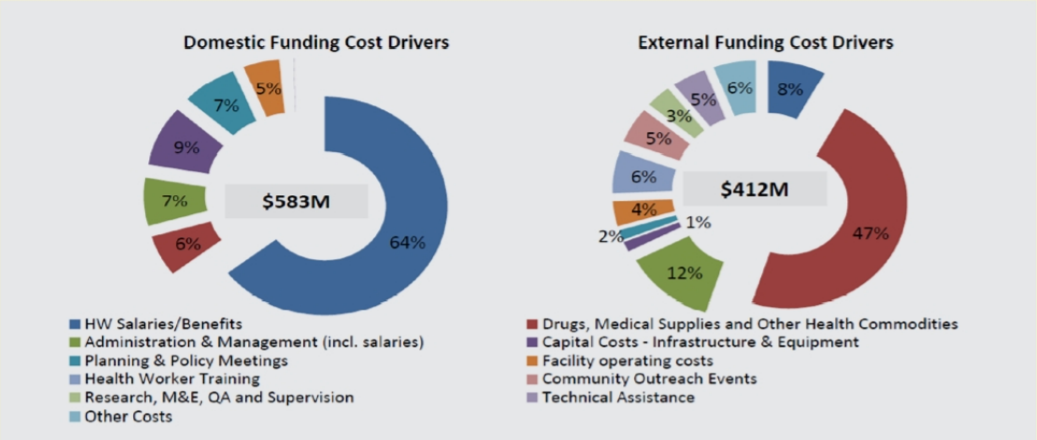
Zimbabwe has made significant improvements in health outcomes in the last five years. However, despite some progress in some health factors, the country did not meet its Millennium Development Goals (MDGs) and current progress falls short of the Sustainable Development Goals (SDGs) milestones. The country is facing national economic challenges coupled by high inflation and increasing levels of poverty. This has impacted significantly on the poor and vulnerable, many of whom are failing to access health services because of financial constraints, leading them to resort to home treatment remedies. The government has had to largely rely on external funding support, particularly with regard to HIV and AIDS expenditure, which in the long run is not sustainable. Despite improvements in nominal allocation from previous years, the 2019 health sector budget allocation of US$694 million fell significantly short of the US$1.39 billion required for the NHS High Impact Scenario for 2019[7].Given this context, there is a call for efficient utilisation of the available healthcare resources for maximum impact in the wake of declining ability of government to fully fund healthcare and a global decrease in donor support to developing countries.

Several assessments have recommended efficient utilisation of healthcare funding as the most promising option to achieve better results in the current country context. The 2015 NHA revealed important inefficiencies in current public and private health spending and recommended measures such as allocating more resources for preventive care since current health financing allocations favour curative services. The increasing burden from non-communicable diseases (NCDs) requires prioritization of preventive care to avert the high costs of NCD treatment; developing strategic purchasing mechanisms to enhance the efficiency of available funding; and strengthening the integration of vertical and disease specific programs, which are concentrated on HIV/AIDS, malaria, and tuberculosis, to leverage disease-specific donor funding.

The 2019 Resource Mapping Study conducted by the Ministry of Health and Child Care showed that the Government of Zimbabwe is the major funder of the health sector and that its contribution is heavily skewed towards health worker salaries. There is a significant cost-sharing imbalance between the government and partners as government funding goes mostly toward health systems costs while partner funding goes toward disease specific activities (e.g., commodities) as shown in Figure 9 below.

7 Zimbabwe National Health Strategy 2016-2020 Costing Report.

Figure 9: *Domestic funding and external funding cost drivers*



Domestic and External Funding Cost Drivers: Source Resource Mapping 2019

1. Resource Mapping 2019 Report

The above figure shows that healthcare funding deficits are to a large extent being met by external funding from development partners and donor countries. The biggest expense for domestic resources (64%) is going towards salaries and benefits of health workers, leaving less than 10% allocations for critical areas such as drugs and medical supplies and facility operating costs amongst other expense. The reliance on external funding for key cost categories represents a challenge in terms of sustainability and predictability of health system funding. Funding from external partners is critical for drugs, and some important items (research and M&E or infrastructure and equipment-related expenses) are only paid for by external assistance. HIV, vaccines, malaria, reproductive and maternal, neonatal and child health (MNCH), and TB programs are highly donor dependent.

In 2017, a fiscal space analysis study was conducted to look at opportunities for making additional resources available for government spending on health through: (i) establishing conducive macroeconomic and fiscal conditions; (ii) prioritizing health within the government budget; (iii) allocating health sector-specific financing from other sources; (iv) negotiating higher development assistance for health; and (v) improving efficiency of outlays for health. The analysis concluded that the current financial crisis and macroeconomic situation in Zimbabwe did not constitute an enabling environment for generating fiscal space for health. In this context, using the current level of resources allocated to the health sector in the most effective and efficient way is the most urgent and plausible option for increasing fiscal space for health. Looking at the disease profile and health seeking behaviours of the poorest, the fiscal space analysis recommended reallocating more resources to the lowest levels of care, where most of the vulnerable go and where most cases can be treated at a lower cost. Reassigning some resources from curative to preventive services, focussed on NCD prevention, could also alleviate the significant burden of NCD curative treatments on health systems and health financing. The analysis also suggested improvements in budget processes, from planning to execution and implementing PFM reforms to better turn allocated funds into inputs. It also acknowledged that the large wage bill represents a major constraint for the country and the health sector, and substantial efficiency gains could be achieved within the sector without implementing public sector wage reform.

The Health Financing Strategy (HFS) recommends a significant focus on efficiency gains. The HFS places emphasis on implementing reforms that prioritize low-cost, high-impact interventions; on improving allocative and implementation efficiencies; and on improving the integration of services at all levels of the health system. The HFS short to medium-term interventions focus on efficiency; notably, the importance of increasing efficiency gains from existing resources and improving efficiency of external assistance on health.

Using the Health Interventions Prioritization Tool (HIP tool) an analysis on Improving Allocative Efficiency in Zimbabwe's Health Sector was conducted based on the 2016 fiscal year. The analysis indicated that a shift in spending from hospitals to community and PHC platforms of care could significantly increase the amount of disability-adjusted life years (DALYs) averted by the NHS package in Zimbabwe. Disease interventions could be more broadly delivered at the PHC and community levels to improve cost-effectiveness. Strengthening budget formulation processes is a key and urgent reform.

The NHA (2017-2018) identified inefficiencies within the healthcare expenditure system. The analysis revealed that Government is spending more on Hospital Curative care while the rest of the world is putting more resources towards preventive services. Households and Corporations also spend a substantial figure on Hospital curative care. Curative care consumed 58.5% of the total allocated resources to health care providers compared to preventive care which consumed 15.2% of the budget.

The biggest portion of the curative care budget is supported by government (51.4%), followed by individual households (17.4%) and corporations (16.4%). External funding account for only 14.8% of the curative funding resources. On the other hand government funding of the preventive care budget declined from 17.9% in 2017 to 14.5% in 2018. The biggest proportion of the preventive care budget in both years (82.2%) was funded by external donor partners.

There is need for Government to balance funding between Curative and Preventive care in line with the mandate of MOHCC as pronounced in the Public Health Act. The NHA analysis recommended that the Government should not wait for diseases to occur as this may prove costly in the long run. It is more cost effective to invest more in preventive care which is cheaper. The preventive care budget is largely supported by donors and hence not sustainable in the long term and hence the need for government to shift more resources towards preventive care.

There was no government expenditure towards respiratory infectious diseases for both years despite them being amongst the top ten conditions affecting Zimbabwean population. HIV/AIDS and Malaria continue to be supported significantly by partners putting the county at risk if funds are withdrawn. Sustainability of continuing treatment will be seriously constrained. Government needs to step up efforts in order to ensure equitable distribution of resources across all programmes. There is low commitment towards capital investment in health from both Government and Development partners. This has an overall effect on the capacity of the health sector to deliver quality services.

HIV and AIDS prevention interventions, totalled US$ 87 384 659 in 2014 and this increased slightly to US$91 704 409 in 2015. PMTCT and VMMC had the highest share in terms of expenditure as compared to other categories in both years. Prevention of STIs had the least expenditure for both years. Also, worth-

noting is the significant drop in expenditure for Public and commercial sector male condom provision from US$5 752 367 in 2014 to US$323 698 in 2015.

3.8.3 Mechanisms for Safeguarding and Accounting For KP Funding

As already been discussed in the preceding sections, the MoHCC budget does not have a specific budget for key populations. The ministry's definition of key population is mainly focused on prisoners and artisanal miners, which are classified as most at risk population groups. The National AIDS Council, through the Global Fund has a specific budget to support key populations as has already been pointed out in the previous sections.

In its Key Populations Action Plan (2014-2017) the Global Fund issued new Country Coordinating Mechanism eligibility requirements and minimum standards, which emphasize the importance of including key populations and addressing gender equality. Community systems strengthening investments can serve to increase the capacity of key populations to participate in and monitor Country Coordinating Mechanisms and other Global Fund governance processes. The action plan emphasises that countries should ensure measurable budget allocations and deliverables related to key populations in Global Fund grant agreements, and support monitoring and reporting against those deliverables and planned expenditures to: (1) improve the ability of organizations representing key populations to participate in program management and service provision; (2) understand grant performance; and (3) replicate successes and remediate failings.

The expected outcomes of the action plan include dedicated budgetary resources for key populations include increased reporting against program delivery measures and budget expenditure for key populations. This action provides a platform for countries to monitor allocation of funds and expenditures for key population and to determine if the funds have been used for the intended purposes. The key population groups thus need to be incorporated into the Country Coordinating Mechanisms for the Global Fund to ensure that there is accountability on utilisation of funds allocated for key populations. In Zimbabwe, the KPs are represented in the CCM.

NAC reports on expenditure for key populations in the Global AIDS Monitoring (GAM) Indicator tool. There are specific expenditures reported on sex workers and their clients, MSM and people who inject drugs. The GAM reports provides a platform for key population to monitor use of funding targeted for this group. There is also a periodic review of ZNASP and there is a technical working group on key populations, which includes representatives of KP organisations, that focuses on the review of key population programmes within ZNASP This provides an opportunity for the TWG to assess expenditure on KP budgeted funds.

3.9 Challenges and Gaps in Healthcare Financing

Several challenges were identified in the healthcare financing landscape in Zimbabwe. These challenges impact negatively on KP's access to health services. Some of the key challenges are discussed below.

Policy Challenges

The main challenge for implementation of the health financing policy for KPs is that some of the KP groups such as LGBTI and sex workers are criminalised by the government. As such, they are not specifically considered in the national budgeting processes and resource allocations. The Ministry of Health and Childcare's definition of KPs includes mainly prisoners, artisanal miners, and People with Disability and excludes LGBTI and sex workers who are criminalised. As a result most of the funding for KPs come from external donors. This however is not sustainable in the long run given global trends of dwindling donor support to developing countries in general. Strategies need to be developed to support KPs through domestic resources.

Revenue Generation and resource mobilisation

(a) Government funding of the health sector in general is below the minimum standards that have been agreed upon internationally and regionally. The current per capita level of government funding at $51 in 2018 is below the Chatham House estimated $86 needed to provide an essential benefit package (in low and middle income countries). Government Health Expenditure as a percentage of total government expenditure declined from 8.7% in 2015 to 6.7% in 2017 and then increased to 10.1% in 2018. This is well below the Abuja commitment of 15%. Low Government funding levels have resulted in limited access to health services, particularly by the poor and vulnerable groups, who cannot afford to pay for health services out of pocket. The 2017 PICES report indicates that 34.5% of people in all wealth categories did not seek treatment when they were ill because of financial constraints. For those that seek health services they risk incurring catastrophic health expenditure. KPs are particularly affected because besides being among the most at risk population groups, they are also among the most vulnerable as they face discrimination and Government does not have specific funding targeted at KPs.

(b) For HIV and AIDS funding, Government has mainly relied on external donor funding. Over the past five years, Government funding for HIV has averaged 11.4% while external donor funding averaged 75% of the total HIV and AIDS national expenditure. Specific funding for KPs is only provided through donor funding such as the Global Fund as government has no specific provisions. This puts KPs in a vulnerable position in the event of decreased funding from external donors as the KPs have no fiscal space within Government health budget.

Public participation in the national budgeting process

Public participation in national budgeting processes is generally low across the country. Zimbabwe performed poorly on the OBS composite rating of budget transparency, public participation and oversight. Out of a score of 100, Zimbabwe had a score 20 in 2012, which increased to 35 in 2015 but declined to 23 in 2017. In a 2019 ZIMCOD Open Budget Survey (OBS), only 1.7% of the respondents had accessed the Pre-Budget Statement by the Minister of Finance and only 3.8% had knowledge on the budget presentation period. At local government level, 93.7% of the respondents had no knowledge of the Ministry of Local Government budget guidelines. Public participation in the national budgeting process is limited. Although public participation should occur throughout the whole budgeting cycle, public participation was only occurring during public consultations on the national budget conducted by parliament. The ZOMCOD 2019 survey established that 57.3% of the citizens had never participated in pre-budget consultations. While more than 40% have participated, most of them did so without having accessed the Budget Strategy Paper or having known about the timelines in advance. The majority of the respondents (56.1%) surveyed

did not believe that their contributions during the pre-budget consultations sessions will be adopted in anyway by the central government.

The lack of adequate space for public participation in the budget making process presence challenges for the KPs. Given the stigma and discrimination that KPs encounter, it is not going to be easy for them to represent their constituency publicly during public budget consultations conducted by parliament. This implies therefore that their concerns are unlikely to be captured in during the budget consultations. The limited public participation at budget implementation and oversight levels also implies that KPs have no opportunity to influence implementation that addresses their needs, neither are they able to hold government to account during the monitoring of budget implementation.

The ZIMCOD OBS study established that only 25.8% of citizens engaged indicated that they have had access to budgetary performance reports. At post budget processes, survey results show that only 2.4% of respondents have access to the Auditor General's report. This implies that CSOs, including KPs have limited capacity and space to hold government to account.

4. RECOMMENDATIONS

CSOs

- There is need for evidence based advocacy capacity development for KP CSOs on national and local government budgeting processes so that the KPs can effectively participate at all stages of the budget cycle including implementation and lobby for health resource allocations to meet their needs
- Identify champion MPs in parliament to champion KP issues, including during the budget public consultations
- Through the National AIDS Council, KP Forum and TWG, lobby for a seat in the CCM to ensure representation of interests during strategic planning and proposal writing forums.
- CSOs need to take advantage of the ongoing consultations on review of the PVO Act to highlight obstacles that they face in registration and operations and provide recommendations that can create an enabling environment for these CSOs, particularly those that are supporting KP such as LGBTI and sex workers.

Health Financing

- There is need for increased lobbying and advocacy by CSOs for a well-defined government policy and strategy on key populations as well as for the decriminalisation of KP groups such as LGBTI and sex workers
- CSOs need to lobby and advocate for specific budgets/programmes for KPs that are domestically funded for long-term sustainability and reduce reliance on external funding
- HIV/AIDS funding is largely funded by external donors and the situation is not sustainable in the long-term. CSOs should intensify advocacy for increased domestic funding for HIV/AIDS.
- Government is yet to meet the Abuja declaration health funding threshold of 15% of total government budget. More advocacy and lobbying for the achievement of the target is needed through CSOs participation in the national budgeting processes.
- Public participation in national budgeting and local government budgeting processes is very low particularly at execution and monitoring stages. CSOs need to empower citizens so that they are able to participate at all stages of the national and sub-national budgeting processes to ensure prioritisation of key health needs and accountability by the Ministry of Health.

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This document was complied by: George Zimbizi, Development Consultant