FACULTY OF ARTS

DEPARTMENT OF DEVELOPMENT STUDIES

The search for Sustainable Domestic Financing Options for Sexual and Reproductive Health in Zimbabwe

A dissertation submitted to the Faculty of Arts in partial fulfillment of the requirements for the award of the Master of Arts in Development Studies Degree

By

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October 2019

APPROVAL FORM

This serves to confirm that the undersigned have read and recommended to the Midlands State University for acceptance of a dissertation entitled,

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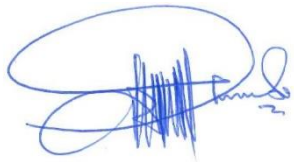

Blessing Tafadzwa Nyagumbo

Abstract

The focus of this study was to identify, assess and recommend sustainable domestic financing options for Sexual and Reproductive Health in Zimbabwe. The study tracks the various health care system funding models employed by the Government of Zimbabwe from the 1980s to date highlighting their shortcomings and ultimately justifying the need for re-thinking the financing of Sexual and Reproductive Health and the need to pursue homegrown financing options. The research makes use of qualitative research methods and data is collected through key informant interviews, focus group discussions and observations. The general realisation of this study is that foreign aid which remains the backbone bank rolling the health sector is not sustainable since donor funding has timeframes and budget caps. The findings of this study establishes that the country has to implement a basket of domestic financing strategies as part of its financing model. To ensure that the health system is robust, the study also establishes that there is a critical need of strengthening the health care system. The study's findings and discussions culminates into the development of a domestic financing model. It is anticipated that this model will re-dress over 2 decades of poor primary health care outcomes, unsound governance and lack of confidence in the public health delivery system.

Acknowledgement

Acknowledging the Lord Almighty for His sovereign Grace that has brought me this far. I extend my heartfelt appreciation to my thesis supervisor, Mr. R. Sillah for the guidance throughout this study. I am also humbled by the untainted participation of this research's participants- both the key informants and focus group members. Without their treasured input this study would not have been concluded.

Dedication

A dedication to my wife, Victoria Gamuchirayi. This is to a lifetime blissful marriage my Queen.

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Abbreviations

CSOs	Civil Society Organisations
FGDs	Focus Group Discussions
GoZ	Government of Zimbabwe
KIIs	Key Informant Interviews
LDCs	Least Developed Countries
MDGs	Millennium Development Goals
MoFED	Ministry of Finance and Economic Development
MoH	Ministry of Health
NGOs	Non-Governmental Organisations
OOP	Out-of-Pocket
PPPs	Public Private Partnerships
RBF	Results Based Financing
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
UN	United Nations
VfM	Value for Money
ZNFPC	Zimbabwe National Family Planning Council

CHAPTER ONE: INTRODUCTION

1.1 Background to the Study

Article 25 of the Universal Declaration of Human Rights (UDHR), provides for the international right to health by stating that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family including medical care and necessary social services…motherhood and childhood are entitled to special care and assistance." This implies that provision and access to health is a fundamental human right that should be enjoyed by citizens of the international community regardless of race, geographic location or country status. It therefore becomes imperative that countries ensure sustainable availability and utilisation of this critical right among their citizens.

The United Nations Sustainable Development Goals (SDGs) captures global targets for member states that will guide multi-sector development upto December 2030. The 17 goals came into effect in January 2016 as a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity (achieve a better and more sustainable future for all). Of interest for this study is SDG 3 which seeks to "ensure healthy lives and promote wellbeing for all at all ages." Sub-target 3.7 of this goal states that "by 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes" (United Nations, 2016). Based on this SDG target it is clear that achieving health and wellness among citizens is central to governments, as such there should be significant budget allocation for access to primary health care.

Section 76 of the Constitution of Zimbabwe (2013) stipulates that, every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including

reproductive health-care services. Guided by this constitutional provision, every Zimbabwean is entitled to primary health care provision across all heath institutions. It is imperative that the Government of Zimbabwe (GoZ) through the parent Ministry of Health (MoH) ensure there is sustainable health provision, including Sexual and Reproductive Health (SRH), by ensuring adequate resources are availed.

However, despite all these international treaties and laws on health as a fundamental human right that countries are signatories to and despite constitutional provisions to uphold access to health, there is paucity of homegrown strategies and approaches to resource primary health care especially in least developed counties (LDCs). In these LDCs in regions like Asia, Latin America and Africa there is over reliance on donors and non-governmental organisations (NGOs) to support access to health. This has a challenge on sustainability since donor and NGOs grants have life spans and some are availed based on certain conditions that may not be favorable to the benefitting country. It is therefore critical that countries engage and analyze their contexts to develop strategies and approaches for domestic financing options to ensure sustainable health provision.

Generally, Zimbabwe has a high cost of accessing a comprehensive basket of SRH services especially family planning methods. Considering that government and local authority owned clinics mostly run out of family planning commodities most ladies are forced to visit private clinics. When a woman or young lady approaches a health facility for family planning services they are expected to pay a user fee then service fee for each family planning method they want to access. Most rural women cannot afford these user fees which averages USD3 per each clinic visit related. This is also further aggravated by the fact that in most rural facilities, nursing staff are not trained in inserting critical family planning methods like jadelle, Implanon (Zimbabwe National Family Planning Council report, 2018). Women who require these services unfortunately resort to private sector health facilities which charges exorbitant prices and some

even in foreign currency. There is therefore need to develop a domestic financing model that sustains SRH service provision to ensure that citizens enjoy their fundamental health rights.

1.2 Statement of the Problem

Most LDCs, Zimbabwe included, have relied on external funding (donor financing) for socio-economic development. However, there are domestic opportunities for these countries to self-finance and sustain development especially of critical sectors like health. Donor financing has timeframes for instance spanning three to five years but after the end of these financing cycles, health provision and development should be sustained to ensure countries achieve Sustainable Development Goal (SDG) 3 on "ensuring healthy lives and promote well-being at all ages." SRH as a fundamental right should be accessed and utilized by every citizen of Zimbabwe regardless of class and location and for this to be achieved there is need to establish a well-thought out and resourced sustainable domestic financing model that ensures access to affordable services of choice. It is the ultimate aim of this research therefore to identify and assess domestic financing options available to support and sustain SRH development in Zimbabwe and to develop a domestic financing model.

1.3 Research Aim and Objectives

Aim: The overall aim of this study is to identify and assess domestic financing options available to fund and sustain health sector development in Zimbabwe. The assessments will culminate into a domestic financing model for SRH financing in Zimbabwe.

Objectives

1. To identify and assess SRH services provision challenges in Zimbabwe
2. To identify and assess existing financing options for health provision in Zimbabwe
3. To establish and recommend a sustainable Domestic financing model for SRH in Zimbabwe

1.4 Research Questions

This study will revolve around and be guided by the following key questions;

1. What are the challenges in sustainable health provision?
2. What are the current financing options available in Zimbabwe?
3. What is the sustainable domestic financing model for SRH in Zimbabwe?

1.5 Theoretical Framework

1.5.1 Lewin change management model

One of the key terms in change management is transformation which concerns itself with the process of change and how that process is steered in order to arrive at the desired state at the end of the process.

Lewin posited key issues around change management on the three staged model- unfreeze, change and refreeze. These stages are key as a guiding framework for this study that seeks to analyse sustainable domestic financing options to ensure SRH provision in Zimbabwe thus bringing about transformation in terms of funding health provision which is largely donor centered. The unfreezing stage basically focuses on preparing development players for change thereby creating a situation ideal for change. In this context, the research will identify how the stakeholders involved in national level health development and financing are prepared for change from donor funding to domestic funding. Intertwined to this is the Force Field Analysis which focuses on the pros and cons (factors) around change. In this regard, if factors for change outweigh those against, then change is possible. This study will also be guided by this Force Field Analysis to determine whether policy makers consider factors for change as more significant thus driving and motivating the zeal to opt for domestic financing options.

Figure 1.1: Lewin's Change Model ***Adapted from Whittall and Barry (2005)***

In the changing (transition) stage, Lewin highlights that change is a process and never an event. In this stage people are skeptical and make reactions as they are unsure of change having been used to their own way of doing things. As change unfolds resistance may also be realized. Adaptation to change is affected by two forms of resistance. Whittall and Barry (2005) identify them as systemic resistance and behavioral resistance. Systemic resistance is cognitive in nature and is oftenly as a result of lack of knowledge, information, or skills. It can be addressed through communication and information. Information and communication are also critical in the Lewin's change stage to manage people's adjustment to change. Behavioral resistance is emotional in nature and is founded on reactions, perceptions, and assumptions. It can be dealt with through the natural, individual and group processes to address prejudice, assumptions, perceptions, and conclusion formulation. Migrating from donor financing to domestic financing is influenced or affected by these forms of resistance as the health sector has largely been donor funded for around three decades. Systemic resistance in this subject emanates from people's lack of knowledge on which domestic option is viable and will sustain health provision at least in the same way as donor funding is doing. Behavioral resistance oftenly manifest in reaction to new and or unfamiliar developments that seeks to change the way the

health sector has been financed. In this understanding, this research will assess and establish how resorting to domestic financing options is effective in addressing systemic and behavioral resistances thus ensuring sustainability of health services provision in Zimbabwe.

The last stage is Freezing (Refreezing). This stage entails people establishing stability within the change brought about. This stage can take time as people adjust to change. This study will assess and present how policy makers and players in sustainable health provision can be adapt and be compatible with domestic financing options. It will assess the changes in behavior and practice in adjustment to the identified and recommended options. If policy makers and health sector players are freezed with change then sustainable health provision is achieved.

Since this research is an assessment of how Zimbabwe can migrate from being largely donor funded to domestic financing, the change management theoretical framework modeled by Kurt Lewin is applicable, relevant and useful. It is relevant because the government has to be motivated for change (unfreezing) based on uncertainties of donor funding; then it implements the change through various strategies that will be discussed in this study the finally it makes that migration from donor funding to domestic financing permanent (refreezing). In this regard, the change management theoretical framework will be employed to guide this study.

1.5.2 The dependency theory

The current financing of the health sector in Zimbabwe, SRH included can best be described by the dependency theory by Andre Gunder Frank (1967). Funding of health provision is predominantly external through donor funding notably from the governments of Britain, the United States of America and Sweden among others. There is a dependency syndrome that Zimbabwe has developed on these first world economies for funding of not only health development but all development sectors- socio-economic, political and environmental. In this regard, Rodney (1972) accurately states that the political independence of Africa from

colonialism did not change the dependency arrangement but it further deepened it. This study therefore seeks to liberate Zimbabwe's health sector from an external dependency syndrome to more sustainable domestic options.

1.5.3 The African Renaissance theory

This study on sustainable domestic financing options also dovetails with the major tenets on the African Renaissance theory. This theory has been supported by former African political leaders including Thabo Mbeki, Nkwameh Nkrumah and Kenneth Kaunda. It has also received overwhelming support from the African intellectual community including scholars like Matunhu. The strength of the theory is encapsulated in its capacity to be adaptable to change and innovations which are initiated within the value systems of the African populace. It is this context that Matunhu (2011) posits that the African Renaissance is the panacea to the development irregularities in Africa. Guided by the African Renaissance theory, it is imperative that African states, Zimbabwe included develop models that best addresses challenges and issues emerging in their countries. It is therefore the focus of this research to analyse how Zimbabwe can establish its own sustainable domestic financing model for SRH services provision.

Besides financing models and guided by the African Renaissance theory in the context of this research, Africa in general and Zimbabwe in particular could resort to use of herbs as part of the SRH medication basket. It is in this understanding that the African renaissance theory encourages Africa to act in a world that is dominated by the metropolitan countries by suggesting micro-level development. It is a fact that Africans could use herbs to treat different ailments. However, the coming of modernity forced Africans to be apathetic about their abilities, knowledge and skills. The use of traditional medical practice was degraded by

modernity and modern medical practices were promoted. In the process of modernizing Africa, the people of the continent lost their identity and development path.

Therefore this study was be guided by both the Lewin change model and the African Renaissance theory. Both these theories acknowledges need for change and in this case of the development status quo. The African Renaissance further posits that this change and innovation should be Afro-centric and very considerate of an average African. The African Renaissance theory drove this current study by influencing the need to address challenges in the health sector using domestic options as opposed external aid thus African remedy for African problems. Lewin Change Model guided this study through providing a transitioning path to be followed as the country transforms from external aid to domestic funding.

1.6 Conceptual Framework

The conceptual framework guiding this study was based on the premise that planning and implementation of domestic financing options to achieve change in health sector is a multi-staged process. The options that best suit a country are decided basing on the sustainable change envisioned by the citizens, experts and policy makers. This implies that any option settled for should be in tandem with and or feeding into the outcomes perceived by these groups of people. In this way, it is clear that deciding on a domestic financing model requires consultation and planning involving those who will be affected by the change.

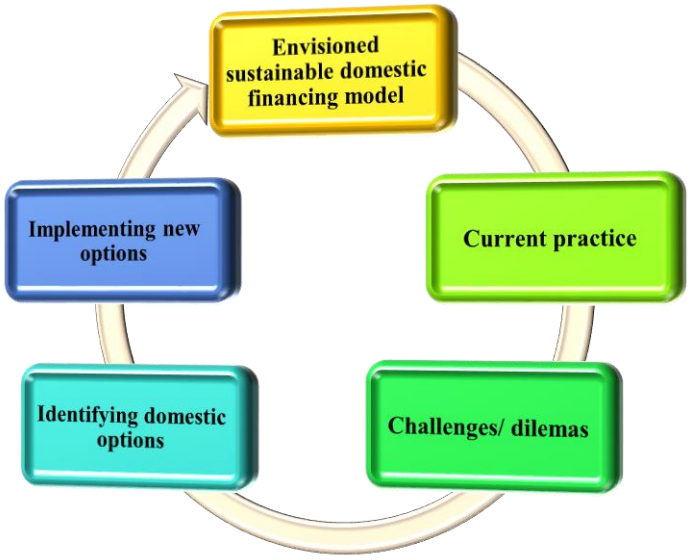

Figure 1. 2: Conceptual framework- Process of change ***Source: Researcher (2019)***

Review of the current practice and the challenges faced is critical in deciding on other alternative options and in this case domestic financing ones. It is in the study of current financing practices and challenges that a researcher, development practitioner or policy maker get hints on the options that can be identified and implemented to achieve transformation. Through enquiring on current practices and challenges the researcher can also identify some strengths within the national and sub-national structures thereby capitalizing on them as part of the Strength Based Approach (SBA). Having studied the community's practice and challenges, the researcher then identifies alternative financing opportunities and the options that generate a high impact anticipated is recommended for implementation.

The World Health Organisation (2016), identifies a good health financing system as one that raises adequate funds for health, in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them. Health financing systems that achieve universal coverage in this way also encourage the provision and use of an effective and efficient mix of personal and non-personal services.

Three interrelated functions are involved in order to achieve this:

- ✓ the collection of revenues from households, companies or external agencies;
- ✓ the pooling of prepaid revenues in ways that allow risks to be shared – including decisions on benefit coverage and entitlement; and purchasing;
- ✓ the process by which interventions are selected and services are paid for or providers are paid.

Central to a sustainable model for domestic financing is one that reduces reliance on external assistance and that progressively replaces it as the financing source needed to improve the health of women, children, and adolescents. In the context of this study, a domestic financing model is a financing matrix nature whereby various domestic players and approaches are involved to sustain SRH service provision. The model should involve the government, private sector and the communities- largely beneficiaries of the health services delivery. These stakeholders complement each other to ensure sustainable service provision in the health sector.

Another key attribute of a sustainable domestic financing model is one that has a smart financing agenda that promotes value for money through improving efficiency and accountability. One can testify whether a health system is sustainably funded basing on perennial availability and affordability of SRH services and commodities across the country regardless of remoteness.

Some of the key indicators of a sustainable SRH services provision system are,

- ✓ subsidized SRH services especially for poor women and girls even in the remotest parts of Zimbabwe
- ✓ perennially accessible SRH services by all social groups

1.7 Justification of Study

This research identified, assessed, established and recommended domestic financing opportunities to ensure sustainable health provision at national and sub-national levels thus improving healthy lives and well-being of citizens. Through this research policy makers, civic society organisations, donor agencies and United Nations (UN) agencies will be informed of financing options to integrate in health development planning and implementation. They will use these to capacitate government departments and assist in official roll-out of the financing options and nurture the roll-out till fully functional. More so, this research will not only influence domestic financing options for the health sector but findings and recommendations will also influence financing of other development facets including agriculture; Water, Sanitation and Hygiene (WASH); governance and environment. Domestic Financing Options remain a dream in the pipeline without meaningful progress being implemented. This research therefore proffered approaches of how to roll out domestic financing solutions to sustain the health sector. Overall, policy makers will have expert knowledge and guidance on domestic financing that is less dependent on external or donor funding.

1.8 LITERATURE REVIEW

This section reviewed pertinent literature on health financing models in Least Developed Countries context. During the course of reviewing literature attempts were made to establish intrinsic knowledge gaps between existing literature and the current research topic and establish a means through which the knowledge gap can be filled. Dependence was given to reliable secondary data sources in this section to justify the relevance of the current research in the academic domain. Dominant theories that have not been altered and refined though from archaic sources were also critically reviewed in this section. The section proceeded to present

the main schools of thought on the notion of health systems financing observing the points of convergence and divergence. These attainments were critically reviewed within the purview of the health financing outcomes for SRH under study. Efforts were made in relating reviewed literature to the research objectives and questions especially those that relate to health financing. As part of this literature review, the researcher also explored a country specific practice in various health financing models focusing on accomplishments, shortcomings and success factors in implementing health financing models.

Review of literature was basically conducted and presented based on two themes that forms the research question that is “health financing” and “SRH provision.” Literature that includes journals, articles and textbooks with key issues related to these themes were presented and reviewed to establish the research gap that justifies this study. Literature around foreign aid was also reviewed to justify the need for domestic financing options.

1.8.1 Evolution of Foreign Development Aid

The origin of aid can be traced back to the aftermath of the second World War (WWII) and the Cold War, where it was used as a diplomatic measure to foster political associations and gain strategic advantages by the two conflicting superpowers that is, the United States of America (USA) and the then Union of Soviet Socialist Republics of Russia (USSR) (Walters and Blake, 1992). There are indications that this type of aid was reformative as it assisted belligerent nations to recuperate in the post war period. In peace times, aid is composed of grants and loans to least developed countries from donor countries to promote political, developmental and welfare objectives in the recipient countries (Kanbur, 2003).

Apart from being used for political purposes aid is now availed to achieve developmental goals in least developed countries (Hjertholm, White and White, 1998). Aid was extended to the least developed countries under social development themes such as “health for all” and “education for all” as well as intensive efforts to reduce poverty and uplift livelihoods of the general

populace (Bonfrer, 2015). The pattern of health financing indicators reveals that overall health spending in sub-Saharan Africa is low, especially in comparison with other regions (Pascual Serrano, Vera Pasamontes and Girón Moreno, 2016). Conscious of these revelations, the current study sought to rethink the health financing system and model in line with the resource constraint predicament to achieve perennial access to sexual and reproductive health services. The study also ascertained how Results Based Financing (RBF) has performed over the years since it is proving to be the emerging preferred funding model for health systems in least developed countries.

Earlier forms of aid under the Marshall Plan were compensation payments and support for the struggle against communism which critics argued were strategic for USA in avoiding a regression of its economy through generating a market for USA capital goods and a pleasant environment for American investment (Hjertholm, White and White, 1998). Imperative to note is the fact that the money provided by the USA was in the form of grants and no repayment was expected. The Marshall Plan proved to be an effective strategy to promote development as it helped countries in Europe to reconstruct and expand their economic base in a relatively short period of time (Roberts et al., 2002). The achievement of the Marshal Plan as the instrumental means to expedite development was replicated in least developed countries though in different and modified formats. Numerous models of foreign aid delivery have evolved over the years, guided by the strategic interests of the donors and needs of the least developed countries (Radelet, 2006; Mitchell, 2010). In the face of a multitude of foreign aid delivery approaches, it is critical to assess and rethink how domestic financing options can be developed and rolled out to offer sustained results in a developing country context with the hope of improving health services delivery. This is the primary focus of this study.

1.8.2 Debates Surrounding External Aid

The use of aid to stimulate development in developing countries has attracted a lot of controversy over the years. Two main schools of thought with divergent objectives have emerged; the Welfarist school of thought and the Dependency school of thought. The Welfarist school of thought propounded by Jeffrey Sachs, Joseph Stieglitz, Nicholas Stern and lately championed by Philanthropist Bill Gates argues that foreign aid is necessary (Kaufmann, 2008). On the other extreme, the dependency school of thought with scholars like Andre Gunder Frank, Walter Rodney, Julius Nyerere, Dambisa Moyo, Thoetinos Dos Santo, Joseph Frankel, Amir Amin and Paul Prebisch is critical of foreign aid (Radelet, 2006).

The Welfarist school of thought holds the belief that aid is an essential tool that if utilized effectively and efficiently can be employed to disengage developing countries from the devastating effects of poverty thus spur economic growth. In this regard, Sachs and Ayittey (2009) argues that with support from foreign aids, most developing countries have managed to increase access to health services. More so, foreign aid has contributed to poverty reduction and economic growth in least developed countries (Kaufmann, 2008). The kindness in foreign aid as propounded by the Welfarist scholars has been critically reviewed by the works of Sachs (2012) who however, contends that foreign aid related problems arise when pre-conditions are attached by donors which tend to misrepresent its effectiveness. In this regard, most health financing approaches are tied to a specific condition that outcomes have to be substantiated and evident for further financing to be availed. Within the framing of the current study, it has to be established whether setting conditions can decrease the conceptual appeal of health financing in terms of achieving positive health results.

Sachs (2012) is of the belief that to augment the effectiveness of a health financing system, it is essential to tie some conditions to development aid. Brazen abuse and misappropriation of

aid funding have compelled the need to assign donor expectations to foreign aid (Burke and Sridhar, 2013). Most least developed countries have weak governance systems for accountability of foreign aid, as such, there has been a noticeable decrease in funding availed as donors seek to have an active participation in the health delivery systems to achieve high impact results. The donor community is attracted by a health financing model that is clearly transparent, effective, efficient and sustainable. Accordingly, the current study critically analyzed various health financing models with the aim of unlocking value to governments, donors, civic society organisations and the beneficiaries in terms of achieving positive health outcomes.

The main import of the dependency school of thought is that offering aid will generate a dependency syndrome as recipients rely on donor support to sustain them 'forever'. Foreign aid perpetuates dominance of rich powerful countries over poor developing countries and in most cases, which were their former colonies (Engelbert and Tull, 2008). Foreign aid bad as it enlarges the state bureaucracy, perpetuates bad governance and enriches the few political elites (Easterly, 2008). Rodney (1972) concurs that conditions often attached to foreign aid are structured in such a way that the developing countries remain dependent on the rich donor countries. In support of these views and in the context of Zimbabwe, the European Union (EU) head of delegation to Zimbabwe, Mr. Philippe Van Damme said the recovery of the health sector remains fragile as long as there was still over dependence on donor funding which accounted for 95% of all medicines in rural clinics and district hospitals (EU report, 2015).

Moyo (2010) corresponds to the notion that there is paucity of evidence that the benefits of foreign aid are serving the basic social human needs such as health and education. For decades running into their independence, most African nations have not yielded concrete health related developmental outcomes notwithstanding receiving enormous foreign aid funding. Donors are

exploring ways to scale up funding while, at the same time, demonstrating the outcomes they are achieving (Pearson, 2011). What is clear from various discussions across most academic communities on foreign funding, is that despite widespread denunciation of foreign aid by dependency theorists, more and more least developed countries are making rigorous efforts to attract foreign aid at whatever terms it is offered. Examples of such states begging for foreign funding regardless of conditions attached to it can be drawn in Africa including countries such as Zimbabwe and Zambia. It can therefore be noted that, in resource constrained states that are synonymous with most developing countries, the misery of receiving conditional aid is better off than the misery of not receiving donor funding at all. This study therefore intended to address this misery of begging for foreign funding to develop third world economies by opting for homegrown domestic financing options. Through this study as well, the researcher filled the gap in literature by showing the link between health care financing and the performance of health systems as shaped by the key debates on foreign aid in developing countries. This can be achieved through rethinking the processes of health systems within the dispensation of resource limitations and the need to achieve health results.

1.8.3 Health Systems Thinking

Health systems thinking denotes the philosophical underpinnings that shape and direct the aims and objectives of a health system within a given political context (Olmen, Van, Marchal, Damme, Van, Kegels, and Hill, 2012). Health systems are products of their time, emerging from specific discourses (Olmen et al., 2012), health systems thinking has evolved over the years as articulated below;

The genesis of health systems thinking can be traced back to the advent of the Alma Ata Declaration. The main thrust of the Declaration was to link health to social action. The declaration was reached at out of the discovery that health issues had seized to be purely medical and technically focused. The major significance of the Alma Ata Declaration was the

development of an agenda that obliged states to provide primary health care services to their people (Olmen et al., 2012). The Management Science for Health (2012) agrees that the Alma Ata Declaration focused on primary health care as the ideal approach to influence healthy communities. The deployment of health workers was influential in attaining the objectives of primary health care. In the context of this study, SRH falls within the confines of primary health care thus the researcher sought to establish how the government of Zimbabwe could roll out domestic financing options to sustain SRH service provision at national level including in hard to reach areas. Health systems thinking including a robust homegrown financing model therefore becomes imperative to sustain health services delivery.

Under the dictates of this Declaration, the United Nation's World Health Organisation (WHO) played an imperative role towards warranting access to universal health care through making funds available to nations. The health financing focus under the Alma Ata Declaration was concentrated on output such as training of health staff and construction of health centres at community level. The involvement of WHO as a health financing partner expedited the inclusion and consequent advancement of community participation in health-related issues (Health, 2012). Community participation in this regard meant the inclusion of community members in reducing the impact of specific diseases. Even in this study, the researcher included community members (through Focus Group Discussions) who are beneficiaries of SRH service provision to establish their viewpoint with regards domestic financing and sustaining SRH services delivery. Kirigia et.al (2006), highlights that, the social action approach was successful in countries such as India, China, Guatemala, Bangladesh and Nicaragua.

The 1990s marked the occurrence of austerity measures under the World Bank's structural adjustment programmes and the adoption of the New Public Management thinking. These changes ignited shifts in health systems thinking as there was a striking decline of government

funding of social services in general and the health delivery system in particular in least developed countries. Health system funding was gradually entrusted in the hands of private players. Mcintyre (2012) notes that, "in contexts where government is not fulfilling its responsibility for funding health services, community-based health insurance schemes may be a temporary second best option for providing some financial protection." Guided by Mcintyre's realisation, this study also sought to establish whether Zimbabwean local communities have localized financing options as alternatives to dwindling government support to health services including SRH. It is anticipated that localized financing options are based on community's realisation of its needs and means to achieve the same, hence these options may be sustainable as they are homegrown and tailor-made to suit that community and its expectations.

In the post 2000 period, three major developments in the health sector emerged and they compelled a paradigmatic shift in health systems thinking. The first development was a global change in the health systems actors' landscape (Olmen et al., 2012). Private foundations and Global Health Initiatives emerged alongside strategies such as the Millennium Development Goals (MDGs). A number of foundations including the Melinda and Bill Gates foundation arose and became major sponsors of health systems in areas such as malaria control. In the USA, former President George Bush launched the Presidential Emergency Fund for AIDs Relief (PEPFAR) aimed at assisting low-income countries affected by the AIDS epidemic (World Health Organisation, 2009). Secondly, the WHO became pre-occupied with performance of health systems. The rational underlying increased emphasis on the performance of health systems was on upgrading health services and motivating governments to ensure that their health systems are responsive to the expectations of the population (Meesen, Soucat, 2011). Thirdly, the intricacy of the health systems was identified in health system research. Scholars working on health systems encouraged an exodus from mechanical thinking that characterised the health systems to a more holistic approach that included multiple actors

(Olmen et al., 2012). According to WHO (2009), the systems thinking approach advanced by Peter Senge drew attention to the multifaceted nature of health systems, the interactions and feedback loops between blocks, role of the populace and the revolving effects of change.

Under this study, the health systems' thinking is imperative as it offers philosophical underpinnings and frameworks for analyzing performance of health systems including services delivery in relation to financing.

1.8.4 Health financing

To a larger extent, development investments including the health sector in LDCs have been predominantly donor funded. This is highlighted by Evans and Etienne (2010) who carried out a survey on funding streams for the health sector and realised that, donor commitments to health increased more than fourfold since the Millennium Declaration was signed in September 2000, reaching more than US$20 billion in 2008. This analysis which was conducted in Africa clearly articulates that over the years donors have invested billions of dollars in Africa to either resuscitate or strengthen her health sector. It can therefore be noted that with increased donor funding, there is also increased over-reliance on the same thus we have reports of some previously donor funded projects down scaling with others closing immediately after the donor financing period lapsed or when the project ended. It is therefore imperative that the mindsets of LDCs policy makers and development practitioners be decolonised from over reliance on donor (external) support to home-grown domestic financing options.

Countries that opt for domestic financing options to sustain health provision generate the resources through a number of approaches. According to the Millennium Development Goals report (2009), improving universal coverage requires systems that raise the bulk of funds through forms of prepayment for instance taxes, and then pool these funds to spread the financial risk of illness across the population. They require health financing systems with inbuilt incentives to ensure that these funds are used efficiently and equitably. Lessons of such

domestic financing of health services can be drawn from Zimbabwe which taxes every employee AIDS levy which goes towards financing the national fight against HIV and AIDS. This is a successful model of domestic financing that is sustainable. However, resources for health response will always be inadequate thus the need to come up with a number of different strategies for domestic financing. Also, the amount of revenue governments can raise from taxes is constrained due to the risk of excessive taxation dampening nascent economic growth. It can therefore be challenging to identify additional domestic budgetary flexibility for investments in health, without compromising fiscal stability.

Any financing option for health provision should address bottlenecks that forestall sustainability. More so, health financing systems should be robust enough to accomplish and sustain increased coverage for access to health. According to Evans and Etienne (2010), financing for universal health coverage is based on two interlinked foundations. The first is to ensure that financial barriers do not prevent people from using the services they need. The second is to ensure that they do not suffer financial hardship because they have to pay for these services. In both of these two variables the critical issue of economic development comes into play that is, the economy of a country has to be performing well to support health investments and to ensure that citizens have some disposable income to pay for health services. In this regard, it can be noted that sustainable health service provision in LDCs is compromised owing to economic challenges which directly stifles investments in the health sector. These economic challenges also affects disposable income available to citizens including that of covering health fees as there are increasing unemployment rates. It can therefore be realised that economic challenges poses great threats to sustainable health services provision. Working towards economic turnaround and developments especially in LDCs therefore becomes imperative.

1.8.4.1 Community-Based Health Financing

Private and out-of-pocket (OOP) expenditure accounts for almost half of total health spending in LDCs. Taking into account, LDC governments' restricted abilities to mobilize incomes, country and donor attention is now on the informal sector insurance mechanisms in a bid to improve financial protection, mobilize revenues, and improve the efficiency of OOP spending. Community-based Health Financing (CHBF) is a broad term that encompasses various types of community financing arrangements that have emerged due to high OOP spending among society members, uncertainties surrounding donor support, and large and unregulated private players in the health sector system. In this context, CBHF refers to pre-payment plans that attempt to pool risks to reduce the financial risk an individual faces because of illness (Atim and others 1998; Bennett, Creese, and Monash 1998; Bennett, Kelley, and Silvers 2004). CBHF is found throughout the world but is particularly prevalent in Sub-Saharan Africa (Bennett, Kelley, and Silvers 2004).

In addition to the above, Schieber et.al (2008) states that CBHF procedures are somewhat heterogeneous in terms of citizens covered, services offered and accessed, regulation, management function, and goals. The Commission on Macroeconomics and Health established that CBHF plans provided substantial financial safety and protracted access to a large number of rural and low-income populaces (WHO 2001), but that affordability obstructed access for the very poor. Consequently, the commission called for amplified support for CBHI and for the formation of a co-financing scheme that matches the contributions individuals paid for their health insurance with a government or donor dollar (WHO 2001).

In the context of this study, the researcher sought to establish whether CHBF is a noble solution or at least one key element of the sustainable domestic financing model for Zimbabwe. Whatever the case, community involvement in the financing model is imperative to sustain

financing and access to health service like SRH, either through consultations or localized financing options at village, ward or district level.

1.8.4.2 Obama Care

ObamaCare is the Affordable Care Act (ACA) of 2010 that transformed the way America delivers health care. The Act's primary goal was reducing the rise in the cost of health care. It had three components that worked and began to accomplish this target. One of the components was ensuring that every American is insured. Prior to the emergence of the ACA, insurance firms excluded people with pre-existing medical conditions that will most likely blow medical cover premiums. Consequently, the patients with the greatest health expenses were shunned and had to live without insurance thus they could not afford treatment. They often ended up in hospital emergency rooms with hospitals passing such expenses onto Medicaid, causing rises in health care costs. Obamacare allowed such patients to afford preventive care, reducing hospital visits, and decelerating the rise of health care costs.

Another component of ACA was central subsidies to help citizens afford the required insurance. However in December 2017, Congress repealed the tax effective 2019 in the Tax Cuts and Jobs Act. This considerably weakened ObamaCare’s capacity to lower health costs. By repealing the Care, Congress essentially assured that health care costs would rise steeply.

In the same breathe, one can realise that if government intervenes in the health sector with supportive and implementable policies, adequate health services provision will be achieved and citizens will enjoy the universal right to good health including sexual and reproductive health choices. However, the challenge in most third world economies is of resources to bankroll such policies like the Affordable Care Act since they require the government to raise and allocate significant budgets to implement these. In the context of this study, it is therefore apparent that considering the economic challenges bedevilling LDCs like Zimbabwe,

opportunities to fundraise like meaningfully engaging the private sector for Public-Private-Partnerships (PPPs) be pursued to finance the health sector. The other option will be to meaningfully plough the gains of Community Shares Ownerships and Community Social Responsibility in the respective districts or provinces around firms. These are some of the key considerations for a sustainable domestic finance model for the health system in Zimbabwe.

Sustainable health provision is to some extent also affected by user fees charged by health institutions. Looking at the poverty bedevilling citizens in the third world vis-à-vis health user fees, there is a challenge of poor people accessing health services as they are expected to pay at least consultation fees and possibly buy medicines. Yates (2010), after his study in Armenia, focuses on how funds for health are raised and makes a case for abolishing user fees, starting with services for women and children. In his proposition, Yates makes an interesting reference to women and children because generally women and children are of a high health seeking behaviour as compared to men and adults. Generally, health services including Sexual and Reproductive Health (SRH) are critical to women to reduce maternal mortality, unwanted pregnancies and to give women an opportunity to focus on other developmental issues outside reproduction. It is therefore imperative to remove user fees on such services as SRH to ensure sustainable health provision. This is also corroborated by Fagan, Fox, and Malarcher (2018) who states that lack of public financing for family planning and limited coverage of prepayment mechanisms means that individuals often rely on out-of-pocket (OOP) expenditure to pay for contraceptives and services. Although mobilizing OOP among groups with the ability to pay is often part of a strategy to support sustainable, domestic financing for family planning, many low- and middle-income countries, including Ethiopia, have acknowledged that heavy reliance on OOP payments can make healthcare inaccessible to vulnerable households. Also, the need to pay OOP for contraception can propose a particularly significant barrier for adolescents and women who lack financial autonomy.

1.8.4.3 Other health financing models

Table 1.1: Summary of other financing models extracted by researcher from various sources

Model	Revenue Source	Groups Covered	Pooling Organization	Care Provision
National Health Service	General revenues	Entire population	Central government	Public providers
Social Health Insurance	Payroll taxes	Specific groups	Semi-autonomous organizations	Own, public, or private facilities
Community-based Health Insurance	Private voluntary contributions	Contributing Members	Non-profit plans	NGOs or private facilities
Voluntary Health Insurance	Private voluntary contributions	Contributing members	For- and non-profit insurance organizations	Private and public facilities
Out-of-Pocket Payments (including public user fees)	Individual payments to providers	Household members	None	Public and private facilities (public facilities)

1.8.5 Requirements for Health Financing Models

User fees are a pre-condition that sustains the health delivery system. Schieber et al., (2006) highlights that user fees also referred to as known as out-of-pocket (OOP) health financing accounts for around 60% of all health care spending in LDCs and only 20 per cent in high income countries. In Cambodia, high OOP spending and low levels of utilization have hampered the extension of coverage and advancement in health outcomes (Ensor et al., 2017). The emergence of user fees in the African health delivery system was stimulated by extensive downward pressure on public expenditure and diminishing aid flows during the late 1980s (Yates, 2006). Economic recession and structural adjustment programs imposed by the International Monetary Fund (IMF) led to the introduction of user fees in developing countries especially in Africa (Olmen et al., 2012). The economic explanation for charging user fees are that they streamline access and use of health services and also primarily prevent unnecessary

service usage by community members (Savedoff, 2011); health care service providers retain them partially or totally (Quaye, 2007); they move the obligation of health care funding from the state to the public through a cost sharing arrangement that suits both donors and governments (Yates, 2006) and they act as a cost recovery instrument to ease the burden on tax-based health financing.

In instances were user fees have been eliminated; the challenge has been the introduction of a substitute health financing mechanism that does not drain the fiscal space. Burundi in 2006, introduced systemic health financing through the fusion of user fee exemptions for expecting women and children under 5 and performance-based-financing. The systemic arrangement in Burundi appeared to have given positive results since it created a formal channel for substituting revenue from user fee exemptions. An incentive scheme was put in place to manage staff demotivation related to attending to high volumes of patients following the removal of user fees (Musango et al., 2013).

The table below, shows average costs of accessing SRH/ family planning methods across Zimbabwe. This information was gathered by the researcher through market price research across private facilities offering SRH services. The prices below (table 1.2) justifies literature that proposes abolishment of user fees because they are generally high for an ordinary woman or adolescent girl. Government does not have SRH commodities like family planning services captured in the table to women and adolescent girl.

Table 1.2: Average family planning prices across Zimbabwe (as at August 2019) *Source: Author*

Family Planning Services	USD
IUCD insertion	$ 10.00
Implant insertion	$ 10.00
Emergency contraception	$ 5.00
General counselling	$ 10.00
SRH counselling	$ 5.00
FP medical exam	$ 10.00
Implanon renewal	$ 10.00
IUCD renewal	$ 10.00
Jadelle renewal	$ 10.00
Side effects management	$ 5.00
Injectable	$ 5.00
Pills	$ 1.00
Permanent method	$ 15.00

Supporters of the pro-poor approach to health care access proclaim that many governments have introduced mechanisms to safeguard the poor and vulnerable by eliminating or reducing user fees (Musango et al., 2013). The scrapping of user fees works commendably when there are broad investments in the health care system of a country. In March 2001, Uganda abolished user fees expecting that there would be improvements in access and use of health services particularly among the poor, reduce OOP expenditure on health and ultimately eliminate poverty. Deliberate efforts were made to increase funds apportioned to primary health care. Unfortunately, around 80% of these funds were paid in wages. Nonetheless, there was no evident improvements in health access among the poor (Musango et al., 2013).

Inspired by this point of view, user fees play a role in safeguarding sustainability of health care systems (Savedoff, 2011). Nevertheless, effective private sector engagements and partnerships with some control on prices can help to guarantee the delivery of quality health services (Musango et al., 2013).

In the wake of the challenges presented by the OOP approach to health care funding, the concept of social insurance and private public partnerships (PPPs) emerged. Social health

insurance draws both the health risk and the citizens on one hand and the contributions of citizens, households' enterprises and the state on the other hand (Akortsu, 2013). In the context of Zimbabwe, a social health insurance was introduced in response to the HIV/AIDS pandemic and climaxed in the introduction of the Aids Levy which is 3% of an individuals' tax payable and is mandatory (ZIMRA, 2013). Health financing through the development of social health insurance is generally recognized as an influential technique to achieve universal coverage with sufficient financial resources for all against health care costs (Akortsu, 2013).

Private financing of health care is founded on contributions paid by members. Monthly premiums paid by members depend on their risk exposure (Green, 2007). The success of private funding of health care is based on the chance to avoid huge OOP expenditure. Private health insurers pool health risks across space and time for a large number of policy holders who differ in their risk exposures (Johannessen et al., 2014). Contributions remitted by an individual are distributed between the employee and the employer. In some cases, the employer fully services the health costs and insurance agents manage the premiums fund. The state may subsidize the cost of private health insurance riding on tax credits or tax relief. In Zimbabwe, private health insurance costs are tax deductible (ZIMRA, 2013). In many low-and middle-income countries, private health insurance could be the only form of risk pooling obtainable and it usually affords principal coverage to those in the formal sector, with private policies regularly funded by employers (Akortsu, 2013).

Regardless of private health funding being tax deductible, it is not all-inclusive since it side-lines the poor. In essence, private funding of health care affects the accessibility of the same by the poor (Sithole, 2013). It only observes the formal sector where there arrangements between the employee and the employer to contribute to a private funding of health care scheme. Unfortunately, the marginalised members of the community are not formally employed or not even employed and they depend on menial and non-formal modes of income

generation like in the case of Zimbabwe were unemployment rate is estimated to be over 80%. In this regard, this substantial section of the population is omitted from the private funding of health care scheme. In reinforcement of this assertion, Burke et al. (2013) states that about 14% of South Africans use private health insurance, the rest rely on public sector health care which is free to the marginalised- the unemployed, the poor and children.

Public Private Partnerships are a substitute form of health finance, which is a precondition for a functioning health care system. Health development partners such as multinationals, bilateral and multilateral donors provide financial support to beneficiary governments' treasury through set aside funds for specific health interventions (Akortsu, 2013). The condition for PPP is that public services remain under the regulation of the public sector. PPPs in health care financing are essential as they increase service technical efficiency, quality and accountability. These agreements are a way of encouraging private players to invest in health care interventions that lack public funding (Johannessen et al., 2014). External assistance accounts for about seven percent of all health investments in developing countries and is not a significant source of health financing in developed countries (Schneider et al, 2006).

In spite of the conceptual appeal of external assistance, the negative side of this approach is that in countries where health is not a priority, health finance is compromised and the gains of budgetary support reserved for achieving health targets will not be met. More so, the private sector is profit driven, is risk averse and is less likely to invest in poor communities as they reduce their profit margins. Enterprises are not ready to service the low income market as they lack working experience with the poor clients (Johannessen et al., 2014). Zimbabwe is one such country where health is not prioritised. Where national budgets are concerned, it appears that the Office of the President and Cabinet, ministry of State security and the defence Ministry takes precedence over the health Ministry (Sithole, 2013). This will definitely compromise

health outcomes. The table below shows health investments by GoZ in 2015 as evidence of how health is not prioritised in terms of budget allocation by the government,

Table 1.3: GoZ health expenditure for 2015

National Health Accounts (NHA) Indicators (General) 2015	
Total population (Zimstats)	13,943,242
Total nominal GDP (USD) (Zimstats)	$14,007,108,087
Total government health expenditure (USD)	$309,699,620
Total health expenditure (THE)	$1,447,785,504
THE per capita (USD)	$103.83
Government health expenditure as % total government expenditure	8.72%

Source: adopted from Gwati (2017)

Substitute health financing approaches are meant to supplement existing health financing approaches. Public health facilities habitually raise finance by undertaking other activities that are not directly related to the delivery of health care. These might include the operation of a cafeteria, gift shop, space or equipment rentals, parking fees and research grants (Akortsu, 2013). Most teaching hospitals usually finance their activities through research grants as well as funding from pharmaceutical companies to test new drugs and products (Lane and Nixon, 2001). Advanced economies such as the USA make use of marketable investments as alternative sources of finance. These includes trade in mutual trusts, stocks and bonds on the stock exchange (Akortsu, 2013).

Nevertheless, different hospitals have different strategies were the use of alternative sources of health care financing is concerned. Some hospitals prefer to invest in the stock market that provide higher returns at higher risks while others invest in more conservative fixed rate of return investments such as bond and money market funds (Akortsu, 2013).

Having looked at various health financing approaches that are available, it is imperative that the current study narrow down to focus its attention on a sustainable domestic health financing model for Zimbabwe.

1.8.6 Country experiences with health financing models

1.8.6.1 Key Success Factors for Results Based Financing Implementation in Rwanda

Mutopo (2017) gives an interesting account of how Rwanda successfully rolled out the RBF model in its health sector. Rwanda is one of the African countries considered to have successfully rolled out the RBF framework on a nationwide scale within its health system (WHO, 2015). Every administrative unit from the village level to the ministries attest to a performance contract within its hierarchy (Renaud and Semasaka, 2014). The RBF was introduced to the Rwandan health system during 2001 and 2002 and it was up scaled to become a national programme in 2008. The successful implementation of the RBF in Rwanda was assessed through a well-documented and credible impact evaluation and it found impressive results on the volume and quality of health services (Sithole, 2013).

As a country emerging from a war experience, it was expedient to hold warring parties together for the common good, as such there was unwavering commitment towards the RBF initiative. Post war trauma can be asserted as one of the building blocks towards the remarkable success of the RBF initiative in Rwanda. The most critical factor that contributed to success of RBF in Rwanda was strong political will, full support and commitment by the Rwandan government (World Bank, 2010). The Government allowed the implementation of mechanisms that enabled transparency, accountability and responsiveness. In addition, there was close cooperation with the donor community who provided the bulk of the funds to finance the health system. This helped to reduce the mistrust and suspicion that is usually associated with government and donors in the management of funds (Basinga et al, 2011).

The Rwandan RBF programme had a positive impact on quality of health care (World Bank, 2014). Information on RBF was widely disseminated to all the stakeholders in the health system as some sense of ownership was developed. Target beneficiaries particularly those in the rural areas were encouraged to visit health institutions for health care. There was a widespread buy-in from the critical stakeholders who included the government, health care providers and the target beneficiaries (Basinga et al, 2011).

Differences in the implementation of the RBF between Rwanda and Zimbabwe is that in Rwanda there was zeal in social programs that could unite the nation since the country was emerging from a devastating war. Whereas the RBF was first introduced in Zimbabwe in 2010 three decades after gaining political and economic independence. The resounding and apparent perception in Zimbabwe is that the budgetary allotment towards the Defence Ministry versus the Health Ministry is too much for a peaceful country. As Paganini (2004) rightfully quips, it appears that in the wake of the fiscal deficits facing the Zimbabwean government, "…the government financial allocation to public health, in the best cases, is barely enough to pay the salary of the staff." Despite all the odds that were cast against it, Rwanda appears to operate a robust result based finance programme than Zimbabwe.

1.9 RESEARCH METHODOLOGY

This section reviews the phenomenological research philosophy that guided this study on sustainable domestic financing options for sexual and reproductive health service provision in Zimbabwe. The section lays out the methodological process involved to answer the research questions and ultimately address the research topic. The section also highlights the systematic process of data collection, data sources, data analysis, data explication and data presentation.

1.9.1 Research Philosophy

Central to this research is the need to add to a body of knowledge and practice around domestic financing options and sexual and reproductive health. This is guided by Saunders et al (2009), who states that research philosophy alludes to the advancement of knowledge in a certain field of study. In this regard, this research will identify, assess and propose domestic financing options and ultimately a model thus enriching these two fields of domestic financing and SRH. The study's recommendations and identification of further research opportunities will also add more insights and reflections in the two areas.

In order to have an authentic understanding of sustainable domestic financing options in relation to SRH, the researcher used the phenomenological research philosophy. Dahlberg et al (2008), states that the overall aim of research is to describe and elucidate the lived world in a way that expands our understanding of humanity and its experiences. In this context, the researcher sought to analyse and have a deeper understanding of how analyse how a sustainable domestic financing model can be effective in ensuring perennial SRH services provision.

1.9.1.1 Phenomenological research philosophy

This study falls within the confines of a phenomenological research. As stated by Finlay (2008), phenomenology asks, "What is this kind of experience like?", "What does the experience mean", "How does the lived world present itself to me (or to my participant)?" Guided by this assertion the researcher's aim therefore was to guide participants so that they express their experiences as directly as possible in relation to current financing practices and models vis-à-vis SRH service provision and also to establish what they perceive to be the best way forward. The researcher had to be attentive during data gathering since in phenomenological research the meanings uncovered by the researcher are dependent on his attitude and the way he administer questions to respondents.

Textbox 1.1: Strengths of phenomenological research philosophy

Garza (2008) posits that phenomenological research is flexible and utilisation of its wide approaches to inquiry is its supreme strength. Finlay (2008:3) explains that "rather than being fixed in stone, the different phenomenological approaches are dynamic and undergoing constant development as the field of qualitative research as a whole evolves". Wertz (2005) notes that Phenomenological research's value is established by honoring concrete individual instances and demonstrating some fidelity to the phenomenon ('to the things themselves')

Source: Wertz (2005), Garza (2008), Finlay (2008)

1.9.2 Research Design

This study combines two research designs namely exploratory and case studies to collect data in a way that target to join significance of the research to the research purpose. Basically, there are different research designs identified by Malhotra (1993) and Young (2000) which are exploratory, experimental, survey and case study. This study combines exploratory and case study because the researcher intended to explore the dynamics around domestic financing options in the case of SRH service provision in Zimbabwe. In this context therefore, SRH was the case study and sustainable domestic financing options were explored to develop a model.

In this research, data was collected through Key Informant Interviews (KIIs), Focus Group Discussions (FGDs) and Observations. KIIs were employed to gather information from experts in development, donor financing and government financing; FGDs were used to gather data from samples of communities who are the beneficiaries of SRH service provision and observations were employed so as to triangulate and verify data collected during KIIs and FGDs.

Babbie and Mouton (2009) identify two different forms of research design which are empirical and non-empirical design. Empirical design uses primary data from surveys, experiments, case studies, evaluations and ethnographic studies. Empirical research also analyses existing data.

In harmony with Babbie and Mouton (2009), the researcher used SRH as a case study in evaluating how sustainable domestic financing options can ensure perennial health services provision. Fig 1.3 below illustrates the study's research design informed by research questions.

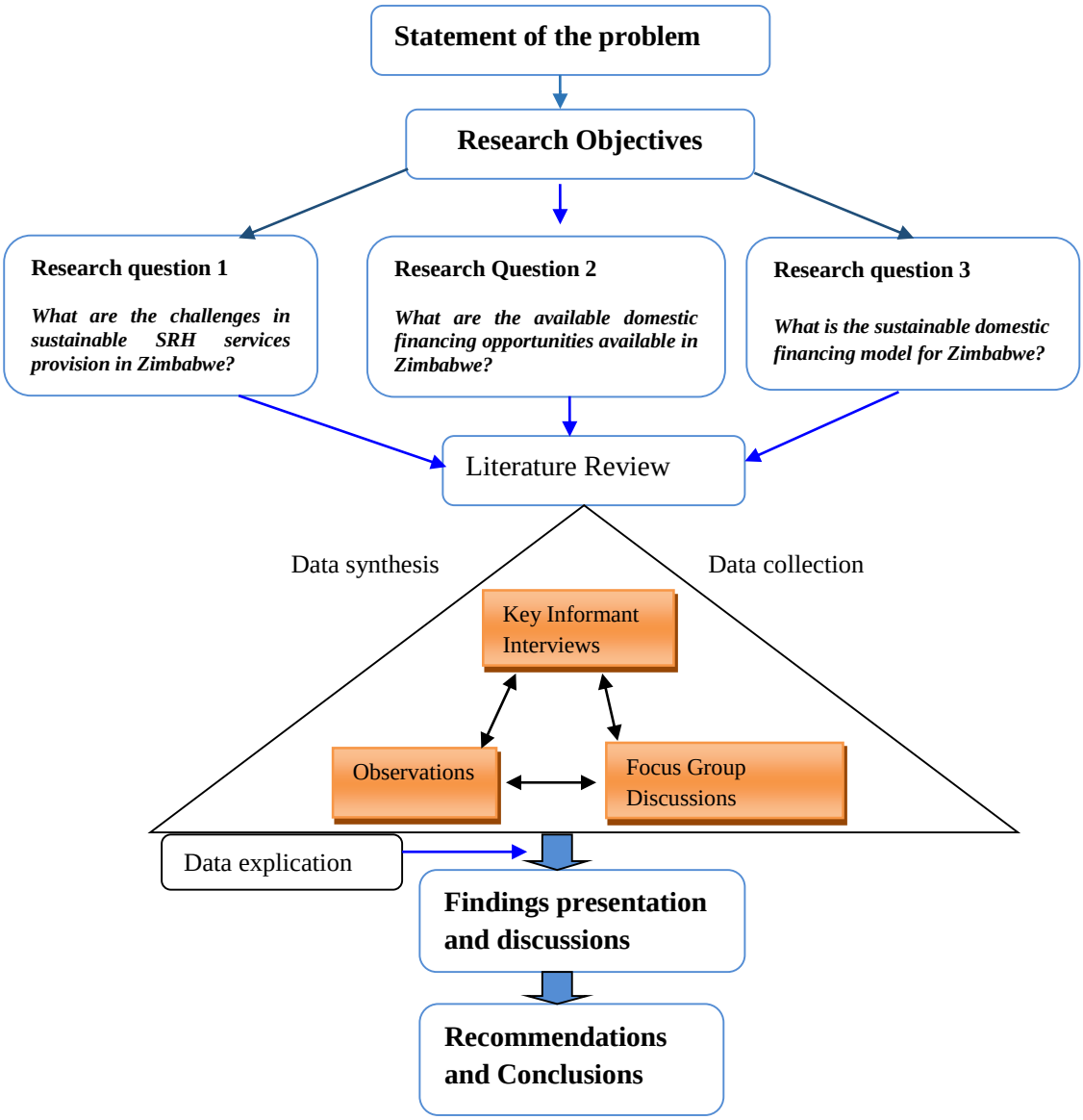

Figure 1.3: Research Process ***Adapted from Kwaramba (2012)***

1.9.3 Research Population

This study on sustainable domestic financing options for SRH service provision drew its research population from a diverse group of experts including donors, Non-governmental

Organisations (NGOs), United Nations Agencies (UN), government and communities. This population was deemed central to addressing the focus of this research since Hair et al (2003) states that research population is a complete group of objects or elements relevant to the research project.

1.9.4 Sampling Procedure

This study used purposive sampling in selecting participants for data collection. The bias involved in selecting participants under purposive sampling makes the selection criteria rich in terms of data quality and reliability. This is justified by Kumar (2009) who submits that purposive sampling technique is most effective when one needs to study a certain domain with knowledgeable experts within. This study took a sample of the target population and this made the research manageable, economic and was completed on time.

Textbox 1.2: The purpose of sampling

Simplify the research- Studying the whole population is a mammoth task hence studying a representative of it becomes manageable.
Saves time- Studying a representative sample is less time consuming than studying an entire population.
Cut costs. The processes involved in data collection are high when an entire population is studied.

Source: Brynard & Hanekom (2005)

1.9.4.1 Purposive sampling

Patton (1990) highlights that the logic and power of purposive sampling lies in selecting information rich cases for the study. Information rich cases refer to those respondents from which the study will gather informative data of central importance to the research study thus the term purposive sampling. It was critical then, that before data collection, key people with relevant information for this study were selected and contacted. Purposive sampling was useful especially in selecting respondents for KIIs as the researcher judged which experts from the

research population are experienced in financing options and in SRH programming at both national and international levels. Other forms of sampling like simple random would have picked experts who are not aware or not involved in SRH programming.

Table 1.4: Key Informant Interviews respondents

Name	Designation	Sector	Comments
Ms. Angelica Broman	First Development Secretary-Embassy of Sweden	Donor Agency	An expert in international health sector management. Experienced in health policy issues in Africa, Latin America, Asia and Europe. Currently responsible for awarding of donor grants from Sweden to International and National NGOs and United Nations Agencies operating in Zimbabwe.
Mr. Brighton Muzawazi	National Monitoring and Evaluation Specialist	Government	Brighton is the information hub for the Ministry of Health at national level. He is charge of all critical information regarding all health programmes, their impact and lifespan.
Mr. Itai Rusike	Executive Director-Community Working Group on Health (CWGH)	Civil Society (National)	Itai leads CWGH a network of civic, community based organizations which collectively enhance community participation in health issues in Zimbabwe. The CWGH takes health issues a common concern. The organisation is a voice in the health sector and it builds community power, organizing involvement of communities in health actions within their communities including mobilizing resources to support health centres.
Dr. Alex Gasasira	Country Representative (Zimbabwe)-World Health Organisation	United Nations	An international health expatriate currently heading WHO Zimbabwe's country health portfolio. He has an informed appreciation of health programming and can share experiences from other countries he has worked in and those can be adopted in Zimbabwe.
Mr. Abebe Shibru	Country Director-Population Services Zimbabwe (PSZ)	Civil Society (International)	An international health expert leading PSZ (an affiliate of Marie Stopes International). PSZ is the largest NGO in Zimbabwe in terms of Sexual and Reproductive Health service provision (MoH, 2018). Based on his country level experiences, he can expertly guide how Zimbabwe's health sector can be funded through robust domestic financing opportunities.

Source: Researcher (2019)

1.9.5 Sources of data

In a research, primary data source refers to the original research material on which the research is founded. In this case, it refers to the data and experiences gathered in the field under study. Under this study, the primary data sources were KIIs, FGDs and Observations guides administered by the researcher.

1.9.6 Data collection methods and instruments

In this study, the researcher used interviews in form of FGDs and KIIs. Powell (1998) highlights that a variety of data collection methods are usually used and these include questionnaires, interviews, observations and analysis of documents. The researcher also employed observations to verify the current trends in SRH services provision. These research instruments were critical in collecting qualitative data for this study.

1.9.6.1 Research Instruments

The researcher carefully considered a number of research instruments before opting for the KIIs guide, FGDs guide and Observations guide which were considered to gather central information for this research. The strength of using relevant instruments like this in research is highlighted by Gjersing et al (2010) who states that in research emphasis should be on using standardized and validated research instruments since the use of validated instruments increases the certainty with which the instruments accurately reflect what they are supposed to measure. There are three types of interview discussions namely structured, semi structured and unstructured. In this study both KIIs and FGDs were semi structured discussions. The research instruments are discussed in detail below.

1.9.6.1.1 Key Informant Interviews

The National Collaborating Centre for Infectious Disease (2014) refers to Key Informant Interviews as expert interviews because of their nature of collecting data from experts in a certain field related to the research. Guided by this assertion, the researcher conducted semi structured discussions to Key Informants who are specialists and experienced personnel in the study variables- domestic financing and SRH. The key informants' feedback was captured and presented in codes as presented below;

Table 1.5: KII respondent's codes

Name	Designation	Sector	Code
Ms. Angelica Broman	First Development Secretary- Embassy of Sweden	Donor Agency	KII.01
Mr. Brighton Muzawazi	National Monitoring and Evaluation Specialist- Ministry of Health	Government	KII.02
Mr. Itai Rusike	Executive Director- Community Working Group on Health (CWGH)	Civil Society (National)	KII.03
Dr. Alex Gasasira	Country Representative- WHO	United Nations	KII.04
Mr. Abebe Shibru	Country Director- Population Services Zimbabwe (PSZ)	Civil Society (International)	KII.05

1.9.6.1.2 Focus Group Discussions

According to Kitzinger (1995) a focus group is a research method that uses a group interview to capitalize on communication between a researcher and research participants in order to gather data. He further states that although group interviews are often used simply as a quick and convenient way to collect data from several people simultaneously, focus groups explicitly

use group interaction as part of the method. This is one of the key advantages of FGDs since one question can get multiple responses as the group gives various experiences and opinions to the research question. The participants can even comment on each other's point of view thus the researcher gets informed, verified and correct responses. Kitzinger further highlights that the method is particularly useful for exploring people's knowledge and experiences and can be used to examine not only what people think but how they think and why they think that way. To elucidate research questions to participants during FGDs, the researcher used the local vernacular languages thus Chi Budja in Mutoko, Chi Ndau in Chipinge and Chi Kore-Kore in Rushinga. This also enabled participants to freely express their experiences and issues using their own language. The major focus of FGDs was to understand community perceptions on financing of SRH service provision.

Textbox 1.3: FGD interviewees

In this study, the Researcher conducted 3 FGDs of 7 people per group. These participants are representatives of three selected rural districts- Nkayi, Chipinge and Mutoko. The researcher believed that these FGD participants are conversant with trends around SRH services provision and what can possibly be done to improve on such

Source: Researcher (2019)

Table 1.6 below presents information on the FGD groups and individual codes assigned to them within that specific group. Responses were captured based on a code of each respondent. Since the researcher ensured FGD participants were seated in a horse-shoe sitting position, each respondent was assigned a code on that sitting arrangement to avoid double capturing and coding.

Table 1.6 Table of FGD respondents

Group Name	Area	Individual Codes
FGD 1	Kondo ward, Chipinge, Manicaland	FGD 1- RI; RII; RIII, RIV; RV; RVI; RVII
FGD 2	Dakamela, Nkayi, Matebeleland North	FGD 2- RI; RII; RIII, RIV; RV; RVI; RVII
FGD 3	Mushimbo, Mutoko, Mashonaland East	FGD 3- RI; RII; RIII, RIV; RV; RVI; RVII

1.9.6.1.3 Observations

In this study, the researcher carefully employed observations as an instrument to gather physical evidence on the current SRH service provision dynamics in health centres and Youth Friendly Centres as was stated by interviewees during KIIs and FGDs. Observations was used in ascertaining whether data gathered during KIIs and FGDs is in tandem with the actual service provision in SRH provision facilities. In conducting the observations, the researcher was guided by Silverman (1993) quoted in Mulhall (2003) who expresses the importance of observations in research when he highlights that some researchers unfortunately become a little reluctant to use their eyes during the process of field data gathering. Observations in this regard become a critical research instrument in gathering data on physical elements including human beings within the research field. The primary basis for observations is to verify whether what people say tally with reality (what is physically present in the field). According to Mulhall (2003), observational data is subject to interpretation by the researcher. This is so because, the researcher as an observer has a great degree of freedom and autonomy regarding what he chooses to observe, how he filters information and or evidence he sees, and how he analyses it.

1.9.7 Data collection procedure

Data collection through FGDs and KIIs was conducted in a systematic manner guided by semi-structured discussions. Observations were undertaken with the aid of an observations guide. Lofland quoted by Groenewald (2004) states that the human mind quickly forgets. Bearing this in mind, the researcher captured responses on audio recorder for KIIs and FGDs discussions. Observations were captured by a digital camera and observations notes were written on a notepad. Audio recording was imperative otherwise a lot of data would have been lost since some research questions received multiple responses with some respondents talking at the same time during FGDs. At the end of the day, interview notes were captured on the laptop then

audio recordings played so as to synthesize data from the 2 data sources (notepad and audio). No judgments were done on the data during capturing. Table 1.6 below presents the data collection procedure based on the research questions guiding this study.

Table 1.7: Data collection method against research questions

Research Question	Research Methodology
What are the challenges in sustainable health provision?	- Key Informant Interviews - Focus Group Discussions - Observations
What are the current domestic financing opportunities available in Zimbabwe	- Key Informant Interviews - Focus Group Discussions
What is the sustainable domestic financing model for SRH in Zimbabwe?	- Key Informant Interviews - Focus Group Discussion

Source: Researcher (2019)

1.9.8 Rationale for Semi structured discussion guides

Teijlingen (2004) notes that there are three forms of interview discussions which are structured, semi- structured and unstructured. In this study the researcher opted for the semi-structured discussions that were administered face to face with respondents in both KIIs and FGDs. The main task in interviewing was to understand the meaning of what the interviewees say thus describing the meanings of central themes in the life world of the subjects.

In this study's semi-structured discussions, the questions were predetermined. The order of questions were modified during the interview stage basing on the interviewer's perception of what seems most appropriate. The semi- structured discussions were open in the sense that question wording was in some instances changed and explanations given to suit the interview context and process. In this understanding, questions that were found to be inappropriate to a certain expert or group were omitted in as much as additional follow up questions were included.

All the three types of interview discussions were considered and weighed against the semi structured discussions. It is in this regard that the researcher singled out the semi- structured

discussion guides as they allowed the participants to discuss a number of issues when a question was asked whilst the researcher was picking valid study data from the deliberations. Table 1.7 below presents the strengths and weaknesses of the semi- structured interviews. The weaknesses were considered weaker to disqualify semi- structured interviews.

Table 1.8: Advantages and disadvantages of semi- structured discussion guides

Advantages	Disadvantages
Well suited for exploring attitudes, values, beliefs, and motive.	Equivalence of meaning difficulties may arise
Non-verbal indicators assist in evaluating truthfulness (validity) and urgency.	Preferred social response
Facilitates getting every question answered	Non-response to some questions
Can potentially increase response rate	Prejudices, stereotypes, appearances and perceptions of researcher may alter response

Adapted from Teijlingen (2014)

1.9.9 Interview process

Though the researcher opted for the semi- structured discussions, the process needed conscious and attentive planning as well as meticulous verification of questions. This section details the interview process followed by the researcher. A pre-test was conducted for the actual data collection exercise as highlighted in the textbox 1.4 below.

Textbox 1.4: Interview process pre- test

The researcher conducted a pre- interview test for the KIIs guide, FGDs guide and Observations guide. One key informant who was not part of the 5 KIIs that were actually interviewed was interviewed during the pre- test. The FGD guide was pre-tested on 5 community members who were not part of the study's FGD respondents.

Source: Researcher (2019)

Semi- structured questions were weighed to ascertain on ambiguity, repetition and on easy administration especially when translating to participants in FGDs. During the interview process, later interviews drew lessons, information and patterns discovered within earlier

interviews hence later ones were quite flexible and a bit fast. Throughout the research process, the researcher stood guided by Teijlingen (2014) who states that conducting interviews is an iterative process in which data collection, on-going data analysis, reflections and generating new questions are part of a continuous comparative effort. In this regard, the researcher kept on reflecting back and forth to ensure that the interview process is effective in data gathering. Figure 1.4 below presents a flow diagram that summarises the interview process undertaken in this study.

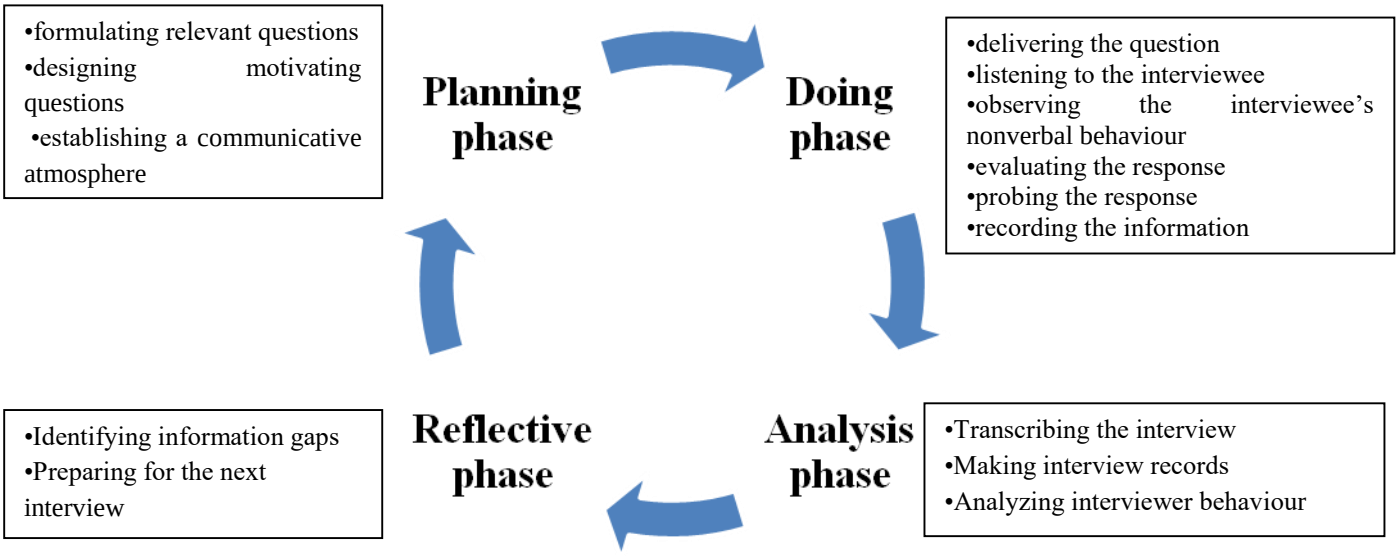

Fig 1.4: Interview Process ***Adapted from Teijlingen (2014)***

1.9.10 Data Explication Procedure

Lester (1999) identifies one of the characteristics of phenomenological research when he highlights that they are comprised of large quantities of data. He further states that data explication is a mammoth task since the data does not come in neatly and or well-ordered form. These are true assertions with regards to phenomenological research because on this study there were large quantities of data collected from KIIs, FGDs as well as observations. The data captured on notepads was not in good order but was too congested since the researcher reflected back and forth to add more information on points earlier on noted but later on discussed with another angle. Through this process data was squashed on paper. However, all the data was

transcribed from notepads and audio records and was captured on computer. Soft copy data commenced the process of eliciting meaning from gathered data.

The researcher used clustering in order to explicate data gathered during KIIs, FGDs and observations. As an outcome of clustering, themes were created through meanings that naturally cluster or were clustered by drawing meaning closeness by the researcher. According to Hycner (1985), clustering involves rigorously examining each individual unit of relevant meaning and trying to elicit what is the essence of that unit of meaning given the context. In this regard, the researcher used thematic analysis of data whereby emerging themes and concepts from data explication were given a label that describes them. Tabled below (1.8), is the seven step data explication process undertaken by the researcher.

Table 1.8: Data Explication Process

Stage	Stage Name	Stage activities
1	Transcription	The first step was having the interview tapes transcribed. This included the literal statements. The researcher tried as much as possible to note significant paralinguistic communications.
2	Bracketing and phenomenological meaning	This stage emphasized the unique own experiences of research participants. This was an essential step in following the phenomenological reduction necessary to elicit the units of general meaning.
3	Delineating	The process involved going over every word, phrase, sentence, paragraph and noted significant nonverbal communication in the transcript in order to elicit the participant's meanings. This was a process of getting at the essence of the meaning expressed in a word, phrase, sentence, paragraph and significant non-verbal communication. The process was basically to crystallize and condense participants' responses. Delineating was done first to get a general meaning then later on to get meaning that directly responds to research questions.
4	Eliminating redundancies	The researcher looked for units of relevant meaning and eliminated units of meaning that were clearly redundant.
5	Clustering	At this stage, the researcher determined units of relevant and non-redundant meaning that naturally clustered together. Groups of themes were formed by alignment of meanings. Also, through this process topics were formed.
6	Summarizing	Through reverting back to interview transcriptions, summary write ups of each interview were done that incorporated themes that had been elicited from the data. Summarizing gave sense to the interview process as well as accord context to the emergence of themes.
7	Extracting themes	Key themes emerging from the data were established from clusters and summary obtained on the above stages.

Adapted from Groenewald (2004:19), Matsvimbo (2014), Hycner (1985)

1.9.11 Presentation

The seven step data explication process tabulated above elucidated the truth around sustainable domestic financing options for SRH service provision. During data explication, common findings were identified and grouped together basing on their contribution to the research topic. Tables, narrative descriptions, pictures and textboxes were used by the researcher in presenting research findings.

1.10 Limitations of the Study

The major limitation could be getting hold of key informants. These experts may either be on international trips, in the field or critical meetings on the preferred booked appointments. This may therefore delay the interview process. However, all the KIIs will be conducted. The other limitation could be on transcribing data from notepads and audio into the computer. Phenomenological research data is generally in large quantities and it needs considerable time to transcribe and analyse. However, the researcher will ensure that data gathering is done on time to manage anticipated cumbersome data transcription and analysis.

1.11 Ethical Considerations

Research ethics are critical in studies like this one. The researcher will not fabricate the data gathered through interviews since the study should proffer expert guidance on feasible domestic financing options for Zimbabwe. All the respondents will be assured of privacy and confidentiality in that information they give will be solely used for academic and professional purposes and not otherwise. The researcher will also design a consent form that will be signed off by each expert before interview.

1.12 Structure of the Dissertation

1. **Chapter One: Introduction**

Proposal

Literature review

Research methodology

2. **Chapter Two**

An Overview of Health Financing Models in Zimbabwe since 1980

History of health financing in Zimbabwe

What does the National Health Financing strategy for Zimbabwe state?

What is there currently for the health sector?

What is there for sexual health in particular?

3. **Chapter Three**

Weaknesses of Current Health Financing Models in Zimbabwe for SRH

What are the weaknesses of the current models and show the need for something domestic and sustainable?

4. **Chapter Four**

A Sustainable Domestic Financing Model for Sexual Health in Zimbabwe

What can be done to achieve sustainable domestic financing?

5. **Chapter 5: Conclusion**

Overall Overview of Dissertation

CHAPTER TWO

2.1 HISTORY OF HEALTH FINANCING IN ZIMBABWE SINCE 1980

The health system for Zimbabwe has been funded by a basket of funding streams. The major ones to date being; Government through central budget allocation and subnational governments' that is local authorities; AID Agencies and Multilateral Organizations; Private companies; Non-Governmental Organizations; households (through out-of-pocket payments).

Mutopo (2017) gives a detailed account of the domestic financing models implemented by GoZ since the immediate post-independence period (early 1980s) when she highlights that, as the country emerged from the colonial era, the first decade was dedicated to strengthening the socialistic promises of the struggle to ensure there is free-education and free-health for all. Hence, there was goodwill on the part of GoZ as it was duty bound to deliver quality social services inclusive of health care at highly subsidized rates following the tenets of the Standard Model. Though the government went on an overdrive to construct health centres across the country, one of the major impediments was a high doctor-to-patient ratio. The country faced an acute shortage of trained and qualified medical doctors. The focus then was reliance on its bilateral relations with the government of Cuba which supplied expatriate doctors in the country's health facilities across the country especially district hospitals and rural health hospitals.

In the period from early 1990s, which marked the turn of the second decade post independent Zimbabwe, poor performance of the economy saw the country adopting more capitalistic approaches to health financing. Mutopo (2017) states that the health financing paradigm shift was influenced by the Bretton Woods institutions, which advocated for cuts in social service expenditure. This culminated in the establishment of the Economic Structural Adjustment Programme (ESAP). Consequently, the health financing trajectory promoted the introduction

of user fees which was basically informed by the provisions of Bamako Initiative, a decline in the GoZ stronghold on health services provision which is a case of Decentralised Government Funding Model and a vivid plea to the donor community and the private sector to cooperatively invest in the health delivery system thus advocating for the Coordinated Basket Funding.

The new millennium witnessed a severe corrosion in economic variables in Zimbabwe, and for the period of 2000 to 2010 all major health delivery investments made over the past 2 decades, from 1980 were lost. The drought of the 2002 was characterised by significant increases in infant mortality due to malnutrition. This was exacerbated by the inflation and exchange rate rise of the mid 2000s which saw the public health institutions becoming virtually empty of vital medicines and drugs as GoZ failed to resource them in line with the notions of the Standard Model of health financing. The total breakdown of the economic fundamentals in 2007/08 period became the last straw that broke the horses back on health care delivery in Zimbabwe. The downstream effects of this economic collapse witnessed medical personnel deserting the country in pursuit of greener pastures in the diaspora. Inflationary pressures including high unemployment also meant that citizens were incapacitated to pay for medical attention. The politically intimidating environment of 2008 election period was marred with regime change propaganda; and this deterred the efforts of the donor community to invest in the health care system of the country (NANGO, 2012). From 2010, it was essential to rethink health financing models in the reality of the obvious failure of the aforementioned health financing models since 1980 and the need to meet the Millennium Development Goals (MDGs) on health outcomes.

2.1.1 The Standard Model

Amongst the objectives of the standard health-financing model is the drive to make health services more efficient and equitable. Guided by this need, Quaye (2007), highlights that the goal was to introduce sector changes and use other incentive methods to ensure efficient delivery of health services by health care providers. The primary initiative towards

guaranteeing accessibility of health care was to scrap user fees. This had the envisioned goal of protecting societies' most vulnerable. The issue of user fees generated arguments amongst health financing professionals. White et al (2006) states that the imposition of user fees is regressive to the health care delivery system since they pose the risk of inequality in access to and utilization of health care services. User fees are an inefficient, regressive, and unfair way to cover funding gaps in basic social sectors, since the most needed segments of the population get excluded from access to these services (Multi Donor Trust Fund, 2011). Proponents against the imposition of user fees ground their arguments on the basis that poorer segments of the society are kept away from health services since they cannot afford to pay health access user fees. In the immediate post-independence era, Zimbabwe implemented this standard health financing model through the free health for all. Then in the 1980s, the health care system was solid, well-funded and medication was readily available. Even to date, health service access in public health facilities is free notwithstanding the acute shortage of medicines and equipment in these facilities. The picture below was captured by the researcher at Dakamela rural health centre in Nkayi district to show that the GoZ currently waivers user-fees in health facilities (the board is written, "…no health fees are to be charged at this facility") however, the actual health care service is unavailable due to unavailability of medication. Even for SRH services this facility had no products for women and girls in stock.

Pic 2.1: Sign board at Dakamela rural hospital showing health services are for free Source: Author

In East Africa, the Kenyan government also pursued the same standard model, which in its quest to achieve equity in health delivery announced a policy directive that exempted the poor from paying for health services (Wang'ombe et al., 2002). To this extent, Akortsu (2013) notes that designing and implementing such systems has proven to be difficult in developing countries that face under-funded health delivery systems. This assertion by Akortsu best explains the current situation in Zimbabwe whereby, though the government is pushing for free health for all, there is virtually no medication in the health care facilities due to the economic turbulences being experienced. In relation to the current research, it seems that health systems thinking must develop a financing model that rationalizes on the implementation of user fees to those who have the capacity of paying them. A significant number of the Zimbabwean population are without health insurance due to the pre-dominantly informal structural make-up of the economy (Sithole, 2013).

2.1.2 Decentralized government funding

Public funding of health care services encompasses all governmental sources of finance for health care services (Akortsu, 2013) financed through budgetary provisions (Ackon, 2003) from both direct and indirect tax revenues. Decentralization can be identified as the designation of powers, responsibilities and resources from higher to lower levels of government. Nibbering and Swart (2008) highlights that a nation may embark on decentralization to democratize government, increase the effectiveness and efficiency of service delivery, generate an enabling environment for local economic development, or a combination of any of these. Under the decentralized government funding system, the Treasury and local authorities apportion a vote towards the funding of the health sector at national and sub-national levels respectively. According to the GoZ Gazette, the decentralized financing model is the one adopted by Zimbabwe immediately after independence that saw a number of public health facilities constructed in form of district hospitals, rural health hospitals and clinics. Then the government was in full control and support of the health care system and it was one of the best in Africa. Though the health system had also been adopted from the colonial master, GoZ allocated significant budgets to ensure health care services delivery is above board and are accessed and utilized by all.

In Africa, there are also good case studies of this decentralized financing model. According to Care (2015), Tanzania had a successful decentralization programme of health systems where the Government decentralized most operations through Decentralization by Devolution. Under a decentralized government financing initiative, budgetary provisions are meant to guarantee that citizens access desirable basic health care. WHO (2005) recommend that the budget provisions at national and sub-national levels in relation to health financing should be pro-poor, observe the principles of fairness and responsiveness. It remains to be established whether decentralized government financing leads to better-quality health outcomes in terms of equity

and sustainability since different health facilities have varying needs that have a bearing on the identified health outcomes.

Many developing countries are getting involved in some form of decentralization in response to the gradual erosion of centralized states and recognition of the potential role of local government in availing basic social services, especially to poor people (Nibbering and Swart, 2008). The global call for democratization and good governance has also powered societal demands for local democracy and accountability of local government. Decentralization has the capacity to link decision-making closer to local priorities and bring processes of planning, implementation, monitoring and accountability closer to the citizens who are beneficiaries of health services. From a health financing perspective it appears that democratization of health systems can result in better health outcomes as resources are juxtaposed to health interventions. This therefore justifies the scope of this study in assessing and developing a domestic financing model to ensure robust health services provision in respect of SRH.

As a reinforcement of this assertion, Akortsu (2013) brings to the fore that in Ghana almost fifty-one per cent of all health care spending is from public funds, in South Africa it is forty-one per cent and in Nigeria it is twenty-five per cent. The rationalization of government involvement in health care funding is that in countries where the majority of health care facilities are government owned, the same owner (government) must play a leading role in allocating substantial resources to this effect. In the context of Zimbabwe, economic structural adjustment programmes have diminished the government's role in health funding. Therefore, the implementation of a well-thought out, practical and sustainable domestic financing model has to be rolled out otherwise the government will continue to fail on its constitutional mandate of ensuring healthy lives for all citizens. There are also possible opportunities of decentralization by devolution in Zimbabwe, drawing lessons from a similar successful roll out

in Tanzania, whereby each province may generate and invest its resources in the health of its provincial citizens for instance proceeds from Marange diamond fields will be invested to improve the health including SRH situation in Manicaland province and proceeds from Victoria Falls and Hwange be invested to improve Matebeleland North's health sector. It is therefore the basis of this research to highlight that donor funding has terms and life-spans but health provision has to span throughout the lifetime of current citizens and generations to come hence the need to formulate and implement sustainable homegrown financing models to achieve desirable health outcomes as well as influence performance of the health system.

2.1.3 The Bamako Initiative

The Bamako Initiative was funded by the United Nations Children's Fund (UNICEF) and the WHO and was adopted by African ministers of health in 1987. Ebrahim (1993) posits that, the model was based on the realisation that the primary health care systems in most sub-Saharan African states were tormented by acute lack of resources and practical implementation strategies. The publications of Olmen et al., (2012) concur that health facilities in low income countries were short of resources and supplies to operate effectively. Tenets of the Bamako Initiative have substantial impact to the findings of the current research, since Zimbabwe is a highly indebted economy whirling under both local and foreign debt re-servicing commitments. This has subsequently resulted in the apportionment of resources especially towards health systems strengthening being weaker.

Furthermore, Quaye (2007) highlights that that the main goal of the Bamako Initiative was to resuscitate the public sector health care delivery system by strengthening district management teams and capturing some of the resources the people themselves are spending on health. In this context, footprints of the Bamako initiative are visible in Zimbabwe as the Ministry of Health established and to date stresses much emphasis on capacitation and involvement of district management teams referred to as District Health Executives (DHEs) constituted among

other members by the District Medical Officer (DMO), District Nursing Officer (DNO), District Health Promotion Officer (DHPO), District Environmental Health Officer (DHPO) and District Pharmacy Manager in each of the 63 administrative districts of Zimbabwe. These DHEs manage all health issues at district level, all health interventions by NGOs in that district and the distribution of drugs and commodities including SRH services and products in that district. Olmen et al., (2012:4) corroborates the above views by stating that the Bamako Initiative was "comprised of a package of interventions to increase access, sustainability and efficiency, the most prominent of which were drug revolving funds and community participation both in funding and decision-making." The importance of the Bamako Initiative approach is that it identifies the prominence of community involvement and health service decentralization. In the same vein, the current study seeks to identify and propose a robust domestic financing model towards health systems funding to establish quantitative and qualitative improvements in health systems through linking health funding to positive outcomes in sustainable SRH services provision.

Circumstances that gave way to the emergence of the Bamako Initiative were that most health facilities lacked the resources and supplies to operate effectively (Ebrahim, 1993). Paucity of mandatory resources increases lean time of the health care system translating to low-impact outcomes in terms of sustainability, efficiency, responsiveness, equity and effectiveness. As is the current practice in Zimbabwe and some countries like Somalia, Uganda and Zambia, resource constraints in the public health facilities results in health workers merely prescribing drugs to be bought from pharmacies and in some instances from unlicensed and unsupervised street vendors and dealers (oftenly cheaper). This has led to patients losing confidence in the inefficient and under-resourced public health facilities, with some patients not even bothering to seek for health services when sick, from the inefficient public health facilities (Paganini, 2004).

The Bamako Initiative was extensively employed in Tanzania through a community-financing programme. Paganini (2004:1), emphasizes that the “Bamako Initiative was a pragmatic strategy to implement primary health care in the era of economic structural adjustment” as influenced by UNICEF and WHO.

In the same context, the current study seeks to investigate and develop a health financing model for SRH which directly falls in the primary health care system. Indeed, some of the key tenets of the Bamako model especially on capacitating and strengthening the health system should influence a sustainable domestic financing model for Zimbabwe.

2.1.4 Coordinated basket funding

The most commonly employed and applied financing mechanism is the coordinated basket funding. Murray and Fenkel (2006), highlights that under the coordinated basket funding mechanism the donor community pools funds together to the recipient country to finance the health system. The coordinated basket financing approach permits multiple players other than the state to finance the health system. Donor resources are managed by a central institution commonly referred to as the administrator. Hansen and Tarp notes that the organ that administers the pooled funding is usually the government through the Ministry of Health with the expectation that they will be used to bolster the budget vote allocated to health. However, in some countries where the donor community questions the accountability of the central government, the coordinated basket is managed by the United Nations (UN) agencies or multi-lateral institutions. For example in Zimbabwe, the Health Transition Fund (HTF) is a multi-donor pooled fund, administered by UNICEF (on behalf of the donors), to support the Ministry of Health and Child Welfare to achieve planned advancement towards ‘achieving the highest possible level of health and quality of life for all Zimbabweans' (HTF 2015). This fund pools resources from the European Union and the Embassies of Sweden, Britain, Canada,

Switzerland, Norway and Ireland. For decades' the donor community has used this mode of financing the health sector in least developed countries including Zimbabwe and other countries like Mozambique, Sudan and Ethiopia. However, this method of financing health has proved to be challenging in these LDCs. There is evidence on the ground that most governments who have directly received these funds have diverted the allocated donor funds meant for health investments to something else (Bangura, 1992) and this has led to donors shunning remitting the funds directly to central governments but through UN agencies and multilateral institutions as is the case of Zimbabwe. This has distorted the effectiveness of donor grants in the health systems of low –income countries. It is therefore imperative that domestic financing models be adopted in countries like Zimbabwe as accountability of self-generated resources is usually better off compared to accounting donated funds.

2.2 National Health financing policy for Zimbabwe

The goal of the Health Financing Policy (HFP) 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.

The National Health Financing Policy focuses on reaching the following objectives; mobilizing sufficient resources for foreseeable sustainable financing of the health sector; guaranteeing effective, equitable, efficient and evidence based apportionment and consumption of health resources; augmenting the adequacy of health funding and financial security of households and guarantee that no-one is impoverished through spending on health by promoting risk pooling and income cross subsidies in the health sector; Certifying that purchasing arrangements and provider payment procedures stress incentivizing delivery of quality, equitable and efficient health care services; reinforcing institutional framework and administrative measures to

warrant effective, efficient and accountable links between revenue creation and collection, pooling and purchasing of health services.

Sustainable Resource Mobilization and Revenue

The researcher analyzed the financing policy for GoZ to understand the approach with which the state seeks to fund its health care system. It is clear that the GoZ seeks 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. However, this against a current total budget allocation to health of 9% which is less by a significant 6%. The GoZ targets to spend not less than $60 per capita per year to ensure the minimum comprehensive benefit package is financed. The GoZ will explore options for progressive earmarked taxes and levies to raise additional resources for health. 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.

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. In this study, these financing models will be analysed to establish their feasibility and sustainability taking into account issues economic meltdown, high unemployment rates thus very little disposable income.

Private health insurance will continue to be available as a voluntary prepayment mechanism for services not covered in the minimum benefits package. Special revenue generation provisions will be made for diseases of high national public health concern as and when they emerge.

All external aid for health will be harmonized, coordinated, monitored and evaluated in line with health priorities and plans of the GoZ. The government will continue to encourage and expand involvement of local philanthropy and charities for special health initiatives at all levels of care. In this case, the financing policy makes reference to the coordinated basket funding with pooled resources from the donor community which of late is the largest funding to health way above government support.

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 Public Private Partnerships, joint ventures and outsourcing guided by a strong regulatory framework. The inclusion of private players in health financing as dictated by the national financing policy is interesting to this research because the study is premised on the understanding that GoZ is currently incapacitated to fund its health system due macro-economic issues and to some extent misappropriation of resources like the reported USD15 billion. In this case, engagement of the private sector like viable large corporates such as Zimplats, Econet and Delta beverages become inevitable as PPP partners for health financing or through Community Social Responsibility mandates.

Reading through and analyzing the national financing policy, the researcher establishes that the policy has great opportunities for a broad financing mix that the country should ride on. This basket of domestic financing opportunities mentioned including earmarked taxes should rolled out effectively and efficiently, plugging all fissures of corruption to ensure that funds allocated or reserved for investment in the health sector are used as such. In this context, this study will be in constant reference to the national financing policy to justify developing a robust domestic financing model.

2.3 What is currently available on health financing?

2.3.1 Results Based Financing

Results Based Financing (RBF), also commonly referred to as Payment by Results (PbR) is a form of financing that makes payments dependent on the verification of predetermined results (SIDA, 2015). The perspective of Meessen and Sekabaraga (2011) shows that performance-based financing is a mechanism by which health providers are, at least, partly financed on the basis of their performance. This health funding approach takes a fundamentally different viewpoint to the health system through giving organizational units' considerable decision rights over their resources. An RBF approach, as stated by SIDA (2015), makes it possible to transfer the focus from activities and plans to tracking and monitoring results and learning about what actually works. Spors, Carbon and Specialist (2014) applied RBF tool to climate finance and realised that the RBF tool is a valuable financial tool to manage the large flows of finance essential to scale up mitigation activities and to escalate flexibility to adjust plans in light of unexpected events through mutually agreed planning indicators. RBF appears to have rescued health financing in Zimbabwe where the government played a leading role in health funding in the 1980s to early 90s. However, along the way, the government drastically reduced investing on social services under the auspices of Economic Structural Adjustment Program (ESAP).

The emergence of RBF in recent years as a key aid management tool in sustainable health services delivery has stimulated renewed interest world-wide in the area of aid management. It is still not clear whether the implementation of RBF is the remedy to aid management in the developing countries context. Countries that include Zimbabwe, Rwanda and Uganda have rolled out RBF as a health financing model albeit externally funded by the donor community. In Zimbabwe RBF is administered by Catholic Organisation for Relief and Development Aid (CORDAID) but funded by the World Bank's multi-donor pool. The case of Zimbabwe's

public health is predominantly strong given its insistent challenging environment in respect to governance, accountability and reduced public spending on health due to poor economic performance.

RBF as compared to other financing models like Decentralized government funding and Coordinated basket funding approaches, links funding to outcomes whereas the other mechanism are output focused (Meesen et al, 2011). Health system funding under RBF is aimed at bringing about improvements in health care services in a way that safeguards greater accountability and allocative efficiency. To this effect, the World Bank (2005), highlights that to improve efficiency in LDCs, there is need to considerably increase government spending and investments in the health sector. It is essential to identify the pattern of health spending in order to get a holistic appreciation of allocative efficiency in the health sector (Care, 2015). While the RBF model is not a panacea that ensures aid effectiveness it, at least, provides a feasible framework for managing health funding that is linked to health system deliverables.

RBF was introduced in Zimbabwe in 2010 and has also been successfully employed in other developing countries such as Burundi, DRC and Rwanda. Grittner (2013) distinguishes the approach of performance- based financing with line item approach, which funds the health system through supply of inputs such as drugs. The underlying thinking behind performance-based financing is that health sector funds should be closely intertwined with outcomes. Attention to performance-based financing as a conceptual issue in health systems financing originates from the reflection that although public investments on development health assistance have somewhat increased in LDCs, results have been below target (Fretheim et al., 2014). Meesen et al., (2011) notes that the notion of performance-based financing from which RBF is founded targets among other things to advance accountability, efficiency and to bring comparable results to inputs invested in the health systems. It is therefore critical to note that the performance based financing framework warrants moderate to high supply of resources and

a multifaceted network of institutions to implement which may not be readily available in many developing countries. In the same breathe of attaching performance monitoring to health financing and promoting outcome focus as opposed to output focus, this study proposes that the sustainable domestic financing model for Zimbabwe should be performance based where resources or payments are made based on positive intended and unintended outcomes. If funding is initially availed at input level, it may be misappropriated but if it is availed based on high impact outcomes then that will be effective and efficient distribution of resources.

2.3.2 Financing from Government

Government financing of the health sector is mainly through three avenues namely central general revenue; local government revenue; and earmarked tax revenue for the health sector. These are briefly described below,

2.3.2.1 Central General Revenue

This is the main source of funding for government expenditure on health. It is from revenue accruable to the central government from both tax and non-tax revenue which is allocated to various sectors through a revenue sharing and budgeting process. In 2015, this accounted for 21.4% of total health expenditure (Zimbabwe Health Financing Strategy, 2017). These funds are used in financing health care in government health facilities and to subsidize health care provision in mission and rural council facilities. Over the last few years, government's disbursements have been unreliable and unpredictable affecting the delivery of health services.

2.3.2.2 Local Government Revenue

Local governments (also referred to as councils) finance and provide primary healthcare services from their revenue. They generate revenue through rates, levies, licenses and user fees for services provided, such as water. In addition, local councils receive grants for education and health from independent government statutory bodies, and in some instances, grants and

capital funds for infrastructure development through the Central Government Public Sector Investment Program. Local councils can also borrow, although rural councils are limited to borrowing from the central government. In 2015 local councils contributed 18.8% of domestic funding (National Financing Strategy, 2017). In addition, lower revenue collection in some councils has led to higher user fees for patients. These local authorities are responsible for Council clinics dotted in their areas of jurisdiction in both urban and rural areas.

2.3.2.3 Earmarked Tax Revenue for Health Sector

Currently, there are two earmarked tax revenue sources for health. The AIDS levy is 3% of income tax paid by formal employers and employees. It is administered by the National AIDS Trust Fund (NATF) and is for strengthening the national response to HIV/AIDS, and reducing donor dependence. The contribution of the National AIDS Trust Fund has increased from US$5.7 million in 2009 to US$38 million in 2014 (NAC, 2016). More recently there has been a 5% levy on mobile airtime data. This is intended for drugs and equipment in hospitals as a way of ring-fencing funds for critical health services. From February 2017 to September 2017, just over US$ 18 million was raised from this levy in total (GoZ gazette, 2019).

2.3.3 Private Funds

2.3.3.1 Direct Household Payment

The inadequacy of government funding has resulted in a high dependence on direct household payments, out of which around 95% is accounted for by out-of-pocket payments (OOPs). Household payments through user fees and co-payments (for those who are insured) remain a major source of health financing. Household payments accounted for around 25% of total health expenditures in 2015 (MoH report, 2016). OOPs are an inequitable and unfair mechanism for generating revenue for the health sector as some citizens do not afford paying for health fees yet access to good health services and a healthy life are universal rights to

humanity. In addition to limiting access to much needed care, OOPs are associated with a lack of financial protection and can result into catastrophic health payments (CHP) that compromise household consumption of other basic needs. In Zimbabwe, 7.6% of all households incurred catastrophic health payments in 2015; incidence of CHP was highest among households in the poorest quintile (MoH report, 2016).

2.3.3.2 Health Insurance Schemes (Medical Aid Schemes)

An estimated 10% of the population are covered by voluntary health insurance schemes. Contributions to these schemes are mainly by employers (private and public), and therefore these schemes mainly cover the formally employed and their dependents. Estimates from the NHA show that employers' contribution to private health insurance on behalf of their employees constituted 28.43% of total health expenditures (Medical Societies report, 2017).

Although community-based health insurance schemes are currently being piloted, their viability has not yet been fully evaluated. Zimbabwe is currently considering a mandatory health insurance scheme. However, the timing and nature of the mandatory scheme is still under debate in the policy arena.

2.3.4 Development Assistance for Health

Over the past 15 years, external funding for health has been increasing. Currently, major development partners are Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), The United States President's Emergency Plan for AIDS Relief (PEPFAR), United Nations Funds for Population Activities (UNFPA), UNITAID, European Union (EU), Department for International Development (DFID), Irish Aid, Global Alliance for Vaccines and Immunisations (GAVI), Sweden, the World Bank, the Bill and Melinda Gates Foundation and a few other philanthropic organizations. A key challenge with donor funding is the unpredictability of funding from donors. In addition, most external funding is earmarked

towards a few disease areas with the Resource Mapping 2016 exercise indicating that HIV/AIDS and reproductive, maternal, new-born and child health (RMNCH) receive over 54% of total external funding for health.

2.4 Pooling of Resources

Pooling of resources involves accumulating prepaid revenues for health on behalf of some or all the citizens with the view of promoting income and risk cross-subsidization. Zimbabwe's health sector is characterized by fragmentation, with multiple resource pools, most of which are small. The existing resource pools include government pool (from general tax revenue), the AIDS Trust Fund, multiple voluntary prepayment schemes and multiple pools for development assistance for health.

2.4.1 Government Pools

Government pools include the consolidated revenue fund (which includes AIDS Trust Funds that are earmarked specifically for HIV/AIDS), and funds collected by local governments. These various pools are described below,

2.4.1.1 Consolidated Revenue Fund

The GOZ's budget allocation from the consolidated revenue fund to the MOHCC is the largest domestic health pool, with funds contributed from tax and non-tax revenue and other direct budget support. Considering the progressive nature of personal income tax in Zimbabwe and zero-rating of basic foods, overall contribution to this pool by design promotes income cross subsidization. This pool is targeted at covering the entire population of Zimbabwe. The size and composition of the pool provides an opportunity for income and risk cross subsidization where the rich subsidize the poor and the healthy subsidize the sick. However, the resources available are inadequate compared to the scope of services and scale of coverage needed by the

population. For example, per capita allocation is on average US$20 whereas per capita need is US$93 (National Health Survey costed figures). Furthermore, the allocation is biased towards providing curative care at hospital level leaving primary care facilities under funded.

2.4.1.2 Local Councils

Local authorities have two major streams of revenue. The first is their own revenue which is from taxes and levies; the second is from transfers from the central government in the form of grants and revenue sharing. The grants are in the form of block grants (unconditional) and conditional grants that are tied to specific functions. Functions funded through these conditional grants have reduced over the years and now focus mainly on health and roads. Local authorities, through a participatory budgeting process determine how much of their discretionary revenue is allocated to finance health services. There are 28 Urban Councils and 58 Rural Councils. Both sets of Councils run their own health facilities. In total, these Councils own and run 96 primary care clinics (MoH report, 2016). Each local council is an independent pool. These councils have different revenue raising capacities thus affecting their ability to adequately cover health needs for their catchment areas. With no explicit risk-equalization mechanism, there is limited risk and income cross-subsidization between council-pools.

2.4.1.3 Earmarked Taxes

Finances from earmarked taxes such as the National AIDS Trust Fund, 5% levy on mobile airtime or data, and the Assisted Medical Treatment Order (AMTO) are separate pools although all are derived from the consolidated revenue fund. By design, these pools promote income and risk cross-subsidization. AMTO is administered through the Ministry of Labour and Social Welfare. It was established to cover health fees in public facilities for indigents when the government introduced the Economic Structural Adjustment Program in the 1990s. The target population are: the elderly (over 65 years), the poor and indigent (who are means tested before accessing the benefit), pregnant women and children under 5 who access public health facilities

(local council clinics and government hospitals). The fund is meant to reimburse providers for user fee exemptions for using local council clinics' primary health services and for referrals to hospital to enable these populations to have equitable access to care. However, in recent years, AMTO has not adequately covered its target population. Factors such as non-disbursement, a high level of debt and a lack of awareness among the target population of their entitlements have been identified as the main challenges.

2.4.2 Multiple Pools of Development Assistance for Health

Development assistance for health is channeled through various separate donor pools. Notable pools by size of resources include PEPFAR/USAID, the GFATM and the Health Development Fund (HDF). The first two pools are largely disease specific, while the HDF pool focuses mainly on primary health care. Although the HDF pools resources together from various donors, most of the donors are still operating independently beyond this fund. The HDF is a partnership fund established to pool together the funds from external resources. This fund enables the donors to harmonize programming and directing funds towards high impact programs while also ensuring alignment to the priorities of the MOHCC as articulated in the NHS. This fund also enables the funders to reduce overhead costs and streamline reporting, operations and administration. The expenditure allocations of the HDF fall under the following pillars for support: medical products, vaccines and technology; planning and financing; maternal, new-born and child health and nutrition; and human resources for health. In addition to the PEPFAR/USAID, GFATM and HDF, there are several development partners who support the health sector with additional resources that are not channeled through these pools. Each partner (such as the World Bank, the Bill and Melinda Gates Foundation, Japan International Cooperation Agency (JICA), Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and UNITAID) therefore has a pool of funds that they manage, resulting in multiple health pools.

2.4.3 Contributory Schemes

Zimbabwe has various contributory schemes covering different population groups. These include:

2.4.3.1 Voluntary Health Insurance Schemes

There are 36 medical aid schemes operating in Zimbabwe. Three main schemes (First Mutual AID, Premier Service Medical Aid Society and Commercial and Industrial Medical aid Society) provide cover for most of those with medical aid (Medical Societies report, 2018). The level of cover depends on the package subscribed to by the member. In addition, due to the various co-payments based on specific membership packages and a limited range of services covered by various medical aid funds, their ability to effectively and adequately pool risk is limited. Also, there are limited mechanisms for risk equalization across these schemes. Co-payments exist with most of these schemes, which reduces the financial protection of their members. A major concern for the GOZ in the medical aid scheme environment is the absence of adequate regulatory oversight of the operations of the medical aid schemes.

2.4.3.2 The Workers Compensation Investment Fund (WCIF)

This pool covers health related costs for employees involved in accidents at the workplace, but excludes government and domestic workers. The resources of the scheme are collected through contributory insurance where the employer is required to pay a premium that is calculated using a risk factor depending on the type of industry of employment (WCIF report, 2016). The scheme also gets additional funds from interest earned from investment projects financed by savings from the WCIF and occupational health and safety. It is important to note that the prevailing economic conditions in the country have resulted in a decline in contributions due to job losses as a result of company closures. This has adversely impacted the ability of this pool to provide adequate coverage for the workers. In addition, there are concerns of

underutilization of this fund. Anecdotal evidence suggests that health providers are reluctant to accept reimbursement through WCIF because of the associated administrative challenges. In addition, employers and employees often do not complete paperwork necessary for the fund to cover treatment when needed.

2.4.3.3 Motor Vehicle Insurance Based Health Support

Motor vehicle insurance, in particular the Third-Party Motor vehicle insurance is the minimum mandatory insurance required in Zimbabwe as part of vehicle licensing under the Road Traffic Act Chapter 13:11. In addition to coverage for various accident related claims, this insurance covers third party bodily injury or death (pedestrians or other road users); passenger liability (for public vehicles only); medical expenses and death benefit. However, while this pool of resources exists, it is highly fragmented as each insurance company collects and administers its funds, it is also underutilized and the intended beneficiaries do not in most cases claim from this fund; some are unaware of their entitlements, and some just use their private insurances for medical expenses. Anecdotal evidence indicates that some providers do not accept the motor vehicle insurance because of a history of challenges with reimbursement (MoH report, 2016). These challenges include delays in payment and non-payment. These are resource pools for health that are underutilized, which need to be fully taken advantage of.

2.4.3.4 Health Services Fund (HSF)

The HSF allows facilities to pool collected revenues from user fees, interests, grants and donations and use these at facility level. HSF income between 2009 and 2012 averaged US$31 million, with hospital fees contributing about 99% of all income (HSF report, 2018). The annual estimate for the GOZ HSF in 2016 and 2017 was US$35 million. The HSF gives facilities supplementary funds to respond to specific needs that have not been met through national budgeting. The full retention of fees at each facility means that each health facility acts as an independent pool and there is no built-in mechanism for cross-subsidy across

facilities. However, in times of need, such as when there are shortages in some of the facilities, there is some cross subsidization across facilities, for instance with medicines. The main weakness of the HSF is its regressive nature and the fact that it does not offer financial protection to patients.

2.5 What is there for Sexual and Reproductive Health (SRH) in particular?

2.5.1 UN system contribution to SRH

UNFPA has a running Adolescent Sexual and Reproductive Health (ASRH) programme that adopted and is implementing a comprehensive approach to influence behaviour change among young adolescents, tackling factors at individual, community and society levels. With the support from the British government, Government of Sweden, Irish Aid, Swiss government and Canadian government, UNFPA is able to expand the following interventions;

Comprehensive sexuality education (CSE) – Under the Safeguarding Young People (SYP) Program, UNFPA has supported both in and out of school CSE. This included supporting policy and strategy development, technical support to development of syllabi, teacher and learner materials. In 2015 alone, 105 332 learners were reached with sessions on life skills education in schools.

Out of school vulnerable adolescent girls (10-19 years) are recruited into girls only clubs and mentored under the Sista2Sista program in order to enable them to make informed sexual and reproductive health decisions. This program has reached over 23 000 girls and recorded a pregnancy rate of less than 1% among the recruited girls.

Youth friendly health services were supported through the public sector through the ISP, to encourage uptake of integrated SRH and HIV services including family planning. This included

training of specific service providers as well as sensitization of all staff. In 2015, at least 98 000 young women aged 16-24 were reached with family planning services.

Working with parents and the community to encourage young people to adopt responsible SRH behavior a parent to child communication program, Let's Chat, is being piloted in Hurungwe district, Mashonaland West in Zimbabwe.

The community is mobilized through the involvement of community leadership in establishing youth friendly services and through youth open days promoting adolescent sexual and reproductive health such as condom use and HIV testing.

National policy: UNFPA has supported development of various policy documents inclusive of the Primary and Secondary Education Life Skills, HIV and AIDS Education Strategy, National ASRH Strategy as well as research and assessments, including the review of ASRH interventions.

2.5.2 Civic society organisations contribution to SRH in Zimbabwe

2.5.2.1 Family Planning 2020 platform (FP 2020)

There is a basket of civic society organisation (CSOs) operating under the banner of FP 2020 complementing the GoZ in terms of fulfilling its family planning and SRH mandate by 2020. Zimbabwe's mandate since 2012 is ensuring that all women of reproductive age have access to quality family planning and SRH services by 2020 (KII.05). While struggling with an insistent scarcity of health providers, the Ministry of Health is intent on improving access and uptake of voluntary contraceptive services among adolescents and reducing their unmet need for modern methods of family planning from 12.6% to 8.5% by 2020. Committed to expanding method options and ensuring informed choice, the government in collaboration with partners is training health facility service providers to offer a comprehensive package of family planning

services that includes long-acting and reversible methods. This FP 2020 platform is bankrolled by donors and UN agencies.

2.5.3 Government contribution to SRH in Zimbabwe

Generally, the government support for SRH has been insignificant. The GoZ established and mandated the Zimbabwe National Family Planning Council (ZNFPC) to have overall oversight on family planning and SRH issues. However, ZNFPC has been starved over the years in terms of budget allocation to implement national FP/ SRH activities. For instance in 2017 ZNFCP received a paltry USD200, 000.00 from treasury for the whole year against a budget request of around USD2.2 million. Corroborating this matter, KII.05 sadly highlighted that, *"…due to these low funding streams from central government, ZNFPC has been directly mobilizing resources from the UN agencies and donor community for effective discharge of its SRH mandate and this implies that the donor community is the highest investor in Zimbabwe's SRH field."*

According to the United Nations Populations Fund (UNFPA), due to the economic meltdown, GoZ faces challenges in accomplishing the SRH financial commitment of increasing the national budget allocation of SRH from 1.7% to 3%. Government affords funding of salaries for SRH employees working for ZNFPC. However, all family planning and SRH funding for programming and commodities are still wholly provided by development partners, which is not sustainable. The budget allocation for SRH services by the government remain low as compared to the actual budget expectation for the country.

2.5.4 Donor agencies contribution to SRH in Zimbabwe

Zimbabwe's sexual and reproductive health services have been mainly financed by the donor community since GOZ's support is so measly, with a paltry allocation of $200 000 to the Zimbabwe National Family Planning Council (ZNFPC) in 2017 (ZNFPC, 2017). Though there is paucity of data on the actual budget per year by donors the researcher managed to gather from Key Informant Interviewee 1 (KII. 01) that *"...the Swedish Embassy has invested around USD50 million in 2017 and 2018 alone to support various SRH interventions through UN agencies, International and local NGOs."* Other key informants especially KII.03 and KII.04 also noted that USAID has also bankrolled various SRH programmes with KII.03 noting that in 2014 to 2016 their organisation *"...received USD10 million for the implementation of a national SRH programme."* All the respondents generally agreed that the Embassy of Sweden, DFID, the EU and USAID continue to fund major national programmes around SRH in Zimbabwe to date hence they are the major donors in this area.

By and large, the discussion above clearly shows that GoZ is meagerly contributing towards SRH services in Zimbabwe and the bulk of financing in this respect is from the donor community and CSOs. This implies that if funding streams from donor agencies runs dry, there will be virtually no support to SRH in Zimbabwe. This therefore means that GoZ, policy makers and CSOs are desperate for domestic financing model to sustain SRH services delivery and use by citizens beyond the donor community. Donor agencies funding has timeframes spanning 5-10 years but when these funding windows close, citizens will still need to access and use SRH services hence the need to establish homegrown funding options for SRH care. More so, at some point in time, donors shift their focus for instance from SRH to other health issues like malaria or cancer and in the possibility of this shift, SRH will be left unfunded and very vulnerable. The only way to fund it sustainably will be through a domestic financing model.

Chapter summary

This chapter details the transition that Zimbabwe has gone through under various financing models since 1980. The current financing options have also been presented and analysed including current funding streams for SRH. GoZ is guided by its health care financing policy and its key provisions have been presented and analysed as well in this chapter to bring to the fore government's thinking and strategy around resource mobilisation for health care delivery. With an understanding of the policy, it is easy to analyse how best the health care system in Zimbabwe can be financed.

CHAPTER THREE

WEAKNESSES OF CURRENT HEALTH FINANCING MODELS IN ZIMBABWE FOR SRH

3.1 Introduction

An evaluation of evidence from various studies and researches including the current one exposes some key issues concerning public sector financing of health. Due to the challenging macro-economic and fiscal environment, publicly generated resources are very limited. Central government spending on health ordinarily covers salaries, leaving little for non-wage inputs around health interventions implementation (National Heath Strategy, 2016). Based on the National Health Strategy, a substantial increase in government spending on health is required as most resources are expected to be mobilized domestically. The 2015 baseline amount of USD955.3 is an approximate amount of what is required to sufficiently sustain the current levels of population and health programme coverage at national level.

Government allocations to health have fluctuated significantly over the years. Although this has been partly as a result of the changing macro-economic and fiscal environment, it has resulted in unpredictability in public sector financing. Also, budget execution has been a challenge; averaging 81.6% within the period 2009 to 2016. The low budget execution has been mainly attributed to failure by Ministry of Finance and Economic Development (MOFED) to release the allocated funds on time, as result of inadequate revenue collection.

Although performance based budgeting has been introduced in the health sector, line item budgeting still prevails. Also, the resource allocation process is quasi-historical and is not strongly linked to population needs. There are challenges around transparency, accountability and failure to adhere to procedures. The Auditor General (AG) has routinely documented areas

where the MoH has failed to adhere to financial management practice as per the Public Financial Management (PFM) Act. Challenges highlighted by the AG include; weak budget control procedures, including unauthorized budget expenditures and transfer of funds between budget lines without prior MOFED authorization; non-adherence to accounting procedures and standards, especially with regard to the Health Services Fund, for which the MOHCC did not keep proper records (such as receipts, payment vouchers, goods-received vouchers, cashbooks and ledgers); weak internal budget controls and management systems, such as the weak fuel and medicines stock management, which lead to losses and facilitate corrupt practices and weak procurement systems associated with high transaction costs and financial loss to the MOHCC (Auditor General report, 2016).

According to the United Nations Populations Fund (UNFPA), due to the economic meltdown, GoZ faces challenges in accomplishing the SRH financial commitment of increasing the national budget allocation of SRH from 1.7% to 3%. Government affords funding of salaries for SRH employees working for ZNFPC. However, all SRH funding for programming and commodities are still wholly provided by development partners, which is not sustainable. Based on this realisation by the UNFPA, it is clear that external aid funding, through funding models like coordinated basket financing, for the health sector need to be complemented (in the short-to-medium) and ultimately substituted (in the long run) by domestic financing options if sustainable health provision is to be achieved in Zimbabwe. This therefore provides a clear justification for undertaking the current study. On the other hand, budget allocation to SRH services by the government, through the decentralized government financing model, remain very low as compared to the available needs for the country. This is also implies that though this study is advocating for domestic funding options, they may not necessarily have to be from the Treasury but other funding sources like private players (PPPs). Weaknesses of the two major current financing models are presented and analyzed below based on feedback from key informants, focus groups and some observations made by the researcher in the field.

3.2 Coordinated basket funding

The Coordinated Basket Funding (CBF) is basically external aid pooled from multiple donors (foreign aid). Pronk et.al (2004) provides a broad and comprehensive definition of foreign aid which states that it can understood as financial flows from donor; these could be donor countries or even several organizations. Such financial donations may consist of the funding of official financial loans, economic aid, trade, charity organizations, as well as military, security and political aid. Charitable aid represents the efforts of the donor countries to combat hunger, misery and despair in low incomes countries. Economic aid refers to the efforts of the donor community to support citizens of economically challenged countries to develop their resources and to craft appropriate conditions for economic sustainable development to emerge as self-sufficient countries. Political, security and military aid are understood as aid programmes provided by donor countries, and efforts to achieve political stability in recipient countries, thereby reducing the risk of conflict and war, strengthening peace, promoting democracy, maintaining the political independence of former colonies of the donor countries, and, finally, to create new dominance for foreign donor countries.

Generally, as presented and analyzed below, evidence on the ground indicates that some foreign aid has been adversely ineffective due to corruption, weak policies, and fragile institutions in the recipient countries. This therefore implies the need to re-think and re-strategize on the best model of financing the health care sector in Zimbabwe and other economies receiving foreign aid.

Moyo (2009), a Zambian economist, is adamant that foreign aid is not only ineffective, but is in fact detrimental to the beneficiary countries' growth. Moyo discusses why foreign aid has repressed African nations from prospering economically, socially, and politically yet receiving multi-million dollar funding support. Though African countries vary in magnitude, the issues

of corruption, poverty, government uncertainties and diseases can be found across Africa. Moyo's hope is for African leaders and policymakers as well as for leaders in developed countries and development organizations to appreciate that the cycle of poverty and disease can be ended and Africa can thrive without aid. Moyo queries why after more than USD$3 trillion of funding over the course of fifty years, the situation in Africa has not significantly improved. She analyses the broader impact of the favored course of action over time and realizes that the results would be anticipated to be more substantial. She states that the poor are getting poorer and corruption is only worsening. She describes aid as "an unmitigated political, economic, and humanitarian disaster for most of the developing world." Easterly (2008) agrees with Moyo's assertion by noting that, Moyo's main argument against aid has two main strand the first being a complaint about how the West is denigrating Africans and the second being it documents explicit ways in which aid has impaired Africa.

Moyo's assertion of foreign aid having caused damage to the growth of recipient countries, mostly African, can be substantiated in the case of Zimbabwe. One of the greatest weaknesses of foreign aid in Zimbabwe has been failure to address fissures with which aid leaks through misappropriation hence it ends up in the hands of wrong beneficiaries. During this study's key informants interviews the issue of foreign aid leaking into undeserving hands was clearly articulated by KII.01 who stated that, *"the donor community has recently been worried about reports of 15 CSOs failing to account for millions of United States dollars which were part of the over USD310 million grant extended by USAID to these CSOs between 2014 and 2019."* In addition to this, two respondents in FGD1 and FGD3 highlighted that *"muma clinics macho hamuna mishonga nezvimwe zvatinenge tichida zve family planning sevanhukadzi kuti tibatsirike, tinongonzwa kuti ma Nurse ndiwo arikutora zvese izvi echitengesa nerweseri" (The clinics do not have medications and family planning commodities that we need as women, we hear that Nurses are the ones taking these and sell them behind the scenes).* In other funding streams channeled to Zimbabwe, there have been numerous reports of CSOs heftily paying

themselves good salaries at the expense of deserving communities in need of a good health systems. This is totally against the prescribed 30-70% ratio whereby the donor community stresses that 30% of funds received should be for administration costs including salaries and 70% should be used directly to respond to and address challenges being faced by communities.

The case of misappropriation of foreign aid is however not unique to Zimbabwe alone. Easterly (2014) makes an illustration of the complications and misuse of aid specifically for healthcare. Triangulation can be made by studies in Cameroon, Guinea, Tanzania and Uganda which shows that about 30 - 70% of donated drugs do not reach the intended patients as much of aid for health vanishes in the health bureaucracies. Easterly further highlights that, experts estimate that 25% of foreign aid is misappropriated by corrupt government officials. To this extent, Moyo (2008) makes a scathing attack on foreign aid and states that, one of the most disheartening aspects of the whole aid fiasco is that donors, policymakers, governments, academicians, economists and development specialists know, in their heart of hearts, that aid doesn't work, hasn't worked and won't work. Inefficiencies in implementation, poor governance, lack of understanding of the recipient country's needs, and corruption are serious problems when it comes to aid effectiveness. She highlights that corruption not only hinders putting foreign aid to good use, but at the same time, aid actually contributes to corruption by financing corrupt practices. She points out that the countries receiving the most aid actually have declining growth rates. Moyo believes this decline is the result of corruption and also the practice of consumption rather than investment of aid. Instead of pursuing long run success, countries choose not to invest the donations they receive but consume right away.

Her confidence is that aid aside, corruption would decrease and innovation and progression would increase in Africa. This could begin a new phase of economic growth in Africa and with it, better health, education, and lifestyle outcomes. Moyo's specific plan for development

would be a gradual decrease in aid each year, with new financing coming from trade, foreign direct investment, micro finance, investments and savings.

Based on the above weakness of foreign aid as exposed by Moyo and Easterly, as also corroborated by key informants and FGD participants, one can realize that external funding has its own severe shortcomings that the same funding is failing to address but is somewhat fuelling it. In Zimbabwe, misappropriation of donor funding did not start with USAID funding discovered to have been abused between 2014 and 2019 but it has been reported over the years yet funding continue to come though entrusted in the hands of a set of other potential funding abusers. Though this study is not advocating for abolishment of external funding outrightly, at least donor funds for health sector should also be invested towards capacitating a strong health system that does not have opportunities of misappropriation but one is solid and accountable. However, going forward, domestic financing is the best approach to fund health services provision in Zimbabwe since there tend to be strictness associated with domestically generated resources compared to donations received from outside due the tendency that we will receive more.

It should be highlighted that one of the weaknesses associated with some external aid is of imposing western solutions on African problems without consulting the beneficiaries themselves. This is one of the greatest challenges raised and criticized by the African Renaissance theory which is one the theoretical frameworks guiding this study. The theory states that Africa should formulate and implement own solutions to its own problems, if it is to be assisted then it is her (Africa) that would be leading the process not vice versa. Easterly (2006) in his book, "The White Man's Burden: Why the West's Efforts to Aid the Rest Have Done So Much Harm and So Little Good," argues that the developed countries of the western world need to discontinue pushing their systems and beliefs on LDCs in dire need of aid. While the western donors appear to believe they know what is best for the third world, it is the citizens

living in the poverty stricken, disease-ridden countries that know best how to improve their state of affairs. He points out that even the United Nations Development Programme (UNDP) while mobilizing for more aid resources, admits that the "weapon of aid" is imperfect and needs to be employed more efficiently (Easterly 2006).

Easterly sets up his argument against the status quo by explaining the difference between planners and searchers. He describes the leaders and institutions behind the previous global goals referred to as Millennium Development Goals (MDGs) that have been replaced by Sustainable Development Goals (SDGs) and other aid decisions as planners. He elucidates that planners have a predetermined goal and brainstorm to advance an imposing plan to reach their envisioned goal. In the case of development, the UNDP decided on the MDGs as their eventual end goal for development. They then assigned substantial resources to reach their own set goals. The argument here is that planners assume they already know the remedies and are convinced that their plan will be successful and will automatically lead to the expected outcomes.

On the other hand, searchers do not assume they have the answers but rather seek out prospects to learn about and solve problems. The major take-off for searchers is on obtaining feedback to solve the problem in the most efficient manner. Since planners are centred on a top-down approach, their strategy lacks a beneficial feedback accountability loop (Easterly 2006). Essentially, the planners believe they have and they control the remedy so they implement solutions based on their own developed plan. The plan itself predicts results, rather than obtain an understanding of all the variables to best comprehend the outcomes.

The discussion above, clearly articulates a great weakness in some external aid in that they are imposed on beneficiary countries without necessarily engaging them. This is one of the greatest contributors of failure of development programmes thus the mantra, "nothing for us without us" implying if a people is not involved in the planning of a programme then automatically that

planned intervention is not for them. The imposition of aid on Zimbabwe was clearly highlighted during all the three FGDs whereby women expressed concern over menstrual hygiene management products imposed on them which are not necessarily their preferred ones. For instance respondent II (RII) in FGD 2 stated that, *"takazi trikuda kumubatsira ne cup kuitira patinenge tiri panguva yedu ye mwedzi ne mwedzi asi isu chi cup cho hatichidi, hatisati tambochishandisa uye vanhu vazhinji varikuchivhunduka" (we were told that we would receive a menstrual cup to use during our monthly period cycles but we do not want that cup, we have not used it before and a lot of people are scared of it.)* When the researcher observed an outreach team that was offering SRH services in Lupane district, there was indeed resistance of the cup with women preferring the methods they are used to like the sanitary pad. Some women were even overhead expressing disgruntlement and were already concluding that these cups are being dumped and imposed on Zimbabwe's rural women by the western world. Discussions with some health officials indeed indicated that *"no consultation was made on whether the country's women and girls are interested on the cup. It was just imposed on us because one can use the cup for about 10 years without worrying about buying sanitary pads. They thought that this would be received well in Zimbabwe because it is cheaper."* This basically means that even with regards to their sexual and reproductive health options women are not engaged by agents of aid donations on the best alternatives for them but what is available is just imposed on them. This may result in some women failing to practice the hygiene expected of them thus the failure of SRH programmes to offer solutions to women.

With some donor community imposing their aid on the third world, it is critical to note that governments like Zimbabwe need to have significant budgets that addresses the basic health requirements of their people like SRH. Usually local solutions to local problems will be endowed with lived experiences. If Zimbabwe in particular and the rest of the third world in general, have significant allocative budgets for SRH then they will address their own challenges using own resources based on consultation with users not imposing on them.

Citing the weaknesses of foreign aid as discussed above shows that coordinated basket funding model has its shortcomings that will affect sustainable access and utilization of SRH health services in Zimbabwe. As such there is need to develop a domestic financing model that is funded locally, that takes into account the expectations and aspirations of its citizens into perspective, that is bottom-up in approach not top-bottom. This is therefore the core focus of this study to develop a sustainable domestic financing model for SRH service delivery in Zimbabwe.

3.3 Decentralized government funding

Bonfrer (2015) states that the problem in most low-income countries is that their governments have been incapacitated to fund their health systems sufficiently due to factors such as shrinking revenues, low performing economies and low prioritization of health. This has unlocked the door for donor funds support, oftenly accused of coming with stringent conditions.

There are a number of options that governments like Zimbabwe could pursue to ensure high spending on health. Easterly (2006) dejectedly notes that studies have found that poor states such as Chad, DRC and Zaire received the most aid for years running yet also exhibited the worst growth rates. Other nations that were once enormously poor such as Botswana and China have ascended out of poverty without significant aid and now enjoy admirable growth rates. Easterly raises the question of whether lack of aid is the reason countries have limited or no growth or it is an issue of governance. Easterly is skeptical that aid is the solution to the challenges of development in LDCs. For countries with natural resources and commodities, meaningful trade with emerging global markets like China will be a step towards capitalist and growth-centred economies. Countries that cannot count on natural resources could focus on capital markets. If financing transpires through these capitalist venues, corruption would likely

decline because other countries would shun trade with or lend to countries that misused funding.

Based on the above, one will realize that if GoZ would prioritize health system funding through domestic models, then the health sector will be funded. Just like Botswana's success story mentioned above, Zimbabwe equally has natural resources like precious expensive minerals that should be accounted for and harnessed towards sustainable health provision in. However, misrule and misappropriation has destroyed this economy thus the former President, Mr. Mugabe bemoaned the embezzlement of over USD15 billion in diamond revenue. During key informant interviews minerals as a source of sustainable funding for the health sector was over-emphasized; KII.02 clearly stated that *"with an accountable system that ensures national resources are put to good use, Zimbabwe would largely benefit from diamonds in Marange and gold in Midlands among other expensive minerals to fund a robust health system that ensures access and utilization of health services including SRH*." This idea was further hammered on by KII.05 who stated that *"... it's a matter of willingness to act, the country is blessed with natural resources which in my view should be the game changer for financing critical services like health."* In this case, the researcher strongly believes that Zimbabwe is endowed with natural resources which, if productively harnessed and accounted for will fund a sustainable domestic financing model not only for the health sector but a number of other sectors including education and agriculture.

Chapter summary

This chapter presents limitations of the previous and current domestic financing models. Under the central government financing option, the health sector has deteriorated dismally especially in the past two decades thereby presenting an opportunity for re-thinking GoZ financing approaches. Most financing models in Zimbabwe largely revolved around external aid from donors. However, with the donors admitting that donor funding support to the health sector is

not sustainable, this presents a justifiable case for Zimbabwe to pursue domestic financing options which once planned, strategisied and implemented well will ensure perennial resources for SRH services provision and utilization across the country.

CHAPTER FOUR

TOWARDS A SUSTAINABLE DOMESTIC FINANCING MODEL FOR SEXUAL AND REPRODUCTIVE HEALTH IN ZIMBABWE

4.1 What needs to be done to achieve a sustainable domestic financing model for SRH in Zimbabwe?

In pursuit for a sustainable domestic financing model, Zimbabwe has to implement a number of approaches and strategies. It has been evident that for decades, GoZ has been incapacitated to fund the health sector including SRH. As part of its FP2020 commitments, GoZ targets to increase SRH support from 1.7% to 3% by 2020 though it is yet to achieve this target with only a few months left. Even when delivering the 2019 national budget, the Minister of Finance and Economic Development, Professor Mthuli Ncube admitted that Zimbabwe has a long track record of delivering comprehensive health services across the country, which was eroded during the economic difficulties of the past decade. The goal for the ministry of health with support from treasury thus is to ensure that the four levels of care (primary, secondary, tertiary, and quaternary) have the appropriate infrastructure, equipment and health commodities, and are staffed with individuals trained in needed techniques and skills at the respective levels. The 2019 Budget provision of US$686.9 million (inclusive of health levy) targets to ensure that the referral system is re-established in order to reduce bottlenecks being experienced at tertiary and central hospitals. However, this budget provision is *"…meagre for the health ministry let alone sub-sectors of the ministry like SRH."* (KII.04)

The various domestic financing options available for Zimbabwe emerged during key informant interviews and focus group discussions and are presented below. These are also presented in light of the conceptual framework guiding this study of what a sustainable domestic financing model should be like to ensure perennial SRH service provision.

4.1.1 Resource mobilisation

4.1.1.1 Earmarking revenue

In this context earmarking involves separating all or a portion of total revenue, or revenue from a tax or group of taxes, and setting it aside for a designated purpose (WHO, 2016). There is a noble motivation for GoZ to earmark for SRH health provision considering that sexual and reproductive health is a central issue to every citizen of Zimbabwe regardless of gender or class. In the past, GoZ earmarked HIV/AIDS levy on every employee and it was very successful and became a regional model that aimed at responding to the HIV/AIDS scourge. The AIDS levy is a local resource mobilisation initiative for Zimbabwe's HIV response (NAC, 2015). About the success of the HIV/AIDS levy, the Global Fund (2016) states that the fund is one of the pathfinders in domestic financing for health rolled out by Zimbabwe and its existence set an example for the recommendations (Article 50) of the AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria (2012) that urges countries to implement strategic investment approaches to health. The statutory levy is a 3% deduction from Pay as You Earn (PAYE) for individuals as well as 3% of income tax levied on corporates. The levy is collected monthly by the Zimbabwe Revenue Authority (ZIMRA) and deposited into an account of the National AIDS Council (NAC) for independent administration by Zimbabwe National AIDS Trust Fund (ZNATF).

Under this study, all the five key informants noted earmarking as one of the more reliable domestic financing options for SRH provision in Zimbabwe. KII.01 highlighted that, *"if SRH awaits national budget allocation then the country may never achieve its 3% budget target in the near future, maybe in the next generation but if employees are levied a certain small amount towards SRH then the country is guaranteed of a stable financing for SRH."* This was also expanded by KII.04 who stated that, *"as a country, we achieved financing our national response towards HIV and AIDS through the AIDS levy, what can stop us from rolling out another very small levy per employee towards SRH, in light of few resources from national*

fiscus at our disposal to address critical SRH issues?" Another interesting dimension to earmarking was brought in by KII.03 who stated that, *"every working citizen knows that at some point in life they will pay for an SRH service especially family planning be it for them, their spouse or their sister. In such a context, SRH levy is most likely not to be resisted if there is an assurance that with earmarked resources, no one will pay for any SRH or family planning service at national level. To me that is a solid justification for earmarking levies towards SRH financing. It's worth pursuing, I am for it!!!"*

Analysing these feedbacks one can realise that issues of good governance including accountability have to be intertwined to this SRH levy. Sound corporate governance principles have to be ensured in the administration of the Fund. Administration of this fund should be through the Zimbabwe National Family Planning Council (ZNFPC) which is mandated by GoZ to have oversight on SRH issues. ZNFPC board must ensure expenditures are in a manner intended to achieve stated objectives thus safeguarding accountability. In the same vein, ZNFPC should develop and share an annual work plan and budget with the Ministry of Health. The fund administration must also take place guided by the guidelines and policies approved by the Minister. The Fund should then be decentralised through ZNFPC structures at provincial, district and ward levels, where SRH activities are being implemented. District SRH forums should be the active components of the decentralised structures where action plans will become the basis for disbursements of funds to ensure that responses are tailor made to meet district needs since districts activities are unique thus should be tailored as such.

4.1.1.2 Public-Private-Partnerships (PPPs)

Public-private partnerships are gaining traction as initiatives that establish a contract between a public agency (in this context government) and a private institution (for profit or for non-

profit) for the provision of services, facilities and equipment. A PPP exists when members of the public entity, such as central government or local authority, join with members of the private sector, for example service providers, employers, philanthropists, media, civic groups, families and other service providers, in pursuit of a common vision and goals (The World Bank, 2013). In equal partnerships, all of the partners bring resources to the table, contribute to the development and implementation of the project, and benefit from its results. Critical to note is that in a PPP arrangement, the private sector does not replace the public entity but it comes in to complement and be partners in health sector support.

Considering how GoZ continue to face perennial challenges in financing the health sector including SRH, PPPs is one strategy that should be meaningfully pursued either directly by government or through the ZNFPC mandated to manage national SRH issues on behalf of GoZ. Pursuing PPP to finance SRH service provision in Zimbabwe was clearly articulated by two key informants and 1 focus group. K11.01 based her contribution on a successful PPP she previously managed in Colombia and highlighted that *"…economic challenges that private sector is also currently facing aside, PPPs are a key source of health financing in any country and in this case we can zero down to SRH. ZNFPC should consider engaging philanthropic private players like Econet who have a history of supporting the public sector. They can come up with a meaningful PPP arrangement to support one or more components of SRH like awareness raising on SRH issues to young people through message blasting on phones or going live on air or in print media. I had a similar PPP arrangement I successfully modelled and rolled out in Colombia and it is still being implemented to date."* The call for PPP is further championed by KII.02 who states that, *"at international level, governments are faced by health financing budgets, even in some first world economies and PPPs are emerging to be handy in international development. I know South Africa has good models of PPP in health financing, why can't we emulate and follow the same? It should be a matter of interests otherwise it's a possible funding mechanism for SRH in Zimbabwe."* It became apparent that even community

members identify PPPs as possible funding stream for SRH. This came up in FGD 3 where RIV stated that, *"tine ma companies akati kuti muno ma Mutoko arikuchera granite redu. Zvazvakadiniwo kuti kanzuru yedu ye Mutoko ne hurumende ibatane nema kambani aya awakewo makiriniki akanaka anewo zvatinoda semadzimai zvakaita se family planning. Mamirire ezvakaita aya, hapana kana chimwe hacho chirikubatsirika nharaunda ino nacho kubva mukucherwa kwe granite iri." (We have a number of companies extracting our granite rock here in Mutoko. Cannot Council and government partner these companies so that they at least construct good health facilities that meets the SRH requirements of us as women? As it stands our community is not benefitting anything from the extraction of this granite.)*

As discussed above, governments all over are grappling with escalating healthcare costs and increased demand for healthcare services in the face of ongoing budget constraints. As states struggle to stretch their healthcare funding and produce better results, many are increasingly turning to PPPs with the private sector. Some of the key factors driving governments worldwide to use the PPP model for health sector improvement include, the need to increase operation of public health services and facilities and to expand access to higher quality services; prospects to leverage private investment for the benefit of public services; wish to formalize arrangements with non-profit partners who deliver an important share of public services. The possible benefits of public funding and private delivery of health facilities and services are well-known, but the path from publicly-run hospitals to publicly funded and privately-provided hospital services is not so well-known.

4.1.1.3 Decentralization by Devolution

One key domestic financing opportunity to ensure that SRH provision is well-funded in Zimbabwe is decentralization by devolution. In the context of this study decentralisation refers

to central government assigning key authorities and functions of government to sub-national level structures like provincial and district authorities. Warioba (1999) points out that decentralisation refer to those tasks and activities which are not executed from the centre. He proceeds by pointing out that decentralization is divided into two main components which are deconcentration which refers to delegation of authority by the central government to the field units of the same central government department, that is giving decision making power to senior government servants in the provinces or districts (Warioba, 1999). This form of decentralization is sometimes referred to as administrative decentralization (Warioba, 1999). It is the delegation of authority from the higher to lower echelons within the bureaucracy, taken as a basis for development and change. Devolution refers to transfer of decision making power and much policy making powers (especially development and social service policy) to elected local representative authorities or units or to autonomous public enterprise. This model of decentralization is sometimes referred to as political decentralization. Devolved local authorities have the power to make laws of local nature and raise revenue needed to meet development with very minimum interference from the centre (Warioba, 1999).

Key informants under this study reiterated the need to decentralise government operations down to provincial level for concentrated development, generating finances and management of affairs. Drawing cases from Tanzania KII.05 highlighted that, *"I believe Zimbabwe can draw lessons from the successful decentralisation by devolution that was done by the government of Tanzania in Dodoma. Government in our context should implement the long-awaited devolution through allowing provinces to be independent, to generate finances for social development including health sector development. That way our provinces will most likely generate much for themselves and good proportions of that revenue will go towards SRH funding within the various districts that make up those provinces."* This was corroborated by KII.02 who stated that, *"...if only we could decentralise, that's when we will only realise surplus that will go towards health services support and even surplus in this respect. There are*

a lot of opportunities for devolution in Zimbabwe…imagine if Manicaland would be decentralised with all those diamonds in Marange and gold in Penhalonga and Chimanimani areas. Imagine what would come out of Midlands province in terms of health sector development with the province having those vast deposits of gold, platinum and chrome? If all these resources are concentrated in their specific provinces and earmarked for development then we will not hear of any deficits in any sector with health included and in this context SRH." In addition to KIIs, an opinion leader who was part of the Nkayi focus group sadly noted that, *"…our province has been left behind on issues of national development…if it was possible, we would appreciate if we get detached from GoZ and become our own state as the people of Matebeleland and make either Bulawayo or Lupane are our capital. Trust me, that way we will develop Nkayi district and many other districts like Binga that have never experienced any form of development in the past many years." (the whole FGD members clapped hands and ululated in support of this statement)* (FGD 2, RVII)

Based on the submissions from key informants and focus group members, it is apparent that decentralisation by devolution is one strategic approach GoZ should plan for and roll-out. It has numerous opportunities for generating resources within each province of the 10 provinces in the country. This will also lessen the national burden of centralizing government functions in Harare. Under devolution, the central government will just play oversight role whilst receiving certain agreed percentages of revenues from the decentralised provinces. It should also be highlighted that under devolution, some provinces may remit budget surpluses to other provinces struggling to generate own resources probably because they are not endowed with natural resources or there are little opportunities for fundraising within them. To this extent and as discussed in this study's conceptual framework, the World Health Organisation (WHO) identifies a good health financing system as one that raises adequate funds for health, in ways that ensure people can use needed services and are protected from financial catastrophe or

impoverishment associated with having to pay for them. Decentralisation by devolution therefore, highly likely guarantees this adequacy in funds for health including SRH.

4.1.1.4 Community Based Health Insurance (Financing)

Community Based Health Insurance (CHBI) is an intervention based on a strong conviction that community members must be directly involved in informing and influencing the decisions that affect their lives. Most of the financing models like devolution by decentralisation, PPPs are usually top-down in approach but the CHBI is largely bottom-up hence in most cases it is sustainable as there is a high level of ownership among community members.

Discussions from KII and FGDs as well as observations made in the field by the researcher established that CHBI could be viable as a measure of ensuring sustainable SRH provision in rural health facilities. Governments have the overall mandate for ensuring all social segments of their citizens access services they need without encountering financial stress associated with their utilisation. Feedback from KII.05 on what could be the possible domestic financing options for Zimbabwe was that *"…outside the formal health structures, government involvement is often realised as a critical factor of successful and sustainable health financing in community based arrangements such as Community Based Health Insurance (CBHIs)…even in the event of a non-existent government policy, CHBIs are will likely play an important role of improved health equity."* This notion is further augmented by KII.01 and KII.03 who are of the view that government stewardship is central to the success of the schemes on condition that the government acknowledges these CHBIs as an approach for achieving health equity and universal health coverage objectives. In addition to KIIs, FGD participants also highlighted the critical role they play provided government is willing to engage and involve them. One striking submission is made by FGD1.RIII who says that *"…madhodha eshe emuganga, anga badakadzwa maningi kana hurumende ikadzika kubva Harare yogumawo kanyi kwedu unono*

tobhuyirana zveshe neakadzi edu nenharaunda yeshe kuti se anhu emu Chipinge tingaitewo sei kwedu uno uno kuti tirambe tichiwana nekubatsirika munyaya dze family planning pasina kunzi zvipatara zvedu hazvinawo mhando dzimwe dze family planning." (all group members nodded in agreement to this submission) (all the men of Chipinge will be happy if government officials will come down to our area and we have discussions including our women, on how our community can participate so that we ensure continued availability and access to family planning methods without any commodities being out of stock).

It has been highlighted that enormous inconsistencies in healthcare expenditure do exist and are evident among countries with low and middle income countries (LIMCs) which mostly rely on OOP expenditure to finance healthcare because central governments are failing to bank roll their health sectors. With the WHO (2016) research highlighting that in 2013, households in LIMCs contributed 42.3% and 40.6% respectively of Total Health Expenditure (THE) compared to 21.2% in high income countries, initiatives like CHBI becomes imperative in countries like Zimbabwe since healthcare financing functions are modeled within CBHIs and since they will most likely have impact on realization of health equity with government stewardship being treated as the regulating factor. In Zimbabwe, communities have contributed and saved considerable amounts of monies at their localised levels through arrangements known as "societies" and internal savings and lendings (ISALs). These can be capitalised on in nurturing and harmonising communities' efforts to finance sustainable access to SRH.

4.1.2 Advocacy and lobbying

In this study, the researcher appreciates that advocacy serves a critical role in a sustainable domestic financing model, it is a key ingredient that keeps the model serving its full purpose. Critical advocacy and lobbying issues in this regard include advocating for an increase in the

SRH budget allocation to reach the 3% which is GoZ FP2020 commitment. There is also need to advocate for increased government spending on health basically focusing on advocating for the allocation of government budget for health, thus addressing the degenerating trend of budget allocation.

The issue of advocacy emerged strongly during focus group discussions largely because the communities are aware that if their voices are recognized they indeed play a critical advocacy role thus influence domestic financing. FGD3.RIV clearly noted that, *"...sezvo tirisu tinonyanyoda kushandisa family planning, tinofanira kutosimba pakubatana tichienda ku hurumende nezwi rimwe tichiwataurira kuti kuno kuma Budja tinodawo kuti ma clinics edu ange aine zvibatsiridzo zvese zve family planning. Tikasatopereka zvichemo zvedu tega, sevanhu vanokanganisika nekushaikwa kwezvatinoda, pamwe paya wanokanganwa kuti kune warikugara kwaMutoko, saka ndinoona sekuti kupota tichisimudza mazwi edu tichitungamirirwa naana watenzi wedu, ma Councilors edu na MP wedu zvinogona kutisunungura munyaya dzezveutano idzi." (Since we are the major users of family planning, we should be strong to approach the government in one voice, to tell them that here in Mutoko, our clinics should have perennial supply of family planning services. If we do not inform them about our issues, as people affected by the scarcity of these services, they may forget that there are people living in Mutoko, so I see that periodically raising our voices being led by our traditional leaders, our political leaders- Councilors and MPs, may liberate us on these health issues.)* In FG2 the issue of advocacy also came out strongly with the community clearly highlighting that they have been left out of major developments in general and health in particular. They now believe that if they make a lot of noise through district and provincial government structures, maybe they will be heard and development will finally come to Matebeland North.

As established during field data collection, advocacy is an important tool in unlocking domestic financing. Funding a robust SRH programme to meet the FP2020 goal of increasing funding for SRH from 1.7% to 3% will likely need to incorporate multiple financing options in conjunction with various strategies. GoZ through the MoH will require buy-in from various funding stakeholders, in particular the Minister of Finance, PPP partners and advocacy will be a critical part of delivering this. The MoH may not necessarily need to advocate alone to the Ministry of Finance. They can instead harness the power of women and girls in dire need of SRH services and make them partners in the fight for sustainable domestic financing for critical health services. Civil society can also come in handy to mobilise the communities and influence them to demand for their SRH universal rights. Meaningful engagements with civil society throughout the process ensures that their perceptions are captured and they in turn are furnished with the knowledge to effectively support and augment advocacy efforts related to financing. Alongside other interventions such as lobbying to key stakeholders like decision and policy makers, private sector players; civil society can also accomplish the need for reliable institutions that consistently disseminate reliable information. This serves an essential role when trying to influence a larger and more united voice demanding change as they can effectively intensify awareness in the wider community.

4.1.3 Health care system strengthening

Though various fundraising initiatives for SRH provision are being advocated for in this study, these may not serve the anticipated purpose if the health care system is not strengthened. The health care system of Zimbabwe has been marred by various issues spanning misappropriations, lack of accountability, procurement inconsistencies and overall the paucity of value for money (VfM) principles. To this extent the Auditor General (AG) has routinely documented areas where the MoH has failed to adhere to financial management practice as per the Public Financial Management Act. Challenges highlighted by the AG include; weak budget

control procedures, including unauthorized budget expenditures and transfer of funds between budget lines without prior Ministry of Finance authorization; non-adherence to accounting procedures and standards, especially with regard to the Health Services Fund, for which the MoH did not keep proper records (such as receipts, payment vouchers, goods-received vouchers, cashbooks and ledgers); weak internal budget controls and management systems, such as the weak fuel and medicines stock management, which lead to losses and facilitate corrupt practices and weak procurement systems associated with high transaction costs and financial loss to the Ministry (Auditor General report, 2016).

Based on recommendations that emerged during data collection engagements, below are some of the critical themes and areas of health care system strengthening that GoZ should analyse and implement as part of its domestic financing for health in general and SRH in particular.

4.1.3.1 Payment by Results/ Results Based Financing

Though the sustainability and continuity of SRH financing in Zimbabwe revolves around domestic financing options, GoZ can adopt some of the noble financing approaches employed by donor agencies under the coordinated basket funding. Payment by Results (PbR), popularly known in Zimbabwe as Results Based Financing (RBF) is one of such noble approaches. PbR is a contemporary financing model that makes payments contingent on the achievement of objectively verifiable results. DFID (2014) highlights that PbR has is guided by elements which include, funds disbursement attached to the achievement of clearly specified results that is, payment for outcomes such as improvement in universal access to SRH services, rather than payment for inputs such as constructing Youth Friendly Centres; beneficiary discretion implying that the beneficiary government or organisation has space to decide how results are achieved and robust verification of results as the trigger for disbursement. Through focusing

and paying based on outcomes and not inputs, the model allows funds beneficiaries to innovate to achieve the targeted result in the way that best suit their context.

In the context of this study, it was overemphasized by the respondents that funding to the MoH for various programmes had been "misappropriated" or "embezzled" especially at sub-national levels that is provincial and district levels. More so, medicines and drugs extended to the MoH had in some cases reported "abused" or "missing" thereby disadvantaging the targeted beneficiaries. According to the KII.02 the best way *"…to manage such scenarios is extensively rolling out the RBF framework across all SRH funding streams in the country. If health personnel and national level down to village level are aware that they will be tracked, monitored and paid based on results achieved they will not misappropriate the tools of trade that will give them the results."* This feedback from an expert in the health sector clearly puts into context the need to strengthen the health care system of Zimbabwe through PbR to ensure that the domestic financing options discussed previously, will generate the greatest outcome of ensuring national coverage- availability and utilization of SRH services by all groups regardless of income status, social class, gender, religion or race.

4.1.3.2 Value for Money

Value for Money (VfM) in the context of this financing model refers to the optimal use of resources to achieve intended outcomes. The decision to invest in an intervention requires a judgement of whether the expected development results justify the costs. Generally, VfM is guided by efficiency and effectiveness including cost-effectiveness. Efficiency relating to how well are inputs converted into outputs (outputs being results delivered throughout the lifespan of the investments and beyond). Effectiveness referring to how well are the outputs from an intervention achieving the desired outcome on health development. Cost-effectiveness being how much impact on health does an intervention achieve relative to the inputs invested in it. A

VfM cycle must ensure that resources are allocated and managed so that the maximum development impact is achieved.

In the context of this study, it was gathered that if the principles of VfM are safeguarded that will activate a number of funding streams especially from the private sector. KII.01 highlighted that *"one of the greatest challenges affecting private sector investments in health is lack of confidence in the systems that manages the funds. There have been a lot of complains about how public entities abuse private sector finances for instance the USD10 million that Econet donated to the government in response to the cholera that struck the nation mostly in Harare. There were a lot of abuse reported around that funding. However, if there is an assurance and evidence from GoZ through the MoH that VfM is guaranteed, trust me that will unlock millions of funding from the private sector, even from us as donors."* This was further corroborated by KII.05 who stated that *"…one challenge in the health sector including SRH is that after a period of funds' investments, the value or benefit of those funds is somewhat not visible for long. This affects availability of next funding opportunities. We therefore need to ring fence value for money through ensuring that the positive outcomes of a financing cycle are protected, safeguarded and sustained."*

Based on the findings above, it is critical that GoZ through MoH implements the VfM principles. These can be safeguarded through putting in place a solid procurement system of all health services, products and equipment; monitoring, evaluating and challenging health personnel to delivery VfM across the health care service delivery system. If the value of every investment made is substantiated by evidence that emanates through improved access to SRH services that alone is motivating both to government, private players and communities. Financiers are motivated and encouraged to deliver more if value is attached to their investments. VfM therefore, ultimately leads to the accomplishment of this study's conceptual framework of ensuring universal SRH access and utilisation across the country by all groups

since assuring the greatest value for all funds availed will unlock opportunities for more funding thus ongoing increased support to SRH.

4.1.3.3 Monitoring and evaluation of health systems strengthening

The MoH in Zimbabwe should have a primary aim of having a robust monitoring and evaluation (M & E) system in place for national SRH sector strategic plan that comprises all major programmes and health systems. The national M&E plan should address all components of SRH and lay a solid foundation for consistent reviews throughout the implementation of the national plan. Present country health-sector evaluation processes are key to measuring progress and performance. Implementation of the country's M&E plan should generate the information required for monitoring. The health sector of Zimbabwe has had and still has a number of M&E systems for monitoring service delivery and performance. However, the systems have been grossly affected by low budgets that have been set aside within the ministry for monitoring and evaluation, which is a downstream effect emanating from the low budget apportioned to the ministry by Treasury (MoH report, 2017).

The need for a robust M&E system for SRH was emphasised on during both KIIs and FGDs. FGD1.RVII stated that, *"…mahlupeko amweni aripo panyaya dze health kusanganisira SRH ngekuti, isusuwo se anhu anokanganiswa nezvirongwa izvi hatisi kupinzwa wo ba panenge peirongwa zviro izvi uye peiongororwa kubudirira kana kusabudirira kwazvo. Zvinozondouya zvakuti ku ndawo ye Chipinge ngakuitwe zvakati, asi tisina ba kumbotaurawo pfungwa dzedu. Ndinobhuya kudai ngekuti ndisu tinofanira kuzobhuya gwinyiso yekuti chirongwa ichi chabudirira ere kana kuti kwete ngekuti tisu tinonatsoziva kuti zvainge zvakamira sei pashure apo uye zvamira sei parizvino." (the other challenge that is there in our local health sector including SRH, is that as the community we are excluded from the planning processes as well as the monitoring of success of these interventions. Activities are just imposed on us down here*

in Chipinge, without us inputting into the process. I say this because we are the ones who will testify whether an intervention has been successful or not since we are the people who knows how our situation was like in the past and how it is right now.) This response was applauded by all the group members.

The need for strengthening SRH health system monitoring and evaluation also emerged from all the five key informants who concurred that a robust M& E system is central to a sustainable domestic financing model and for improved and continued access to and utilisation of SRH services. The call is summarised by K11.04 who points out that, *"…over the years one of our main challenges has been allocating very little resources to the monitoring and evaluation of our SRH work, regardless of how key M&E is in development work. Going forward M&E should be our yardstick. Through this we will know what is working and what is not then adjust accordingly."*

In the context of this study, a national Country Health Systems Surveillance working group or platform is needed to harmonise monitoring and evaluation work in SRH, with cross-cutting issues such as tracking human resources, logistics and procurement, and health service delivery. It should also include a context specific components that defines health systems in a systematic manner for easy tracking. In the Zimbabwean context, the mandate of surveillance working group will be to advance the obtainability, quality and use of the data required to inform country health sector assessments and planning processes, and to monitor health progress and system performance. This platform will enable national, and subnational reporting and alignment of partners in SRH at country level around a common approach to country support requirements.

The results framework for health systems strengthening monitoring and evaluation should basically comprise of four major indicator domains which are system inputs and processes, outputs, outcomes, and impact (WHO, 2009). These are critical to consider when either

resuscitating or developing a robust M&E system for Zimbabwe since system inputs, processes and outputs reflect health systems capacity. Outputs, outcomes and impact are the results of investments and reflect health systems performance. Each block of indicators has ideal and substitute data sources attached to it, covering a time horizon from the immediate to the longer term. The framework also outlines what is needed across the results chain with regards tools for data quality assurance, synthesis and analysis, with a focus on capacity building and or strengthening of country level teams. The framework ultimately addresses the significance of dissemination, communication and use of the monitoring and evaluation results to inform and influence policy making at all levels.

4.1.4 Make SRH services universal

Ultimately and as prescribed in the conceptual framework of this study, a sustainable domestic financing model has to address inequities of utilisation of SRH services and catastrophic health expenditure by subsidising the poor possibly through removing user fees as they present a major barrier to accessing SRH services.

As articulated by the UN (2015), universal health coverage (UHC) is the aim of safeguarding that all members of the population and their communities have access to all the health services they require and that are of appropriate quality to be effective, without being exposed to financial hardship. Making progress towards UHC obliges GoZ to strengthen those building blocks of the health system that paves way for the delivery of high quality services. This consist of investing in basic infrastructure, human resources and financing systems; developing an effective health information system; systems for procuring and distributing essential medicines, vaccines and technology, and systems for governance and accountability. In this regard therefore, the ultimate goal is to ensure national accessibility of SRH services.

Based on the discussions above, the researcher developed a sustainable domestic financing model which should ensure perennial SRH service provision,

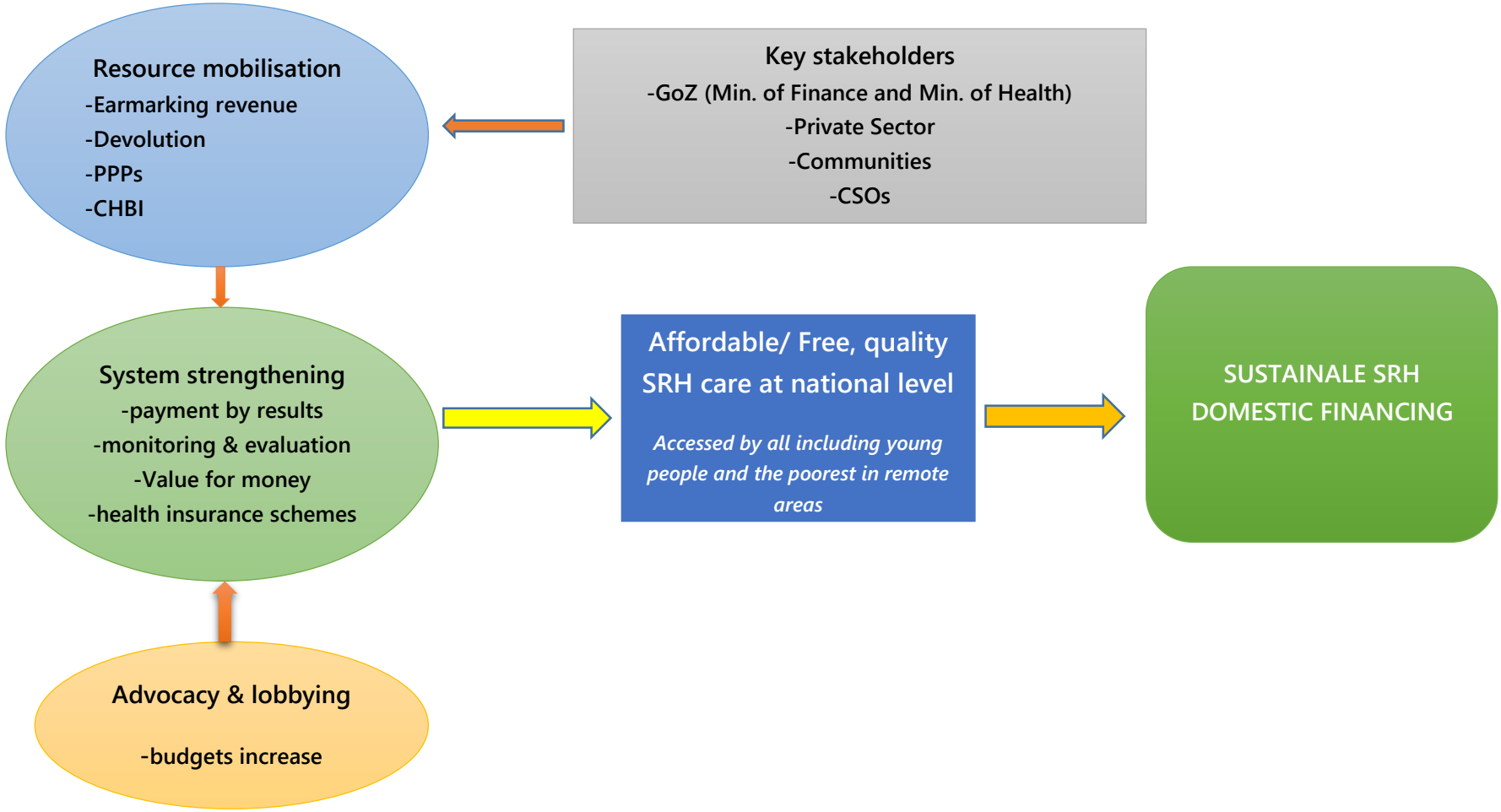

Figure 4: Proposed sustainable domestic financing model for SRH in Zimbabwe **Source: Researcher (2019)**

Chapter summary

The discussions above which presents key findings of this study, points out to the conclusion that over the past two decades, the SRH system of Zimbabwe has been failed by low budget allocations to the MoH and ultimately low budgets for SRH. Though GoZ has an FP2020 target of improving SRH budget allocation from 1.7% in 2012 to 3% by 2020, this target has failed to be reached considering that the last budget allocation for 2019 failed to service this target. It is therefore imperative that a number of domestic financing options discussed above which culminated into the development of the above domestic financing model be seriously considered for implementation. GoZ alone cannot fund SRH therefore the need for meaningful engagement and involvement of various stakeholders including private players (through PPPs) and the community (through community based health financing).

CHAPTER 5: SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

5.1 Introduction

This chapter provides a conclusion of the key findings of this research study that identified and assessed domestic financing options for sexual and reproductive health in Zimbabwe. The conclusion of key findings are summarised in line with the research objectives and questions as well as discussions elucidated in the second, third and fourth chapters. Guided by the findings of this study, this chapter also provides recommendations to decision and policy makers in government, private sector and the community as well as highlight possible areas of future research.

5.2 Summary

The empirical research aimed at evaluating the various domestic financing options in Zimbabwe to come up with a sustainable domestic financing model for SRH in Zimbabwe. In tandem with this research aim, the study sought and provided answers to the research questions as summarised under key findings section below.

The research philosophy for this study was phenomenological and the methodological approach was qualitative. To select research participants, purposive sampling technique was employed. The research instruments used to collect data were Key Informant Interviews, Focus Group Discussions and Observations. Data explication guided by emerging themes was imperative in this study and this provided useful data in relation to domestic financing options for SRH as well as their effectiveness. It is authentic and justifiable to conclusively remark that phenomenological research philosophy is imperative in socio-economic studies like this current one.

5.3 Summarised key findings based on research questions

Research question 1: What are the challenges in sustainable health provision?

Donor reliance- Though external aid from the donor community has financed health provision in Zimbabwe for around three decades, the continued support from the donors is not sustainable because donor funding has lifespans, has budget limits and the donor is not obliged to keep on funding Zimbabwe. The donor community inclusive of the European Union head of delegation and the United Nations, which have bank rolled the Zimbabwean health sector through multi-million dollar investments admitted that the country's health sector is over relying on donor support (95 % of rural health support is from the donors) and this is very unsustainable.

Economic meltdown- The economic plunge that Zimbabwe has gone through in the past 2 decades and that were exacerbated in the turn of the new millennium from 2000 rendered the government incapacitated to meaningfully support its health sector. The economic meltdown challenges have over the years been aggravated by departure of health personnel in pursuit for green pastures in the region and in the United Kingdom. Unavailability of medicines, drugs and equipment in health facilities hammers a final nail on the challenges bedeviling sustainable health provision in Zimbabwe.

Low prioritization- The interviews conducted with key informants established that there is generally less prioritization of the health sector in Zimbabwe compared to other sector like state security. For instance over the years the health sector budget allocation has hovered around 9% against a demand of 15% and the specific budget for SRH has been around 1.7% against a preferred allocation of 3% yet the state security- defense, home affairs and president's office have been funded to the brim. This less prioritization continue to threaten the sustainability of the health sector.

Weak health care system- The other topical challenge affecting sustainability of the health sector is a weak health care system. Feedback from key informants and focus group members indicated that there are reported cases of misappropriation and abuse of funds and medicines in the health care delivery system thus weak governance systems of accountability. This is further aggravated by weak monitoring and evaluation mechanisms.

Research question 2: What are the current financing options for health in Zimbabwe?

In this study, the researcher identified various financing options open to bank roll the health sector in Zimbabwe. These include Results Based Financing; government financing- earmarking tax, local government financing; private funds- OOP; Health insurance and Development assistance for health. These are summarised below,

Results Based Financing- RBF which is a coordinated basket funding from donors being admistered by CORDAID. It is one of the financing models currently under implementation in the ministry of health. During the study it was realised that RBF had managed to improve the health care system though it has an overall weakness of creating donor reliance on a critical sector like health.

Government financing- though the government has not adequately funded its health sector, it also has some funding streams trickling into the sector. One good example is of the HIV/AIDS levy which is an earmarked tax managed by the National Aids Trust Fund. This AIDS levy is a success story of health financing in Zimbabwe through levying a 3% tax on every employee and employer to respond to HIV/ AIDS issues in the country.

Private funds- one of the greatest yet not recommended financing option present in Zimbabwe is the household financing or out-of-pocket payments. This is basically families funding their own health. It is on the rise since families are turning to private health facilities which charges

handsomely. The rise in private funding for health is pushed by the unavailability of medicines in public hospitals.

Development assistance- assistance from the country's development partners basically donors and multilateral institutions remains the greatest financing stream for Zimbabwe's health sector. These funds basically manifest through coordinated basket funds, NGOs directly funding health activities at national and sub-national levels.

Research question 3: What is the sustainable domestic financing model for Zimbabwe?

As presented in the fourth chapter, the domestic financing model for Zimbabwe has multiple stakeholders, multiple funding strategies and multiple support interventions around systems strengthening and advocacy. The key funding strategies are earmarking revenue, devolution, public-private partnerships and community based health insurance. The key health systems strengthening interventions discussed are ensuring value for money, implementing a robust monitoring and evaluation system, nationalizing the payment by results framework. Multiple stakeholders that should be part of this model from the onset are government, public sector, civil society and community members' representatives. It is highly anticipated that this model will subsequently result in universal access and utilisation of SRH services provision in Zimbabwe.

5.4 Recommendations

There is no single financing option that can support SRH service provision in Zimbabwe. Even to date, with donor funding available one realises that health service provision is not optimally financed thus Zimbabwe is currently experiencing acute shortage of medicines and equipment in health facilities. It is therefore recommended that the GoZ implement a number of resource mobilisation strategies presented in the proposed domestic financing model. To sustain resource mobilisation there is also need to implement the other supporting pillars of the same

inclusive of advocacy and health system strengthening to achieve universal SRH provision at national level.

In terms of governance of health systems, it is recommended that the government engage and re-engage private players to resuscitate and establish PPP, especially with key partners like Econet, Delta and Zimplats. In the short term, as the government prepares for a fully domestic financed SRH programme, PPPs can as well be forged or maintained with development partners like donors and the UN. However, that should just be for transitioning period till domestic options have been activated. Such PPP arrangements in SRH financing ensures mutual accountability, harmonisation of efforts to safeguard positive SRH outcomes and ownership of the initiative due to active involvement of communities and the state. PPPs improves the provision of resources, augment equity in health care provision and are a good governance approach that ensure the health delivery system is functioning well.

As a way of sustaining the domestic financing model, it is noble and highly recommended to link and align the model to the Treasury budgetary system and apportion more resources to the health sector thus ensuring downstream programmes under MoH like SRH also have increased budget allocations. The World Bank (2013) as quoted by Mutopo (2017) reports that Burundi managed to integrate its RBF health financing needs with the national budget with the national fiscal space contributing up to 52 % of the financing costs of the RBF program, which is a strong pre-determinant of sustainability, commitment, and assumption of ownership of RBF. It is therefore apparent that integrating the domestic financing model with the central government's Treasury will go a long way in guaranteeing positive development outcomes.

All-inclusive health care systems are more sustainable. It is therefore recommended that to achieve higher levels of inclusiveness in SRH provision, there is a priority need to nurture community engagements and involvement as promulgated through partnerships and social participation. These initiatives will go a long way in enabling accessibility of health centres,

and the involvement of marginalised and excluded people especially the adolescents and the youth in SRH services access and utilisation. It is therefore imperative that the GoZ rolls out financing models like Community Based Health Financing which are highly engaging of communities.

The proposed domestic financing model can also be rolled out in other sectors that have been heavily dependent on external support as well. These include education and agriculture. Dependency of critical sectors on donor aid should be dismantled and replaced by sustainable domestic financing options.

5.5 Areas for further research

How to effectively transition from donor funding to domestic financing?- there is need to conduct an assessment of how a low income country like Zimbabwe that has been dependent on external aid for decades can transition to domestic financing options and sustain the same in development of its health sector and other sectors like climate change and agriculture.

The role of the donor community in implementation of domestic financing model in Zimbabwe- Though the focus of this study was on migrating from donor financing related models like coordinated basket funding to domestic models, it does not imply that the donors just fold off and vacate. It is critical to research on the role of the donor community in ensuring that domestic financing is implemented and sustained. Should they facilitate this transition? Should they support with a reserve funding mechanism? Should they be involved in monitoring and evaluating how the domestic model is performing and how it can be improved? All these are critical questions that can be addressed by future researchers.

What is the role of citizens in developing and implementing domestic financing models? - There is also a research opportunity to establish what is the actual role and impact of community involvement and participation in domestic financing options or models. They key

research question could be, does the involvement of community members promote sustainability of any domestic financing model or not?

5.6 Conclusions

It can concluded that the politics of access to health funds has been a topical issue in health financing of Zimbabwe. The works of Akortsu (2013) highlight that lopsided flow of funds and regular delays in the disbursement of funds results in poor implementation of the health initiatives. In the context of Zimbabwe, the government has been riddled with disbursing funds to the health sector, including other key sectors in the economy even if the funds were properly budgeted for.

The health sector has been characterised by poor primary health outcomes, unsound governance and a lack of confidence in the public health delivery system. To this effect, Mutopo (2017) states that the government's central role as the chief financier of health services, threatened the viability and sustainability of health care funding initiatives. The donor community through coordinated basket funding that include the RBF ushered in a new dispensation in health care financing in Zimbabwe characterised by attempts towards a health systems strengthening through availing complementary health sector budget provision with the view of influencing and unlocking positive health outcomes. However, with all these efforts the health care system remains adversely underfunded as evidenced by the current scenario whereby health facilities are death traps without adequate medicines and equipment.

All these current financing options weaknesses gave the justification for developing a multi-pronged domestic financing model for Zimbabwe presented in the fourth chapter of this study.

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Zimbabwe Health Care Financing Strategy (2017)

Zimbabwe National Family Planning Strategy (2016-2020)

Appendix 1

RESEARCH INSTRUMENT 1

Semi-structured Key Informant Interview Guide

Good day Angelica

My name is Blessing Tafadzwa Nyagumbo. I am a student at Midlands State University, pursuing a Master of Arts in Development Studies degree. I am working on my dissertation in partial fulfillment of the programme. The rationale of my research study is to explore sustainable domestic financing options for SRH provision in Zimbabwe guided by the research question, "The search for Sustainable Domestic Financing Options for Sexual and Reproductive Health provision in Zimbabwe." Successful completion of this research will therefore be mutually beneficial to the SRH sector in Zimbabwe inclusive of the Ministry of Health, policy makers, donor community and the entire civic society.

I am therefore kindly requesting you to assist by objectively participating in this data collection exercise. I would like to assure you that your valuable input will be treated with utmost confidentiality and will be used for academic and professional purposes only.

I will gladly share with you the final product of this study.

Your co-operation would be highly appreciated.

Section A

Date:_____ Time:_____
Organisation name:_____
# of years SRH/ health financing/ programming :_____

Section B: Challenges in SRHR provision in Zimbabwe

1. What are the bottlenecks in sustainable health provision?
2. What is your proposal for addressing these challenges/ bottlenecks?

Section C: Prospective domestic financing opportunities

3. What are the possible domestic financing opportunities available in Zimbabwe?
4. Which ones do you think are easily attainable/ implemented in our current socio-economic context?

Section D: Sustainable domestic option

5. What do you think is the sustainable domestic financing option for Zimbabwe?

THANK YOU FOR YOUR VALUABLE INPUT AND COOPERATION!!!

Appendix 2

RESEARCH INSTRUMENT 2

Semi-structured Focus Group Discussions Guide

Good day Ladies and Gentlemen

My name is Blessing Tafadzwa Nyagumbo. I am a student at Midlands State University, pursuing a Master of Arts in Development Studies degree. I am working on my dissertation in partial fulfillment of the programme. The rationale of my research study is to explore sustainable domestic financing options for SRH provision in Zimbabwe guided by the research question, "The search for Sustainable Domestic Financing Options for Sexual and Reproductive Health provision in Zimbabwe." Successful completion of this research will therefore be mutually beneficial to the SRH sector in Zimbabwe inclusive of the Ministry of Health, policy makers, donor community and the entire civic society.

I am therefore kindly requesting you to assist by objectively participating in this data collection exercise. I would like to assure you that your valuable input will be treated with utmost confidentiality and will be used for academic and professional purposes only.

You community may benefit from the findings of this research

Your co-operation would be highly appreciated.

Section A

Date: _____
Time: _____
Group Name: _____
Composition: Males: _____
Females: _____
Persons with Disabilities: _____
Total: _____
Community Name: _____

Section B

1. What are the bottlenecks in sustainable health provision?
2. What is your proposal for addressing these challenges/ bottlenecks?

Section C

3. What are the possible domestic financing opportunities available in Zimbabwe?
4. Are you aware of any community which financing models?
5. Do you think they will work in your context?

THANK YOU FOR YOUR VALUABLE INPUT AND COOPERATION!!!

Appendix 3

RESEARCH INSTRUMENT 3

Observation Guide

Date:_____Time:_____

Location/Community Name:_____

Units of Observations

Bottlenecks in health services provision

- *Are there any issues with the actual service provision at health facilities or SRH centre like Youth Friendly Centres*

Financing opportunities

- *Are there any visible financing options within the communities?*

SRH services

- *Are there any observable SRH services in the communities like Youth Friendly centres, Outreach activities for FP/ SRH including roadshows etc.*

Model

- *Is there any health financing in practice that is observable on the ground*