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ZIMBABWE

Health and Child Care

Budget Brief



Health and Child Care 2018 Budget Brief

Key Messages and Recommendations

- ❖ **Whilst welcoming the improved allocation, at 8.3% of the total budget, funding for health remains short of the sector requirements.** The Government should aim at increasing the allocation to meet the 15% Abuja declaration target and funding under the NHS 2, including through leveraging on private sector financing and reprioritization within the government budget.
- ❖ **Having missed on the MDGs targets, (e.g both under 5 and infant mortality), the country remains at greater risk of failing to meet the SDGs, with the current level of public investment.** There is need for the government to improve and sustain investments in health, whilst prioritizing NCDs given that they are increasingly becoming a burden and leading cause of mortality and morbidity in the country and therefore require corresponding strategies to deal with them.
- ❖ **Equity considerations should be at the center of health resources allocations, if no one is to be left behind in line with the SDGs.** This entails a more equitable allocation of funds, more aligned to health needs in a way that prioritizes the economically disadvantaged and neediest social groups.
- ❖ **The sharp rise in health care inflation in 2017, driven by hospital and pharmaceutical inflation, is a major risk to health care provision.** The potential implication of rising healthcare costs is to deter health care seeking, which has serious equity implications particularly for the economically disadvantaged children and women.
- ❖ **Key to sustainable funding for health is the need for the government to prioritize the National Health Insurance (NHI) program.** This will support the inclusion agenda by ensuring every citizen has access to healthcare services.
- ❖ **Development partner support remains an important source of investment in the health sector.** However, harmonization and alignment of external funding to national priorities is urgently required to reduce transaction costs and to improve the efficiency of spending. On the government side, there is a need to explore more sustainable solutions to finance the health sector given the declining donor funding.

1. Introduction

This Budget Brief is one of five Briefs that explore the extent to which the health budget addresses the needs of children under 18 years in Zimbabwe. The Briefs analyse the size and composition of budget allocations for the year 2018 as well as offer insights into the efficiency, effectiveness, equity and adequacy of past spending. Their main objectives are to synthesize complex budget information so that it is easily understood by stakeholders and put forth key messages to inform financial decision-making processes.

2. Health Sector Overview

The provision and regulation of healthcare services in Zimbabwe falls under the jurisdiction of the Ministry of Health and Child Care (MoHCC), which is currently guided by the National Health Strategy (2016-2020). Zimbabwe has over the years recognized the importance of health which is enshrined as a fundamental human right according to Section 76 of the Constitution. In line with the NHS, the MoHCC seeks to achieve equity and quality in health, in a bid to make sure that no one is left behind in line with Sustainable Development Goals (SDGs) and the country's development plan – ZimASSET (2013 -2018).



The NHS provides key priorities for health care provision that have been costed. The major priorities include: communicable diseases; non-communicable diseases (NCDs), reproductive, maternal, new-born, child and adolescents; and public health surveillance and disaster preparedness and response. Hence, the Ministry's 2018 budget priorities were guided by the recommended NHS - scenario 2, which estimated the 2018 cost at US\$1.35 billion. The NHS 2 scenario is shown below.

NHS2: High Impact Interventions

Reduce mortality associated with the 20 established leading casues within limits of the proposed financial space

- Scale-up of RMNCH, malaria, HIV, Nutrition and NCDs interventions with emphasis on lower levels of care
- Shift provision of preventive services at the primary health level
- Infrastructure improvements at the primary level only
- Investments to improve availability and security of medicines and supplies
- Capacitation of skilled Human Resources

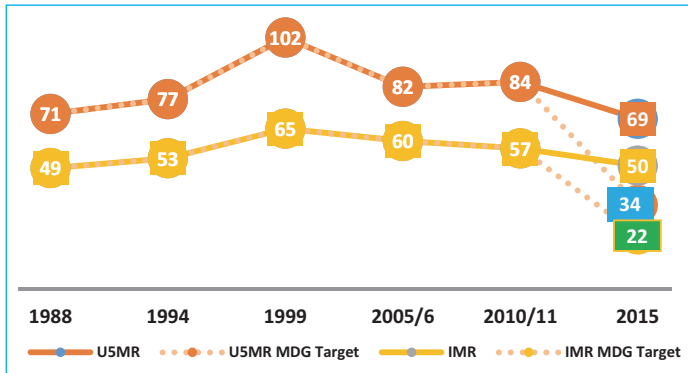
Sector Performance

Despite the many challenges that continue to engulf the health system, significant milestones have been achieved to date. These achievements include, reduced maternal mortality from over 1,000 per100, 000 live births to 614, reduction in Under 5 (U5) mortality rate from a high of 102 per 1000 live births in 1999 to 69 in 2015 (Figure 1), HIV incidence has fallen from 1 to 0.48 while PMTCT rate has fallen from above 30 to 5.7%. Furthermore, the country has entered malaria pre-elimination in Matabeleland South and Midlands.

Although Zimbabwe has been able to bent the curve, the progress has been significantly below the health Millennium Development Goals (MDGs) targets. For instance, the U5MR in 2015 is almost twice the MDG target of 34 deaths per 1000 live

births while the infant mortality rate stood at 50 against a target of 22, (Figure 1).

Figure 1: Child Mortality Trends against MDG Target



Source: Zimbabwe Demographic and Health Survey (ZDHS), 2015

Furthermore, the progress remains uneven as U5 mortality remains high among the poor and vulnerable households.

According to Zimbabwe Health and Demographic Survey (ZDHS), (2015), U5 mortality rate for the poorest quintile was estimated at 85 per 1000 live births, compared to 58 per 1000 live births for the richest quintile, (Table 1). Real progress in this regard requires more efforts and sustained high public investments to strengthen the healthcare system and scaling up of health coverage, otherwise the country won't be able to meet the SDGs for health. The investments in health should focus on closing significant gaps in coverage and outcomes by removing observed income and geographical disparities that continue to exist in key health indicators.

Table 1: Selected Health Indicators by Wealth Quintile

| Health Indicator | Poorest Quintile | Richest Quintile |
|---|------------------|------------------|
| At least one ANC check-up (%) | 88.4 | 94.6 |
| Institutional Delivery (%) | 46.2 | 89.9 |
| C-section (%) | 2.5 | 9.2 |
| PNC check-up within first 2 days after birth (%) | 15.7 | 46.6 |
| Children 12-23 months reported receiving all basic vaccines (%) | 54.6 | 72.8 |
| Children with diarrhea who received no treatment | 25.3 | 11.8 |
| Infant mortality (per 1000 livebirths) | 55 | 48 |
| U5 mortality (per 1000 livebirths) | 85 | 58 |

Source: Zimbabwe Demographic and Health Survey (ZDHS), 2015

Key Takeaways

- Although Zimbabwe has been able to bend the curve on key health indicators, the progress has been significantly below the health Millennium Development Goals (MDGs) targets and risks are high that the country will miss out on the SDG targets for health.
- In addition, the progress remains uneven as the poor and marginalised children and their families remain worse off, calling upon the need for more equitable health care spending by the government.

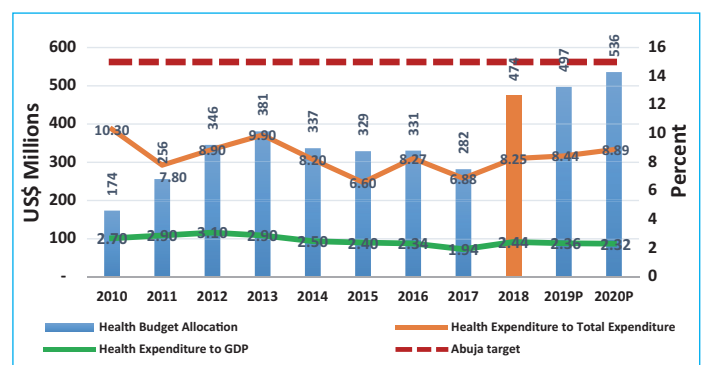
3. Health Care Spending Trends

Budget Allocation to the Health Sector

There has been a significant increase in the allocation towards health care in 2018. The MoHCC was allocated a total of US\$473.9 million in 2018, which is 68.1% higher than US\$281.98 million allocated in 2017. This includes the additional US\$65 million allocated following serious lobbying by the Parliament to increase the health budget. The total budget allocation to health represents 8.3% of total expenditure, some 1.4 percentage points up from 6.9% in 2017. The increased budget allocation is against a background of increased national budget, by 40.1% from US\$4.1 billion in 2017 to US\$5.7 billion in 2018.

Although the 2018 budget allocation is higher in both absolute and relative terms, it remains below the Abuja Target. At 8.3% of the total budget, the 2018 health care budget allocation is 6.7 percentage points lower than the 15% budget share recommended under the Abuja Target, (Figure 2) and also falls short of the Southern Africa Development Committee (SADC) average budget share of around 11.3%. In this regard, there is

Figure 2: Trends in Health and Child Care Budget Allocations: 2010-2018



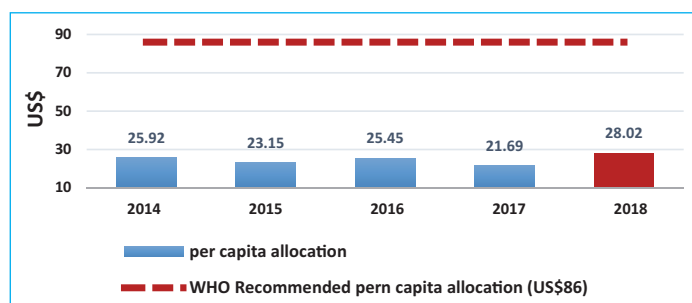
Source: Various Estimates of Expenditures and Author's Calculations

need for the government to at least double its budget commitment to health in line with regional standards, for the benefit of the health sector and children in particular. This could be achieved through leveraging on private sector financing (joint ventures and public private partnership arrangements), reprioritization within the government budget and strengthen the management and efficiency of the healthcare system.

As a share of GDP, the allocation is low relative to regional average. The 2018 health care allocation translates to 2.4% of GDP, up from 1.9% in 2017, albeit 4.2 percentage points below the SADC average of 6.6% of GDP. Better health outcomes could be achieved by increasing budget commitment to health, hence the need for a medium-term health financing plan by the government for resource mobilisation.

In addition, the 2018 allocation is relatively lower than regional averages and internationally recommended allocation for health. Zimbabwe's per capita allocation of US\$24.18 in 2018, is US\$57.98 less than the US\$86 per capita health spending recommended by WHO (Figure 3). Furthermore, it is US\$106.88 below the SADC average per capita spending which stands at around US\$134.90. Comparison with regional peers shows that per capita health allocation is US\$650 in South Africa, US\$200 in Angola, US\$123 in Swaziland and US\$90 in Zambia. The Zimbabwe's per capita allocation is even much lower after excluding employment costs. Furthermore, the current per capita spending is only half of the per capita cost for an Essential Health Benefits (EHB) package at primary care level which is estimated at US\$56. This, therefore, suggest the need for the government to increase its level of funding to achieve better health outcomes and make progress towards the SDGs.

Figure 3: Trends in per capita Health spending in Zimbabwe: 2014-2018

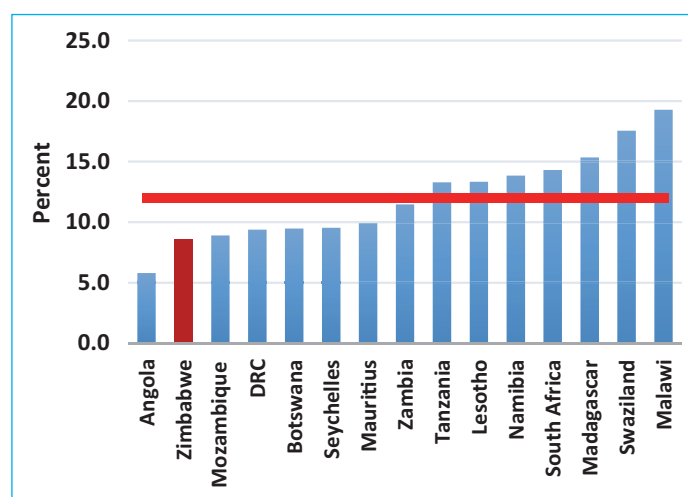


Source: Various Estimates of Expenditures and Author's Calculations

The low levels of per capita spending cannot guarantee adequate access and quality services for the population, including children. The implication of the inadequacy in public health spending is that the health sector will continue to

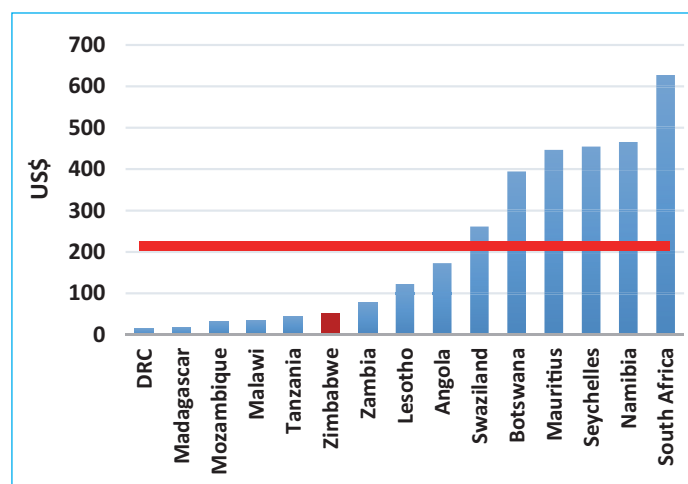
significantly rely on out-of-pocket (OOP) expenditures and donor assistance, which are both unsustainable (Figure 4a & 4b). Already, donor support has been on a decline¹, putting the health sector in a financially vulnerable position. With no major financing innovation in the sector, a shock or withdrawal of donor support is highly likely to reverse the significant gains achieved to date. Safeguarding such gains therefore calls for the government to look for innovative health financing mechanisms, such as prepayment mechanisms and gradually reducing the share of external funding and OOP.

Figure 4a: 5yr-average Share of Total Gvt Spending on Health in the SADC Region (2010 to 2014)



Source: World Bank (2017) and Author's calculations

Figure 4b: Average per capita health spending in the SADC Region (2010 to 2014)



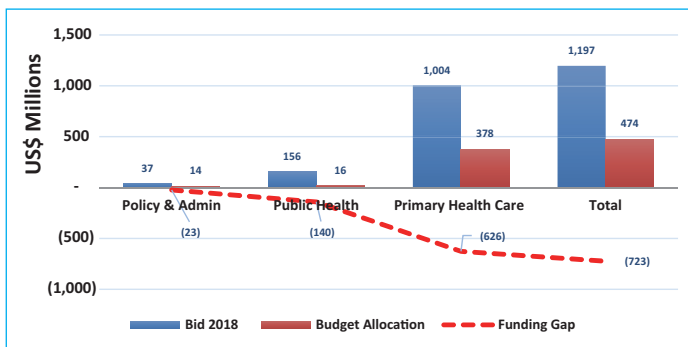
Source: World Bank (2017) and Author's calculations

¹ A review of Global ODA Flows to Zimbabwe reported that Development Assistance for Health declined from a high of US\$740.4 million in 2012 to a projected US\$200.4 million in 2017. This was against a decline in total ODA flows to Zimbabwe from as high as US\$944.9 million in 2012 to a projected US\$445.9 million in 2017.

Total budget allocations to the health sector in the current fiscal year fall far short of the sector financing requirements.

The 2018 health budget allocation only represents about one third of the total need for the health sector as costed by the NHS. In particular, government financing for 2018 is only 34% of NHS2 Bid for 2018 of US\$1.197 billion, leaving a financing gap of US\$723.4 million, (Figure 5). In addition, the 2018 per capita allocation is just about a third of the ideal per capita cost of US\$93.8 as estimated under the NHS 2 scenario. With such inadequacies in public health funding, the country remains at high risk in terms of its preparedness in dealing with the disease burden engulfing the nation such as typhoid and maternal related health complications putting children at high health risks. Worse still is the increasing incidences of NCDs which require high level interventions.

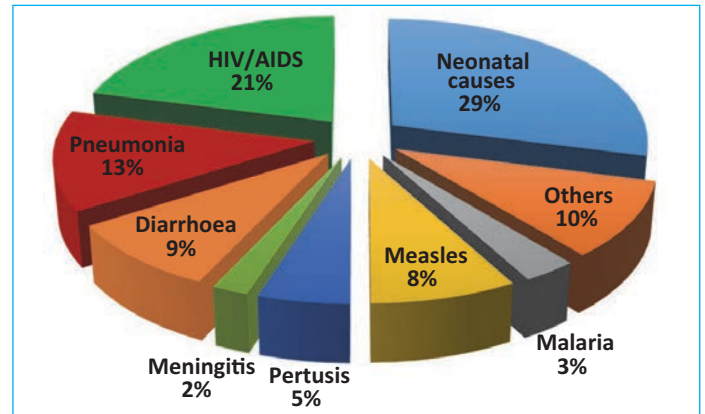
Figure 5: 2018 Budget Allocation vs NHS 2 Bid for 2018



Source: Estimates of Expenditures for 2018 and National Health Strategy

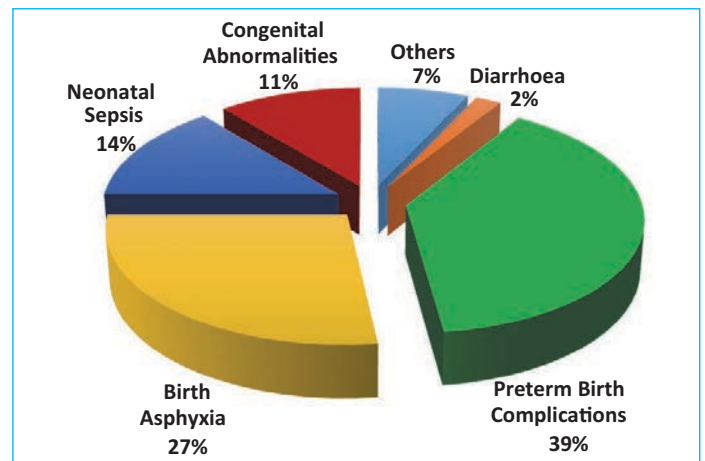
The current public spending is inadequate to respond to the disease burden in the country. For instance, although significant progress has been made over the years, the country is increasingly facing a twin burden of communicable and non-communicable diseases. HIV prevalence remains relatively high at 15% amongst adults with gains achieved to date threatened by risky behaviours particularly among youth and the increasing number of teenage pregnancies. Furthermore, even preventable and curable diseases like malaria and TB remain major causes of deaths. Compounding the situation, NCDs such as cancer, are increasingly burdening the country, with both the poor and rich being severely affected. All these challenges are exacerbated by health system constraints, particularly related to critical health worker shortages, dilapidated infrastructure and equipment, all emanating from limited health funding. Figure 6 shows some of the causes of child mortality in Zimbabwe, which can be avoided with adequate funding of the sector.

Figure 6a: Causes of Under-five child mortality in Zimbabwe



Source: Zimbabwe Demographic and Health Survey (ZDHS), 2015

Figure 6b: Causes of Neonatal deaths in Zimbabwe



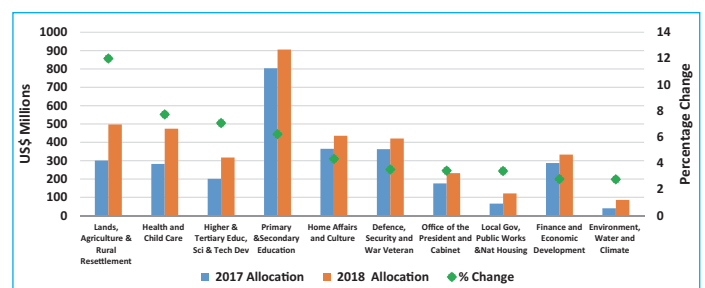
Source: Zimbabwe Demographic and Health Survey (ZDHS), 2015

Health Care Allocation Against Other Sectors

Despite falling below key spending targets, the health sector remains among the key financial priorities of the government.

The 2018 Health Budget allocation marks a change in priority for the Sector, as it ranks third ahead of security ministries and land and agriculture (Figure 7). This is among the five biggest movers

Figure 7: Top 10 Priority Allocations to Ministries (2017 Vs 2018)



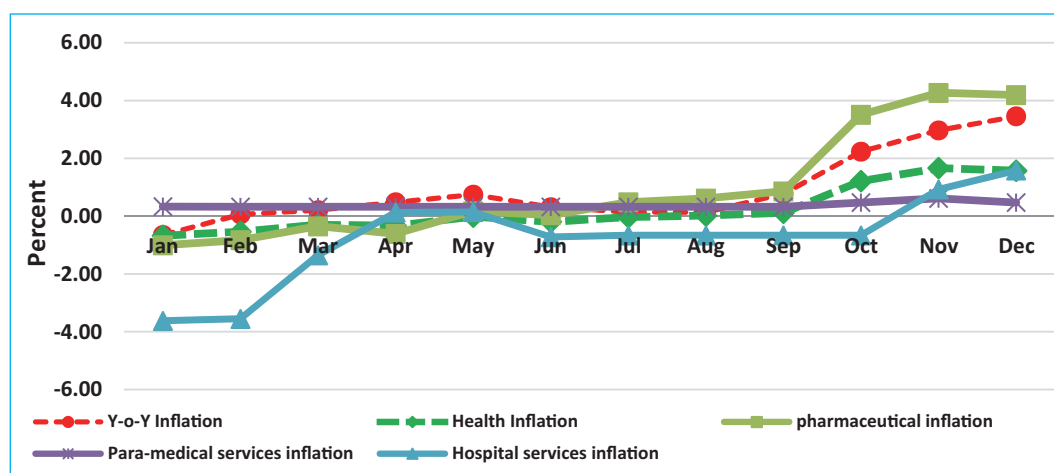
Source: 2018 National Budget Statement

in the 2018 Budget accounting for 7.7% of the increase in the total budget, (Figure 7).

Health Care Inflation

Rising health care inflation and user fees continue to burden patients and clients, with the economically disadvantaged children and women suffering the most. The cost of health care products has been on an upward trend in 2017, rising from -0.71% in January 2017 to enter the positive territory in August at 0.02%, and continued on an upward trajectory to close the year at 1.61% (Figure 8). Overall, health inflation has however trended below general inflation throughout the year. The rising inflation mainly emanated from pharmaceutical products, with pharmaceutical inflation rising from -1% in January to 4.2% in December 2017. Further health inflationary pressures came from para-medical services inflation, which was positive throughout 2017. Rising costs of drugs is attributed to foreign currency shortages which has constrained drug importation, resulting in retailers increasing prices of drugs as medicines fall short of supply. However, the Government has committed to improving the availability of medicines and medical accessories through NATPHARM in its 100 Day Plan.

Figure 8: Trends in Monthly Health Inflation in 2017

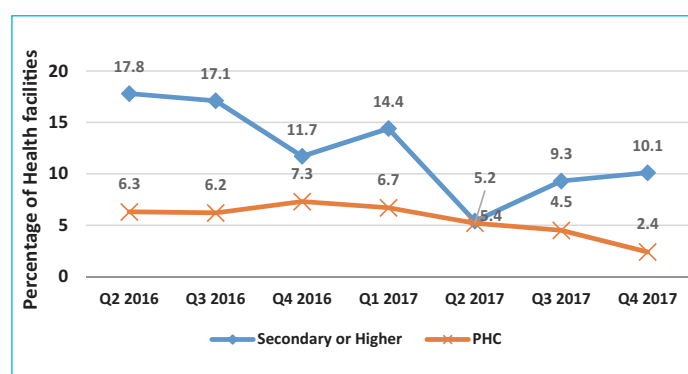


Source: ZIMSTAT Monthly Inflation Updates for 2017

The upward trend in health inflation acts as a barrier in accessing health care services, with the poor groups, particularly vulnerable children and women being the most affected. Furthermore, this has serious equity implications in the health sector given that the poor are hit the hardest. Through advocacy efforts by partners, MoHCC has prioritised the implementation of the User Fee Policy² under its 100 Day Rapid

Results Initiative, as a social safety net, with a view to increase access to health services to selected population groups, including children and expecting mothers. Figure 9 shows the proportion of health facilities charging antenatal care (ANC) user fees by health facility level for 2016 and 2017.

Figure 9: Proportion of Health Facilities charging user fees for ANC by type of Facility³



Key Takeaways

- The low levels of per capita spending in Zimbabwe cannot guarantee adequate access and quality services for the population, including children. This, therefore calls for the government to look for innovative health financing mechanisms, to guarantee equitable access to health care.
- The current public spending is inadequate to address the current health challenges facing the nation, including some preventable causes of mortality among children, which can be avoided with adequate funding of the sector.
- The upward trend in health inflation is a barrier to accessing health care services, particularly by vulnerable children and women, hence the need for the government to fully implement the User Fee Policy, whilst at the same time ensuring availability of drugs in public hospitals.

² The User Fee Policy stipulate that Government health facilities should not charge user fees for the under 5, pregnant women, over 65, mental patients and other categories. Under the 100 Day Rapid Results Initiative of the MoHCC, 100% of primary level facilities (including mission and council clinics) and District, Provincial and Central Hospitals scrapped user fees with effect from 15 January 2018.

³ Presentation by UNICEF Chief of Health, Nejmudin Kedir Bilal on the 2018 Budget Stakeholder Meeting in Harare, 14 December 2017

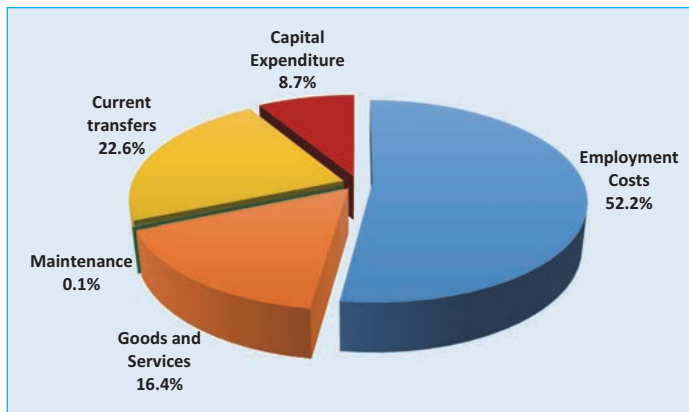
4. Composition of the Health Budget

Composition of Allocation by Economic Classification³

As is the trends across all government Ministries, wage costs accounts for a large share of the total health care budget.

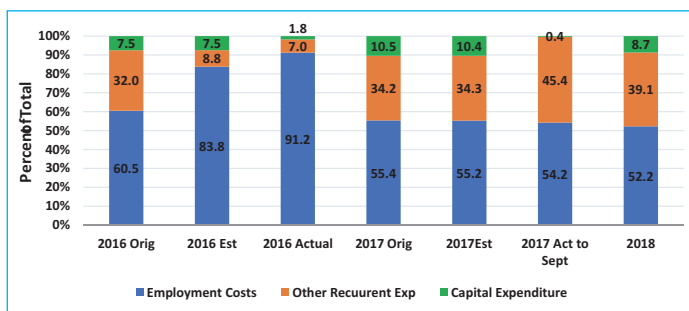
However, there has been an improvement in the expenditure mix as employment costs now account for 52.2% while non-wage spending stands at 47.8% in 2018 (Figure 10a). Although the share of employment costs in the health budget has declined from 55.2% in 2017, actual employment costs have increased by 37% from US\$156.09 million in 2017 to US\$212.8 million in 2018. Non-wage spending has significantly increased by 106.5% from US\$126.46 million in 2017 to US\$261.08 million in 2018, (Figure 10b).

Figure 10a: Composition of the 2018 Health Budget



Source: Various Estimates of Expenditures for 2010 to 2018

Figure 10b: Trends in the Budget Composition



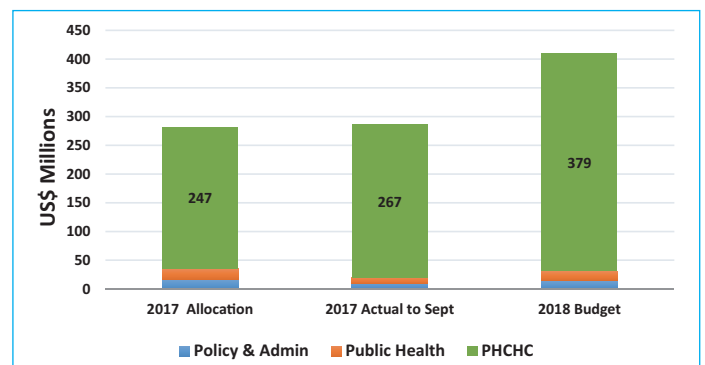
Source: Various Estimates of Expenditures for 2010 to 2018



Health Budget Allocation by Program⁴

The budget allocation to health is divided into three programs – Policy and Administration, Public Health and Primary Health Care and Hospital Care. As has been the trend, a large share of the Health Budget goes towards Primary Health Care and Hospital Care (PHCHC), (Figure 11), which was allocated US\$378.12 million, translating to 92.5% of the Health Budget. Public Health Care and Policy and Administration were allocated US\$16.3 million (4.0%) and US\$14.5 million (3.5%) respectively. The huge allocation to PHCHC however largely reflects the labor intensiveness of the program with 53.7% of the US\$379.13 million going for employment costs.

Figure 11: Trends in the composition of Health Allocation by Program



Source: Estimates of Expenditures for 2018

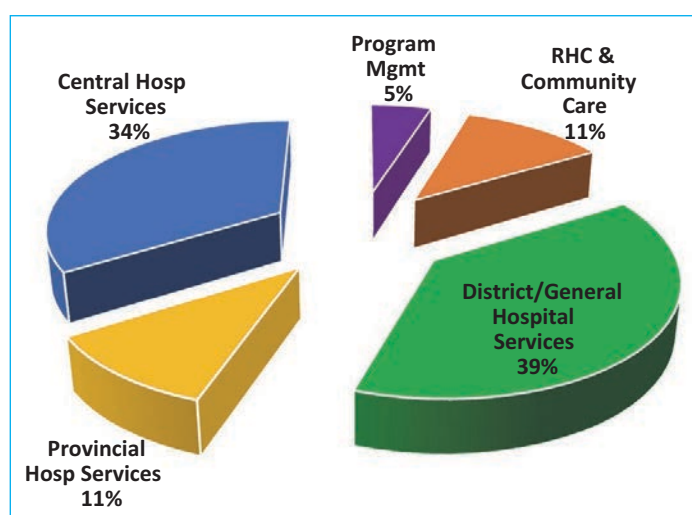
³ The Ministry of Health and Child Care was allocated an additional US\$65 million from the Unallocated Reserve resulting in an increase in the overall budget allocation from the initial US\$408.9 million to US\$473.9 million. However, the disaggregation of the US\$65 million by economic classification was not available at the time of producing this budget brief.

⁴ The analysis of health budget allocation by program is based on the initial total of US\$408.9 million since the disaggregation of the additional US\$65 million is unavailable at the time of producing this brief.

Primary Health and Hospital Care (PHCH)

The lion's share of spending on primary health services goes to hospitals. Of the US\$378.12 million allocated to PHCHC, 39% goes to District/General Hospitals while 34% goes to Central Hospitals, (Figure 12). All the sub-programs under PHCHC received higher budget allocations in 2018 compared to 2017 (Figure 13). Although this looks impressive, actual spending may be significantly much lower. For instance, with the exception of Program Management (1,157%) and RHCCC (426%), actual disbursement to September 2017 was poor in 3 of the 5 sub-programs with disbursement rates at 34% for District/Gen Hospital Services, 11% for Provincial Hospital Services and 50% for Central Hospital Services.

Figure 12: Composition of the Pri Health & Hosp Care Allocations for 2018



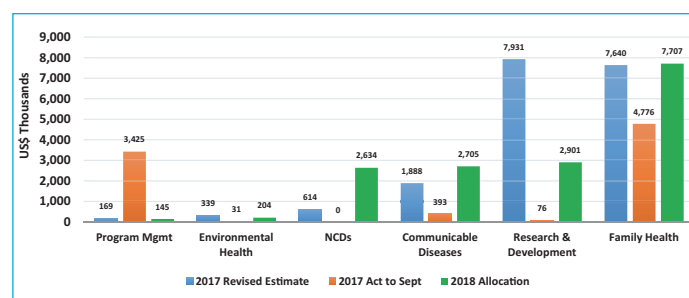
Source: Estimates of Expenditures for 2018

Service delivery in PHCHC faces challenges in understaffing owing to the unrevised staff establishment coupled with the freezing of posts. This has resulted in huge human resource deficit at public health institutions with the situation worse in some rural areas. The MoHCC reports that most provinces, except Bulawayo, have health workers less than 10 per 10,000 population against a target of 23 health workers per 10,000 population as recommended by WHO. The situation is further worsened by inadequate and dilapidated public infrastructure in most health centers which results in poor service delivery, escalating the incidence of communicable diseases, and other preventable diseases, such as cholera, typhoid and malaria. Worse still, a significant number of patients in some rural areas continue to endure travelling extremely long distances to access primary health care facilities.

Public Health Allocation

Family Health continue to receive relatively larger share of the Public Health Budget. In 2018, the allocation towards Family Health accounted for 47% of the US\$16.3 million in 2018, R&D received 18% while NCDs received 16%, (Figure 13). Communicable diseases NCDs and Family Health received higher allocations in 2018 compared to 2017, while Program Management, R&D and Environmental Health received lower allocations. Poor execution rates were experienced in 4 of the 6 sub-programs with disbursement rates to Sept 2017 at 21% for CDs, 0% for NCDs, 9% for Environmental Health and 1% for R&D.

Figure 13: Public Health Allocations: 2017 vs 2018



Source: Estimates of Expenditures for 2018

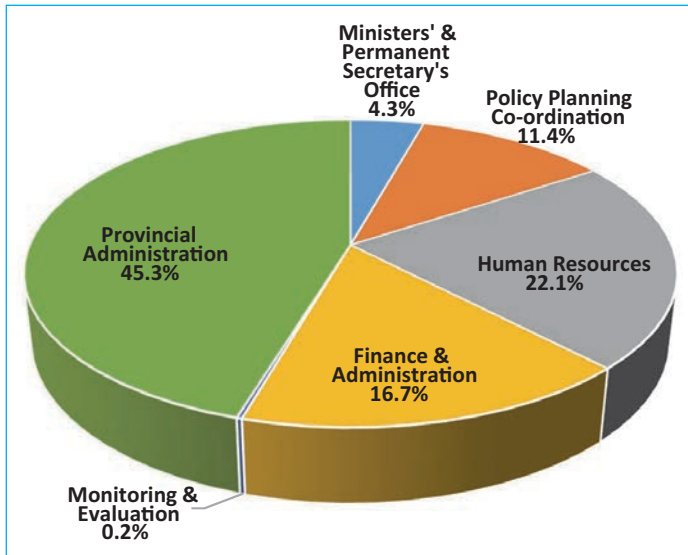
There has been a marked improved in the allocation towards NCDs, albeit from a low base. This is in response to the fact that cancers and other NCDs have become leading causes of mortality and morbidity in the nation against a background of rapid urbanization and changes in lifestyle which combine to increase the risk factors that cause NCDs. Worse still is the high cost of NCDs treatment which make such treatment generally inaccessible to most people. For instance, cancer treatment averages between US\$100-1,000 per session. Furthermore, the budget allocation and poor disbursement rate to R&D is very worrying given the important role that it plays in the delivery of quality health services. For instance, R&D helps identify cost-effective interventions to improve results, helps inform policy and program choices and delivering services without waste and duplication. Program Management and Family Health had strong disbursement rates at 2026% and 63% respectively.

Policy and Administration

Policy and Administration receives a relatively small share of the Ministry's total budget. Policy and Administration was allocated US\$14.5 million, accounting for 3.5% of the total Ministry's budget. A significant share of the allocation will be

spent on Provincial Administration (45.3), Human Resources (22.1%), (Figure 14).

Figure 14: Composition of the Policy & Admin Allocation



Source: Estimates of Expenditures for 2018

Key Takeaways

- Wage costs accounts for a large share of the total health care budget, emphasizing the need for improved allocative efficiency in the health care budget.
- Human resources gap remains a major challenge, affecting health service delivery, particularly in rural areas. Government would need to progressively increase the human resources for health to 23 health workers per 10,000 population as recommended by WHO.

5. Performance of the Health Budget

Budget Execution

High execution rate was achieved in 2017 compared to previous years. By end-September 2017, US\$286.02 million had been disbursed to health sector, against an allocation of US\$282.5 million – translating to a budget execution rate of 101% and 6.3% of the total US\$4.534 billion expenditure to September 2017. While the overall picture may seem impressive, a disaggregated analysis shows that most of this expenditure is recurrent, with US\$155 million having been spend on employment costs against

a target of US\$156 million, representing a disbursement rate of 99%. These recurrent expenditures continue to crowd out productive capital spending as actual spending on capital projects was only 4% of target (US\$1.2 million against US\$29.5 million) and 0.4% of total disbursement.

Table 2: Health Budget Execution by Economic Classification

| Expenditure Line | 2017 Allocation | 2017 Actual to Sept | Disbursement Rate | % of Total Disbursement |
|-----------------------------|--------------------|---------------------|-------------------|-------------------------|
| Employment Costs | 156,091,000 | 154,999,933 | 99 | 54.2 |
| Other Recurrent Expenditure | 96,998,000 | 129,810,142 | 134 | 45.4 |
| Capital Expenditure | 29,460,000 | 1,214,820 | 4 | 0.4 |
| Total | 282,549,000 | 286,024,895 | 101 | 100.0 |

Source: Estimates of Expenditures for 2018

In terms of program disbursements, PHCHC had the highest disbursement rate. By end-September 2017, PHCHC had a disbursement rate of 108%, accounting for 93.3% of total actual disbursements for the Ministry, (Table 3). This is so given the labor intensiveness of the program. Even so, the health sector continues to face a huge human resources deficit with the situation worse in rural areas. As at end-2017, there were 7,063 vacancies in the health sector with an additional post requirement of 5,421.

Table 3: Health Budget Execution by Program

| Program | 2017 Allocation | 2017 Actual to Sept | Disbursement Rate | % of Total Disbursement |
|----------------|--------------------|---------------------|-------------------|-------------------------|
| Policy & Admin | 16,881,000 | 10,517,457 | 62 | 3.7 |
| Public Health | 18,581,000 | 8,702,325 | 47 | 3.0 |
| PHCHC | 247,087,000 | 266,805,113 | 108 | 93.3 |
| Total | 282,549,000 | 286,024,895 | 101 | |

Source: Estimates of Expenditures for 2018

Budget Credibility

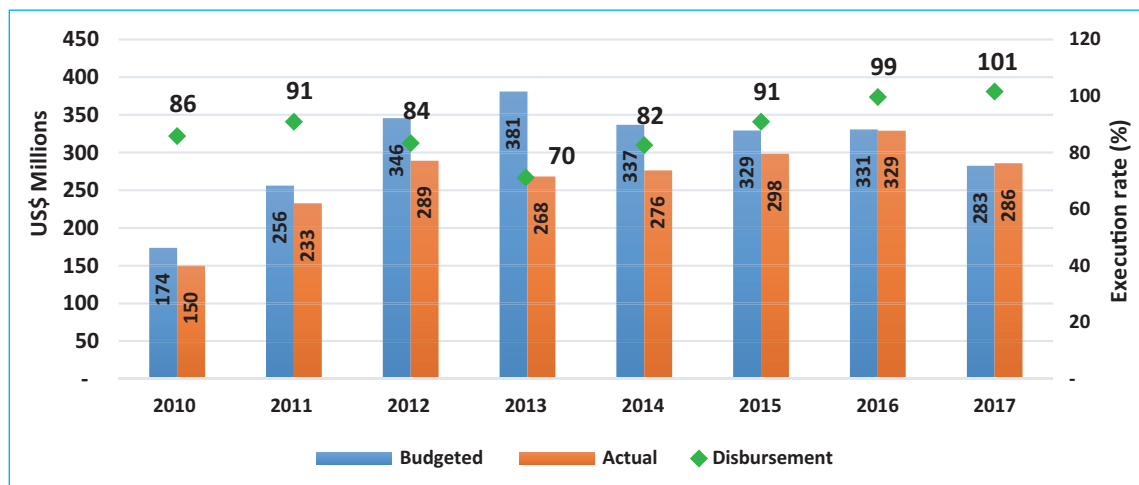
There have been significant improvements in the overall health budget performance over the recent past. Actual health budget execution rate rose from 70% in 2013 to 101% by September 2017 (Figure 15). However, the composition of this expenditure continues to be heavily skewed towards employment costs which have consumed more than half of actual spending

over the years. This therefore calls for the need for the government to improve disbursement rates to non-wage programs.

Key Takeaways

- Budget execution rate for health is high, underpinned by high expenditure on employment costs, hence the need for deliberate policy stance by the government to rebalance the expenditure mix, for better outcomes.

Figure 15: Trends in Health Budget Execution: 2010 -2017



Source: Various Annual Financial Reports for 2010 to 2017





6. Equity Considerations in Health Spending

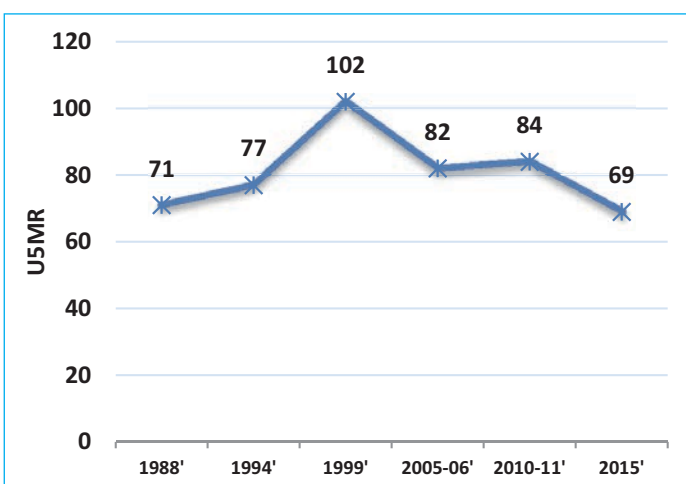
Current resource allocation is not contributing to achieving equity of health outcomes. While U5 mortality has declined at the national level from 89 deaths per 1000 in 2010/11 to 69 per 1000 in 2015 (Figure 16a & 16b), it has significantly increased among five of the ten provinces between 2011 and 2015 (Figure 16b). These provinces include: Matabeleland South, Matabeleland North, Mashonaland West, Mashonaland East and Manicaland which recorded an increase of 62.5, 86.1, 8.6, 78.9 and 15.5 per cent, respectively in 2015 compared to 2010-2011 rates. Hence, allocation of resources based on average figures

only might be inadequate in addressing the problem of childhood mortality in the country. The scenario has the potential to create huge costs for the government, while simultaneously leaving significant inequity and inequality gaps among Zimbabwean children on account of their socio-economic status or geographical location. There is need for government to allocate resources targeting the highly-risk groups.

Key Takeaways

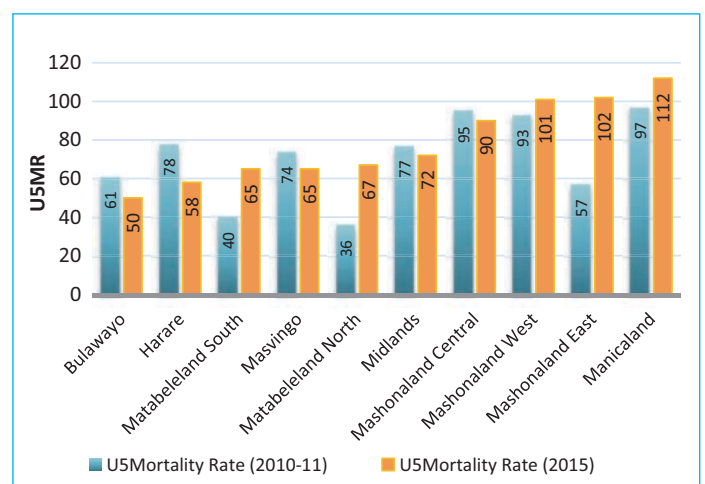
- Current resource allocation is needs to be improved to achieve equitable outcomes across the different provinces and districts of the country.

Figure 16a: Trends in U5MR (1988zdhs to 2015 zdhs)



Source: Zimbabwe Demographic and Health Survey (2015)

Figure 16b: U5 Mortality Rate by Province



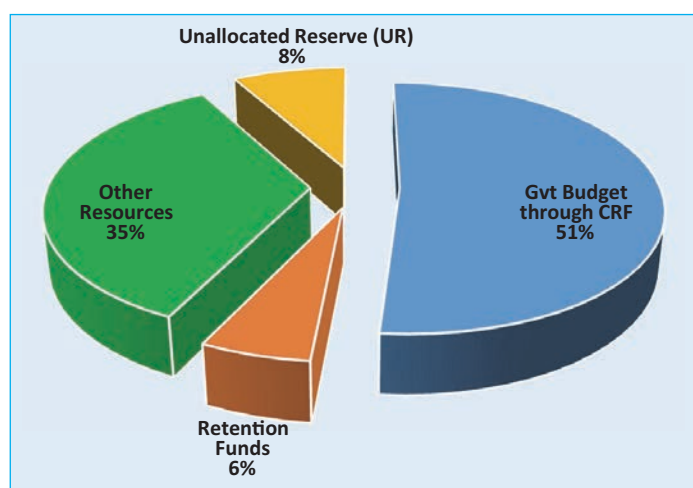
Source: Zimbabwe Demographic and Health Survey (2015)

7. Health Care Financing

Financing from the Government Budget

A significant share of the health sector budget is financed by the government budget. The 2018 Budget projects total resources for health to amount to US\$520 million, with government support constituting 59%. Retention Funds which come mainly from user fees administered through the Health Services Fund (HSF), AIDS Levy and 5% Airtime levy under “Talk, Surf and Save a Life” are estimated to mobilize a total of US\$45.1 million, translating to 6% of the resource envelope. Other resources, which are expected to come mainly from the donor community will contribute a total of US\$275.36 million, representing 35% of the total resources for health.

Figure 17: Sources of Health Financing for 2018



Source: Estimates of Expenditures for 2018

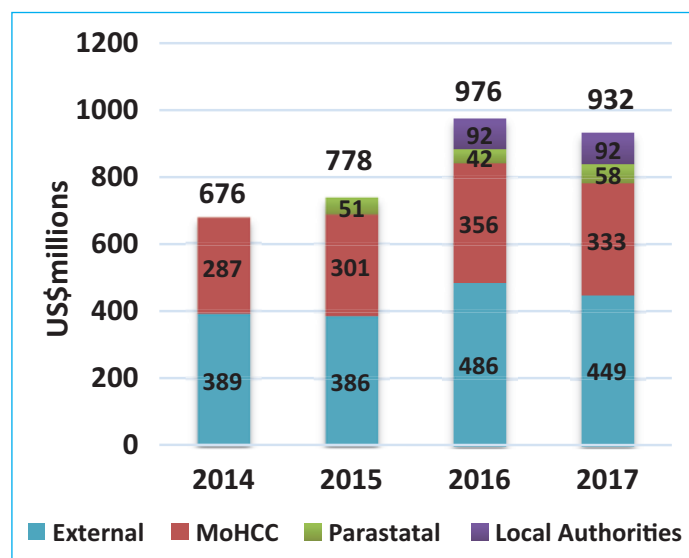
Role of Development Partners

Donor support still play a significant role in financing health in Zimbabwe. However, most of the resources are channeled directly to programs and preclude the government systems. Notwithstanding the importance of donor support in a fiscally constrained environment, continued reliance on such funding is not only unsustainable, but puts the health sector in a vulnerable situation in case of a shock in donor funding. Thus, there is need for innovative mobilisation of domestic resources which is critical in building financial capacity and creating fiscal space for sustainable financing of the healthcare sector.

This will go a long way in reducing the unsustainable financial dependency on external support which has been experienced

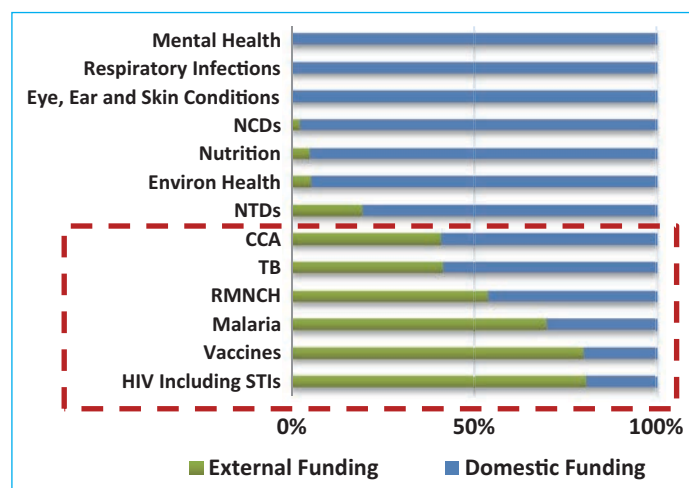
over the years as shown in Figure 18a and 18b. According to MoHCC the huge share of domestic funding in Nutrition is due to the high workload for human resources as most government’s human resource funding is allocated to this disease area.

Figure 18a: Resource Mapping for Health (2014-17)



Source: National Health Strategy

Figure 18b: Gvt vs External Funding by Disease in 2017

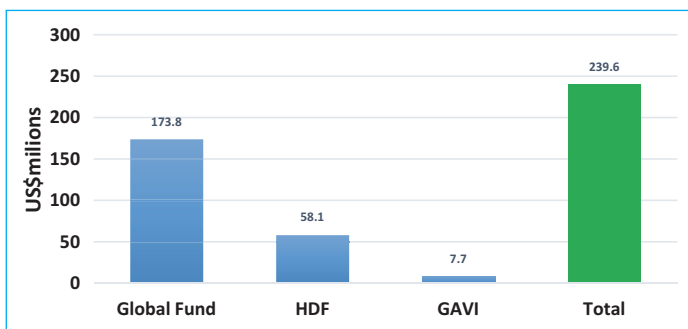


Source: National Health Strategy

Global fund and the Health Development Fund (HDF) remains the major sources of external financing for health in Zimbabwe. The two are expected to contribute a combined total of US\$231.9 million in 2018, (Figure 19). Despite its importance in funding the health sector, DAH usually target specific programs and is thus not flexible, which presents resource challenges in other sectors. Against this background, it becomes necessary to look for equitable financing mechanisms which can be flexibly used to allocate health resources across health programs, service levels and geographies. In the same vein, it is also equally important to

strive for effective and efficient use of allocated resources in order to achieve intended results. This therefore underscores the importance of strengthening performance based financing mechanisms (Results Based Financing) particularly in the Health sector. Furthermore, there is a pressing need and scope for the harmonisation and alignment of external funding to national funding. This could help eliminate the fragmented nature of health financing which has been a significant blockage to the transparency, efficiency, and effectiveness of national health financing. Going forward, factors that hinder external partners from using existing national channels, such as lack of transparency and accountability of the system need to be addressed.

Figure 19: Development Assistance for Health in 2018



Source: Estimates of Expenditures for 2018

There is need for government to explore a number of options and strategies for innovative mobilisation of significant resources building on best practices in global health financing in order to boost public health spending in a way that does not undermine fiscal sustainability. This can be done through supply side mechanisms such as the implementation of fiscal decentralisation with increased transfers from the central government to local governments and peripheral health facilities on the basis of needs and performance. Demand side mechanisms such as the establishment of a health insurance system, which includes cross-subsidies from richer to poor categories can also be considered.

Key Takeaways

- Whilst development partner support remains important for Zimbabwe, sustainability requires greater domestic resource mobilisation, to avoid reliance to declining donor support.
- To achieve better results from the current aid flows in health, there is need for harmonisation and alignment of external funding to national priorities, whilst at the same time enchainning efficient utilisation of the available resources.

List of Acronyms

| | |
|-------|--|
| ANC | Antenatal Care |
| CRF | Consolidated Revenue Fund |
| DAH | Development Assistance for Health |
| EHB | Essential Health Benefits |
| HSF | Health Services Fund |
| MDGs | Millennium Development Goals |
| MNCH | Maternal, Neonatal and Child Health |
| MoHCC | Ministry of Health and Child Care |
| NCDs | Non-Communicable Diseases |
| NHI | National Health Insurance |
| NHS | National Health Strategy |
| OOP | Out-of-Pocket |
| OPC | Office of the President and Cabinet |
| PHCHC | Primary Health Care and Hospital Care |
| PMTCT | Prevention of Mother to Child Transmission |
| SADC | Southern Africa Development Committee |
| SDGs | Sustainable Development Goals |
| WHO | World Health Organisation |
| ZDHS | Zimbabwe Demographic Health Survey |

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