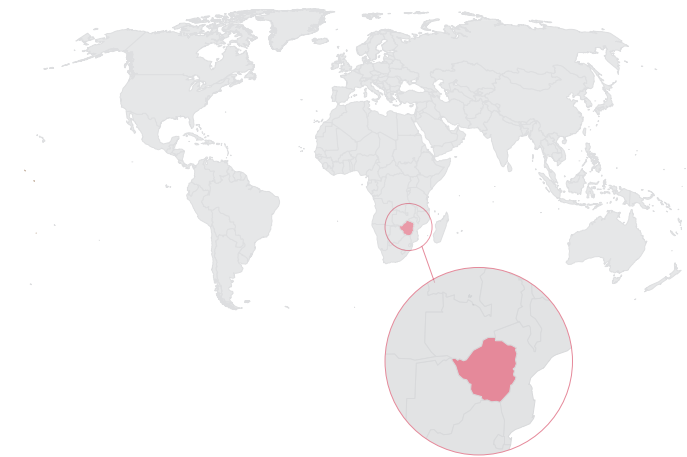


CRC 1342 No.44

# Social Policy Country Briefs

Zimbabwe



Tatenda Nhapi

## The Health Care System in Zimbabwe



Global Dynamics  
of Social Policy CRC 1342



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## **Tatenda Nhapi**

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# THE HEALTH CARE SYSTEM IN ZIMBABWE

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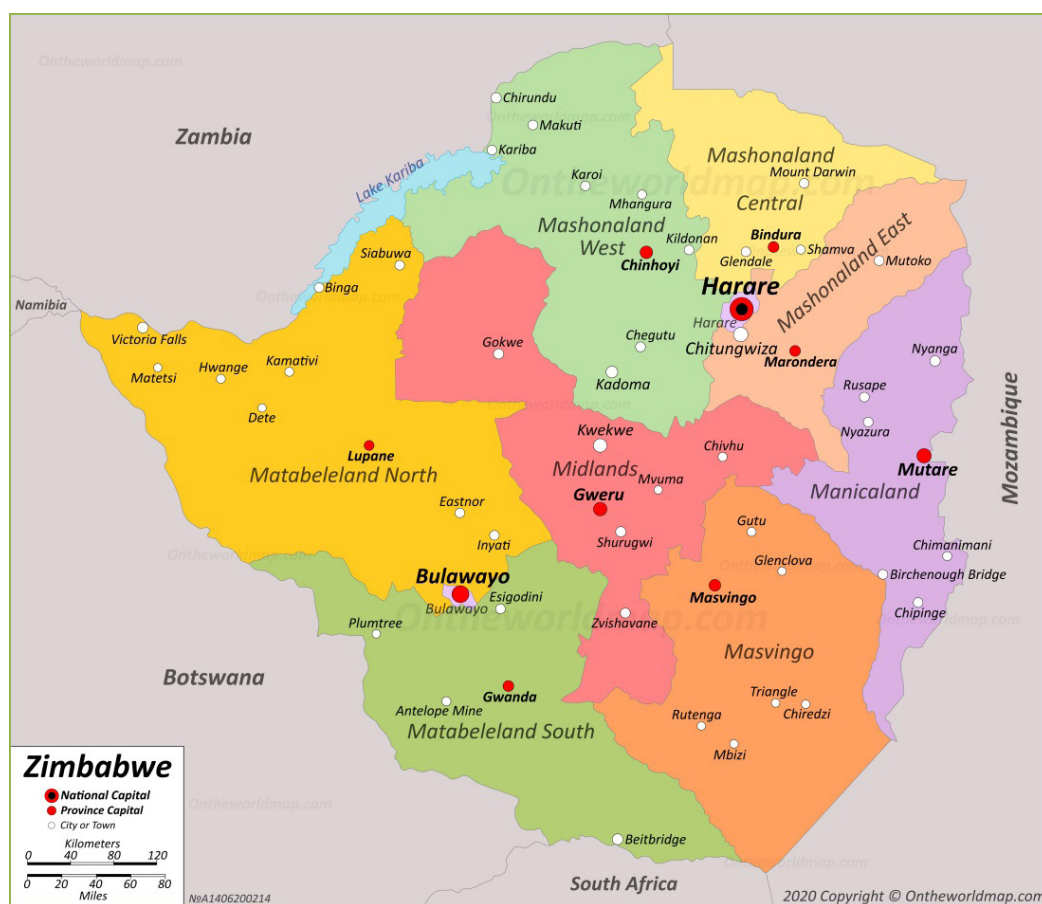
Tatenda Nhapi\*

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## 1. COUNTRY OVERVIEW (LATEST DATA AVAILABLE)



Source: On the world map <https://ontheworldmap.com/zimbabwe/map-of-zimbabwe.jpg>

Geographically, Zimbabwe is located in Southern Africa, bordered by South Africa, Mozambique, Botswana, and Zambia. The landlocked country has a tropical climate with high plateaus and mountains in the east. There are 8 rural provinces and 2 metropolitan provinces, which are further divided into 63 districts and 1200 wards.

Present day Zimbabwe in 1923 became a colony as Southern Rhodesia after annexation by Cecil John Rhodes and the British South Africa Company (BSAC) in 1890. The primary tactic of British economic control was widespread land appropriation, forcing peasantry into employment in mines and on farms for poverty wages. After neighbouring Zambia and Malawi became independent of Britain in 1964, Southern Rhodesian Prime Minister Ian Smith vowed that there would never be African majority rule in Southern Rhodesia and announced unilateral declaration of independence from Britain in 1965. The ensuing civil war and white minority rule ended with an internal settlement and general elections and Britain recognized Zimbabwe's independence in 1980, and Robert Mugabe became prime minister.

- » Sub-Region: Sub-Saharan Africa
- » Capital: Harare
- » Official Language: Shona, Ndebele, English and 13 others
- » Population size: 16,320,537 (World Bank, 2022)
- » Share of rural population: 61.4% (Zimbabwe Census, 2022)
- » GDP: 27.37 Billion (World Bank 2022)
- » Income group: Lower-middle Income (World Bank 2022)
- » Gini Index: 50.3 (World Bank 2019)
- » Colonial period and independence: Great Britain annexed Zimbabwe in 1891 and established Southern Rhodesia in 1923. The United Kingdom recognised Zimbabwe's independence in 1980.

## 2. SELECTED HEALTH INDICATORS

Indicator	Country	Global Average
Male life expectancy	56 years (2021)	69 years (2021)
Female life expectancy	62 years (2022)	75 years (2022)
Under-5 mortality rate (per 1,000 live births)	39.8 (Census 2022)	37
Maternal mortality rate (per 100,000 live births)	363 (Census 2022)	223
HIV prevalence	13.8% (15-49 age range)	39.0 million [33.1–45.7 million] people were living with HIV (2022)
Tuberculosis prevalence (per 100,000 people)	99 (2019)	134 (2021)

Source: The World Bank

## 3. CHARACTERISTICS OF HEALTH CARE SERVICES DURING THE COLONIAL PERIOD

### a. Organizational structure

Before the advent of colonialism, Mugumbate and Bhowasi (2021) note the prevalent well-established systems that responded to social and health issues were kinship care usage, reliance on platforms as King's Granary (*Zunde ra Mambo/Isiphala seNkosi*), and work parties (*nhimbe*). Social services providers comprised the immediate family (parents and siblings), near-immediate family (*vatete* - father's sister, *sekuru* - mother's brother), extended family or clan structures such as *sahwira* - a very close family friend, community leaders and well-wishers. Missionaries did not promote these providers but replaced them with western-styled practitioners who included counsellors, social welfare officers, ministers of religion, teachers and later social workers. Gaidzanwa (1999) noted that in the pre-colonial phase Cecil Rhodes procured a medical doctor to cure Ndebele King, Lobengula of gout for which the king was grateful.

Southern Rhodesia became a British colony after annexure by Cecil John Rhodes and the BSAC in 1890. In 1895 Bulawayo and Salisbury the biggest towns in the colony had the first government general hospitals. By 1898, the hospital system had expanded to other towns with Umtali, Fort Victoria and Gwelo all having hospitals of a reasonable size (Masakure 2015).

Prime health care provision service users were the colonial administrators and the expatriates, with separate care or second-provision made for Africans (Ncube 2015). As noted by Nyazema (2010) no legislation was needed to guarantee health care provision to the settler community. According to Ncube (2012) in 1929 colonial secretary at the time, William M. Leggate, was said to have been keen for recruitment of a candidate with new ideas for taking of the colony's health care sector forward. This was after the colony's inaugural medical director Andrew Milroy Fleming's retirement after 33 years of service. Leggate was said to have tried unsuccessfully to encourage Fleming to work out a programme akin to a national health service that would encompass the entire colony (Ncube 2012). An outsider, former Medical Officer of Health (MOH) for the city of Bristol, Robert A. Askins, secured the position (Ncube 2015).

### b. Coverage

From 1890, the early colonial occupiers dealt with healthcare as part of the broader "native question". Health coverage was a fragmented and two-tier medical service highly skewed in favour of the urban population particularly the white minority. Up to the early 1920s, there existed a dominantly rudimentary and enclavist health service where the state arranged private practitioners catered for white colonialists, as well as their African employees' health needs (Steele 1972).

Government run urban health institutions, serving the white community like Andrew Fleming, [now renamed Parirenyatwa] were not only better equipped and staffed but received a disproportionately large health budget share annually. At the time advances in tropical medicine were crucial for the colonisers and the Africans' health to ensure the colonisation project succeeded. For example, Ncube (2012) asserts endemic amoebic and bacil-

lary dysentery amongst Southern Rhodesia natives was noted to be transmitted by African “carriers” to the “unsuspecting” European “victims”. Askins as further noted by Ncube (ibid) listed the other menacing “native” diseases to be bilharzia (which he said infected six per cent of European children), cerebro-spinal meningitis, and sleeping sickness as some of the endemic diseases that were frequently transmitted to Europeans by Africans. According to Ncube (ibid), Askins argued all dysentery as having originated from native carriers and also disputed the that big game was to blame for the spread of sleeping sickness. For Askins, the endemic disease in the colony of sleeping sickness originated from Africans. In Askins’ 1930 official *Annual Report*, this danger was increasing because the colony was “becoming more closely settled by Europeans” (Ncube 2018). In further analysis by Ncube (2018) the faulty reasoning that civilisation had driven diseases away from urban areas and that most of the remaining scourges were rural and by extension African was the rationale for the renewed focus on the rural epidemiological arena.

### c. Provision

In colonial times, disease vectors for African men and women reflected their living conditions. The better-off citizens (mainly white) showed disease patterns associated with affluence similar to patterns in industrialised countries. The majority of the population, however, suffered from nutritional deficiencies, communicable diseases, problems associated with pregnancy, low birth weight in 10–20 per cent of all births owing to maternal malnutrition and protein energy malnutrition, predisposing the victims to more severe and often fatal infections (Matshalaga 2000). In Sanders’ (1990) analysis of the occupational diseases, industrial lung diseases such as asbestosis, silicosis (and tuberculosis) and coalminer’s lung; stress-related disorders such as high blood pressure; and plantation-related problems such as schistosomiasis, malaria and the toxic effects of pesticides and herbicides, were increasingly visible but under-reported. Mental ill health and alcohol related problems were also common, the latter being reflected in liver disease and indirectly in sexually transmitted diseases, and AIDS. The system of production prevalent in Rhodesia drove this disease pattern, and structures of racial domination reinforced its distribution. Airborne infections spread easily in the cramped, often smoky housing conditions existing in both urban and rural areas (Sanders 1990).

In the late 1970s, for the 230,000 white Rhodesians the doctor-patient ratio was 1:830 and there was one hospital bed for every 219 whites (Ministry of Foreign Affairs n.d). For especially urban hospitals, the level of care was comparable to that of Western countries hospitals (Government of Zimbabwe n.d). Auret cited in Bijlmakers (2003) noted that in the 1979-80 financial year, Andrew Fleming hospital in Harare (renamed the Parirenyatwa central hospital) was allocated almost a third (32%) of total government budget for health. In contrast, Hebrst quoted in Bijlmakers (2003:52) indicates the majority and predominantly rural black population only had one doctor for as many as 50.000 to 100.000 people and one hospital bed for 525 people.

The only health care providers in many rural areas were churches whose health facilities were of poor quality and overcrowded. As of 1978 approximately 280 doctors serviced the country’s 232,422 whites and only 850 doctors for the seven million Africans (Mhazo, Maponga, Mossialos 2023). Health services standards for whites were comparable to those of the industrialised West populations, with crude death rates at 8.2 per 1 000 (cf to 11.2 per 1 000 in England and Wales) while infant mortality rates at 1977 were 17 per 1 000 (cf 16 in England and Wales) (Ministry of Foreign Affairs n.d). Comparatively, African infant mortality rates were 122 per 1 000 and reached as high as 300 per 1 000 in remote areas like Binga. By 1980, only four referral hospitals existed consisting of two in Harare, the other two in Bulawayo. Of these, two were reserved for whites, while the other two served the entire black population. In rural areas the only health care access for blacks were church-run clinics or clinics provided by white farmers for their workers. Accordingly, besides missionaries, other keen believers in the notion of early development of rural healthcare services were Native Commissioners. The Native Affairs Department to which Native Commissioners belonged to, did not control African education and health functions. Eventually the Native Affairs Department got to have the function of health aligned to its services. The rationale for this was on basis of disease control and modernising African society. Facilitation of common treatments, made Native Commissioners to be keen to put up a positive face among Africans to justify colonisation. In 1909, diseases like syphilis had for years been a concern. Therefore, a proposal by Herbert J. Taylor, Chief Native Commissioner (1894- 1928) tabled a motion that provision be made for increasing the vote estimates for Native Education and for special contributions to those missions’ affording facilities for medical treatment of na-

tives and for the teaching of hygiene. This agenda-setting motion by Taylor was adopted by the Superintendents of Natives (SoNs) who were a corps of senior Native Commissioners.

#### d. Financing

As of the early 1930s the new colonial administration was now sympathetic to natives' affairs which resulted in prioritisation of rural health facility expansion. This was also coupled by trans-colonial learning and pressure to prove the colony's capacity for self-governance. Unlike other parts of Africa where pioneer efforts were driven primarily by religious organisations, Southern Rhodesia medical services development was directed by the central colonial administration. For example, Herbst quoted in Ncube (2018) noted that during 1980, ZWD 144 per person was the yearly average expenditure for medical services of white patients. In contrast, for predominantly black people public health care expenditure was ZWD 31 per person, reducing to four dollars per person for those in rural areas.

#### e. Regulation

Post the 1896-7 Sand Ndebele communities uprisings against colonisation, colonial officials explored overarching theoretical premises and hegemonic ideas for the BSAC's enforcement of law and order (Cheater 2005). This was alongside according to Ncube (2018) exploitation and governance considerations given concerns about Africans requiring taming as they were viewed as primitive and their communities prone to physical and moral degeneration.

### 4. LEGAL BEGINNING OF THE SYSTEM AFTER POLITICAL INDEPENDENCE

Name and type of legal act	Primary Health Care (PHC) framework (1980)
Date the law was passed	1980
Date of <i>de jure</i> implementation	1980- onwards
Brief summary of content	A central PHC approach feature was "community participation". Before and after political independence, central to understanding the process of popular involvement or "community participation", institutions of popular organisation have been in all areas of social development, including health. 'Growth with Equity' was post-independence Zimbabwe's flagship policy and entailed, <i>inter alia</i> , the improvement and expansion of social services and consumption levels in the local economy (Government of Zimbabwe 1981:6).
Population coverage	The basis for comprehensive PHC provision was health care centres construction and between 1980 and 1989, 273 were constructed, giving a total of about 927, inclusive of local government, mission and industry-owned facilities. This improvement in infrastructure fed into government health policy and strategy for the period 1980-1990, aimed at building and upgrading district level hospitals and clinics (Mhike and Makombe 2018). On basis of 2024 trends, healthcare for the population of 16 million people (67% rural and 33% urban) is delivered through 1,848 facilities, most of which are public health care facilities. The rest are non-profit and church affiliated facilities (referred to as mission facilities), private for-profit facilities and company operated clinics.
Type of benefits	PHC approach adoption resulted in directing resources towards disadvantaged areas and active participation of communities in transforming their health. The integration of curative and preventive services under PHC approach resulted in transformation of management and delivery of care. The establishment of provincial and district health team structures, made doctors in rural district hospitals no longer curative professionals only, but responsible for mobilizing through the range of health promotive services being developed by the health team and the integration with other sectors (Saunders & Davies 1988b: 198). Nearly every district ( $\pm$ 250 000 population) has at least two medical officers; every PHC centre has at least two qualified nurses; 59% of administrative wards have an environmental health technician and 60% of villages have access to a village health worker (Ray and Masuka 2017).



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Socio-political context of introduction	<p>In the 1980s, government social policy objectives implementation was through broad strategies of agrarian reforms, labour market regulations, education and health care interventions, drought/food security responses as elaborated in a document entitled Growth with equity (GoZ 1981). At independence, high levels of national expectation for people's conditions to improve, resulted in health sector interventions being grounded on equity in health and PHC.</p> <p>A PHC focus was described as a means to "... fight a war on disease and malnutrition ... poverty and ignorance" (GoZ 1981:12). This approach sought to transform the health care system from a centralized, curative, costly, urban-biased and racially divided system to an integrated, decentralized one focused on preventive and promotive health approaches.</p> <p>Not only would attention be given to treating illness, but also health promotion and ensuring that people do not get ill. With this strategy, significant were gained over a few years, in improving health and access to health care nationally, despite the war and under-development of the 1970s.</p>
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First and foremost, independence attainment in 1980 was after an armed struggle against a right wing, white minority government led by Ian Smith. In 1980, a policy of equity in health, incorporating explicit commitments to redistribute health resources was declared by the Zimbabwe government. Following the Alma Ata Declaration in 1978, adoption of the Primary Health Care (PHC) approach by the government as of 1980 directed resources towards disadvantaged areas and stimulated active participation of communities in transforming their health (Loewenson and Sanders 1988). In 1980, Zimbabwe due to movement from a curative, urban-based and minority-focused health care system to one emphasising health promotion and prevention, achieved some acceptable level of health care to the majority rural population. 'Planning for equity in health' made equity a central policy principle and by organising health systems around PHC strengthening access and availability of public services and personnel resulted in redistribution of resources to district services and among underserved areas. Extreme income inequality, inherited from a century of British colonialism evidenced the wide disparities in the health of Zimbabwe's people. The maldistribution of facilities was matched by a concentration in urban areas of health professionals. This is where lower-level auxiliaries, medical assistants were disproportionately urban based. National health strategies have been underpinned by the PHC approach for health needs responsiveness, ill health prevention and incorporating community participation. Health investments in the 1980s improved preventive and curative health services access and produced significant morbidity and mortality reductions alongside reduced differentials between urban and rural communities (Loewenson and Chisvo 1994).

There was repealing of the 1979 Medical Services Act, through which in the best government hospitals beds would be reserved for private patients of designated medical practitioners and closed the African wards to private doctors. Of note was the markedly different quality between 'open' and 'closed' wards which permeated every facet of treatment and care, including food and drugs (Bijlmakers 2003).

Also, significant to note is that during the 1980/81 to 1984/85 (financial years) transitional period the resource allocation by government evidenced commitment to PHC. The Ministry of Health's recurrent budget reflected a clear priority for the development of a functional patient referral chain by. More specifically, considerable progress was achieved until the late 1980s like over the three-year transitional period from 1981 to 1984/85, 316 new rural health centres were constructed and 450 existing ones upgraded. By 1989 better geographical accessibility was achieved as primary care services, rural health centres and clinics increased to 1062 from 247 at the time of independence (Auret, 1990). Health services were viewed as an integral part of development and their access as a human right (Government of Zimbabwe (GoZ), 1981). This guided government's post-independence health policy, resource allocation decisions and human resource development (Bijlmakers, 2003).

Between 1980 and 1986 the health budget's share of government spending hovered between 4.5 percent and 5.1 percent (Davies and Saunders 1987:15). However, spending shifts emerged, whereas in 1980/81, 26.8 percent of the ministry's budget went to salaries, by 1985-86 salaries accounted for 44.7 percent. Despite pursuit of a PHC preventive services-based health care strategy the health ministry allocations did not match the increased salary costs reflecting a growing workforce. The growing health workforce was demanding, inflation adjusted pay resulted in side-lining resource allocations to PHC. "Grants" declined from 53.8 percent to 33.3 percent, while "supplies and services" increased slightly from 10.2 percent to 11.1 percent. In the 1980s, for persons like domestic workers, unskilled and semiskilled workers in industry, farm workers and lower levels of the civil service earning less than ZWD 150/month (about USD 90) free health entitlement existed. This would have

been upon producing a payslip, an identity card, employer letter or Department of Social Services assessments indicating that the bearer(s) were on “public assistance. Scarnecchia quoted in Mate (2018:8) observes at the time donors gave multi-sectoral policy advice, human and material support and at the 1981 donor conference held for resources mobilisation for the newly independent Zimbabwe, over USD 1 billion was pledged. However, because of the Cold War and other geo-political calculi, pledges were paid piecemeal (Mate 2018).

It is also worth noting that through the Village Health Workers’ (VHW) linkages between the organised village community and the local health service were reinforced (Anenden 1987). VHWs selection was by their own communities at mass meetings, the main criteria being basic literacy and political commitment to serve the village. Alongside individuals and community mobilisation on environmental and personal hygiene, nutrition, immunization, mother and child health issues the VHWs’ role was also fundamentally promotive, educative and preventive. In 1983, 67% of doctors were at central level, with only 1596 at provincial level and a further 15% at district, hospitals. By 1988, the proportion of doctors at central level had increased to 72%, with 12% in the provinces and 16% in district and mission hospitals.

Despite not functioning as referral facilities central hospitals absorbed the bulk of the high-cost personnel whilst rural mission and district hospitals continue to be poorly staffed and reliant on expatriate doctors. Critique by Saunders noted of how doctors had unwillingness to work outside the main centres. Therefore, the use of academic merit alone in medical students’ selection had resulted in the maldistribution of doctors as it became an urbanised, higher income profession. The 1980 policy of holding new graduates for several years in the public sector was opposed by the profession (Sanders 1990).

Given this state of affairs, the economic deterioration by 1987 exacerbated by inappropriate policies and excessive public sector spending triggered strikes by junior doctors in 1988/89 against serving in what they described as the poor conditions of many rural health services. The economy trajectory was of an annual inflation rate of 25%, a budget deficit of 10% of GDP, a government debt of 53% of GDP, and rising unemployment. Between 1980 and 1989 when the government was still following the socialist ideology of development the policy to have ‘health for all people by the year 2000’ was immensely pursued. The socialist ideology of development influences came from the Union of Soviet Socialist Republics (USSR) and China (Madzokere & Matanda, 2015; Matanda & Madzokere, 2015). However, after its defeat by capitalism led by United States of America (USA) and Great Britain, socialist ideology collapsed in 1989/90, health ideology adopted in 1980 tumbled. Mhike and Makombe (2018) comment that debate on the Zimbabwean socialist experiment of the 1980s highlighted policy and execution discrepancies. The government peddled the rhetoric of its unwavering commitment to providing free health care, yet it lacked financial and infrastructural capacity. Mhike and Makombe cite the gradual decline of government financial support for mission hospitals in the late 1980s and even more so under the Structural Adjustment Programmes of the 1990s. In 1990/1991 adoption of the capitalist ideology, the Economic Structural Adjustment Programme (ESAP) resulted in expensive and unaffordable health services. ESAP was on the advice of the International Monetary Fund (IMF) and World Bank to manage pervasive economic challenges. Hit by low growth and ESAP, focus shifted from equity to cost recovery and greater efficiency. While the second *Health for all Action Plan* for the period (1991–95) maintained the focus of its predecessor on equity, emphasis of the plan was on quality of care, effective resource usage, value for money and appropriateness of services, including increased private sector facilities usage (Chirwa et.al 2013). In the structural adjustment era government adopted a new National Health Strategy 1997–2007, which stressed the need for decentralisation and contracting-out of health services. The Medical Services Act was passed to regulate the medical industry, and operations of medical aid societies.

However, the economic deterioration in the 1990s and declining government financing triggered introduction of user fees by public and not-for-profit health providers. In 1980, the health ministry’s expenditure provision was pegged at 71% (Ministry of Health and Child Welfare (MoHCW 1984). By 1994, this expenditure share had fallen to 29%, with 31% coming from individual direct payments, 12,2% from donor financing and a total private sector share of health expenditure of 48,8% (Loewenson 1998).

Notwithstanding social mobilisation and health service delivery milestones, mounting public and professional concern arose as of the 1990s over declining quality, access and equity in health services. This concern was also about increased demands on people to finance and contribute to health services. Centralised decision making and authority, where administrative officials had the dominant input whilst excluding civil society groups, weakened the local government mechanisms for participation developed post-independence (Loewenson 1998).

Consequently, infant mortality rate (IMR) increased from 77 and 53 per 1,000 live births in 1992 to 94 and 67 in 2009. Between 1980 and 1990 the IMR had decreased by 50 percent, from 100 per 1,000 live births to 50 per 1,000 live births. Maternal mortality increased dramatically from 283 per 100,000 births in 1994 to 390 per 100,000 births in 1990 to 578 in 1999 to 555 in 2005/6 and 790 in 2008.

## 5. THE SIGNIFICANCE OF PHC, THEN AND NOW

Pre 1980 structures provided sometimes powerful instruments for making the state accountable to white minority interests. Therefore, independence in Zimbabwe offered an opportunity for both widening and deepening participation in the governance of many spheres of public activity, including health.

A study by Loewenson et al. (2004) established that existence functional Health Centre committees and community representatives resulted in quality health services with more resources (financial and staff), fewer drug stockouts, and a higher coverage of PHC services in the community catchment area. However, PHC system faces several challenges that call for exploring ways to alleviate worker fatigue through strengthened community-led care for Non-Communicable Diseases (NCDs) (Kamvura et.al 2022).

### a. Major reform I

Name and type of legal act	Public Health Act
Date the law was passed	2018
Date of <i>de jure</i> implementation	2018
Brief summary of content	The Act aligned to the Constitution the law relating to Public Health. The previous Public Health Act had been passed in 1924 and needed updating to meet the current health challenges and needs of the population.
Population coverage	The Act makes provision for a wide variety of matters affecting public health in Zimbabwe including, amongst other things, food safety matters, safe water supplies, appointment and duties of environmental health officers, diseases communicable by animals to men, slaughter of animals, sanitation, child nutrition. It defines fundamental human rights and freedoms in the field of public health and provides for the observance of international obligations in the field of health in Zimbabwe.
Type of benefits	The Act is divided into 14 Parts: Preliminary (I); Administration of the Public Health System (II); Health Services (III); Infectious Diseases (IV); Sexually Transmitted Diseases or Infections (V); International Health Regulations (VI); Non-communicable Diseases (VII); Water and Food supplies (VII); Infant and Young Children Nutrition (IX); Slaughter Houses (X); Sanitation and Housing (XI); Public Health Emergencies (XII); Public Health Funds (XIII); General (XIV).
Socio-political context of introduction	As a major enabling law in health the Public Health Act (1924) was frequently updated and amended to address new issues. However, the Public Health Act (1924) gaps like on non-communicable diseases, maternal health, cross-border risks and new epidemics necessitated amendments. Also, the Public Health Act (1924) was not reflective of post-independence health policy encompassing rights-based approaches, with outdated terms like <i>'dirty and verminous persons'</i> (Section 28), in relation to primary health care and community involvement in health. In April 2010, the MOHCC (then MoHCW) asked the Public Health Advisory Board to review the 1924 Public Health Act. In 2011 The Board carried out a technical and legal review and relatively wide stakeholder consultation. The Board drew public submissions through a white paper and held community and regional consultations and in July 2011 the final proposals were reviewed and adopted by stakeholders as proposals to government. The review identified the need for a rights-based framework that would, amongst other issues, promote health, address the social determinants of health and access to health care in a manner that 'promotes justice, equity and gender equity.

The public PHC workforce is largely nurse-led, with PHC nurses in rural clinics and nurses, midwives and clinical officers in urban municipality clinics. Nurse-anaesthetists provide the majority of anaesthesia in urban and rural hospitals, where caesarean sections are the main surgical procedure.

Zimbabwe is prone to epidemics including diarrhoeal disease and anthrax and rabies outbreaks being common thus public health surveillance and a disaster preparedness and response programme are crucial. HIV prevalence remain relatively high at 15% amongst adults and gains achieved to date are threatened by the deteriorating indicators and risky behaviours amongst the youth and increasing number of teenage pregnancies; TB deaths remain high due to its twin relationship with HIV and AIDS; and malaria remains a major cause of morbidity and mortality and more so in some geographic areas (National Health Strategy for Zimbabwe, 2016-2020).

The health system emerged from the economic meltdown of 2008, severely constrained in all its pillars. This was well reflected in the 2010-11 Demographic Health survey (DHS) which showed a sudden reversal of downward trends in key maternal and child health indicators. The maternal mortality ratio was up from 612 per 100,000 live births in the 2005 survey to 960 per 100,000 live births (World Bank Group 2020).

From 2009 onwards, economic improvement reflected promising infant/child mortality trends. From 2010-17 Government spending for health steadily increased during a period of macroeconomic stability. The MOHCC accounts for the largest spending on health, followed by local authorities, the Ministries of Public Service, Labour and Social Welfare (including Public Service Medical Aid Society (PSMAS and Assisted Medical Treatment Order (AMTO)), and the National AIDS Council. The economic growth experienced in the period 2010-2017 reflected a macroeconomic stability and health sector prioritisation particularly in the years 2010 to 2015 where average government health spending doubled in per capita terms from US\$20 in 2010 to US\$40 in 2017 (World Bank Group 2022).

However, high poverty incidence and the low quality of reproductive health services and education are the intractable challenges. Cholera is another cause for concern currently. Before the 2023 outbreak, previously a massive cholera epidemic in August 2008 led to a reported 4,269 deaths and 97,469 cases by April 2009 (MoHCW, 2009). The first cholera outbreak of 2023 started on 12 February 2023 in Chegutu town in Mashonaland West Province. As of 20th January 2024, 19,477 suspected cholera cases were recorded, 71 laboratory confirmed deaths, 350 suspected cholera deaths & 2,252 laboratory confirmed cases (International Federation of Red Cross 2024).

According to the 2022 Zimbabwe MOHCC health sector investment case hospital-level services are now user fees reliant and inadequate public funding for health facilities has negatively affected service delivery.

In the 2015 Zimbabwe national health accounts report, the household share of total health expenditure was estimated at 25 percent, and the incidence of catastrophic health expenditure was 7.6 percent, with the poorest households disproportionately affected. The household contribution to health expenditures decreased in the 2017 and 2018 national health account assessment to 16 and 13 percent, respectively.

Furthermore, at one point the government revealed that only five radiotherapy machines were working, resulting in cancer patients having to wait for months to access services. As of June 2024, according to Health and Child Care deputy minister Sleiman Timios Kwidini government signed a three-year contract with an American company, Varian Medical Systems for cancer machines repair and maintenance to alleviate the plight of patients who are forced to go to Zimbabwe's neighbouring countries for specialised treatment (Chikandiwa and Shamu 2024). Global Cancer Observatory data states that in 2020, Zimbabwe reported 16 083 new cases of cancer and 10 676 deaths due to the disease. The most frequently reported cancers included cervical, breast and prostate (Magwaya and Chikandiwa 2022).

## 6. RECENT DEVELOPMENTS IN HEALTHCARE

It is laudable that the adoption in 1980 of '*Planning for Equity in Health*' responded to the inequitable socio-economic situation (MoH 1980), and laid the foundation for PHC philosophy. Subsequent national policies have made equity a central policy principle, organising health systems around PHC. The organising includes measures for public services and personnel strengthening, accessibility and availability and redistributing resources to district services and underserved areas. Village health workers deployment for 'free' services for those earning below Z\$150 (then worth about US\$220) promoted equity in health (MoHCW, 1999). In 2013, for the first-time the constitution guaranteed the right to health care. Zimbabwe's per capita allocation had improved to US\$57 in 2017, but it is estimated to have sharply declined to US\$21 in 2020 risking gains made over the years. On the same note a period of relative macroeconomic stability ended as of 2018, with significant negative consequences for health sector financing. From 2015 onwards increasing macroeconomic challenges, culminating in

the Zimbabwe dollar (ZWL) reintroduction and a huge increase in domestic inflation (over 250% in 2019 and over 550% in 2020) (World Bank 2022). High tuberculosis (TB) and HIV/AIDS prevalence has taken a toll on health outcomes and health financing and the burden of communicable and maternal illness has matched accelerated rates of non-communicable diseases (NCDs). In 2012, NCDs caused approximately 31% of total deaths placing Zimbabwe at the Sub-Saharan African median. Negative lifestyle changes including unhealthy diets, physical inactivity, risky sexual behaviours (especially among youth) and smoking further complicate Zimbabwe's health profile.

Pertinently, the National Health Strategy (NHS) (2016-2020) aligned to the Sustainable Development Goals (SDGs), particularly to Goal 3 which aims at providing equitable quality health care services to all Zimbabweans, focused on PHC promotion. The key priorities are morbidity and mortality reduction due to such diseases as HIV, TB, Malaria and NCDs. In 2020, the inception of the Health Development Fund (HDF) quickly adapted to the challenges caused by COVID-19 and contributed to the National COVID-19 Response plan. The HDF supported the response through coordination activities, infection prevention and control capacity strengthening, risk communication and community engagement activities, treatment of COVID-19 cases, procurement of ventilators, test kits, personal protective equipment, essential medicines and laboratory reagents, and strengthening health controls at the country's borders. The HDF that preceded the Health Resilience Fund was supported by the European Union, Ireland, Sweden, the United Kingdom and Gavi, the Vaccine Alliance. As shown by the 2019 Multiple Indicator Cluster Survey (MICS) and the 2022 National Population and Housing Census, it contributed to improving several health indicators. Improvements were noted on maternal mortality, infant and under-five mortality, adolescent fertility, contraceptive prevalence and chronic malnutrition or stunting. Maternal mortality ratio, for instance, reduced from 614 to 462 per 100,000 live births between 2014 and 2019 (UNICEF Zimbabwe country office 2020). Presently, the National Health Strategy (2021–2025), articulates MOHCC's mission as to

“coordinate, promote, and advocate for the provision of equitable, appropriate, accessible, affordable, and acceptable quality health services and care to Zimbabweans, while maximizing the use of locally available resources in line with the Primary Health Care Approach.”

This approach focuses on health care services decentralisation to administrative wards and rural communities bringing services closer to the population inclusive of five levels, linked by a two-way referral system (U.S. President's Malaria Initiative Zimbabwe 2022). On this note, credit should be accorded to massive health funding that is availed by the former colonisers - Great Britain together with additional funding from the European Union (E.U) and the rest of the world. It is important to highlight that SDGs implementation has been supported by five-year National Health Strategies supported with the last two covering the periods 2011-2015 and 2016 to 2020.

## 7. DESCRIPTION OF CURRENT HEALTH CARE SYSTEM

### a. Organisational structure

Health service delivery is established at four levels: primary, secondary, tertiary and quaternary. The first and lowest is the Primary Care Level comprising a network of over 1,700 health centres, clinics, and rural hospitals, each serving a rural administrative ward or urban area. The MOHCC or local authority manages the vast majority of rural hospitals and clinics facilities with mission and private clinics accounting for only 6 percent of the total. In addition, private clinics now exist on farms and commercial entities such as industry or mines. The network of doctors and nurses' private surgeries falls under this level too where community health work is coordinated. The next is the Secondary Care level consisting a network of District Hospitals and equivalent hospitals such as Municipal Referral hospitals and mission hospitals. At this level emergency, ambulatory, and inpatient services are offered. The secondary care level includes a network of approximately 140 government, mission, and private. Approximately 70 percent of these facilities are managed by missions or private entities. At least one secondary care hospital exists in each of the 62 districts, serving as the next-level referral facility (U.S. President's Malaria Initiative Zimbabwe Malaria Profile 2021).

Third is the Tertiary level consisting of a network of Provincial Hospitals, one each per Province (except Harare and Bulawayo which are urban Provinces) offering emergency, ambulatory and specialist inpatient services. The fourth is the Quaternary level offering specialist inpatient services as well as University teaching facilities. The high-

est newly introduced level is the Quinary level aimed at spearheading research and development with linkages with Higher and Tertiary Institutions, the manufacturing sector and the MOHCC's new divisions of Biomedical Engineering Science and Pharmaceutical /Biopharmaceutical Production (National Health Policy 2020). The public sector (Ministries of Health and Child Welfare and Local Government, and to a lesser extent through Ministries of Education, Defence, Home Affairs and Prison services) provide the majority of health services in rural and urban areas. Public sector health services are complemented by the private sector, which includes both private for profit (e.g. industrial clinics, private hospitals, maternity homes and general practitioners) and not-for-profit private sector (e.g. mission clinics and hospitals and Non-Governmental Organizations) health facilities. Health services at the service delivery level are integrated and every health facility provides a full range of curative and preventive health services. For example, all health facilities offer maternal and child health services, including family planning. Traditional healers and herbalists represented by the Zimbabwe National Traditional Healers Association are also an integral part of the health care system. Western sciences trained doctors largely focus on the biomedical causes of disease, while traditional beliefs take a more holistic approach. Traditional healers are reputed to divine the cause of a person's illness or social problems by throwing bones to interpret the will of dead ancestors. Some healers say they directly channel the ancestral spirit through their bodies. Many have in-depth knowledge of plant materials and their various curative powers and use leaves, seeds, stems, bark or roots to treat symptoms. Most traditional healers are both herbalists and diviners, but some specialize in one aspect (Madamombe 2006).

#### b. Coverage

90% of the health services are accessed through the public health system, while about 10% of the population seek health services in the private sector. Exact numerical information on the share of the population covered by medical schemes is not available. Currently, there are 36 medical aid schemes covering about 10% of the population mostly through employment-based contributions. Medical aid schemes pay for their members when they seek care in both public and private health facilities. However, most are associated with varying co-payments at point of access. The GOZ makes contributions to medical aid schemes on behalf of civil servants (UNICEF 2021).

Since the health-related Millennium Development Goals (MDGs) were not met in 2015, pertinently, bold efforts are needed to ensure meeting the health targets of the 2030 Sustainable Development Goals (SDGs). To ensure health services accessibility to all citizens in line with section 76 of the Constitution, the government plans to roll out National Health Insurance (NHI) by the year 2025. Section 76 of the constitution stipulates that every citizen and permanent resident of Zimbabwe has the right to have access to basic healthcare services. In June 2024 the Ministry of Health and Child Care convened a National Health Insurance Taskforce meeting to discuss the establishment of NHI Scheme, which is expected to eliminate upfront payments at public health institutions. Similar to the National Social Security Authority whose establishment was through an act of parliament, NHI model seeks to have every person in formal employment contributing to the fund which will then be used to finance the public health system including buying essential drugs and equipment and the building of requisite infrastructure. In that regard the National Health Strategy (2021 – 2025) targets improving the health and wellness whilst ensuring universal health services access. Henceforth, the Health Sector Coordination Framework consolidates and coordinates shared efforts by the MOHCC and all key stakeholders to improve sector governance and oversight.

Importantly, the Health Resilience Fund (HRF) is a pooled health fund under MOHCC coordination contributing to improved health care for vulnerable mothers, new-borns, children and adolescents. HRF funding partners are the European Union, the Governments of Ireland, the United Kingdom, and Gavi- the Vaccine Alliance while UNICEF, UNFPA and WHO are the technical partners of the Fund.

#### c. Provision

To satisfy its population's health needs, the country requires at least 124 000 healthcare workers (Makoni 2023). In this regard the government targets recruiting approximately 130 000 workers from the current 64 000 amid chronic shortage of specialists in the health sector (Jena 2024).

Poor remuneration and difficult working conditions for health workers have been due to the fragile economic climate and health system underfunding resulting in health worker's poor remuneration and working under difficult



conditions. According to the 2022 Zimbabwe Health Labor Market Analysis (HLMA), over 1,600 health care workers, 72 percent of whom were nurses or midwives, left the public sector in the first half of 2021 alone. More specifically although doctor positions increased in 2022, rising from 1,657 to 1,724, a decrease eventually arose as 147 doctors still terminated their services. The nursing sector experienced a decline, with 1,454 nurses leaving their positions. The 2022 HLMA concluded that the production of new health workers would be insufficient to replace these losses. Current remuneration for health workers paid by the government includes a basic salary according to grade, a housing and a transport allowance. Most critical cadres also get at least one health sector specific allowance, such as night duty allowance, on call allowance, uniform allowance, rural allowance, psychiatric allowance, residence allowance for junior doctors and representation allowance for deputy directors and others in the same grade.

Health workers have been demanding a living wage of \$540 (£445) a month but the government has said it cannot afford to pay more. Nurses are paid less than \$100 (£82) a month. Despite increased recruitment to attrition, the number of public sector health workers has been reduced by at least 4,600 since 2019. In 2023, the World Health Organization listed Zimbabwe as one of the 55 countries that face the most pressing health workforce challenges related to universal health coverage.

The overall health care system capacity is insufficient. The current MOHCC health facility density target is two health facilities per 10,000 population, the inpatient bed density target is 25 beds per 10,000 population and core health worker density is 23 per 10,000 population. The Zimbabwe Service Availability and Readiness Assessment (2015) highlighted the national average for health facility density was 1.1 per 10,000 population, with low health facility densities in the metropolitan provinces of Harare (0.2) and Bulawayo (0.4) and somewhat higher densities in the rural provinces (range of 1.1–1.7). The national average for inpatient bed density was 18 per 10,000 population (range of 12–41), with only one province, Bulawayo, exceeding the target threshold of 25 (U.S. President’s Malaria Initiative Zimbabwe Malaria Profile 2022). The national average for core health worker density was 8 per 10,000 (range of 6–25). A high share of MoHCC budget allocation is typically earmarked for wage related costs, thereby crowding out capital investment, maintenance, and other expenditures for programs and service provision (U.S. President’s Malaria Initiative Zimbabwe Malaria Profile 2022).

#### d. Financing

The scope of health financing is made up of government (budget releases, internal transfers, and grants), private (corporates including Health Insurance companies and households), and contributions from the rest of the world (donors and Non-Governmental Organizations). Zimbabwe’s health sector is fragmented leading to inefficiencies and draws on multiple financing sources to cover operational costs. This includes budget allocations from the MOHCC, drawing on user fees, insurance payments, and payments from donor partners directly to facilities such as the RBF. As these sources have separate planning, budgeting, accounting and reporting requirements, it leads to inefficiencies and complicates planning and decision making. This is because fragmentation places an undue administrative burden on facility managers who have to manage different reporting and accounting requirements that may pull them away from their medical duties and increase management costs (World Bank 2022).

Although government funding has been the largest contributor to total health funding, however the funding still falls short of the requirements of the sector. The Abuja Declaration is a commitment that was made in 2001 in Abuja, Nigeria, by African Union heads of state, who pledged to allocate at least 15% of their national budgets to their health sectors. However, Zimbabwe has failed to come close to meet this target. In the first decade after independence health expenditure increased steadily to reach 3.1% of GDP and 6.2% of government expenditure – or US\$23.60 per capita – in 1990–91. As of year 2000, per capita health financing stood at US\$8.55. At the beginning of 2008, it stood at only US\$ 0.19 (Nyazema 2022).

Total health spending over the period 2016 to 2020 averaged US\$668 million. The 2017 National Budget allocated US\$281.98 million, representing 6.88% of the total budget (US\$4.1 billion), to the MoHCC, making it the fifth highest vote. While health spending from external partners remained stable at around US\$433 million annually, national budget health spending declined sharply from US\$321 million in 2016 to US\$96 million in 2019. Over the 5-year period spanning 2016 – 2020, on average development partners contributed 65% of total actual health spending while the budget contributed only 35%. The first case of COVID-19 in Zimbabwe,

was recorded on the 20 March, 2020. The COVID-19 pandemic evolved against the backdrop of a difficult macroeconomic environment and climatic shocks (Cyclone Idai and drought).

In 2020 increased government health funding from US\$117 million to an average of US\$460 million over 2021-2024 is laudable and aligns with government's commitment to the National Development Strategy 1 (NDS1) outcome of increasing domestic funding for health. The NDS1 is the national policy which every other policy thrust is built upon. This is evidenced by the National Health Strategy (NHS) (2021-2025) whose objectives and pillars align with the NDS1 health targets (ZIMCODD 2024). However, it is disconcerting that in 2023, the health sector allocation was 11.2 per cent, below the 15 per cent Abuja Declaration target. In 2021 health funding had increased significantly and accounts for 13% of the total 2021 national budget. To meet this commitment during 2024, approximately 8.73 trillion Zimbabwean dollars (448 million United States dollars) health allocation would have been required from the 58.2 trillion-Zimbabwean dollar (2.98 billion-US dollar) national budget to the health sector. Instead, 9.2% was allocated to the MOHCC (Masiyiwa 2024). Zimbabweans reportedly spend up to US\$400 million annually seeking treatment and other health services abroad (Rusike 2024). For realisation of international and national commitments for adequate healthcare provision for all, the government of Zimbabwe must realize in action its commitments to the sustainable development goals, initiating robust pro-poor strategies buttressed with strong monitoring and accountability mechanisms (Nhapi 2019).

#### e. Regulation of dominant system

##### *Role of global actors*

Zimbabwe is a benefactor of the largesse of several international donors. Since 2008, donor funding accounted for 19% of total health expenditure compared to 13% in 1999. Donor partner spending has been consistently large over recent years. Between 2014 and 2020 donor partner support averaged US\$409 million, varying from a low of US\$346 million in 2016 to a high of US\$496 million in 2019.

##### *List of additional relevant legal acts*

The main legislation for health is the Constitution of Zimbabwe Section 76 which states:

- a. Every citizen and permanent resident of Zimbabwe has the right to access basic health care services, including reproductive health services.
- b. Every person living with a chronic illness has the right to have access to basic health care services for the illness.
- c. No person may be refused emergency medical treatment in any health care institution.
- d. The State must take responsible legislative and other measures, within limits of the resources available to it, to achieve the progressive realization of the rights set out in the constitution.

Major regulations include the Health Services Act (2002), the Public Finance Management Act (2010), the Medical Services Act (2001), the Mental Health Act (1996), and the Health Professions Act (2000). The first ever Zimbabwean Medical Aid Society Registration Act was enacted into law in 1999, a historic development in a country that has avoided nearly all forms of health care regulation to date. It provides a foundation for regulation in the future should policy-makers decide that it is warranted.

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