A Feminist Approach to Public-Private Partnerships (PPPs): The case of the Parirenyatwa Group of Hospitals in Zimbabwe

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Abstract

Background

I argue in this paper that all the Public-Private-Partnerships (PPPs) being implemented in the Zimbabwean health sector do not actively mainstream gender equality. The PPPs that currently exist in public hospitals were not consistently guided by any regulatory framework and where it existed the process did not strictly abide by the regulatory framework. Most of the PPPs are based on Memorandum of Understanding (MOU) that are not enforceable and were not guided by adequate legal advice nor participation by main actors affected by the PPPs. The PPPs were introduced as a panacea to the reduction in public health spending caused by the adoption of Structural Adjustment Programs (SAPs) by the Zimbabwean government at the behest of the IMF and World Bank in the mid-90s.

Methodology

I conducted desk reviews of available literature on Public Private Partnerships in the health sector in Zimbabwe and Sub-Saharan, Low Income Countries (LICs). Key words were "Public Private Partnerships", "Gender Equality", "Zimbabwe", Health Sector, LICs and Sub-Saharan Africa. I reviewed legislation for public health and gender equality including national policies and strategies for health and gender equality and legislation governing Public Private Partnerships in the health sector in Zimbabwe. I conducted Key Informant Interviews, with CEOs, Clinical Directors, clinicians, professional health associations, health care professionals working in public hospitals and civil society organizations to understand their experiences and opinions about the five PPPs at Parirenyatwa Group of Hospitals. I also referred to media articles on announcements and opinions about PPPs in the health sector by the different actors involved in support of or aggrieved by PPPs.

Findings

Three waves of socio-economic developments (a period of high public expenditure on health from 1980-1990, secondly a period of liberalization and privatization from 1990-2000 and

thirdly a period of economic downturn from 2000 to date) shaped the health sector in Zimbabwe. The period of high public expenditure resulted in marked improvement in health service coverage and health outcome indicators. This was reversed during the second and third waves after implementation of SAPS in the mid-90s. Reduction in public spending on social services and direction of funding to the private sector was done without consideration of gender equality and human rights. Public Private Partnerships were introduced in public hospitals as a way of mitigating against the reduction in public funding. This resulted in PPP contracts at Parirenyatwa Group of Hospitals without involvement of all the relevant actors neither was there consideration for gender equality. Implementation of the PPPs has also not been transparent and accountable as evidenced by many acts of resistance by health care professionals, legislators, civil society and the general public. The resistance resulted in cancellation of all PPPs in public hospitals in July 2020.

Recommendations

1. Zimbabwe should develop a compulsory National Health Insurance Scheme funded through taxation and support from health development partners
2. The scheme should prioritize coverage for essential health services for vulnerable populations especially women, children and indigents
3. The Joint Ventures Partnerships Act and the Zimbabwe Investment Act should be adapted to PPPs in the health sector with involvement of all actors with consideration for gender equality and human rights and enforcement of legal frameworks in a transparent manner

Socio-Economic and Political Context

Zimbabwe attained independence from Britain in 1980 after ninety years of colonial rule. Independence was a result of a protracted armed liberation struggle from 1965 that culminated in the Lancaster House conference in 1979 where Zimbabwe was granted independence. Immediately at Independence in 1980, the Zimbabwean government adopted and implemented the Primary Health Care (PHC) approach that had been declared in 1978 at Alma Ata [1]. Zimbabwe decentralized health services to administrative wards using the PHC principle of Equity in Health[2]. According to an EQUINET[3], three waves of socio-economic developments shaped the health sector in Zimbabwe. These were;

- A period of high public expenditure on health from 1980-1990
- A period of liberalization and privatization from 1990-2000
- A period of economic downturn from 2000 to date

The Government of Zimbabwe constructed a total of 1,091 health facilities and institutions after independence bringing the total number of health facilities that are reporting into the Ministry of Health and Child Care (MOHCC) District Health Information System (DHIS) version 2.30 to 1,779 to date[4].Zimbabwe made impressive progress in health-care in the years following independence with Life Expectancy increasing to 60 years, immunisation coverage reaching over 80 per cent of the target population, and by 1989 Infant Mortality Rates (IMR) had fallen to 46 per 1,000 live births[5]. These achievements were noted in a UNICEF report that described Zimbabwe as 'a beacon for progress towards child survival and development in sub-Saharan Africa'[3]. By the year 2000, immunization and Antenatal Coverage (ANC) had reached 89% and

[1] Facilitators and barriers to effective primary health care in Zimbabwe, Sunanda Ray, Nyasha Masuka 2017 http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S2071-29362017000100067

[2] The Zimbabwe Crisis and the Provision of Social Services: Health and Education https://journals.sagepub.com/doi/abs/10.1177/0169796X1002600204

[3] Equinet (2009) "Capital Flows in the health sector in Zimbabwe. Trends and implications for the health system". Discussion paper 79.

[4] MOHCC District Health information System version 2.30

[5] . *Paying for healthcare: Poverty and Structural adjustment programmes in Zimbabwe, Jean Lennock 1994 Oxfam (UK and Ireland)*

Infant Mortality was reduced by 80% from 1980-1998[6]. Between 1980-1987 the government of Zimbabwe increased expenditure on health by 80% equating to 2.3% of GDP and this was almost three times higher than the sub-Saharan Africa average of 0.8% of GDP [7].

However, there were clear growing inequities in health provision from the mid 90s onwards due to the Economic Structural Program (ESAP) that Zimbabwe adopted from the World Bank and IMF. These policies were focused on public sector reforms including the health sector and resulted in economic liberalization, privatization and reduction in public expenditure[5]. During this era Zimbabwe adopted a new National Health Strategy 1997-2007 with the aim of creating opportunities for the private sector, scaling up decentralization and contracting out services.[5] There were negative trends in the health sector post 2000 due to foreign currency shortages, inadequate export performance, reduced capital inflows , withdrawal of multilateral financing institutions and scaling down of bilateral creditors[5].Total expenditure on health fell from a peak in 1998 of 10.8% of GDP to 7% of GDP in 2005, with decrease in public expenditure on health and increasing private expenditure on health. The largest increase in expenditure was in household out-of-pocket expenditure to 53% of private expenditure on health in 2001, placing significant burdens on individuals. By the year 2000, per capita public health expenditure had decreased to U$8.55 in comparison with the 1997 Commission of Review for Health that recommended per capita expenditure of U$23.60 and by 2008 per capita health expenditure had reached rock bottom of U$0.19.[4] There was massive brain drain from 2000 with the health sector losing 20% of medical personnel per month and up to 75% by 2004-2008[5].

[6] Munyuki E and Jasi S (2009) 'Capital flows in the health care sector in Zimbabwe: Trends and implications for the health system' EQUINET Discussion Paper Series 79. Rhodes University, Training and Research Support Centre, SEATINI, York University, EQUINET: Harare.

[7] Trane R and Bate R (2005) 'Despotism and Disease: A report into the health situation of Zimbabwe and its probable impact on the region's health', Africa Fighting Malaria and American Enterprise Institute: Washington DC, available at:http://www.reliefweb.int/rw/rwb.nsf/db900sid/EVIU-6E7B8Z?OpenDocument

These policies had a profound effect on the health indicators that had initially performed well. For example, life expectancy at birth was 56 years in the 1980s, increased to 60 years in 1990 and declined to about 43 years by 2010 [8]. Norman Nyazema points out how the Zimbabwean Health System deteriorated from one that adopted the concept of Equity in Health and Primary Health Care to address inequities in health at Independence in 1980 to one that resulted in inequities in health in the early to mid 90s after adoption of the Economic Structural Adjustment Policies. He notes the reduction in life expectancy at birth, an increase in the burden of disease affecting the population especially women and children, massive brain-drain and how the constitution at that time did not recognize the right to health[9]. Nyazema (2007 and 2010) demonstrate how adoption of neoliberal policies did not take into consideration mainstreaming of gender equality and had a disastrous effect on access to comprehensive quality health services for women. The paper demonstrates the reduction in spending for public health services and the increase in maternal morbidity and mortality.[10]

The Zimbabwean health system nearly collapsed in 2008 amid a health worker crisis and a nationwide cholera outbreak but this was followed in 2009-2012 by some recovery of the economy and renewed investment in health services. Economic growth declined again during 2013-2017, with 72% of the population living below the national poverty line and 21% living on less than $1.90 a day.[11] Zimbabwe did not conduct National Health Accounts for about six years from 2004-2009 due to the hyperinflationary economic environment that made it difficult to ascertain expenditures in health. Government expenditures increased from 21.4% in 2015 to 33% in 2017 increased to 44.1% in 2018. There was a decrease in the Private entities' share of financing for health expenditures from 53.7% in 2015 to 32.8% in 2017 and a further decrease to

[8] *The Zimbabwe Crisis and the Provision of Social Services: Health and Education*
Norman Z. Nyazema, 2010

[9] Right to health was only adopted in 2013 Constitution.
[10] Nyazema, N (2007) The Zimbabwe Crisis and the Provision of Social Services: Health and Education
https://journals.sagepub.com/doi/abs/10.1177/0169796X1002600204

[11] . World Bank. Zimbabwe country profile [homepage on the Internet]. 2016 [cited 2017 Sept 24]. [Links] Available from: http://databank.worldbank.org/data/Views/Reports/ReportWidgetCustom.aspx?Report_Name=CountryProfile&Id=b450fd57&tbar=y&dd=y&inf=n&zm=n&country=ZWE

29.2% in 2018[12]. This decrease in expenditure by private entities and households was analyzed and triangulated with the Poverty Income Consumption Expenditure Survey (PICES) report 2018. Analysis showed that decrease in household expenditure was because a third of all the income groups (non-poor, poor and very poor) were foregoing health care because they could not afford[13]. The share of total expenditure from the Rest of the World[14] increased from 24.9% in 2015 to 34.2% in 2017 and decreased to 26.7% in 2018. Overall, the total health expenditure declined by 9.6% from 2015 to 2017 and increased by 27.3% from 2017 to 2018. However, the increase in expenditure did not meet the financing deficit of the government during this period. The government financing deficit was $1138.09 in USD million in 2015 and decreased to 877.4USD million in 2017 and increased to 952.8 USD million in 2018 constituting 78.6%, 67% and 57.2% of the total financing respectively.[15]

The Maternal Mortality Ratio (MMR) reached an all-time high of 960 deaths per 100,000 live births in 2010 and remained high at 651 deaths per 100 000 live births according to the ZDHS 2010 and 2015 respectively; the under-5 child mortality rate at 69 deaths per 1000 live births and 27% of children under 5 years of age being stunted[16]. This socio-economic crises and succession battles within the ruling party, resulted in the ouster of the first President of Zimbabwe in a military coup in November 2017[17]. Zimbabwe is now under the leadership of a new regime that was ushered in after the July 2018 Presidential and Parliamentary elections.

Under 5 mortality has increased to 73 per 1000 and ranges from 51 per 1000 for the richest to 91per 1000 for the poorest. However Maternal Mortality Ratio has decreased from 651 per

[12] Zimbabwe National Health Accounts Survey Report 2017/2018
[13] Zimbabwe PICES report 2018
[14] According to the new nomenclature in the National Health Accounts, "Rest of the World" refers to expenditure incurred through Official Development Assistances (ODA).
[15] Zimbabwe National Health Accounts 2017/18
[16] 4. Zimbabwe National Statistics Agency and ICF International. Zimbabwe demographic and health survey 2015: Final report. Rockville, MD: Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International; 2016. [Links]

[17] Zimbabwe crisis: Army takes over, says Mugabe is safe: https://www.bbc.com/news/world-africa-41992351

100,000 live births to 462 per 100,000 live births with a Skilled Birth Attendance and Institutional Delivery ranging from 82% in rural areas to 94% in urban areas.[18]

The long-term development agenda under the New Dispensation namely Vision 2030 seeks to transform the country into an Upper-Middle-Income (UMI) Society by 2030. In 2018 the GDP for Zimbabwe was U$18 billion and 30% of the GDP was from exports[19]. In order to make progress towards UMI status, a medium term plan the Transitional Stabilisation Programme (TSP) – October 2018 to December 2020 is being implemented[20]. The TSP`s immediate objective is to achieve macro and fiscal stabilisation and laying a solid foundation for attaining the triple 'S' growth - strong, sustainable and shared. The Annual Plan / Budget, for 2019 has focused on 'Austerity for Prosperity' – tension in the means (austerity) and ends (prosperity). Essentially, austerity entails cutting back on aggregate demand, which ultimately will affect growth, employment and poverty. The austerity measures have resulted in erosion of salaries whilst the cost of living has increased more than five-fold without matching salary increments. At devaluation of the ZWL$, was trading at U$1 to ZWL2.50 in February 2019 and by January 2020 was trading officially at U$1 to ZWL18.77 . The monthly consumer basket as of November 2019 was valued at ZWL$ 4,000 in an economy where a Junior Doctor was earning ZWL$2,365.50 a month.

The initial health budget allocation for 2019 was U$650 million (U$52.13 PPP per capita or 7% of the National budget) a far cry from the USD86 PPP recommended by WHO or 15% of the National Budget recommended by the Abuja Declaration. The budget was revised to ZWL 1,2 billion (U$ 120million or U$7.50 PPP per capita at official exchange rates) in August 2019 after the devaluation of the ZWL$ in February 2019. This effectively reduced the health budget by 81.5% in real U$ terms. Seventy five percent of the ZWL$ 1.2 billion (ZWL$900million) is for payment of salaries leaving a paltry ZWL$300million (U$ 30million) for operational service delivery[21]. Below is a table showing trends in decreasing proportion of the budget allocation against trends in increasing per capita GDP allocation from 2013 to 2019 in Zimbabwe.

[18] Zimbabwe Multiple Indicator Cluster Survey Report 2019
[19] Zimbabwe Ministry of Finance and Economic Development Budget statement 2019
[20] Zimbabwe Transitional Stabilization Plan October 2018 to December 2020
[21] Zimbabwe Ministry of Health and Child Care presentation at the Health Financing Symposium 13-14 February 2020

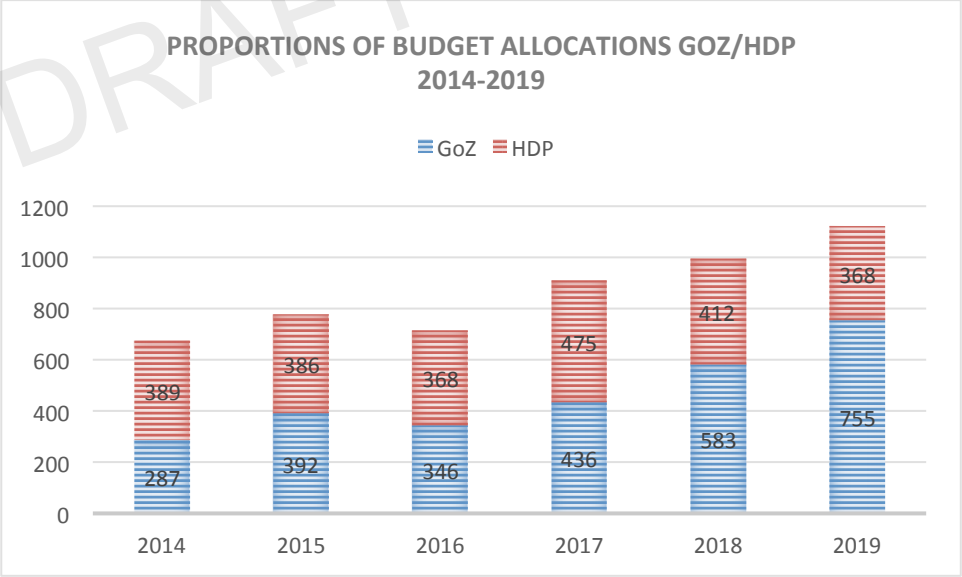
Table 1. Per Capita GDP allocation (U$) and health budget as proportion (%) of Total Government Budget

Year	2019	2018	2017	2016	2015	2014	2013
Per Capita GDP allocation (U$)	52.13	30.29	21.69	25.45	23.15	25.92	24.44
Budget Allocation/Total Government Budget (%)	7.07	5.84	6.88	7.46	6.57	8.18	8.23

Source: MOHCC Budget presentation to Health Development Partners 2019

This economic background has increased reliance on Health Development Partners funding for implementation mostly of vertical disease control programs. Whilst domestic funding for health has been on an increasing trend (for salaries), external funding has been on a decreasing trend, having fallen from $475M in 2017 to $368M in 2019. External funding has also been highly dependent on a few partners, namely the Global Fund and the United States Government Partners[22]. Below is a graph showing trends in Government of Zimbabwe budget allocations and allocations by Health Development Partners (HDP).

Figure 1. Trends in budget allocations (U$millions) by GOZ & HDP 2014-2019



Source: MOHCC Budget presentation to Health Development Partners 2019

[22] Zimbabwe Ministry of Health and Child Care Round 4 Resource Mapping Report 2019

Trends show increase in budget allocations by GoZ relative to funding by HDP over the five-year period. However, the value of the GoZ contributions in U$ purchasing power parity terms is much less because of real economic inflation on the background of an officially controlled exchange rate giving U$ and Zimbabwe Bond note currency a parity of 1:1.

The Joint Venture Partnerships Act is a law/policy by the Zimbabwean government guiding and encouraging PPPs in every sector to fill the public funding gap. The mantra "Zimbabwe is open for business" is a way by the new regime of encouraging investors to invest in private for profit ventures in the country. There have been many "mega deals"[23] shrouded in secrecy that have made media headlines since government embarked on the Transitional Stabilization Plan but the public is yet to see their conclusion let alone benefit from the investments. There are active attempts to engage foreign groups of investors in hospitals to form PPPs with public Central Hospitals for delivering super-specialized care, yet the country still lags behind on Primary Health Care and Universal Health Coverage. This thrust towards PPPs is in contrast to previous assertions by the Ministry of Health and Child Care which suspended all PPPs in 2018 with the aim of reviewing their performance and coming up with a cost effective and transparent framework for PPPs.[24]This pushback on PPPs was by the chairperson of the Parliamentary Portfolio Committee on Health who argued that poor people were facing financial barriers to accessing care at one of the central hospitals that had numerous PPPs that had not been evaluated. Nurses at the same hospital had downed tools in solidarity with the plight of patients that were not able to access care including pregnant women.

Gender equality in accessing health services is under threat in Zimbabwe firstly because of underfunding of health care, secondly because of the increased reliance on funding from Global Health Initiatives who have neoliberal ideologies, thirdly because of the thrust by government directing health institutions to engage in PPPs in the health sector as a way of alleviating the funding gaps and finally the lack of enforcement of an explicit regulatory and legal framework that mainstreams gender equality in the formulation and implementation of donor funded health projects and PPPs in the health sector.

[23] Mega deals are transactions that involve huge sums of Foreign Direct Investment and are supposed to give the impression that they will solve Zimbabwe's economic woes.

[24] https://dailynews.co.zw/articles-2018-01-29-gvt-suspends-hospitals-private-partnerships/

According to the 2009 EQUINET Discussion Paper series 79, "Planning for Equity in Health" is the policy that was adopted by the government of Zimbabwe in 1980 to deal with inequalities and inequities in health status and healthcare. However this changed according to the National Health Strategy 1997-2007 with the introduction of decentralising responsibility for services, liberalising the private sector, strengthening of management and outsourcing of non-essential services as a way of conforming to SAPs. This was in direct contradiction to the 1980-1990 policy, a period when there was criticism of the private health sector by almost every Minister of Health in Zimbabwe and specific target in health policy of the private sector as distorting the allocation of health resources[25].

"***Government policy (MOHCW, 1984) had set its health care priorities as:***

- ***redirecting the majority of resources to those most in need;***
- ***removing the rural/urban, racial and class biases in health and health care;***
- ***overcoming the fragmentation of service providers to develop an integrated, national health care service;***
- ***ensuring accessible care to the majority, with other levels supporting this infrastructure;***
- ***integrating preventive, promotive, curative and rehabilitative care; and***
- ***increasing the participation of and control by communities in their health services***".

The National Health Strategy 1997-2007 acknowledged the policy direction that continued provision of quality health services depended on taking action to address issues affecting the entire health sector. The strategy sought to explore the roles that other sectors public and private could play in health service provision. the role of the then Ministry of Health and Child Welfare transformed to being that of 'supporting, promoting, and advocating for the provision of quality health services and care to all citizens'

According to this reform strategy, five main areas of reform were targeted:

- ***Decentralisation — with the expressed aim of creating an enabling administrative, managerial and operational environment for all stakeholders in the health sector to***

[25] Loewenson 1990

- ***ensure that investment in health, public or private is linked to the achievement of national health objectives.***
- ***Management strengthening and the development of managerial and institutional capacity.***
- ***Subcontracting of non-core services, involving the private sector in service provision at all levels, and***
- ***Regulation of the health sector, with enactment of the Medical Services Act (1998), to regulate the operations of stakeholders in the health sector as a whole***

The EQUINET discussion paper postulates that Zimbabwe's membership to the World Trade Organisation (WTO) could also have pressured the government to pursue liberalization in alignment to the General Agreement on Trade in Services (GATS) promulgated in 1994. However, had EQUINET noted the potential negative effects on governments ability to regulate the health sector if they committed to the GATS agreement in a publication in 2004, and by 2009 Zimbabwe had not made any commitments with regards to the health sector. The paper also concludes that the lack of commitment by the government could have been due to the fact that there was already heavy private health sector presence and international investors had already established themselves in the private-for-profit health sector. The private health sector is well established in Zimbabwe and below is the number of private health providers registered with the Health Professions Authority excluding allied health professionals to date.

Table 1. Registered private health facilities by type of facility in Zimbabwe 2020

Type of Practice	Total Number
General Practitioners Rooms	411
Private Clinics	439
Obstetrics and Gynecology Rooms	99
Private Hospitals	94
Specialist Physicians Practices	69
Specialists Surgical Practices	48
Paediatric Rooms	39
Accident and Emergency Rooms	19
Total	1,218

Source: Health Professions Authority website; www.hpa.zo.zw

The number of registered private health facilities matches the number of government health facilities as demonstrated in table 2 below.

Table 2. Registered health facilities by ownership in Zimbabwe 2020

Ownership	Number of registered health facilities
GOZ	1217
Private	1218
Missions[26]	112
Total	2547

Source: Health Professions Authority website; www.hpa.zo.zw

The EQUINET discussion paper points out that there were four types of capital investments in the health sector in Zimbabwe during the period of liberalization. These were;

- Mergers and acquisitions in the local health sector
- Foreign Direct Investment (FDI) directed at the health sector
- Incentives to the private sector such as training subsidies and tax incentives
- Contracting out

Whyle et al in the publication Health Policy and Planning, Volume 31, Issue 10, reveals that eight distinct Public Private Engagement models (Table 3), are utilized in the Southern African context. They found that the literature is disproportionately representative of PPE initiatives located in South Africa, and of those that involve for-profit partners and international donors. The authors identified a significant gap the literature identified through the study as the scarcity of information regarding the relationship between international donors and national governments. They demonstrate the need for research that disaggregates PPE models and investigates PPE functioning in context[27].

Table 3. Public Private Engagement Typology

[26] Missions are Church Based Organizations that own and run hospitals and schools in Zimbabwe

[27] Whyle, E, Olivier, J, (2016 Health Policy and Planning, Volume 31, Issue 10),Models of public–private engagement for health services delivery and financing in Southern Africa: a systematic review; https://academic.oup.com/heapol/article/31/10/1515/2567069/

Public Private Engagements	**Public Private Partnerships**	-highly collaborative -risk sharing -long term -contractual -shared decision making
	Social Marketing	-uses private sector marketing and communication tools -increase uptake of public goods -usually involve subsidization
	Sector Wide Approach	-non-contractual -shared decision making -centered around national sectoral strategies -pooled funding
	Public Private Mix	-non-contractual -collaborative -Vertical disease focus -involves actors from all sectors
	Vouchers	-demand side financing -defined benefits -target groups
	Contracting Out	-contractual -short term -no-shared decision making -"buying services"
	Dual Practice Regulations	-regulatory control of dual practice -between state and public sector physicians
	Financial support	-public financing of private sector -Through grants or public insurance -non-contractual

In our case study we will focus on two types of models that the case study fits into. These are;

- Contracting Out
- Dual Practice Regulations

Munyuki etal described the levels of functioning contracting out to private-for- profit providers in Zimbabwe in 2009. Our case study has several contracts that have different functions as described in table 4 below.

Table 4. Levels of functioning contracting out to private-for- profit providers in Zimbabwe in 2009

Type of	Functions of contract	National current status of contracting

Contract		
Non-Clinical Services	Catering	Principle generally accepted at national level. No evidence of contracting out services at Central, Provincial, District hospital. Catering services still public provided
	Cleaning	Still publicly provided at all facilities (moves to start at Parirenyatwa hospital in 1995 were shelved). All cleaning functions are owned and provided by government
	Security	Publicly provided at all facilities
	Maintenance (land and Building)	Publicly provided by Ministry of Public Works that owns the buildings. Government employed grounds men to do general maintenance through MPC
	Maintenance (Equipment)	Hospital equipment maintained by public facilities themselves, through the hospital equipment department that exists at all facilities. Internal contracting exists in the form of MPC doing maintenance for certain plant equipment. For some equipment out-servicing of technical staff from specialized private providers is done-but on an as per need basis. Government therefore purchases equipment from private sector but largely retains the maintenance of the equipment only mortuary maintenance is contracted out at Central hospitals
	Laundry	Central, provincial and district hospitals increasingly outsourcing laundry with private-for-profit launderers. Internal contracting with some central hospitals providing laundry services for district hospitals
	Billing	Patient billing done by public facilities. Some public facilities using private debt collectors to collect outstanding patient fees
Clinical Services	Hospitalized care	Mission hospitals although privately owned act as agents for government and provide comprehensive care packages in districts that could otherwise be government provided. Local government authorities are required by government to provide care and receive grants from central government.
	Ambulatory care and related services	Both private and public sectors provide ambulatory services. Private for-profit providers are however not contracted with for ambulatory services. There is a large number of private for-profit emergency facilities offering day care as well as inpatients services. Private physicians offer a variety of services to self-referred day patients at their private rooms

		and clinics. They can also bring their patients to casualty and emergency wards of public facilities. Local government facilities also offer ambulatory services from which they collect fees not on behalf of central government. Public facilities also provide ambulatory services at their casualty, outpatient and emergency wings
	Public Health	All public health functions are provided by government. There are however some private for-profit (like mines and agricultural facilities) that provide public health in their environments as a requirement of their industrial activities monitoring. They are not under contract to do so as this is a regulatory requirement

Source; Munyuki E and Jasi S (2009) 'Capital flows in the health care sector in Zimbabwe: Trends and implications for the health system' EQUINET Discussion Paper Series 79. Rhodes University, Training and Research Support Centre, SEATINI, York University, EQUINET: Harare.

The Case Study of PPPs and Gender Equality at Parirenyatwa Group of Hospitals

Our case study will be Parirenyatwa Group of Hospitals, a central public teaching hospital that was established during the colonial era to cater for white settlers but is now open to all citizens. The hospital is run under the Parirenyatwa Hospitals Act (Acts 16/1975,39/1981; R.G.Ns 1135/1975,899/1978,6/2000, 22/2001). The Act was promulgated in 1975 to establish the Parirenyatwa Hospitals Board of Governors to manage and control the Parirenyatwa Group of Hospitals and to provide for its functions, relating to the care and treatment of the sick and medical education and research, and its powers are; "to provide for the transfer of certain movable assets and certain liabilities to the Parirenyatwa Hospitals Board of Governors and to regulate the financial affairs thereof; to provide for the staffing of such Hospitals; and to provide for matters incidental to or connected with the foregoing.' The Act is elaborated in more detail in the Annexe 1.

The Public-Private Engagements described by Whyle et al were further classified by Munyuki et al into whether they are contracts for provision of non-clinical services or clinical services in

Zimbabwe. The types of contracts in our case study include contracts for both types of services as elaborated below.

PPP Case 1: Laundry PPP at Parirenyatwa Group of Hospitals

The main actors in the formulation of Public Private Engagements at Parirenyatwa Hospitals ideally should be the PHBG, the Minister of Health and Child Care, the health professionals working at the hospital, the Zimbabwe Investment Authority, other government ministries, parliamentarians, patient groups and representatives of civil society. However, according to key informants in management, the first contract at Parirenyatwa hospital came about as a reaction to a crisis by the then Chief Executive Officer (CEO) and management in 2008.[28] The hospital's laundry equipment had become old and dysfunctional and they could not afford to send linen for laundry to private service providers. This posed a great threat to provision of critical surgical services for the biggest specialist quaternary teaching hospital in Zimbabwe. Management purposively approached three laundry companies and made a proposal for public-private partnership for laundry services at the hospital. The conditions for the partnership were that the private laundry company would refurbish the hospital's laundry equipment, bring their own equipment, and get all the laundry business at the hospital. According to the typology of PPPs described by Whyle et al, this is "Contracting Out". According to the same authors, the contract should ideally be short term, with no shared decision making and the hospital would be "buying services" from the contractor.

Interestingly according to key informants in management, laundry companies refused to enter into the partnership because they felt by doing so they would be subsidizing the government and also faced the risk of late or non-payment for services in a hyperinflationary environment. Another private laundry company that had not been approached by management for the PPP approached the hospital and asked to do a feasibility study. After the feasibility study, the company agreed to have a PPP for laundry services. The CEO of PGH took the draft agreement between the hospital and the private laundry to the Joint Ventures Unit in the Office of the President and Cabinet and for authorization. The reason for seeking authorization was that such a partnership had never been formed with a public hospital and even the PHBG did not know how

[28] Nyazema, N (2007) The Zimbabwe Crisis and the Provision of Social Services: Health and Education

to do the partnership. The OPC authorized the PPP and it is still operational to date. This contracting out and can be monopolistic if it guarantees the private partner business without any competition as is the current case at Parirenyatwa hospital[29]. This contract can result in provision of poor quality of services and the hospital can incur huge costs in legal expenses whilst trying to terminate the contract. However key informants in management expressed their contentedness with the quality of services and mentioned that their linen now has a longer lifespan then the standard eight washes because they monitor the use of chemicals that wear out fabric during laundry sessions by the private laundry company.

PPP Case 2: The Dual Practice PPP at Parirenyatwa Group of Hospitals

According to key informants in management at PGH, the second PPP is an agreement between doctors working in the hospital and the PHBG to admit their private patients. This typology of this PPP is called the Dual Practice regulation type of public-private-engagement[2]. The hospital has a private wing called the D-Floor that provides health care services for only those who are adequately insured or can afford whilst the poor use the public wing of the hospital[30]. Clinical specialists that work at the hospital are allowed to admit their private patients on the D-Floor and charge the patients privately for the care provided while admitted in a public hospital. The hospital charges the patient hotel fees and all medical and surgical consumables and drugs that are utilized during the period of admission. This PPP arose as a response to the socio-economic meltdown that culminated in the collapse of the Zimbabwean economy in 2008 and is provided for by the Medical Services Act of 1998. The Government of Zimbabwe started failing to pay doctors reasonable salaries as far back as 1989 and doctors have gone on strike almost every year since then.[31] In response to this predicament and also needing to continue providing specialist clinical services at Parirenyatwa, the PHBG decided to allow specialists to admit their private patients on the D-Floor so that they could supplement their paltry salaries. The first condition for

[29] Whyle, E, Olivier, J, (2016 Health Policy and Planning, Volume 31, Issue 10),Models of public–private engagement for health services delivery and financing in Southern Africa: a systematic review

[30] This feature is peculiar to the Parirenyatwa hospital because the hospital was purpose built to serve the well to do during the colonial era and this was inherited and continued after independence.

[31] https://mg.co.za/article/2017-04-06-00-how-to-fund-a-failing-health-system/

a specialist to get admission rights on the D-Floor is that they should have provided care for a certain number of patients in the public wing of the hospital over a period of time and secondly, that they will include public patients on their operating list without discrimination. While the system of giving specialists admission rights is relatively transparent and objective, there are no clear measures in place that monitor the moral hazard of specialists limiting care for poor patients on the public side of the hospital and shunting them to the private wing. Mudyarabikwa et al (2000) noted that the informal arrangement of accessing facilities in exchange for providing free services to public patients is open to abuse such that during the study for the EQUINET discussion paper, the then Ministry of Health and Child Welfare gave instructions to institutions to stop admission of private patients particularly in maternity where practitioners were unwilling to attend to public patients after admitting their private patients in public hospitals. No attention was paid to the fact that the deterioration of the socio-economic situation in the country had a bigger and worse impact on women because of their disadvantaged socio-economic status. [32]Key informants in management pointed out that there are many cases that have been reported where nurses in the public wing of the hospital direct patients and relatives who are waiting for surgical and medical procedures to the private rooms of the specialists who are supposed to care for them in the public wing of the hospital. Patients experience timely care when they are re-admitted to the D-Floor but there is no evidence that they get better quality care or have better health outcomes.[33] Many patients who cannot afford the timely care given on the D-Floor either complicate or end up asking for discharge and go to seek care in nearby mission hospitals where services are available and cheaper.[34] These are usually women who are already disadvantaged and poor resulting in their ill health and need for care.

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[32] Percival, V, Richards, E, Maclean, T, & Theobald, S (2014, Conflict and Health volume 8, article 19, Health systems and gender in post-conflict contexts: building back better?

[33] Goodman, C, Hanson, K & Mills, A, (2007 *International Journal for Equity in Health* **volume 6**, Article number: 17), Can working with the private for-profit sector improve utilization of quality health services by the poor? A systematic review of the literature

[34] Malmborg, R, Mann, G, Thomson, R &Squire, B, (Bulletin of the World Health Organization 2006;84:752-758) Can public-private collaboration promote tuberculosis case detection among the poor and vulnerable?

This PPP does not streamline gender equality and human rights even for the mostly female nurses who work on the D-Floor. Key informants in management indicated that the only service providers that are paid privately at market rates by the patient or medical insurance are the physician, surgeon, anesthetist and theatre nurse as provided for by the Medical Services Act of 1998, whilst the ward nurses that attend to the patients post-operatively are on a government salary and don't get any extra payment. This is a source of conflict and resistance to the PPPs and some doctors end up paying the ward nurses informally or use punitive measures if the nurses don't give appropriate care to the patients.

Key informants pointed out that there is new PPP that is currently under development for the D-Floor, surgical operating suites and diagnostic equipment at Parirenyatwa hospital. A directive was given in a memo from the office of the Permanent Secretary for Health in 2018 instructing all government central hospitals to advertise tenders for PPPs for establishing super-specialist centers of excellence for clinical services (Annex 2). This was after a pronouncement in the media by the Minister of Health and Child Care, a former central hospital CEO who presided over some PPPs whose effectives was never thoroughly evaluated (Annex 2). PGH flighted tenders in the mainstream media inviting private investors to partner with the hospital by investing in refurbishment of the D-Floor and surgical operating suites and by acquiring modern high-tech diagnostic. The hospital will reciprocate by partitioning the private wing between the hospital and the private investor. The private investor will be allowed to provide super-specialist clinical services that are not currently being provided by the specialists at the hospital. These super-specialist services are the services that Zimbabweans are travelling to India, China and Singapore to get. In his budget statement in 2019, the Minister of Finance and Economic Development estimated that USD400 million was spent on medical tourism in 2018 for a very small proportion of the population. This amount was equivalent to the annual budget for the Ministry of Health and Child Care for 2019. Parirenyatwa hospitals views the PPP as a strategic move to capture the market of patients who travel outside the country for treatment. This typology of PPE according to Whyle et al is the typical PPP that is highly collaborative, with risk sharing, is long term, contractual and has shared decision making. The fact that the PPP comes as a directive from the Ministry of Health and that the health professionals working at Parirenyatwa

hospital, the public and law makers were not consulted demonstrates that the motive of the PPP are not guided by evidence in literature. The Zimbabwe College of Public Health Physicians (ZCPHP) conducted a Continuing Medical Education (CME) session on 15 June 2019 as a reaction to the directives that had been given on formulation of PPPs in public hospitals. The title of the CME session was ***"Public Private Partnerships* (PPPs) *in healthcare: Is a win-win situation really possible in Zimbabwe***".[35]

Below is an excerpt of the policy paper that the ZCPHP submitted to the Ministry of Health and Child Care with findings and recommendations on PPPs after the CME session

"After reviewing much evidence, the ZCPHP acknowledges the necessity of PPPs as a global trend and a way of going around the challenge of unavailability of funds for health services. The college recognizes the favorable factors that are present such as the existence of a legal framework in the form of the Joint Ventures Act of 2014/6; as well as government commitment.

Several risks were noted, and some of these are:

- **Possible blind spot where hospital care is prioritized above primary health care**
- **Possible profiteering by private companies at the expense of the poor**
- **Conflict of interest**
- **Changes in the political climate**

Considering this, the college recommends the following to the MOHCC:

1. **Consider exploring PPPs for primary health care**
2. **The formation of technical teams that thoroughly examine contracts before the MOHCC commits. The college is available to assist with this**
3. **Clear and transparent processes in the agreements and formulation of PPPs**
4. **Agreements that are timed with the political cycles ie not more than 5 years**

[35] https://drive.google.com/drive/folders/1oTp45kJNHdw2gJqAfFrRUBFHbVKy01vo?usp=sharing

5. **Implementation of a clear monitoring and evaluation strategy to document the success of the PPPS**

6. **Separation of power and function in the formulation of PPPs**

7. **Semi-autonomy to be given to sub-national levels so they can explore PPPs at their levels with support from head office and the college; eg engaging corporates in their catchment areas."**

According to key informants, there were eight bidders for the PGH PPP; five international investors and three local investors. A total of three; one international investor and two local investors were shortlisted for the PPP. Two of the investors managed to do feasibility studies. Management is now waiting to adjudicate on the proposals developed by the investors after the feasibility studies. Some of the key issues that key informants in management alluded to were that the model the partnership envisaged was a Build Operate and Transfer (BOT) where the investor after re-furbishing the D-Floor would operate it as a private super-specialist unit over some period of time until they have recovered their initial capital and made enough profit, and then hand over back to Parirenyatwa hospital. According to the World Bank report on evaluation of PPPs, there is significant risk associated with this especially if legal advice in formulating the contract is weak.[36]This kind of arrangement can result in a huge legacy debt on the fiscus and taxpayers or the rest of the hospital being taken by the private investor to fulfill contractual obligations in the event of failure of the government and patients to pay for the super-specialist services. Zimbabwe has demonstrated over the past three decades that it has no capacity to adequately fund health service provision[37]. Another key issue is how the hospital management are going to ensure that poor and vulnerable people would also access the services according to need and not according to ability to pay. Their idea is to give the private investor tax re-bates and holidays based on the number of non-paying patients the investor will have provided care and also duty-free certificates for equipment and drugs that they will bring into the country.

PPP Case 3: The Renal Dialysis PPP at Parirenyatwa Group of Hospitals

[36] World Bank Group Public-Private-Partnerships Legal Resource Center 2016
[37] Zimbabwe National Health Accounts Survey 2013, 2015

The third PPP is with a private company that provides renal dialysis services. This PPP started in 2009 when the hospital's renal dialysis equipment broke down and there was no funding for replacement. The private company, a sole agent for an international manufacturer of renal dialysis equipment, offered to supply and service new renal dialysis equipment for "free". The condition was that the hospital would buy a certain quantity of consumables every year exclusively from the company and ensure that they have done a certain number of dialysis sessions. This typology of public private engagement is also Contracting Out like the laundry partnership. The risks with these types of partnerships are mainly around the monopoly that the supplier of the machines has over provision of the renal dialysis bundles that are used for dialysis and the condition of the minimum number that the hospital has to buy or consume in a year. The contract has been renewed three times since 2009 to date without going to a new tender. This is in contrast to the framework of "Contracting Out" that Whyle et al describe where these contracts should be short term. There are seventeen machines that are working out of a total of eighteen.

Key Informants in management agreed that the hospital entered into the agreement without wide stakeholder consultations and without consideration of gender equality and how the arrangement would impact women's health and rights. Patients were paying out of pocket for renal dialysis at Parirenyatwa hospital until 2018 when the Ministry of Health started providing ringfenced funding for renal dialysis. There was no policy mainstreaming gender equality regarding financial access to renal dialysis services at the hospital. A total of 181 Chronic Renal Disease (CRD) patients are undergoing dialysis at Parirenyatwa hospital and getting three sessions a week each. A total of 7476 dialysis sessions were done in 2019[38]. The dialysis records do not disaggregate the numbers according to gender and this is a stark demonstration of the lack of consideration of gender equality for the dialysis services.

PPP Case 4: The Mbuya Nehanda Maternity Hospital PPP at Parirenyatwa Group of Hospitals

The maternity hospital at Parirenyatwa hospital has a public wing and a private wing. The hotel facilities are different for the patients, but they all receive care in the same theatres and are

[38] Parirenyatwa Renal Dialysis Register 2019

operated on by the same doctors. This PPP further increases inequality between women because poorer women in the public wing of the hospital often times have to bring their own medical and surgical sundries such as gloves and pads whilst women in the private wing are provided because they can afford to pay. Key informants in management narrated of a story where a woman in the public wing of the hospital died in labor because the few nurses and doctors available were busy with emergencies on the private ward. According to the Parirenyatwa Group of Hospitals Health Information Department, there were a total of 8008 deliveries in 2019. Of these, 7177 (89.6%) were public patients and the remaining 831 (10.4%) were private patients[39]. This demonstrates how only very few women can afford the services on the private maternity wing.

PPP Case 5: The Pharmacy PPP at Parirenyatwa Group of Hospitals

The fifth PPP at Parirenyatwa hospital is a private pharmacy that is operating in a building outside the main hospital building but within hospital grounds. Management entered into this PPP because they could not adequately stock the public pharmacy in the hospital. The public pharmacy needs stocks worth U$20 million per year for optimal service provision to patients. Management concurred that it was beneficial to patients who could not get drugs in the hospital to buy from a private pharmacy within the hospital grounds and not incur indirect costs travelling to pharmacies in town. The hospital flighted tenders in the media and the highest bidder got the tender to run the private pharmacy in 2014. The private pharmacy pays rentals equivalent to U$1000 a month to the hospital. The hospital does not buy drugs and consumables from this pharmacy and this contract has no classification in the framework described by Whyle et al. There is no evidence that having a private pharmacy within the hospital grounds has improved availability of drugs that are not in the hospital pharmacy. If at all because of lack of wide stakeholder consultations and specifically paying attention to gender equality and human rights, patients have no choice but to buy even more expensive drugs at this pharmacy especially at night or if they are from rural areas and are unfamiliar with Harare.[40,41]

[39] MOHCC DHIS 2 Parirenyatwa Hospital 2019

[40] Mugwagwa, J, Chinyadza, J, & Banda, G, (2017) Private Sector Participation in Health Care in Zimbabwe: What's the Value-Added?

[41] Prata, N, Montagu D & Jeffreys E, Private sector, human resources and health franchising in Africa; Bulletin of The World Health Organization

Gender and human rights impact of the Parirenyatwa PPP implementation and functioning;

There is a paucity of literature that defines the attributes of a typology of health sector PPPs that mainstream gender equality and human rights. The Constitution of Zimbabwe — the supreme law of the country — specifically provides for gender equality. Amended and approved in 2013, the Constitution recognizes the rights of women and men to equal opportunities in political, economic, cultural and social spheres and guarantees the right to equal pay. The Constitution provides (under Section 4.28) that all customs, traditions and cultural practices that infringe on the rights of women are to that extent void. Finally, it calls for the state to ensure gender balance and fair representation of disadvantaged groups, and promotion of women's participation in all spheres of society. However, this is not reflected in practice in the health sector where since independence in 1980 all ministers of health have been men and only two out of eight permanent secretaries of health are women. The last PHBG consisted of seven board members instead of the fourteen mentioned in the act and only two of the members were women out of the seven. The Public Health Act does not specifically mention gender equality and participation in the constitution and composition of board appointments and secondment to various positions within the Ministry. The Public Health Act also leaves the mandate on private investments into the public sector and Joint Venture Partnerships to be exercised at the discretion of the accounting officer (Permanent Secretary for Health) with no reference to or consideration of gender equality. Such non-representation of women in positions of power means that women do not have a voice in the formulation of PPP policies in the health sector and at Parirenyatwa hospital in particular.

The second National Gender Policy 2013-2017 sought to **achieve a gender *just society where men and women enjoy equality and equity and participate as equal partners in the development process of the country.*** The policy goal was ***"To eradicate gender discrimination and inequalities in all spheres of life and development."*** The Gender Policy did not particularly include issues to do with gender equality in formulating policies on PPPs in health. Health outcome indicators in the Zimbabwe Demographic and Health Survey in 2015 and the ZIMPHIA 2016 showed that Maternal Mortality Ratio remains unacceptably high and HIV incidence and prevalence is higher in women than men among other indicators. Key informants in management

agreed that there was no particular attention paid to gender equality when they went into their PPP agreements and that it was subsumed that women would also equally benefit from the PPPs. This approach did not consider that women are already disadvantaged in terms of education and employment opportunities and income and therefore financial access to privatised services in the hospital. Management confirmed that most of the specialists with admission rights on the D-Floor are male and most of the nurses manning the D-Floor wards are female and do not benefit from the PPP.

Key informants in management and among staff indicated that although they do not deny anyone emergency care at the hospital, there are incidents where they have detained women after they have delivered because of failure to pay their bills. This is against the ministry's own policy and the Zimbabwe Reproductive, Maternal, Newborn, Child, Adolescent Health & Nutrition Quality Improvement Guidelines of 2018.

The Zimbabwe National Health Strategy 2016 to 2020 derives from the Constitution of Zimbabwe and was aligned to the then Government Program of Action during the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset) 2013-2018 era. The strategy for the year 2020 is now aligned to the Economic Transitional Stabilization Plan. The NHS 2016-2020 emphasizes under Goal 5 "**Achieve gender equality and empower all women and girls**" and brings to the fore the need to address specific challenges that affect women and girls who tend to be disproportionately affected by poverty, diseases and violence and other social ills. The NHS 2016-2020, as described in the SDG framework seeks to realize the human rights of all and to achieve gender equality and the empowerment of all women and girls. The subject of PPPs is elaborated under goal 3 in the NHS 2016-2020; **"To improve the enabling environment for service delivery"** through multisectoral partnerships. The strategic thrust was to develop a policy on Public Private Partnerships. The NHS 2016-2020 also notes that "the private for-profit sector presents opportunities for widening access to quality services beyond the middle-class, but a key challenge is the absence of a defined public-private partnership framework within which to cooperate." Besides all these pronouncements in the NHS 2016-2020, none of the PPPs at Parirenyatwa hospitals were formulated and guided by a framework that mainstreamed gender equality and human rights.

Zimbabwe is a signatory to several regional and international protocols, treaties, conventions and other instruments protecting and promoting gender equality in general, and the empowerment of women and girls in particular. These include, among others:
(i) Convention on the Elimination of all Forms of Discrimination against Women (CEDAW);
(ii) Southern Africa Development Community (SADC) Gender and Development Protocol (including its Addendum on Prevention and Eradication of Violence Against Women and Children);
(iii) Beijing Platform for Action;
(iv) Protocol to the African Charter on Human and People's Rights on the Rights of Women;
(v) Universal Declaration of Human Rights;
(vi) International Convention on Economic, Social and Cultural Rights;
(vii) Convention on Civil and Political Rights (CCPR);
(viii) Equal Remuneration Convention (ERC);
(ix) Protocol to the African Charter on Human and People's Rights on the Rights of Women 2005 (The Maputo Protocol);
(x) Millennium Declaration of 2000; and
(xi) United Nations Sustainable Development Goals (SDGs).

Despite having signed this plethora of treaties, there is no evidence that the principles of these treaties are being considered in the formulation of PPPs in the health sector. Key informants amongst management and staff at Parirenyatwa did not know that Zimbabwe was a signatory to these treaties, let alone considering them when formulating PPPs at the hospital.

Transparency and Accountability remarks

The state has numerous laws for managing the private health sector and one such law is the Medical Services Act of 1998. According to the EQUINET discussion paper, the Act was operationalized in 2001 almost a decade after the major changes in the public-private mix had taken place. This law acknowledged the importance of the private health sector who had been operating in an unregulated environment. The aim of the act was to;

- Ensure provision and maintenance of comprehensive hospital services in Zimbabwe

- Provide for admission of persons to government hospitals and the fixing of fees in respect of services provided
- Provide for the granting to medical practitioners and dental practitioners of the privilege of access to certain government hospitals and for the appointment of consultant medical and dental practitioners
- Provide for the registration of medical aid societies
- Set conditions for the registration of private hospitals

There are incentives granted by this Act to private for-profit health care providers such as access to government hospitals for treating their private patients that they cannot look after properly in their practices.

This law also gives the Minister the powers to fix user fees payable at public hospitals and reflects the influence of SAPs in policy shift to reducing public spending on health and introducing user fees. The law does not address issues of equity with regards to payment of users fees thus exposing vulnerable populations to financial barriers to health care.

The regulatory system in the health sector in Zimbabwe was found to have several weaknesses by Kumaranayake et al in 2000.[42]

- They focus on individual inputs rather than health system organizations
- They aim to control entry and quality rather than explicitly quantity, price or distribution
- They fail to address the market-level problems of anti-competitive practices and lack of patient rights
- There is no regulation of private insurance

We used qualitative participatory methods by conducting Key Informant Interviews (KII) to find out the levels of transparency and accountability in formulating PPPs in the health sector. The Key Informants agreed to interviews on conditions of anonymity due to fear of victimization.

[42] How do countries regulate the health sector? Evidence from Tanzania and Zimbabwe; researchgate.net/publication/12205082

Key informants[43] in management acknowledged that they knew about the Zimbabwe Joint Venture Partnerships Act of 2018 and the Zimbabwe Investment and Development Agency Bill of 2019 that were introduced for regulating PPPs. They acknowledged that they were supposed to review all their PPPs and align them to this new legal framework for accountability and transparency. However, they acknowledged that this is proving to be very difficult because of the nature of the contracts that they have that were formulated as innovations without a guiding framework. The new legal framework does not mainstream gender equality in the joint ventures and in any partnerships in general, and in the health sector specifically. The act is silent and does not speak to gender participation and empowerment in joint ventures and partnerships.

The current PPP arrangements at Parirenyatwa Group of Hospitals were formulated as innovative responses to underfunding by the Government of Zimbabwe. The process was spearheaded by management and was not participatory in general and did not include the voice of women, health care professionals and citizens or consider human rights. This is similar to the findings by the Zimbabwe Coalition on Debt and Development Research Findings Report on Social and Economic Impacts of Public Private Partnership Agreements to the Realisation of the Right to Health, at another central hospital in Zimbabwe. 67% of people who were interviewed by ZIMCOD on the PPP were not aware that there was a PPP at the hospital and did not know how it worked. This showed a lack of transparency and it is the root of community suspicions and mistrust of the whole project. In fact an audit of the PPPs that was ordered by the then Permanent Secretary for Health after the ZIMCOD report, revealed that there had been a major decline in revenue for the hospital over the period of the PPPs and that fees paid for services accrued to the private partners and the hospital did not benefit the hospital and communities[44]. Key informants who work at Parirenyatwa bemoaned the lack of transparency and accountability in the formulation of PPPs and indicate that the issue came as a directive from the ministry and even resulted in the resignation of the Clinical Director who did not agree with the approach. Clinicians working at the hospital were asked to make their submissions for the PPPs without any consultations or inputs into whether the policy decision was suitable for Parirenyatwa

[43] Key Informants are Hospital CEOs, Operations Directors, Clinical Directors, Clinicians, health professionals associations and allied health workers

[44] https://www.newsday.co.zw/2019/12/health-minister-sees-red-over-audit-report/

hospital. Key informants amongst health professionals working at Parirenyatwa hospital only know that an advert was flighted for PPPs in 2018 and are not aware of what is going on (Annex 3). We managed to learn what is going on with the new proposed PPP after interviewing key informants in management. None of the key informants among the health professionals that we interviewed knew how much money was being paid for the laundry services provider neither did they know the cost of renal dialysis bundles that the hospital was buying from Fresenius for the dialysis machine. None of the interviewees knew how much the private pharmacy was paying in rentals to the hospital and what the income was being used for.

Experiences of resistances

PPP arrangements for pharmacy services were implemented at two other Central Hospitals that cater for lower wealth income quintiles in the high density suburbs of Harare and at a central hospital in the second largest city Bulawayo in the southern region of the country. These PPP arrangements including the one at Parirenyatwa Hospitals faced fierce resistance from health workers and the general public on the basis of lack of transparency and accountability in their formulation and implementation[45]. Demonstrations were held until three of the private pharmacies at other central hospitals were closed leaving the one at Parirenyatwa Hospitals operating. The Senior Hospital Doctors Association handed a petition against the directive for central hospitals to engage in PPPs to the clerk of parliament in 2019 arguing that these would result in financial barriers to accessing care for the poor and that the PPPs could present an opportunity for corruption.[46] An internal audit into PPPs at one of the central hospitals was ordered by the then Permanent Secretary for health in 2016 because of complains and resistance by health professionals, patients and communities who were not happy with how the PPPs had been formulated. 72% of respondents in the ZIMCOD study indicated this central hospital with PPPs was now very discriminatory against the poor because despite the availability of all treatments under one roof, it was unfair for the poor who would not afford the exorbitant charges

[45] https://dailynews.co.zw/articles-2018-01-29-gvt-suspends-hospitals-private-partnerships/

[46] https://www.newzimbabwe.com/zim-doctors-blast-govt-hospital-privatisation-bid/

and some resorted not to seek treatment, with some dying at home because they could not afford the services.

The fact that resistance to PPPs at this central hospitals resulted in an audit whose results were published indicates that there is still institutional integrity that serves public interest. However the fact that nothing was done after damning findings in the audit report also indicates that there are inherent weaknesses in enforcing existing regulatory frameworks. Lack of enforcement of regulatory frameworks is largely attributable to deep rooted corruption that has dogged Zimbabwe since Independence.[47] The authors attribute the tolerance of corruption by the former president as "part of an intricate power retention matrix"

Key informants in management acknowledged that there was serious resistance to the PPPs on the D-Floor, the Renal Dialysis PPP initially and the private pharmacy PPP. Key informants among staff working at Parirenyatwa hospital confirmed that doctors and nurses who do not benefit from the D-Floor partnership are not happy with the arrangement because it is skewed in favour of older doctors who already have made more money and specialized nurses and does not take into account the contribution of nurses who look after the patients on the wards.

The chief proponent of PPPs in the health sector in recent times was the then Minister of Health and Child Care (2018-2020) and former CEO of Chitungwiza Central Hospital, the hospital that had a damning audit report on PPPs. The Minister was recently fired from government after being implicated in a corruption scandal involving procurement for COVID-19 (Annex 4). The Acting Minister of Health and Child Care wrote a directive suspending all PPPs in public hospitals soon after the dismissal of the substantive Minister in a move that indicates that there was a realization that the PPPs were not formulated in a transparent manner (Annexe 5).

Conclusion

The was massive public health funding in the Zimbabwe health sector during the first decade after independence in 1980 with marked improvements in health coverage and outcome indicators. The main goal for the government during that period was to provide comprehensive,

[47] Corruption and the Comrades: Mugabe and the "fight" against corruption in Zimbabwe 1980-2013; https://link.springer.com/chapter/10.1057%2F9781137543462_11

integrated, continuous, quality health services in an equitable manner through decentralization of services that particularly targeted the vulnerable groups. However with the introduction of SAPs by the IMF and World Bank there was liberalization and privatization of the health sectors without consideration for gender equality and human rights resulting in barriers to access to health services and worsening of health outcome indicators for women. The PPPs in the health sector were formulated without adequate participation of all the actors and there was lack of transparency and accountability resulting in acts of resistance from health care professionals, legislators and citizens. Resistance to PPPs and acts of corruption associated with them resulted in dismissal of the Minister of Health and Child Care on 7 July 2020 and cancellation of all PPPs in Public Hospitals by the Acting Minister of Health and Child Care on 27 July 2020.

Recommendations

1. Zimbabwe should develop a compulsory National Health Insurance Scheme funded through progressive taxation of citizens and corporates that can also be supported by health development partners
2. The scheme should prioritize coverage for essential health services for vulnerable populations especially women, children and indigents
3. The Joint Ventures Partnerships Act and the Zimbabwe Investment Act should be adapted to PPPs in the health sector with involvement of all actors with consideration for gender equality and human rights and enforcement of legal frameworks in a transparent manner- moving from Public-Private-Partnerships (PPPs) to Public-Private-Professionals-People-Partnerships (PPPPPs).

Annexe 1.

Parirenyatwa Hospital Act says' there is hereby established a board, to be known as the Parirenyatwa Hospitals Board of Governors, which shall be a body corporate and shall in its corporate name be capable of suing and being sued and, subject to this Act, of performing all such acts as bodies corporate may by law perform.

The Hospital Board of Governors reports to the Health Services Board the employer of all public health workers in Zimbabwe and the Chairman of the Board also reports to the Minister of Health and Child Care

The composition of Board is as follows;

(1) Subject to section six, the Board shall consist of fourteen members, of whom—

(a) one shall be a person who is not practicing medicine for gain appointed as chairman by the Minister; and

(b)one shall be the Medical Superintendent ex officio;

(c) and five shall be appointed by the Minister, of whom—

i. four shall be persons who are not medical practitioners; and
ii. one shall be an officer of the Ministry responsible for health; and

(d) two shall be appointed by the Minister, of whom—

i. one shall be selected from a panel of three persons who are staff members of the Faculty of Medicine whose names have been submitted by the Council of the University of Zimbabwe; and
ii. one shall be selected from a panel of three persons who are not staff members of the Faculty of Medicine whose names have been submitted by the Council of the University of Zimbabwe; and

(e) two shall be members of the clinical teaching staff appointed by the Minister from a panel of four persons, all of whom shall be full-time staff members of the Faculty of Medicine at the

University of Zimbabwe, elected by the clinical teaching staff in the manner fixed in terms of subsection (3); and

(f) one shall be a medical practitioner appointed by the Minister from a panel of three persons whose names have been submitted by the governing body of the Zimbabwe Medical Association; and

(g) one shall be an honorary consultant appointed by the Minister from a panel of two persons whose names have been submitted by the honorary consultants; and

(h) one shall be a nurse appointed by the Minister from a panel of three persons whose names have been submitted by the governing body of the Zimbabwe Nurses Association.

(2) The Deputy Medical Superintendent shall ex officio be an alternate member to the Medical Superintendent and shall act as a member when the Medical Superintendent is unable for any reason to attend a meeting of the Board.

(3) The panel of persons referred to in paragraph € of subsection (1) shall be elected—

(a) in the case of the first election held in terms of this Act, in accordance with such procedure as the Minister may fix;

(b) in the case of any subsequent election, in accordance with such procedure as the Board may from time to time fix.

Annexe 2

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ZIMBABWE

MINISTRY OF HEALTH & CHILD
CARE HEAD OFFICE
Kaguvi Building
From the Minister's Office
Cnr Fourth Street / Central Avenue
P.O. Box CY1122
Causeway
HARARE, ZIMBABWE

10 April 2019

To: Chief Exceutive Officers
Provincial Medical Directors

RE: REFURBISHING, RE-EQUIPING AND ESTABLISHMENT OF A SUPER SPECIALIST HOSPITAL ON PUBLIC PRIVATE PARTNERSHIP MODEL AT RESPCTIVE HOSPITALS

The Ministry of Health and Child Care intends to modernize all its hospitals by establishing Super Specialist Central and Provincial hospitals in line with global trends. Institutions are being advised to overcome funding challenges from Treasury through engaging with private investors in implementing the above proposal. The Public Private Partnership is one model which can be adopted to bridge gaps of inadequate funding from Treasury.

By this correspondence, you are being requested to come up with Expression of Interest on the above proposal for consideration. Please find attached Parirenyatwa Group of Hospitals Expression of Interest which they recently advertised for your guidance.

Please ensure that the adverts are flighted by the 30th April 2019 at the latest.

The office of the Permanent Secretary is available for any further clarifications you may need to make.

Thank you for your usual cooperation.

Major General (Dr) G. Gwinji (Rtd)
Secretary for Health and Child Care

SECRETARY FOR HEALTH AND CHILD CARE
(01) SECRETARY OFFICE (01)
10 APR 2019
P.O. BOX CY 1122, CAUSEWAY
ZIMBABWE

cc. Hon. Dr Obadiah Moyo – Minister of Health and Child Care
Chief Directors – Ministry of Health and Child Care
Chief Engineer – Ministry of Health and Child Care
Medical Superintendents – Ministry of Health and Child Care

Annexe 3

PARIRENYATWA GROUP OF HOSPITALS

EXTENSION OF CLOSING DATE

Parirenyatwa Group of Hospitals wishes to advise all prospective bidders that the closing date of the below-stated invitation for Expression of Interest has been extended to **3 May 2019.** All interested bidders can access pre-qualifications documents from the Procurement Management Unit. The details of the Expression of interest are as follows:

REQUEST FOR EXPRESSION OF INTEREST: PGH/01/19

REFURBISHING, RE-EQUIPING AND ESTABLISHMENT OF A SUPER SPECIALIST HOSPITAL ON A PUBLIC PRIVATE PARTNERSHIP MODEL AT PARIRENYATWA GROUP OF HOSPITALS

PROJECT SCOPE

The Parirenyatwa Group of Hospitals wishes to engage a Firm or Consortium to refurbish and re-equip various sections of the hospital to modern standards (state-of-the-art) whilst operating a Super-Speciality hospital wing/section within the hospital grounds or at an appropriate location that would be mutually agreed.

The Firm or Consortium will be responsible for assessing, refurbishing, re-equippingand upgrading of:

- Diagnostic services
- Pharmaceutical Services
- Operating Theatre suites
- Critical Care Areas
- Accident and Emergency Department
- Ophthalmology services
- Rehabilitation services
- Ward infrastructure and furniture
- Radiotherapy services
- Water, Electrical and Gas supply
- Corridors, walls, ceilings and floors

Parirenyatwa Group of Hospitals now invites eligible parties to indicate their interest to enter into this Joint Venture. Interested firms/Consortia should provide information demonstrating that they have the required resources, qualifications and relevant experience as well as managerial and organisational capacity to perform the services.

The minimum criteria for short listing shall include, but not limited to the following:

- Resources to channel into the Joint Venture
- Key Professional staff withappropriate qualifications and competencies.
- Managerial and organisational capacity
- Track record and demonstrable experience in similar projects.
- A minimum of two (2) letters from traceable organisations must be submitted.

The following documents should also be submitted:

- Company registration documents
- Detailed company profile
- Detailed curriculum vitaes (accompanied by certified educational certificates of the professional staff)
- Trade references
- Guarantee of availability of resources

Short-listed potential bidders will be selected according Section 3 (2) (a) of the Joint Venture Act.

Short-listed potential bidders will be invited to submit detailed technical and financial proposals. Interested firms may obtain further information at the address below during office hours (08:00 hrs to 16:30 hrs).

Head of Procurement Management Unit
Parirenyatwa Group of Hospitals
Tel: +263 242 791979
+ 263 701555-7 ext 2435

Proposals (Original plus 2 copies) must be in English, enclosed in a sealed envelope, clearly marked **"Expression of Interest for refurbishment and re-tooling Parirenyatwa Group of hospitals"** and must be delivered to the below address by **3 May 2019** before 10:00 hrs.

Internal Audit Department
Parirenyatwa Group of Hospitals
Administration Block
Mazowe Street
Harare

NOM-DI596723-128

Annexe 4

www.herald.co.zw_25 May 2019

Super specialist hospitals for Zim soon, says Moyo

The Interview Paidamoyo Chipunza

Government recently announced that it has embarked on a massive rehabilitation programme of public health institutions. **Health and Child Care Minister, Dr Obadiah Moyo (Dr OM)** speaks to our **Senior Health Reporter Paidamoyo Chipunza (PC)** on his goals, source of funding and implementation of this rehabilitation programme.

PC: What do you seek to achieve with these Joint Venture Partnerships?

Dr Moyo: We want to make sure that the health facility is of very high quality, providing first class services. We want to make sure that our customers are accessing affordable services within easy reach, making sure that all the facilities are well rehabilitated. Our facilities have sat for a long time without any major rehabilitation. At the same time, we need to replenish all the institutions with medicines so that it makes sense. We want to make sure that our facilities are not death-traps, they are hygienic and that they are clean facilities.

However, for us to be able to tackle all these problems as a Government and on our own, we cannot be able to fulfil it that's why you hear the "Zimbabwe is open for business" mantra and it also includes the health industry. We want investors in the health industry to come and provide services, to come and invest and be able to institute higher levels of management in terms of patient care in our institutions. We want to be able to come up with super specialist hospitals and ensure that we do not send people out of Zimbabwe for specialist treatments but that everything is done locally, here in Zimbabwe.

We have to look for partners who have the capability- the financial capability and the general know how and can be able to impart medical knowledge to our people.So it's not just a matter of partners for the sake of partners, its partners who have the capability to train our people who can be able to set up all the relevant high quality care parameters within our institutions.

PC: I have seen adverts from Parirenyatwa Group of Hospitals, United Bulawayo Hospitals (UBH) inviting bidders for these JVPs. Which other hospitals are earmarked for rehabilitation under these JVPs?

Dr O.M: We are looking into entering JVPs with potential investors who are in a position to establish these facilities and be able to come up with training facilities as well, besides provision of medical care. So, already as part of our 100-day plan, Parirenyatwa is earmarked and we are already moving into the other central hospitals like Mpilo, United Bulawayo Hospitals and so forth. We want to do it in phases. We have had some responses from Parirenyatwa. There are some foreign investors who have shown some interest so we are waiting to finalise that.

PC: How has been the response so far?

Dr O.M: There are lots of foreign companies with local consortiums as well who are interested in participating and partnering with the ministry and its various institutions to ensure that we bring forward this super specialisation type of infrastructure within our institutions .We have to move forward, we have to spruce up our hospitals and the only way we can do it at this stage is by partnering with foreign investors who have the foreign currency, especially, so that they can be able to bring in new equipment for us and medicines.

So the situation will be, the partner, through having foreign currency reserves, they will be able

to rehabilitate the infrastructure, bringing new equipment and at the same time bring in medicines so that the facility where they are operating from is continuously served with medicines. At the same time, we are also looking at the fact that, take Parirenyatwa Hospital for instance, they have 21 theatres and most of them are not working so we would expect the partner to refurbish those theatres and putting robotic equipment for the theatres so that we bring our hospital way-way up to standard. The investor should be able to also look up the cardiac issues, the renal issues, neurological issues, all sorts and then come up with a diagnostic centres which are well equipped.

We want a situation where we have diagnostic equipment which is fully functional, laboratories equipment, which is fully functional and fully supported in terms of reagents that are used there, so it is a marathon task, but it is necessary because we are way behind the other countries and we have to catch up.

PC: What will be the cost implication of these JVPs on affordability of public healthcare?

Dr O.M: It will not affect the cost of health care. What is happening is that the socially disadvantaged are the ones who are going to be benefiting. A client will arrive at the reception of the hospital and the client will have a choice of either going to the usual hospital as it is now but upgraded to a five star level, so it is an advantage. There is no change in the cost. The socially disadvantaged will access the facilities as usual and then if someone feels that they have got some money and their medical aid will be able to cover for that cost they got an option of going into a private unit.

These private units will not interfere with the day-to-day running of the usual hospital.

So we are identifying a small section within a hospital, which is given to the private investor and they operate their facility there and they will be able to utilise the same common services like radiology, pharmacy, theatre. There will be that inter-sharing of the common services between those who go to the private sector and those who go to the public sector but the most important thing is that the poor and the socially disadvantaged are still going to have there choice to go to the usual facility, which is earmarked as a public facility at the same cost, without any further increase in the cost because these costs are governed by Government.

PC: When do you expect the first project under this initiative to take off?

DR O.M: Well, already we have bidders for Parirenyatwa Hospital. There are quite a few who have sent through their bids indicating their interest in these Joint Venture Initiatives, so we wait for Parirenyatwa Hospital to look at them advise us. At the same time, United Bulawayo Hospitals, has already entered into some other private arrangement for orthopaedic services. They are already at a very advanced stage, put up fantastic orthopaedic unit there and they want to identify other units where they can enter into Joint Venture Partnerships on a Build, Operate and Transfer basis. Mpilo has also advertised, so we will see how it will go before spreading across the country in that fashion. Chitungwiza Central Hospital has already been running that type of Joint Venture Partnerships and that is what has made Chitungwiza survive. Things are available, to some extent, just because we were utilising the corporate world to come and give assistance.

PC: But the Chitungwiza Central Hospital model has faced its criticism from other sectors…

Dr O.M: Obviously, we realise that we also have to improve the working arrangement with our partners. At Chitungwiza, we are revamping that model. It's already a model that is accepted Africa wide and we've had people coming through from different African countries so, we have modified it so that there is independence of choice with regards to where a client would want to get treatment from. Patients will have a choice of going to the private or public side but the advantage is that, that investor who would be operating a private section would have upgraded other services within the same health facility.

Annexe 5

lephone: +263-242-798537-60
egraphic Address:
EDICUS", Harare
3-779 791 212
ectorzimpathology@gmail.com

ZIMBABWE

Reference:
Ministry of Health and Child Care
P O Box CY1122
Causeway
HARARE

20 July 2020

To All CEOs
PMDs

RE: REQUEST FOR DETAILS OF ALL PRIVATE SERVICE PROVIDERS AT ALL GOVERNMENT HEALTH INSTITUTIONS

Reference is made to the above subject matter.

The Honourable Acting Minister of Health and Child Care is requesting:

1. Details of all Private Service Providers at all Government health institutions; and
2. To have their services suspended while investigations on their ownership and authentication of the Public Private Partnerships [PPPs] arrangement are being instituted.

These service providers referred to include, but are not limited to:

a. Pharmacies;
b. Pathology Laboratories;
c. Radiological services;
d. Canteens; and
e. Others.

Please, submit the information soonest.

MINISTRY OF HEALTH AND CHILD CARE
(01) SECRETARY OFFICE (01)
20 JUL 2020
P.O. BOX CY 1122 CAUSEWAY
ZIMBABWE

Dr G Mhlanga
ACTING SECRETARY FOR HEALTH AND CHILD CARE

Annexe 6

ZIMBABWE

PRESS STATEMENT

PRESS STATEMENT BY THE CHIEF SECRETARY TO THE PRESIDENT AND CABINET: DR M J M SIBANDA ON THE REMOVAL FROM OFFICE OF CABINET MINISTER, OBEDIAH MOYO

Please be advised that His Excellency the President of the Republic of Zimbabwe, Cde E D Mnangagwa, has in terms of section 340, subsection (1), paragraph (f), as read with section 104, subsection (1) of the Constitution of Zimbabwe has removed Dr Obediah Moyo from the office of Cabinet Minister with immediate effect for conduct inappropriate for a Government Minister.

CHIEF SECRETARY TO THE PRESIDENT AND CABINET
07 JUL 2020
P. BAG 7700, CAUSEWAY
ZIMBABWE

Dr Misheck J M Sibanda
CHIEF SECRETARY TO THE PRESIDENT AND CABINET

07 July 2020

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