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

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A FEMINIST APPROACH TO PUBLIC-PRIVATE PARTNERSHIPS (PPPs): THE CASE OF THE PARIRENYATWA GROUP OF HOSPITALS IN ZIMBABWE

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ABSTRACT
I argue in this chapter 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 have not been consistently guided by any regulatory framework, and, where it did exist, the process did not abide by the regulatory framework, nor was there consideration of gender equality and/or human rights. Most of the PPPs are based upon Memoranda of Understanding (MoUs) that are not enforceable and were not guided by adequate legal advice, nor involved the participation of the 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 the Structural Adjustment Programs (SAPs) by the Zimbabwean government at the behest of the IMF and the World Bank in the mid-1990s. Whilst there is a policy that exempts pregnant and lactating women from paying user fees when accessing health services, there is no legislation for the enforcement of this policy. There have been incidents in which women have either been denied such care or have been detained in maternity wards after failing to pay for the services rendered. Women cannot access care in the private wings of some public hospitals or medicines from private pharmacies that are in public hospitals because of prohibitive costs.

1. BACKGROUND
I argue in this chapter 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 have not been consistently guided by any regulatory framework, and, where it did exist, the process did not abide by the regulatory framework, nor was there consideration of gender equality and/or human rights. Most of the PPPs are
based upon Memoranda of Understanding (MoUs) that are not enforceable and were not guided by adequate legal advice, nor involved the participation of the 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 the Structural Adjustment Programs (SAPs) by the Zimbabwean government at the behest of the IMF and the World Bank in the mid-1990s. Whilst there is a policy that exempts pregnant and lactating women from paying user fees when accessing health services, there is no legislation for the enforcement of this policy. There have been incidents in which women have either been denied such care or have been detained in maternity wards after failing to pay for the services rendered. Women cannot access care in the private wings of some public hospitals or medicines from private pharmacies that are in public hospitals because of prohibitive costs.

2. METHODOLOGY
I conducted desk reviews of the available literature on Public Private Partnerships in the health sector in Zimbabwe and Sub-Saharan, Low Income Countries (LICs). The keywords were “Public Private Partnerships”, “Gender Equality”, “Zimbabwe”, Health Sector, LICs and Sub-Saharan Africa. I reviewed all the legislation for public health and gender equality in Zimbabwe, including national policies and strategies for health and gender equality. I reviewed legislation governing Public Private Partnerships in general, and in the health sector in particular. In addition, I also used participatory methods, and, in this case, Key Informant Interviews (KII) with CEOs, Clinical Directors, clinicians, professional health associations, health-care professionals working in public hospitals, and civil society organisations. Key Informants consented to interviews upon the basis of anonymity for fear of victimisation. 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. I used my experience of working in the public health sector in analysing how Public-Private Partnerships were formulated in the Zimbabwean health sector, how they came into being, and how they have impacted negatively on gender equality and human rights. My experience is relevant to this chapter, given the paucity of literature on PPPs in the health sector in Zimbabwe. I have consequently over-relied on work and publications by EQUINET and Training and Research Support Centre (TARSC) in policy analysis in Zimbabwe from the time of its independence in 1980, which describe the Zimbabwe health system and its transformation over time in relation to health-service organisation and the private health sector.
3. 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 Agreement in 1979, in which Zimbabwe, formerly Rhodesia, was granted independence. Immediately following Independence in 1980, the Zimbabwean government adopted and implemented the Primary Health Care (PHC) approach that had been declared in 1978 at Alma Ata (Ray and Masuki, 2017). Zimbabwe decentralised health services to administrative wards using the PHC principle of Equity in Health (Nyazema, 2010). According to an EQUINET Discussion Paper (Munyuki and Jasi, 2009), 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 liberalisation and privatisation from 1990-2000; and
A period of economic downturn from the year 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. 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, the Infant Mortality Rates (IMR) had fallen to 46 per 1,000 live births (Lennock, 1994). 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”. By the year 2000, immunisation and Antenatal Coverage (ANC) had reached 89 per cent, and Infant Mortality had been reduced by 80 per cent from 1980-1998 (Munyuki and Jasi, 2009). Between 1980-1987, the government of Zimbabwe increased expenditure on health by 80 per cent, equating to 2.3 per cent of GDP, which was almost three times higher than the sub-Saharan Africa average of 0.8 per cent of GDP (Tren and Bate, 2005).

However, there were clear growing inequities in health provision from the mid-1990s onwards due to the Economic Structural Adjustment Programme (ESAP) that Zimbabwe adopted from the World Bank and the IMF. These policies were focused on public sector reforms, including the health sector, and resulted in economic liberalisation, privatisation,
and reduction in public expenditure. During this era, Zimbabwe adopted a new National Health Strategy (NHS) 1997-2007 with the aim of creating opportunities for the private sector, scaling up de-centralisation and contracting out or outsourcing services. There were negative trends in the health sector post-2000 due to foreign currency shortages, inadequate export performance, reduced capital inflows, the withdrawal of multi-lateral financing institutions, and the scaling down of bilateral creditors. Total expenditure on health fell from a peak of 10.8 per cent of GDP in 1998 to 7 per cent of GDP in 2005, with a 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 per cent of private expenditure on health in 2001, placing significant burdens on individuals. By the year 2000, per capita public health expenditure had decreased to 8.55 USD in comparison with the 1997 Commission of Review for Health that recommended per capita expenditure of 23.60 USD, and by 2008 per capita health expenditure had reached rock bottom at 0.19 USD. There was a massive brain drain from the year 2000 with the health sector losing 20 per cent of medical personnel per month, and up to 75 per cent in total in 2004-2008.

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

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 per cent of the population living below the national poverty line
and 21 per cent living on less than 1.90 USD a day (World Bank, 2016)). 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 expenditure in health. Government expenditure increased from 21.4 per cent in 2015 to 33 per cent in 2017 and to 44.1 per cent in 2018. There was a decrease in the share of private entities in the financing for health expenditure from 53.7 per cent in 2015 to 32.8 per cent in 2017 and a further decrease to 29.2 per cent in 2018.³ This decrease in expenditure by private entities and households was analysed 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 it.⁴ The share of total expenditure from the Rest of the World⁵ increased from 24.9 per cent in 2015 to 34.2 per cent in 2017, and then decreased to 26.7 per cent in 2018. Overall, total health expenditure declined by 9.6 per cent from 2015 to 2017, and increased by 27.3 per cent 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 1,138.09 million USD in 2015, and decreased to 877.4 million USD in 2017, and then increased to 952.8 million USD in 2018, constituting 78.6 per cent, 67 per cent and 57.2 per cent of total financing respectively.⁶

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 in 2015, according to the ZDHS; the under-5 child mortality rate was at 69 deaths per 1,000 live births, with 27 per cent of children under 5 years of age being stunted in growth.⁷ The socio-economic crises and succession battles within the ruling party, resulted in the ousting of the first President of Zimbabwe in a military coup in November 2017 (BBC News, 2017). Zimbabwe is now under the leadership of a new regime that was ushered in after the July 2018 Presidential and Parliamentary elections.

Under 5 years of age mortality has increased to 73 per 1,000 live births and ranges from 51 deaths per 1,000 for the richest people, to 91 per 1,000 for the poorest. However, the Maternal Mortality Ratio has decreased from 651 per 100,000 live births to 462 per 100,000 live births with a Skilled Birth Attendance and Institutional Delivery ranging from 82 per cent in rural areas to 94 per cent in urban areas (Unicef, 2019).
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 the year 2030. In 2018, the GDP for Zimbabwe was 18 billion USD, and 30 per cent of the GDP was from exports. In order to make progress towards UMI status, a medium-term plan the Transitional Stabilisation Programme (TSP) – from October 2018 to December 2020 - is being implemented. The TSP’s immediate objective is to achieve macro and fiscal stabilisation and to lay 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 between the means (austerity) and the ends (prosperity). Essentially, austerity entails cutting back on aggregate demand, which ultimately will affect growth, employment, and poverty. The austerity measures have resulted in the erosion of salaries whilst the cost of living has increased more than five-fold with no salary increments to match it. A devaluation of the Zimbabwean Dollar (ZWD), which was trading at 1 USD to 2.50 ZWD in February 2019, and by January 2020 was trading officially at 1 USD to 18.77 ZWD. The monthly consumer basket as of November 2019 was valued at 4,000 ZWD in an economy in which a junior doctor earns 2,365.50 ZWD a month.

The initial health budget allocation for 2019 was 650 million USD (52.13 USD PPP per capita or 7 per cent of the national budget) a far cry from the 86 USD PPP recommended by the WHO or 15 per cent of the national budget recommended by the Abuja Declaration. The budget was revised to 1.2 billion ZWD (120 million USD or 7.50 ZWD PPP per capita at official exchange rates) in August 2019 after the devaluation of the ZWD in February 2019. This effectively reduced the health budget by 81.5 per cent in real USD terms. Seventy five per cent of the 1.2 billion ZWD (900 million ZWD) is for payment of salaries, leaving a paltry 300 million ZWD (30 million USD) for operational service delivery. 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.

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Capita GDP allocation (USD)</td>
<td>52.13</td>
<td>30.29</td>
<td>21.69</td>
<td>25.45</td>
<td>23.15</td>
<td>25.92</td>
<td>24.44</td>
</tr>
<tr>
<td>Budget Allocation/Total Government</td>
<td>7.07</td>
<td>5.84</td>
<td>6.88</td>
<td>7.46</td>
<td>6.57</td>
<td>8.18</td>
<td>8.23</td>
</tr>
</tbody>
</table>
This economic background has increased reliance on Health Development Partners funding mainly for the implementation of vertical disease control programmes. Whilst domestic funding for health has been on an increasing trend (for salaries), external funding has been on a decreasing trend, having fallen from 475 million USD in 2017 to 368 million USD in 2019. External funding has also been highly dependent on specific partners, namely, the Global Fund and the United States Government Partners.\textsuperscript{11} Below is a graph showing trends in Government of Zimbabwe (GoZ) budget allocations and allocations by Health Development Partners (HDP).

\textbf{Figure 1: Trends in budget allocations (millions USD) by GoZ & HDP 2014-2019}

\textbf{Source:} MOHCC Budget presentation to Health Development Partners 2019.

Trends show an increase in budget allocations by GoZ relative to funding by the HDP over the five-year period. However, the value of the GoZ contributions in USD purchasing power parity terms is much less because of real economic inflation against the background of an officially controlled exchange rate which gives USD and Zimbabwe dollar (ZWD) currency a parity of 1:1.

The Joint Venture Partnerships Act is a law/policy by the Zimbabwean government aimed at guiding and encouraging PPPs in every sector in order to fill the public funding gap. The mantra “Zimbabwe is Open for Business” is the new regime’s way of encouraging
investors to invest in private “for profit” ventures in the country. There have been many “mega deals”\textsuperscript{12} shrouded in secrecy that have made media headlines since government embarked on the Transitional Stabilisation 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-specialised care, yet the country still lags behind on Primary Health Care and Universal Health Coverage. This thrust towards PPPs is in sharp 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 them (\textit{Daily News}, 2018). 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, including pregnant women, who were not able to access care.

Gender equality in accessing health services is under threat in Zimbabwe, firstly, because of the under-funding of health care, secondly, because of the increased reliance on funding from Global Health Initiatives which have neo-liberal ideologies, thirdly, because of the thrust by government to direct health institutions to engage in PPPs in the health sector as a way of alleviating the funding gaps, and, finally, because of 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.

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 in order to deal with the inequalities and inequities in health status and health care. However, this changed, according to the National Health Strategy 1997-2007, with the introduction of the de-centralised responsibility for services, the liberalising of the private sector, the strengthening of management, and the 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 the specific target in health policy saw the private sector as distorting the allocation of health resources (Loewenson, 1993).

“Government policy (MOHCW, 1984) had set its health care priorities as:
Zimbabwe: A Feminist Approach to PPPs

- 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 - both public and private - could play in health service provision. The role of the then Ministry of Health and Child Welfare was transformed to become 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:

- De-centralisation - with the expressed aim of creating an enabling administrative, managerial and operational environment for all stakeholders in the health sector to 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;
- Sub-contracting 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 Organization (WTO) could also have pressured the government to pursue liberalisation in alignment to the General Agreement on Trade in Services (GATS)
promulgated in 1994. However, EQUINET had noted the potential negative effects on the government’s ability to regulate the health sector if it committed itself 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 2: Registered private health facilities by type of facility in Zimbabwe 2020

<table>
<thead>
<tr>
<th>Type of Practice</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioners Rooms</td>
<td>411</td>
</tr>
<tr>
<td>Private Clinics</td>
<td>439</td>
</tr>
<tr>
<td>Obstetrics and Gynaecology Rooms</td>
<td>99</td>
</tr>
<tr>
<td>Private Hospitals</td>
<td>94</td>
</tr>
<tr>
<td>Specialist Physicians Practices</td>
<td>69</td>
</tr>
<tr>
<td>Specialists Surgical Practices</td>
<td>48</td>
</tr>
<tr>
<td>Paediatric Rooms</td>
<td>39</td>
</tr>
<tr>
<td>Accident and Emergency Rooms</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>1,218</td>
</tr>
</tbody>
</table>

Source: Health Professions Authority website, available at: www.hpa.co.zw.

The number of registered private health facilities matches the number of government health facilities, as demonstrated in Table 3 below.

Table 3: Registered health facilities by ownership in Zimbabwe 2020

<table>
<thead>
<tr>
<th>Ownership</th>
<th>Number of registered health facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>GoZ</td>
<td>1,217</td>
</tr>
<tr>
<td>Private</td>
<td>1,218</td>
</tr>
<tr>
<td>Missions</td>
<td>112</td>
</tr>
<tr>
<td>Total</td>
<td>2,547</td>
</tr>
</tbody>
</table>

Source: Health Professions Authority website, available at: www.hpa.co.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 liberalisation. 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 (outsourcing).

Whyle and Olivier, in the journal *Health Policy and Planning*, (2016), reveal that eight distinct Public Private Engagement models (Table 4), are utilised 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 in the literature regarding the paucity of information relating to the relationship between national governments and international donors in PPEs. They demonstrate the need for research that disaggregates PPE models and investigates PPE functioning in context (Whyle and Olivier, 2016).

**Table 4: Public private engagement typology**

<table>
<thead>
<tr>
<th>Public Private Partnerships</th>
<th>- highly collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- risk sharing</td>
</tr>
<tr>
<td></td>
<td>- long term</td>
</tr>
<tr>
<td></td>
<td>- contractual</td>
</tr>
<tr>
<td></td>
<td>- shared decision making</td>
</tr>
<tr>
<td>Social Marketing</td>
<td>- uses private sector marketing and communication tools</td>
</tr>
<tr>
<td></td>
<td>- increase uptake of public goods</td>
</tr>
<tr>
<td></td>
<td>- usually involve subsidisation</td>
</tr>
<tr>
<td>Sector Wide Approach</td>
<td>- non-contractual</td>
</tr>
<tr>
<td></td>
<td>- shared decision making</td>
</tr>
<tr>
<td></td>
<td>- centred around national sectoral strategies</td>
</tr>
<tr>
<td></td>
<td>- pooled funding</td>
</tr>
<tr>
<td>Public Private Mix</td>
<td>- non-contractual</td>
</tr>
<tr>
<td></td>
<td>- collaborative</td>
</tr>
<tr>
<td></td>
<td>- vertical disease focus</td>
</tr>
<tr>
<td></td>
<td>- involves actors from all sectors</td>
</tr>
<tr>
<td>Vouchers</td>
<td>- demand side financing</td>
</tr>
<tr>
<td></td>
<td>- defined benefits</td>
</tr>
<tr>
<td></td>
<td>- target groups</td>
</tr>
<tr>
<td>Contracting Out</td>
<td>- contractual</td>
</tr>
<tr>
<td></td>
<td>- short term</td>
</tr>
<tr>
<td></td>
<td>- no-shared decision making</td>
</tr>
<tr>
<td></td>
<td>- “buying services”</td>
</tr>
<tr>
<td>Dual Practice Regulations</td>
<td>- regulatory control of dual practice</td>
</tr>
<tr>
<td></td>
<td>- between state and public sector physicians</td>
</tr>
<tr>
<td>Financial support</td>
<td>- public financing of private sector</td>
</tr>
<tr>
<td></td>
<td>- through grants or public insurance</td>
</tr>
<tr>
<td></td>
<td>- non-contractual</td>
</tr>
</tbody>
</table>

In our case study, we will focus on two types of models that the case study fits into. These are:
- Contracting Out (outsourcing); and
- Dual Practice Regulations.

Munyuki and Jasi (2009) 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 5 below.

**Table 5: Levels of functioning contracting out to private-for-profit providers in Zimbabwe in 2009**

<table>
<thead>
<tr>
<th>Type of Contract</th>
<th>Functions of contract</th>
<th>National current status of contracting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Clinical Services</td>
<td>Catering</td>
<td>Principle generally accepted at national level. No evidence of contracting out services at Central, Provincial, District hospital. Catering services still publicly provided</td>
</tr>
<tr>
<td></td>
<td>Cleaning</td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>Security</td>
<td>Publicly provided at all facilities</td>
</tr>
<tr>
<td></td>
<td>Maintenance (land and Building)</td>
<td>Publicly provided by Ministry of Public Works that owns the buildings. Government employed grounds men to do general maintenance through MPC</td>
</tr>
<tr>
<td></td>
<td>Maintenance (Equipment)</td>
<td>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 specialised 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</td>
</tr>
<tr>
<td></td>
<td>Laundry</td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>Billing</td>
<td>Patient billing done by public facilities. Some public facilities using private debt collectors to collect outstanding patient fees</td>
</tr>
</tbody>
</table>
### Clinical Services

<table>
<thead>
<tr>
<th>Hospitalised care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission hospitals, although privately owned, act as agents for the government, and provide comprehensive care packages in districts, which could otherwise be government provided. Local government authorities are required by government to provide care and receive grants from central government.</td>
</tr>
</tbody>
</table>

### 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 in-patient 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 the 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, out-patient and emergency wings. |

### Public Health

| All public health functions are provided by government. There are, however, some private “for-profit” sectors (such as 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. |

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### 4. THE CASE STUDY OF PPPS AND GENDER EQUALITY AT THE PARIRENYATWA GROUP OF HOSPITALS

Our case study will be the 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 their functions, relating to the care and treatment of the sick, 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 Annex.

The Public-Private Engagements described by Whyle and Oliver (2016) were further classified by Munyuki and Jasi (2009) into whether they are contracts for the 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.

4.1. PPP Case 1: Laundry PPP at the Parirenyatwa Group of Hospitals

The main actors in the formulation of Public-Private Engagements at the Parirenyatwa Hospitals ideally should be the PHBG, the Minister of Health and Child Care, the health professionals working at the hospitals, 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 the Parirenyatwa hospitals came about as a reaction to a crisis by the then Chief Executive Officer (CEO) and management in 2008 (Nyazema, 2010). The hospitals’ laundry equipment had become old and dysfunctional and they could not afford to send linen to be laundered by private service providers. This posed a great threat to the provision of critical surgical services for the biggest specialist quaternary teaching hospital in Zimbabwe. Management approached three laundry companies and made a proposal for a 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 receive all the laundry business at the hospital. According to the typology of PPPs described by Whyle and Olivier (2016), 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 the management, the laundry companies refused to enter into the partnership because they felt that, by doing so, they would be subsidising the government and also faced the risk of late or non-payment for services in a hyper-inflationary environment. Another private laundry company that had not been approached by the management for the PPP approached the hospital and asked to do a feasibility study. After the feasibility study, the company agreed to 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 (OPC) for authorisation. The reason for seeking authorisation was that such a partnership had never been formed with a public hospital and even the PHBG did not know how to form the partnership. The OPC authorised the PPP and it is still operational to date. This is “contracting out” and can be monopolistic if it guarantees the private partner business without any competition, as is the current case at the Parirenyatwa hospitals (Whyle and Olivier, 2016). This contract can result in the provision of poor quality services and the hospital can incur huge costs in legal expenses whilst trying to terminate the contract. However, key informants in the management expressed their contentedness with the quality of services and mentioned that their linen now has a longer lifespan than the standard eight washes because they monitor the use of the chemicals that wear out the fabric during the laundry sessions by the private laundry company.

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

According to key informants in the management at the PGH, the second PPP is an agreement between doctors working in the hospital and the PHBG to admit their private patients. The typology of this PPP is called the “Dual Practice regulation” type of public-private-engagement. The hospital has a private wing called D-Floor, which provides health-care services exclusively for those who are adequately insured or can afford private health care, whilst the poor use the public wing of the hospital. Clinical specialists that work at the hospital are allowed to admit their private patients to D-Floor and to charge the patients privately for the care provided while being admitted to a public hospital. The hospital charges the patient “hotel fees” and bills them for all medical and surgical consumables and drugs that are used for treatment 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 (Mail & Guardian, 2017). In response to this predicament, and also needing to continue to provide specialist clinical services at the Parirenyatwa hospital, the PHBG decided to allow specialists to admit their private patients to D-Floor so that they could supplement their paltry salaries. The first condition for a specialist to obtain admission rights to D-Floor is that they should have provided care for a certain number of patients in the public wing of the hospital over a specific 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 and Madhina (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 all admission of private patients, particularly those in maternity, where practitioners were unwilling to attend to public patients after admitting their private patients to 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 (Percival et al., 2014). Key informants in the management pointed out that many cases have been reported in which 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 prompt care when they are re-admitted to D-Floor, but there is no evidence that they receive better quality care or have better health outcomes (Patouillard et al., 2007). Many patients who cannot afford the prompt care given on D-Floor either develop medical complications due to delays in getting appropriate care or end up asking to be discharged and go to seek care in one of the nearby mission hospitals where services are both available and cheaper (Malmborg et al., 2006). These are usually women who are already disadvantaged and poor, which has led to their ill health and need for care.

This PPP does not streamline gender equality or human rights, even for the mostly female nurses who work on D-Floor. Key informants in the management indicated that the only service providers that are paid privately at market rates by the patient or by medical insurance are the physician, the surgeon, the anaesthetist and operating-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 do not receive 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 do not give appropriate care to the patients.
Key informants pointed out that there is a new PPP that is currently under development for D-Floor, to provide surgical operating suites and diagnostic equipment at the 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 centres of excellence for clinical services (Annex 2). This was after an announcement in the media by the Minister of Health and Child Care, a former central hospital CEO who presided over some PPPs, the effectiveness of which was never thoroughly evaluated (Annex 2). PGH published tenders in the mainstream media inviting private investors to partner with the hospital by investing in the refurbishment of D-Floor and surgical operating suites and by acquiring modern high-tech diagnostic equipment and/or technology. The hospital will reciprocate by sharing the private wing between the hospital and the private investor in partnership. The private investor will be allowed to provide super-specialist clinical services that are currently not 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 obtain. In his budget statement in 2019, the Minister of Finance and Economic Development estimated that 400 million USD 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. The 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 and Olivier (2016), 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 the Parirenyatwa hospitals, the public, and law-makers were not consulted demonstrates that the motives behind the PPP are not guided by the evidence in the 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 the 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”.15

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 favourable 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;
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; e.g., engaging corporate entities 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 short-listed for the PPP. Two of the investors managed to do feasibility studies. The 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 the management alluded to were that the model that the partnership envisaged was a “Build-Operate-Transfer” (BOT) model, in which the investor, after re-furbishing D-Floor, would operate it as a private super-specialist unit for a period of time until they have recovered their initial capital and made enough profit, and then hand it back to the Parirenyatwa hospital. According to the World Bank report on the evaluation of PPPs, there is significant risk associated with this, especially if the legal advice in formulating the contract is weak. This kind of arrangement can result in a huge legacy debt on the state and the taxpayers or in the rest of the hospital being taken over by the private investor to fulfil contractual obligations in the event of the 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 fund health-service provision adequately. Another key issue is how the hospital management is going to ensure that poor and vulnerable people will also be able to access the services according to need and not according to their (in-) ability to pay. Their idea is to give the private investor tax rebates and holidays based upon the number of non-paying patients for whom the investor has provided care, and also duty-free certificates for the equipment and drugs that they bring into the country.

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

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. This private company, the sole agent in Zimbabwe 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 had performed 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 mainly concern 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 of consumables that the hospital has to buy or consume in a year. To date, the contract has been renewed three times since 2009 without going to a new tender. This is in contrast to the framework of “Contracting Out” that Whyle and Olivier (2016) describe, in
which these sorts of contracts should be short-term. There are seventeen machines that are working out of a total of eighteen.

Key Informants in the management agreed that the hospital had entered into the agreement without wide stakeholder consultations and without consideration of gender equality, or how the arrangement would impact women’s health and rights. Patients were paying “out of pocket” for renal dialysis at the Parirenyatwa hospital until 2018 when the Ministry of Health started providing ringfenced funding for renal dialysis. There was no policy which mainstreamed gender equality with regard to financial access to renal dialysis services at the hospital. A total of 181 Chronic Renal Disease (CRD) patients undergo dialysis at the Parirenyatwa hospital, and receive three sessions a week each. A total of 7,476 dialysis sessions were done in the year 2019.\textsuperscript{18} 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.

4.4. **PPP Case 4: The Mbuya Nehanda Maternity Hospital PPP at the Parirenyatwa Group of Hospitals**

The maternity hospital at the Parirenyatwa group of hospitals 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 operated on by the same doctors. This PPP further increases the inequality between women because the poorer women in the public wing of the hospital often have to bring their own medical and surgical sundries, such as gloves and pads, whilst women in the private wing are provided with them because they can afford to pay for them. Key informants in the management narrated the story of a woman in the public wing of the hospital who died in labour 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 8,008 deliveries in 2019. Of these, 7,177 (89.6\%) were public patients while the remaining 831 (10.4\%) were private patients.\textsuperscript{19} This demonstrates how only very few women can afford the services of the private maternity wing.

4.5. **PPP Case 5: The Pharmacy PPP at the Parirenyatwa Group of Hospitals**

The fifth PPP at the Parirenyatwa hospital is a private pharmacy that operates in a building outside the main hospital building, but within the hospital grounds. The management entered into this PPP because they could not adequately stock the public pharmacy in the hospital. The public pharmacy needs stocks worth 20 million USD per year for optimal service
provision to patients. The management concurred that it was beneficial to patients who could not get drugs in the hospital to buy them from a private pharmacy within the hospital grounds and not incur the indirect costs of travelling to pharmacies in town. The hospital published tenders in the media and the highest bidder won the tender to run the private pharmacy in 2014. The private pharmacy pays rent equivalent to 1,000 USD a month to the hospital. The hospital does not buy drugs or consumables from this pharmacy and this contract has no classification in the framework described by Whyle and Olivier (2016). There is no evidence that having a private pharmacy within the hospital grounds has improved the availability of the drugs that are not in the hospital pharmacy. If anything, because of the lack of wide stakeholder consultations and because of the specific failure to pay 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 the capital, Harare. (Mugwagwa et al., 2017) (Prata et al., 2005)

5. 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 recognises the rights of men and women to equal opportunities in the 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, as well as the promotion of the participation of women 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 seven members were women. The Public Health Act does not specifically mention gender equality and participation in the constitution, or the composition of board appointments and secondment to various positions within the Ministry. The Public Health Act also leaves the mandate on private investments in 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 the PPP policies in the health sector or at the Parirenyatwa hospitals in particular.

The second National Gender Policy of 2013-2017 sought to achieve a “gender-just society” in which men and women could 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 the Maternal Mortality Ratio remains unacceptably high and the HIV incidence and prevalence is higher in women than men, among other indicators. Key informants in the management agreed that no particular attention was paid to gender equality when they went into their PPP agreements, and that it was assumed that women would also equally benefit from the PPPs. This approach did not consider the fact that women were already disadvantaged in terms of education, employment opportunities and income, and were, therefore, penalised in financial access to the privatised services in the hospital. The management confirmed that most of the specialists with admission rights on D-Floor were male and that most of the nurses manning the D-Floor wards were female, who do not benefit from the PPP.

Key informants in the management and among staff indicated that, although they do not deny anyone emergency care at the hospital, there are incidents in which they have detained women after childbirth because of failure to pay their bills. This is against the ministry’s own policy and against the Zimbabwe Reproductive, Maternal, Newborn, Child, Adolescent Health and 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 Programme 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 Stabilisation Plan. The NHS 2016-2020 emphasises, under Goal 5, its aim to “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, violence, and other social ills. The NHS 2016-2020, as described in the SDG framework, seeks to realise the human rights of all, and to achieve gender equality and the empowerment of all women and girls. The subject of the PPPs is elaborated under Goal 3 in the NHS 2016-
Zimbabwe: A Feminist Approach to PPPs

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 announcements in the NHS 2016-2020, none of the PPPs at the Parirenyatwa hospitals were formulated or 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 aimed at protecting and promoting gender equality in general, and the empowerment of women and girls in particular. These include, among others:

i. The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW);

ii. The Southern Africa Development Community (SADC) Gender and Development Protocol (including its Addendum on Prevention and Eradication of Violence Against Women and Children);

iii. The Beijing Platform for Action;

iv. The Protocol to the African Charter on Human and People’s Rights on the Rights of Women;

v. The Universal Declaration of Human Rights;

vi. The International Convention on Economic, Social and Cultural Rights;

vii. The Convention on Civil and Political Rights (CCPR);

viii. The Equal Remuneration Convention (ERC);

ix. The Protocol to the African Charter on Human and People’s Rights on the Rights of Women 2005 (The Maputo Protocol);

x. The Millennium Declaration of 2000; and

xi. The 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 the management and staff at Parirenyatwa did not even know that Zimbabwe was a signatory to these treaties, let alone take them into consideration when formulating the PPPs at the hospital.

6. 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 operationalised 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, which had been operating in an unregulated environment. The aim of the act was:

- To ensure provision and maintenance of comprehensive hospital services in Zimbabwe;
- To provide for the admission of persons to public hospitals and the fixing of fees in respect of the services provided;
- To provide for the granting to medical practitioners and dental practitioners of the privilege of access to certain public hospitals and for the appointment of consultant medical and dental practitioners;
- To provide for the registration of medical aid societies;
- To set the 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 public hospitals for treating the private patients that they cannot look after properly in their practices.

This law also gives the Minister the power to set the user-fees payable at public hospitals and reflects the influence of the SAPs in the policy shift aimed at reducing public spending on health and introducing user-fees. The law does not address issues of equity with regard to the payment of user-fees, thus exposing vulnerable parts of the population 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.

- They focus on individual inputs, rather than health system organisations;
They aim to control entry and quality, rather than explicitly checking 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 victimisation.

Key informants in the management acknowledged that they knew about the Zimbabwe Joint Venture Partnerships Act of 2018, and the Zimbabwe Investment and Development Agency Bill of 2019, which were introduced to regulate 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 was proving to be very difficult, because of the nature of the contracts that they have, which were formulated as innovations without a guiding framework. The new legal framework does not mainstream gender equality in the joint ventures or in any partnerships in general, nor in the health sector specifically. The act is silent and does not speak to gender participation or empowerment in joint ventures and partnerships.

The current PPP arrangements at the Parirenyatwa Group of Hospitals were formulated as innovative responses to under-funding by the government of Zimbabwe. The process was spearheaded by the management and was not participatory in general and did not include the voice of women, health care professionals or citizens, nor did it 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. Sixty-seven per cent of people who were interviewed by ZIMCOD about 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 which lies at the root of the community suspicion 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 the fees paid for services
accrue to the private partners and did not benefit the hospital or community (Newsday, 2019). Key informants who work at Parirenyatwa bemoaned the lack of transparency and accountability in the formulation of the 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 the Parirenyatwa hospital. Key informants amongst health professionals working at the Parirenyatwa hospital only know that an advert was published for PPPs in 2018 but were not aware of what was going on (Annex 3). We managed to learn what was going on with the newly proposed PPP after interviewing key informants in the 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, nor did they know the cost of renal dialysis bundles that the hospital was buying from the company Fresenius for the dialysis machines. None of the interviewees knew how much the private pharmacy was paying in rent to the hospital or what the income was being used for.

7. ACTS OF RESISTANCE
PPP arrangements for pharmacy services were implemented at two other central hospitals that cater for the 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 the Parirenyatwa hospitals, faced fierce resistance from both health workers and the general public upon the basis of the lack of transparency and accountability in their formulation and implementation. Demonstrations were held until three of the private pharmacies at other central hospitals were closed leaving only the one at the Parirenyatwa Hospitals still in operation. The Senior Hospital Doctors Association handed in a petition against the directive for central hospitals to engage in PPPs to the clerk of parliament in 2019, arguing that the PPPs would result in financial barriers to accessing care for the poor and that the PPPs could present an opportunity for corruption (New Zimbabwe, 2019). An internal audit into the PPPs at one of the central hospitals was ordered by the then Permanent Secretary for Health in 2016 because of complaints and resistance by health professionals, patients, and communities that were not happy with how the PPPs had been formulated. Seventy-two per cent of respondents in the ZIMCOD study indicated that 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 could not afford the exorbitant charges, and resulted in some not seeking treatment and others dying at home because they could not afford the services.

The fact that resistance to PPPs at these central hospitals resulted in an audit whose results were published indicates that there is still institutional integrity that serves the public interest. However, the fact that no action was taken after damning findings in the audit report also indicates that there are inherent weaknesses in enforcing existing regulatory frameworks. The lack of enforcement of the regulatory frameworks is largely attributable to deep-rooted corruption that has dogged Zimbabwe since independence (Mwatwara and Mujere, 2015). The authors attribute the tolerance of corruption by the former president as “part of an intricate power retention matrix”.

Key informants in the management acknowledged that there was serious resistance to the PPPs on the D-Floor, to the Renal Dialysis PPP initially, and to the private pharmacy PPP. Key informants among staff working at the 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 have already made more money and specialised nurses, and does not take into account the contribution of the 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 the former CEO of the Chitungwiza Central Hospital, the hospital that had the damning audit report on PPPs. The Minister was recently fired from government after being implicated in a corruption scandal involving the procurement of testing materials for Covid-19 without a competitive tender process (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 realisation that the PPPs were not formulated in a transparent manner (Annex 5).

8. 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, integrated, continuous, quality health services in an equitable manner through de-centralisation of services that particularly targeted the vulnerable groups.
However, with the introduction of the SAPs by the IMF and the World Bank, there was liberalisation and privatisation of the health sectors with no consideration for gender equality or human rights, resulting in barriers to access to health services and a worsening of health outcome indicators for women. The PPPs in the health sector were formulated without adequate participation of all the actors involved, and there was a 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 the 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.

8.1. Recommendations

1. Zimbabwe should develop a compulsory National Health Insurance Scheme funded through the progressive taxation of citizens and corporations that can also be supported by health development partners;

2. The scheme should prioritise coverage for essential health services for vulnerable populations, especially women, children, and the needy; and

3. The Joint Ventures Partnerships Act and the Zimbabwe Investment Act should be adapted to PPPs in the health sector with the involvement of all actors with consideration for gender equality and human rights, as well as the enforcement of the legal frameworks in a transparent manner - moving from Public-Private-Partnerships (PPPs) to Public-Private-Professionals-People-Partnerships (PPPPPs).

Notes

1. MOHCC District Health Information System version 2.30.
2. The right to health was only adopted in 2013 Constitution, available at: www.parlzim.gov.zw.
5. According to the new nomenclature in the National Health Accounts, “Rest of the World” refers to expenditure incurred through Official Development Assistancess (ODA).
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.

Missions are church based organisations that own and run hospitals and schools in Zimbabwe.

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.

Nyasha Masuki, “PPP Model Overview”, available at: https://drive.google.com/drive/folders/1oTp45kJNHdw2gJqAfFrRUBFHbVKy01vo?usp=sharing.


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

Annex 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 2 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.
10 April 2019

To: Chief Executive Officers
   Provincial Medical Directors

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

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
**Annex 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: PGIH/01/19**

**REFURBISHING, RE-EQUIPPING 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-equipping and upgrading of:

- Diagnostic services
- Pharmaceutical Services
- Operating Theatre suite
- 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 financial and organisational capacity to perform the services.

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

- Resources dedicated into the Joint Venture
- Key Professional staff with appropriate qualifications and competencies.
- Management 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 vitae (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 16:00 hrs).

**Head of Procurement Management Unit**

Parirenyatwa Group of Hospitals

Tel: +263 342 791979
+263 781555-7 ext 2435

**Internal Audit Department**

Parirenyatwa Group of Hospitals

Administration Block

Mazowe Street

Harare

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.
“Super specialist hospitals for Zim soon,” says Moyo

The Interview with Paidamoyo Chipunza

The 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 (JVPs)?

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 the Parirenyatwa Group of Hospitals, the 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 such as Mpilo, the 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 the response been 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, 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 the Parirenyatwa Hospitals, for instance, they have 21 theatres and most of them are not working so we would expect the partner to refurbish those theatres and put in 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, laboratory 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 the affordability of public health care?**

**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 public side of the hospital as it is now or to the private side 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, and operating 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 the 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 the 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 the Parirenyatwa Hospital to look at them and advise us. At the same time, the United Bulawayo Hospitals, has already entered into some other private arrangement for orthopaedic services. They are already at a very advanced stage, put up a 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. The Chitungwiza Central Hospital has already been running this type of Joint Venture Partnerships and this 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 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 regard 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 the investor who would be operating a private section would have upgraded other services within the same health facility.**
Annex 5

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.

Dr G Mhlanga

ACTING SECRETARY FOR HEALTH AND CHILD CARE
PRESS STATEMENT BY THE CHIEF SECRETARY TO THE PRESIDENT AND CABINET: DR M J M SIBANDA ON THE REMOVAL FROM OFFICE OF CABINET MINISTER, OBEĐIAH 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.

Dr Misheck J M Sibanda
CHIEF SECRETARY TO THE PRESIDENT AND CABINET
07 July 2020
References


