Zimbabwe Health Sector Resource Mapping Report

2021

Foreword

Acknowledgments

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List of Acronyms

ART	Antiretroviral Therapy
CCHP	Comprehensive Community Health Package
CDC	United States Centers for Disease Control
CDs	Communicable Diseases
CHW	Community Health Workers
CRF	Consolidated Revenue Fund
DAH	Development Assistance for Health
EHBP	Essential Health Benefits Package
ePMS	Electronic Patient Monitorins System
GBS	General Budget Support
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoZ	Government of Zimbabwe
HCW	Healthcare Worker
HDF	Health Development Fund
HDPCF	Health Development Partners Coordination Forum
HFS	Health Financing Strategy
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HSCF	Health Sector Coordination Framework
HSS	Health System Strengthening
IPC	Infection
MOFED	Ministry of Finance and Economic Development
MOHCC	Ministry of Health and Child Care
MTR	Mid-Term Review
NASA	National Aids Spending Assessment
NCD	Non-Communicable Diseases
NCHS	National Community Health Strategy 2021-2025
NGOs	Non Governmental Organisations
NHA	National Health Accounts
NHS	National Health Strategy 2021-2025
PBB	Program Based Budgeting
PEPFAR	United States President's Emergency Plan for AIDS Relie
PFMS	Public Financial Management System
PHC	Primary Healthcare
RM	Resource Mapping
RMNCH	Reproductive, Maternal, Neonatal and Child Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
UHC	Universal Health Coverage
USAID	United States Agency for International Development
VHW	Village Health Worker
WASH	Water, Santiation and Hygiene
WHO	World Health Organisation

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Executive Summary

As Zimbabwe implements the new National Health Strategy, which will cover the 2021-2025 period, there will be a need to ensure that health financing gaps identified from the Mid-Term Review of the previous strategy are adequately addressed. Critical gaps identified the need to harmonise healthcare resources based on factors like disease burden, and plugging inefficiencies in health funding that cause duplications, lack of accountability, and wastages of resources. Addressing the gaps identified in the previous strategy will move the country towards Universal Health Coverage and sustain the gains achieved so far in ensuring good health for the country's citizenry.

With the current financing for health in Zimbabwe characterized by a mix of domestic resources, total resources for health were estimated to total $1.15 billion in 2021. Most domestic funding came from the Consolidated Revenue Fund allocation to the MOHCC that totaled $568 million, while external funding sources contributed $447 million. Most of the external funding came from three partners, namely the United States President's Fund for Emergency Relief (PEPFAR) partners that contributed $216 million, The Global Fund to Fight AIDS, Tuberculosis and Malaria with $160 million, and the Health Development Fund with $72 million. The year 2021 also saw the country reach the Abuja Declaration Target for the first time since 2014.

While the increase in domestic funding is commendable, there will be a need to ensure the estimated financing level in 2021 is sustained so that the National Health Strategy can be adequately implemented. Zimbabwe will need to move towards a harmonized approach to health funding, where all funding is prioritised towards national strategic plans vs. the current vertical funding structures that cause inefficiencies. As the country fights the COVID 19 pandemic, funding must remain flexible and respond to the changing landscape of the disease as it evolves, where the country will experience various infection waves that will need to be adequately controlled. Efficiencies with health funding will also need to be maximized by leveraging interventions at the community level, using the Comprehensive Community Health Package. The strengthening interventions at the community level will enhance the primary healthcare approach and reduce pressure on higher healthcare system levels.

With funding for health in Zimbabwe coming from three main funding pools, namely the domestic funding pool, donor funding pool, and discrete funding, this has caused fragmentation of activities that have increased administration and transaction costs. For example, strategies for disease areas like Human Immunodeficiency Virus and Reproductive, Maternal, Neonatal, Child and Adolescent Health have adequate funding in 2021. However, allocation of funds across costs and interventions remains sub-optimal, exhibited by funding gaps and surpluses across them. To reduce these costs and maximise funding available at the service delivery level, coordination mechanisms within and across these pools will need to be strengthened. Strengthening of these pools can be done by revitalising the Health Development Partners Coordination Forum and moving the country towards a General Budget Support model, resulting in increased transparency and accountability of health resources. Overall, financing for health in Zimbabwe should move towards the three one's principle (one national plan, one coordination mechanism, one monitoring and evaluation framework) and align all parties to common health outcomes and objectives.

1. Background

The Resource Mapping (RM) report 2021 comes when the National Health Strategy (NHS) 2021-2025 is being implemented. The NHS builds on the 2016-2020 strategy by addressing gaps identified following the Mid-Term Review (MTR) of the NHS 2016-2020. More importantly, the NHS seeks to sustain the gains achieved thus far through a comprehensive response to the burden of disease and the health system's strengthening (HSS) to deliver quality health services to all Zimbabweans.

The MTR identified several reforms that would need to be addressed as the country continues its implementation of the NHS. These included the need to prioritize resources, where resources allocated mainly were focused on communicable diseases (CDs), whereas non-communicable diseases (NCDs) that have a very high potential of generating high future health costs were largely ignored. Inefficiencies with the use of available resources was also seen as a significant gap, where improvements could be made through effective targeting and allocation of resources, while avoiding duplications and wastages. The distribution of funds from Development Assistance for Health (DAH) partners perpetuated a sense that funding must be initially allocated to a particular program before cross-cutting activities or services could be provided to the overall sector. In addition, the fragmentation of funding has also resulted in accountability for resource usage, where limited transparency of financial flows within the sector has left national objectives unmet and unaccounted.

Overall, the NHS aims to strengthen the provision of equitable, affordable, and quality health services at the highest attainable standards to all Zimbabweans. The strategic outcomes stated in the NHS are centred on interventions that aim to improve access to health services, domestic funding, infrastructure, medical equipment, human resources, leadership, and governance for the sector. These outcomes capture targets mentioned in the Sustainable Development Goals and other health-related targets, such as water, sanitation, housing, food, and nutrition. The overall goal of the NHS is to improve quality of life, with the priority areas for programming being;

- ***Policy and Administration*** - to strengthen the enabling environment for service delivery
- ***Public Health*** **-** to strengthen preventive services and promoting healthy lifestyles (scale-up coverage of public health interventions)
- ***Curative Services*** - to strengthen the quality of primary and hospital care services (improved access to quality primary and hospital care); and
- ***Biomedical Sciences and Technology*** - to promote access to affordable, acceptable and effective quality equipment, medicines and sundries for improved service delivery

The strategic direction for the health sector's priority on increasing domestic funding for health services is the Health Financing Strategy's (HFS) implementation. The focus is to;

1. ***Increase efficiency gains from existing resources by;***
   - Placing greater emphasis on investment in and implementation of interventions targeted at primary care and prevention
   - Strengthening planning and governance around procurement for infrastructure development and equipment
   - Improving operational efficiency of existing private voluntary health insurance schemes

- Reviewing structures of the Ministry of Health and Child Care (MOHCC) to stimulate greater efficiency
- Increasing non-wage expenditure on supplies and equipment necessary for quality service delivery

2. Increasing reliance on public resources for health by;

- Implementing evidence-based advocacy for increased allocation of government resources to health at the central and local government levels.

3. Pooling of Health Funds from the private sector and government;

- Strengthening equalisation mechanisms across local authorities that will ensure equitable allocation of resources
- Enhancing the integration of monitoring and reporting of funds
- Establishing a virtual basket of all public funds (including those from church-related missions)
- Strengthen the regulation of the medical scheme's environment

Through RM, the MOHCC has a better understanding of the funding flows present within the healthcare sector, thereby allowing it to better address the financial challenges mentioned in the MTR report. This will allow for evidence-based decision making at both the policy and technical level by identifying areas where funding should be prioritised based on disease burden and other factors. RM also allows for identifying areas where technical and allocative efficiencies can be improved through strengthened coordination of funding across all players involved in financing health. Bringing together all stakeholders will create a harmonized approach to funding, where all players can be aligned to national objectives in developing budgets and operational plans, with a common purpose of improving the health outcomes for the country's citizenry. This can only be achieved through efficient coordination of resources across all stakeholders involved in financing the country's health system.

2. Resource Resource Mapping Process

All health-related organisations, except those involved in the private sector, are asked to submit detailed health budget information by planned activity for both on-budget and off-budget resources. These organisations include relevant government ministries, parastatals, bilateral and multilateral partners, and non-governmental organizations (NGOs). This detailed data shows the budgeted health funds across districts, disease programs, interventions, and cost categories. Figure 1 below outlines the key questions that RM addresses.

Who is providing resources for health programs and who is implementing them?

- Source of funding
- Financing agents
- Implementing agents

What are available funds being spent on or budgeted for?

- What activities are being funded?
- Which programmatic areas do these activities fall under?
- Which cost categories do these activities cover?

Where are the resources being spent or budgeted for?

- How are funds allocated geographically?
- How are funds allocated across different levels of the health system?
- How are funds allocated across various beneficiary groups?
- Where are the funding gaps in government priorities?

By attempting to answer the above questions over four consecutive years (2016-2019) RM has increased transparency and accountability across stakeholders and empowered the MoHCC to improve coordination of funding across the health sector.

Figure 1: Key Questions Addressed by Resource Mapping

The Zimbabwe health sector benefits from the data from several sector-wide resource tracking exercises, including RM and National Health Accounts (NHA). In addition, HIV/AIDS spending has been tracked through the National AIDS Spending Assessment (NASA). These exercises complement each other, as they provide different kinds of data that are used for various purposes.

2.1 Process

The timing of RM is carefully planned to yield results in time for the government's next budgeting and planning cycle. The following steps were followed in carrying out the exercise:

Figure 2: Resource Mapping Data Collection Process

1.2.1 Tool Design

The RM tool is designed to be country-specific and to answer contextual questions for the health sector. The tool is designed to be simple, and user-friendly while maintaining the collection of highly comprehensive data. The tool collects high-level budget and expenditure data from public and private sources of health and disaggregates it into key categories, namely 1) Financiers and Implementers; 2) Programs, Projects, and Activities; 3) Cost Category; 4) Geography; and 5) Currency and Budgeting.

1.2.2 Sensitisation

Meetings with stakeholders were held to create advocacy for the resource mapping process and simultaneously distribute and train the participants on completing the tool.

1.2.3 Data Collection

Tools were distributed, and stakeholders were given time to conduct data entry. During the process, the RM team was available for support and additional data entry training.

1.2.4 Data Processing

Tools were collected from partners, and data was cleaned and processed for analysis.

1.2.5 Results Dissemination

All stakeholders were invited to a data dissemination meeting to discuss and validate the results of the RM process.

	Type	Parameter	Definition of Parameter	Example
1	Financiers and Implementers	Submitting Organization	Organisation that submitted budgeting information	United Nations Children's Education Fund (UNICEF)
		Financing Source	The organization or entity financing the activity	Human Development Foundation (HDF)
		Primary Implementing Agent	Primary organization or entity that is carrying out implementation	UNICEF/MOHCC
		Sub-Implementing Agent	Additional organization or entity carrying out the activity, if applicable	Crown Agents
2	Programs, Projects, Activities	Project Name	Specific project that is supported by the activity	Prevention of neonatal deaths
		Programmatic Function*	Programmatic area, function, or disease supported by the activity	Reproductive, Maternal, Newborn and Child Health (RMNCH)
		Intervention*	Intervention supported by the activity, dependent on the programmatic function	Prevention – Prevention of Mother to Child Transmission (PMTCT)
3	Cost Category	Cost Category*	Classification of activity costs in administrative categories (e.g., capital infrastructure, training, M&E, etc.)	Community Outreach Activities
4	Geography	District	Percentage of funding earmarked for the specific district(s); if national, can be specified 100% national	Bindura
		Central Hospital	Percentage of funding attributable to each central hospital, if applicable	Parirenyatwa
		Province	Which province are is funding targeted	Bindura
5	Currency and Budgeting	Currency	Currency of the submitting organization's budget	USD
		Fiscal Year Start Month	Fiscal year start month of the submitting organization	January
		Budget Year	Expenditure in the previous year, budget amount per year for the next two FYs	Expenditure for FY19, Budgeted amounts for FY20, FY21

Figure 3: Resource Mapping General Structure

2.2 Data Collection

The MOHCC provided the RM team with a list of essential health stakeholders to include in data collection. The RM team distributed the data entry tool to these stakeholders and requested that they complete it and return it within eight weeks. The result included a response rate of 92%, with submissions from the

MOHCC, Local Authorities (City of Harare), three Parastatals (National AIDS Council (NAC), Zimbabwe National Family Planning Council (ZNFPC), Medicines Control Authority of Zimbabwe (MCAZ),11 donors and 33 NGOs. The following donors and NGOs provided data:

Domestic Funding Sources		Implementing Partners	
Harare City		Abt Associates Inc.	ICF Macro
MCAZ		Africaid	Mavambo
MOHCC		BRTI	OPHID
NAC		Care Zimbabwe	Plan International
ZNFPC		CHAI	PSI
Funding Partners		Chemonics	PSZ
CDC	UNICEF	Cordaid	RTI
DFID	UNDP	Crown Agents	SolidarMed
Embassy of Ireland	USAID	CRS	The Palladium Group
Global Fund	WHO	EGPAF	The Union
HDF	World Bank	FACT	WHO
Irish Aid		FHI 360	World Vision
UNDP		HOSPAZ	ZACH
UNFPA		ICAP at Columbia University	Zim-TTECH

Figure 4: Names of Submitting Organisations

2.3 Data Cleaning, Validation, and Analysis

Once submissions were made, the team reviewed populated templates and followed up with organizations on outstanding submissions. Rigorous quality checks on submissions, focusing on consistency, thoroughness, and completeness were conducted, before aggregating submissions into a master database. The master database was reviewed and cleaned further, notably focusing on excluding potential duplicative reporting of funds (i.e., from financing source and implementing agent). Upon completion of reviews and quality checks, the health sector RM database was finalised. For systems investments, such as facility running costs, supply chain management, and human resources for health (HRH), the RM team broke down the government data across disease areas using the split rules from the National Health Accounts 2010.

Once the Resource Mapping team compiled a final database of all cleaned and verified submissions, they conducted a series of analyses to pull out results. The analysis focused on the overall health sector funding trends, mainly on specific questions relevant to the MoHCC and partners, such as funding by disease area, geographic area, and cost categories, to name a few.

2.4 Limitations of Resource Mapping

The resource mapping process tries to capture funding flows from multiple organisations and stakeholders involved in the health sector through a standardised data collection tool. Data are comprised of self-reported planning data, and organisations indicate the sources of data used. The data reporting

systems at these data sources will inherently differ and will need to be converted to the RM data collection tool format. This will cause differences in the interpretation of data for conversion purposes and potentially compromise the quality and accuracy of the data. However, a validation process is conducted to counter this limitation, including checking submissions against indicated sources and generally known funding trends. Other limitations will include:

- Funding for local authorities was flat-lined, i.e., assumed to be constant for 2020 from the 2019 budgets since annual budgets do not contain estimates for future years.
- Data submissions had different levels of disaggregation, which affects the comparability of the different datasets. For example, some organisations provided budgets detailed up to the district level, while some ended only at the national level.
- Collected data does not capture the entire health sector resource envelope– data from the private sector, private insurance companies, medical aid societies, mission facilities, households, or individuals were not included.

3. Overall Funding for Health

3.1 Total Funding for Health

The health financing landscape in Zimbabwe is characterized by a mix of domestic and external funding sources. Most domestic funding comes from the Ministry of Finance and Economic Development (MOFED) and is mainly allocated towards health systems costs, while external funding comes from multiple sources and is ring-fenced towards specific disease areas, health-system components, or objectives. While this prioritized funding may arrive with good intentions, the multiplicity of the donor pools has led to financing that is unprioritised to national needs, resulting in duplications and inefficiencies in usage.

The year 2021 saw a marked rise in total funding for health, with total budgeted resources rising from $672 million in 2020 to $1.15 billion in 2021. This increase was primarily due to a substantial increase in domestic resources for health, which rose from ZWL6.9 billion ($80 million) in 2020 to ZWL54.7 billion ($670 million) in 2021. The significant increase in domestic funding was due to the successful lobbying for additional resources from the MOFED, with larger allocations from the national treasury. External financing increased from $420 million in 2018 to $444 million and $566 million in 2019 and 2020, but decreased to $479 million in 2021. This fall was due to funding falls from three main donor pools, namely the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), and the Health Development Fund (HDF). A summary of overall funding for health over the 2014-2021 period is shown in Figure 5 below:

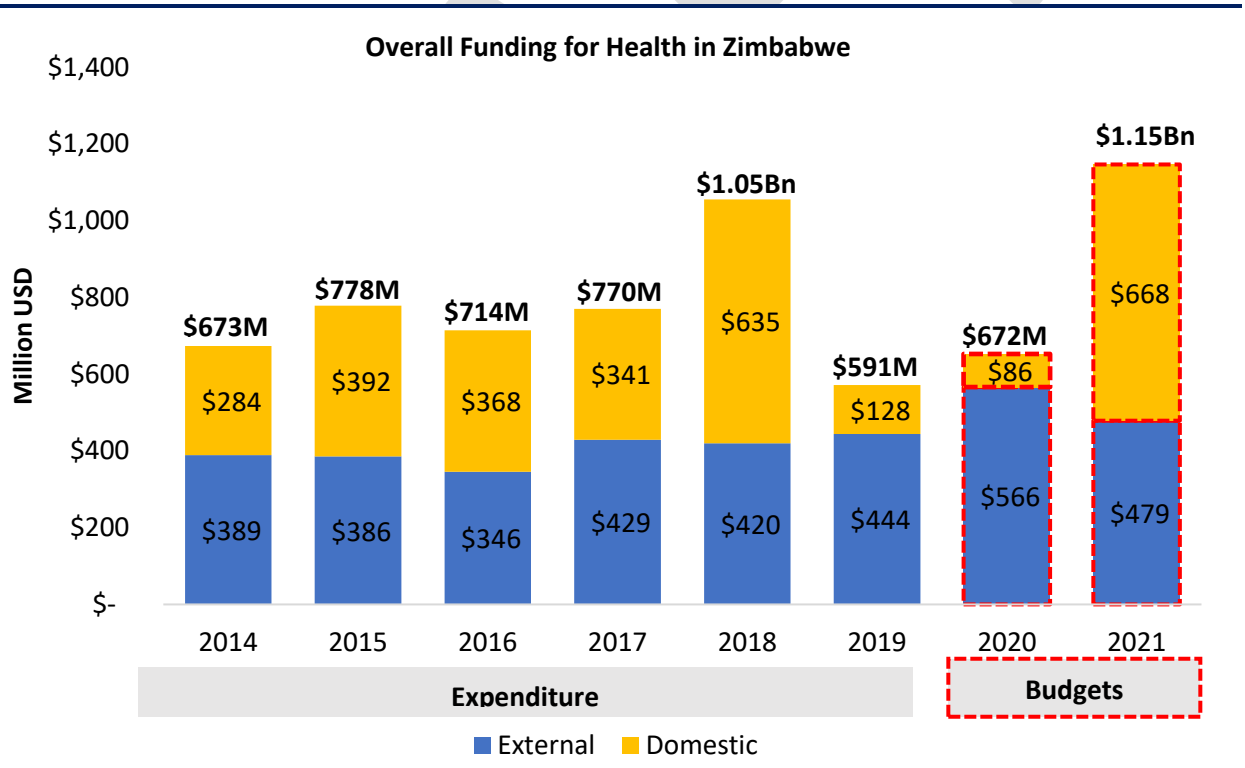

Figure 5: Overall Funding for Health in Zimbabwe

When analysing the trend in funding over the 2014 to 2021 period compared to international benchmarks, the Government of Zimbabwe (GoZ) only managed to achieve the Abuja Declaration target of having at least 15% of total domestic budgets allocated to health in 2021. Similarly, the World Health Organisation (WHO) recommendation of per capita spending of $60 on health was only surpassed in 2018 and 2021,

where spending per capita was $73 and $76 respectively, while the Chatham House recommendation of $86 per capita spending on health is yet to be achieved. As Zimbabwe continues its resourcing pathway towards UHC, there is a need to ensure that adequate revenue streams are available for health so the country can be driven towards regional and international benchmark targets. A summary of the comparison of health funding to regional and international benchmarks is shown in Figure 6 below:

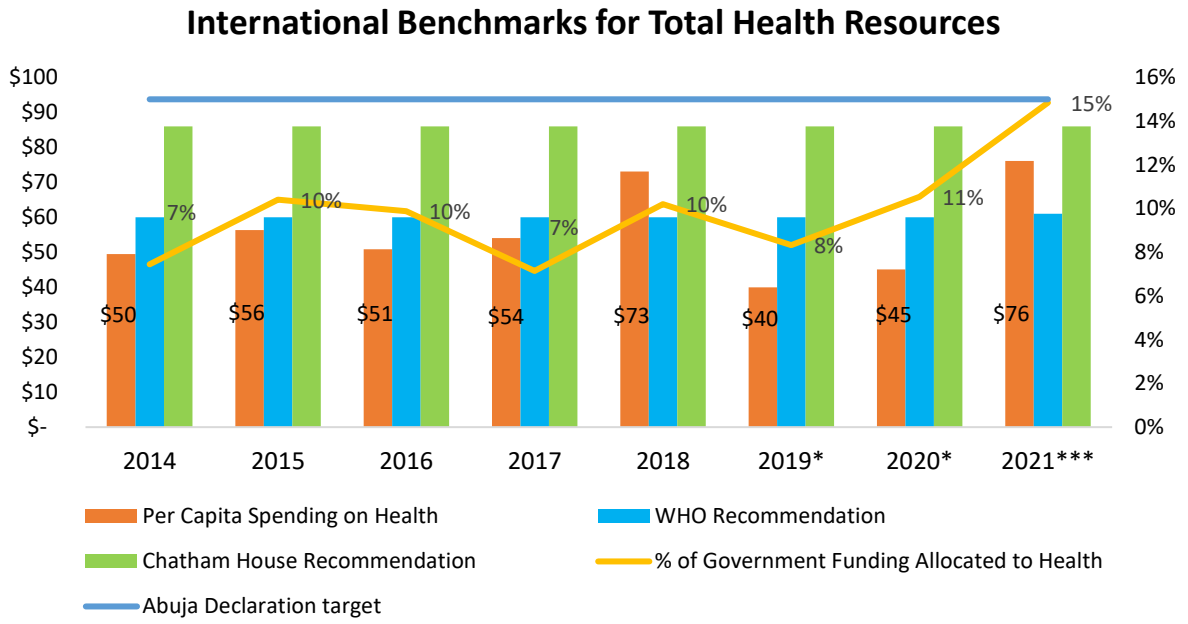

Figure 6: Zimbabwe Health Funding vs. International Benchmarks for Health Funding

While the marked increase in domestic funding is highly commendable, the MOHCC needs to ensure that funding received from the MOFED remains predictable in future years so the NHS and other vertical strategies can be adequately implemented. A resource allocation formula must also be developed so that resources are prioritized according to health needs, and the lower levels of the healthcare system can better understand and influence how resources are allocated. External funding sources must adopt a harmonized approach to health funding, which will ensure that resources are allocated to national priority programs. This will improve efficiencies with health funding, reduce duplications and wastages, ensuring that every dollar spent on health is maximised. Monitoring the financing for health can be achieved by strengthening the program-based budgeting (PBB) approach and improving the Public Financial Management System (PFMS) to include all funding available for health.

3.2 External Funding for Health

3.2.1 Total Development Assistance for Health Funding

Over the 2016-2021 period, at least 86% of total DAH funding has come from three sources. These sources include the GFATM, HDF, and the United States President's Emergency Plan for AIDS Relief (PEPFAR) partners. The PEPFAR partners are the United States Centers for Disease Control (CDC) and the United States Agency for International Development (USAID). DAH funding for health fell from $544 million in 2020 to $481 million in 2021. The fall in total DAH funding for health was due to funding decreases of $81 million by the GFATM ($241 million in 2020 to $160 million in 2021) and a $40M decrease in funding from the HDF ($112 million in 2020 to $72 million in 2021). Despite falls in funding from the GFATM and HDF, total funding from the PEPFAR partners increased from $168 million in 2020 to $192 million in 2021. Most of the funding increase from the PEPFAR partners was due to an $18 million rise in funding from the CDC ($61 million in 2020 to $79 million in 2021) and $6 million additional funding from USAID ($131 million in 2020 to $137 million in 2021). A summary of the total DAH funding for health over the 2016-2021 period is shown in Figure 7 below:

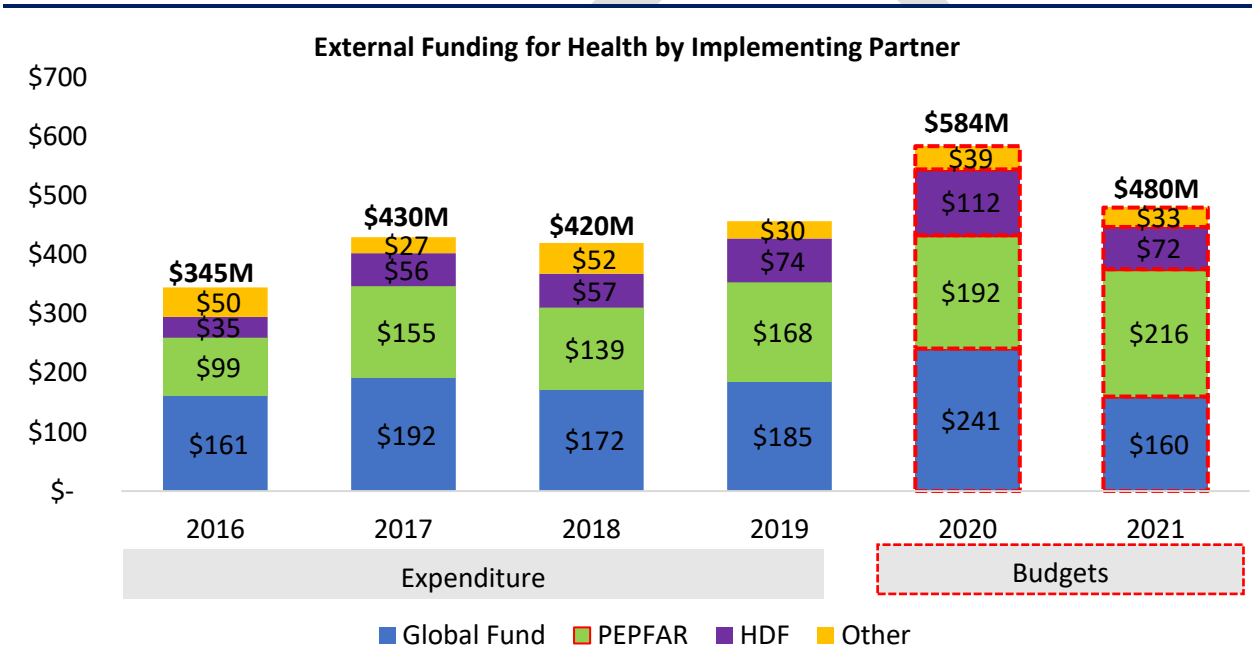

Figure 7: External Funding for Health in Zimbabwe

3.2.2 Funding from the Global Fund to Eliminate AIDS, Tuberculosis and Malaria

A closer analysis of GFATM funding by disease area shows that most of the fall in funding from 2020 to 2021 was for HIV/AIDS, which fell by $89 million ($190 million in 2020 to $101 million in 2020). Within the specific interventions for HIV/AIDS, the most significant decrease in funding was for antiretroviral therapy

(ART), which had a fall in funding from $101 million in 2020 to $45 million in 2021. Other interventions that significantly decreased funding include HSS for HIV AIDS ($61 million in 2020 to $22 million in 2021) and viral load testing ($11 million in 2020 to $102,000 in 2021). Despite the decrease in funding for HIV/AIDS from 2020 to 2021, funding for malaria increased from $13 million to $21 million, while funding for tuberculosis (TB) increased from $8 million to $10 million. A summary of the GFATM funding by disease area is shown in Figure 8 below:

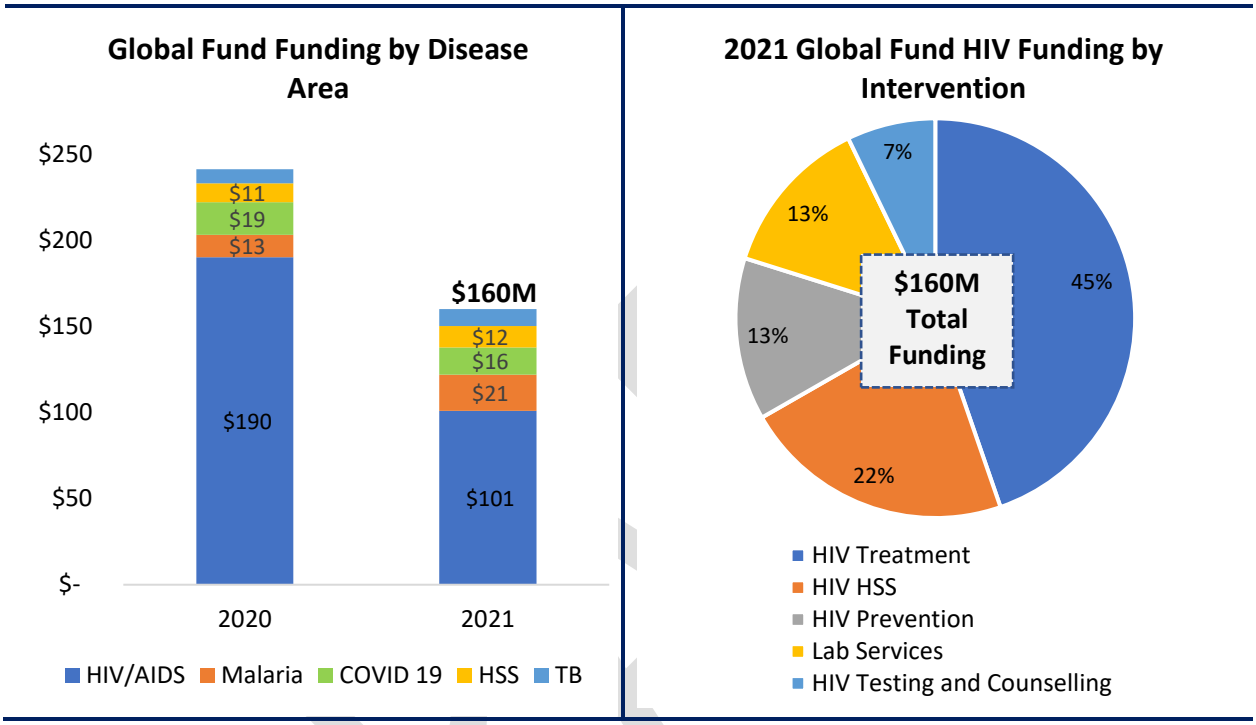

Figure 8: Global Fund Funding by Disease Area

3.2.3 Funding for the Health Development Fund

The biggest fall in HDF funding from 2020 to 2021 was for reproductive, maternal, neonatal, and child health (RMNCH), which fell from $34 million in 2020 to $16 million in 2021. Within the specific RMNCH interventions, most of the funding fell for cross-cutting MNCH interventions ($12 million), while HSS for RMNCH fell by $4 million. Another disease area with a significant fall in funding was overall HSS, which fell from $54 million in 2020 to $41 million in 2020. Within comprehensive HSS interventions, supply chain strengthening funding fell by $16 million ($32 million in 2020 to $16 million in 2021), while community HSS funding fell from $7 million in 2020 to $2 million in 2021. Despite the decrease in funding for these HSS interventions, other interventions like health financing and HRH rose by $14 million and $2 million. A summary of the HDF funding by disease area is shown in Figure 9 below:

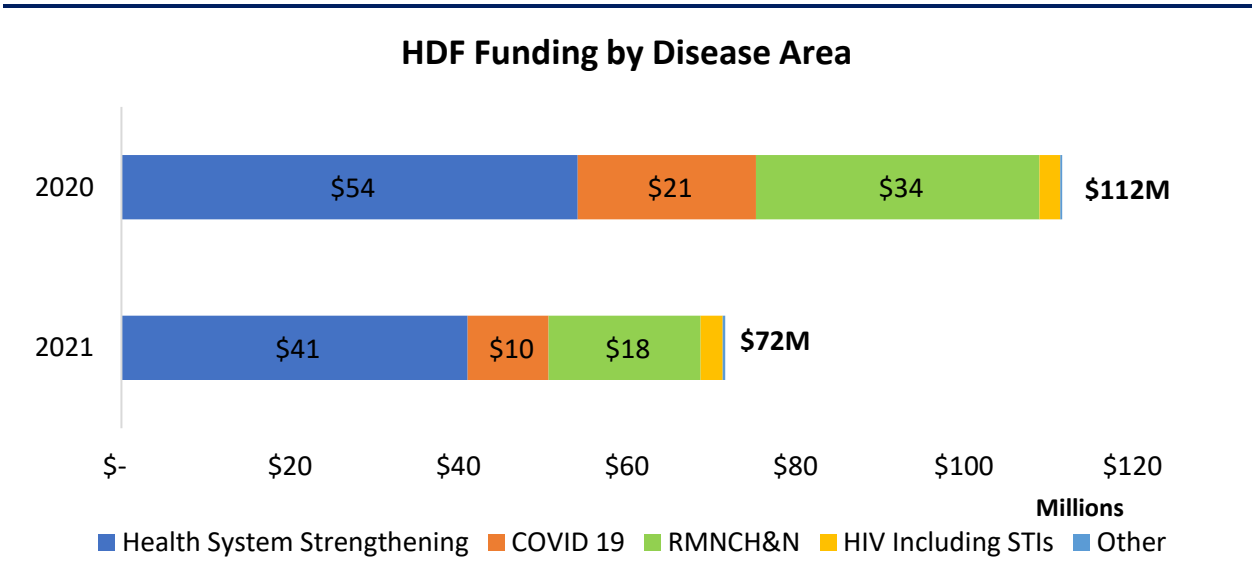

Figure 9: HDF Funding by Disease Area

3.2.4 Funding from the United States President's Emergency Plan for AIDS Relief Partners

The disease areas that had the most significant funding increases from PEPFAR partners were HSS which increased by $25 million ($18 million in 2020 to $43 million in 2021), HIV/AIDS which increased by $7 million ($142 million in 2020 to $149 million in 2021) and COVID 19 funding by $3 million. Amongst the HSS interventions, cross-cutting activities had the highest funding increase of $11 million ($9 million in 2020 to $20 million in 2021), health information systems by $8 million ($4 million in 2020 to $12 million in 2021) and community HSS increasing by $15 million ($3 million in 2020 to $18 million in 2021). For HIV/AIDS interventions, the most significant increase in funding was for HIV testing, which rose by $18 million ($22 million in 2020 to $40 million in 2021), followed by HIV HSS and HIV Impact Mitigation funding that both increased by $4 million. Despite the increase in funding for these three interventions, funding for HIV Research fell from $11 million in 2020 to having no budget in 2021, with HIV prevention and HIV treatment funding falling by $5 million and $3 million, respectively. A summary of the PEPFAR funding by disease area and HIV funding by intervention is shown in Figure 10 below:

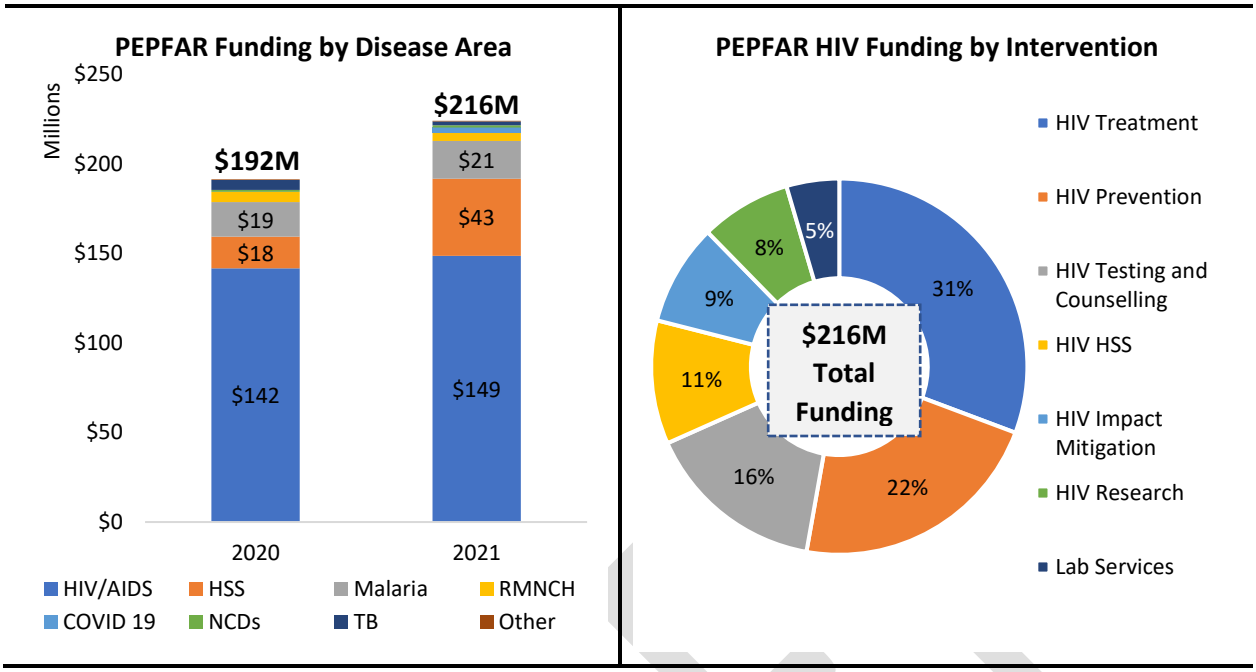

Figure 10: PEPFAR Funding by Disease Area and HIV Intervention

Given the high concentration of funding from the HDF, GFATM, and PEPFAR funding pools, the MOHCC needs to increase its reliance on public sector revenues. This can be done by continuously lobbying the national treasury to allocate more funding for health at both the central and local government levels while exploring innovative health financing mechanisms. The potential innovative financing mechanisms will include sin taxes, exploring methods that will allow communities to contribute funding to HSS, and strengthening revenue from the informal sector. For DAH, the MOHCC must take measures to increase the level and predictability of available financing. This can be done by strengthening the planning and donor coordination unit, and creating virtual pools to ensure DAH funding is more transparent and reported on budget. Efficiencies in DAH funding must be improved by using RM to identify redundancies and underfunded areas, with partners aligning their funding to long-term MOHCC national priorities and strategic plans.

3.3 Domestic Funding for Health

Since Zimbabwe started experiencing an economic downturn in 2012, the MOHCC has faced several persistent issues. These challenges have included inadequate transport, accommodation, and dwindling disposable income for human resources for health (HRH), resulting in industrial actions that have disrupted service delivery. Another significant challenge has been the shortage of foreign currency that has ultimately led to disruptions in the procurement of medicines and equipment

To assist in alleviating these problems, the MOHCC undertook a restructuring exercise in 2020. As part of this exercise, the MOHCC aims to stabilize the health workforce. Activities targeted at stabilizing the workforce include increasing allocations to HRH salaries and the resuscitation of infrastructure for canteens and dormitory provisions that will benefit HRH. A closer analysis of the MOHCC budget by cost category reveals that within the public health program of the MOHCC, $38 million of funding is allocated towards health worker salaries and benefits (59% of funding for the public health program). Within the

curative services program, $246 million (53% of the financing for the program area) was allocated towards HRH salaries. The commitment to upgrade and improve the healthcare system's infrastructure is evidenced by the $96 million within the curative services program being allocated toward infrastructure and $13 million committed to capital and medical equipment. Drugs and medical supplies funding from the GoZ increased significantly from $7 million in 2020 to $45 million in 2021.

To assist in the retooling and recapitalisation the healthcare sector, the MOHCC introduced the bio-medical science, engineering, and pharmaceutical production program. This program was allocated an estimated $15 million in funding, with most funding allocated towards health research and biomedical research. As the MOHCC continues to implement the program, more funding is expected to be allocated towards biomedical engineering and pharmaceutical production. A summary of the MOHCC budget by program area is shown in Figure 11 below:**rere retoolr**

Programme 1: Policy and Administration			
	2019	**2020**	**2021**
Minister and Permanent Secretary's Office	$ 277,286	$137,344	$4,621,489
Policy Planning and Co-ordination	$ 1,158,664	$284,633	$13,118,018
Human Resources	$ 1,739,001	$532,499	$14,601,447
Finance and Corporate services	$ 1,321,331	$1,099,732	$13,863,672
Monitoring and Evaluation	$ 14,980	$320,983	$4,027,568
Internal Audit	$ 918,131	$524,281	$2,685,978
Logistics and Asset Management	$ -	$111,923	$68,264,939
Legal Services	$ -	$ -	$ 1,530,690
	$ 5,429,393	**$ 3,011,396**	**$ 122,713,801**
Programme 2: Public Health			
Communicable Diseases	$ 81,285	$ 238,949	$ 21,576,041
Family Health	$ 1,168,939	$ 1,169,913	$ 22,543,928
Non-Communicable Diseases	$ 145,055	$ 1,576,583	$ 1,763,653
Environmental Health	$ 25,988	$ 260,315	$ 17,898,787
	$ 1,421,266	**$ 3,245,760**	**$ 63,782,409**
Programme 3: Curative Services			
Quinary (Research Hospital)	$ 17,892,446	$ 9,914,418	$ 1,993,608
Quaternary Care (Central Hospitals)	$ 9,051,254	$ 3,741,845	$ 149,628,678
Tertiary Care (Provincial Hospitals)	$ 39,952,341	$ 31,776,758	$ 54,837,485
Secondary Care (District Hospitals)	$ 12,278,548	$ 11,608,407	$ 144,870,405
Primary Care (Rural Health Centres)	$ 31,019,827	$ 16,174,768	$ 108,094,631
Traditional Medicines	$ -	$ -	$ 1,377,482
	$ 110,194,417	**$ 73,216,197**	**$ 460,802,288**
Programme 4:Bio- Medical Science, Engineering and Pharmaceutical Production			
Biomedical Engineering	$ -	$ -	$ 2,777,034
Biopharmaceutical Engineering and Production	$ -	$ -	$ 2,346,628
Bio-Medical Science Research	$ -	$ -	$ 3,602,827
Bio-Analytics	$ -	$ -	$ 2,040,775
Health Research	$ -	$ -	$ 4,222,373
	$ -	**$ -**	**$ 14,989,637**
Grand Total	**$ 117,045,076**	**$ 79,473,353**	**$ 662,288,136**

Figure 11: MOHCC Funding by Program Area

3.4 Funding by Disease Area

In 2021, the majority of healthcare funding is allocated to overall HSS with $683 million (59% of total funding for health), followed by HIV & sexually transmitted infections (STI')s with $265 million (23% of total funding for health), RMNCH with $53 million (5% of total funding for health), COVID 19 with $49 million (4% of total funding for health) and malaria with $37 million (3% of total funding for health). Most financing for HSS comes from the GoZ ($568 million) and is allocated towards salaries and infrastructural costs, with development partners like HDF ($40 million), CDC ($23 million) and Global Fund ($12 million) contributing the remaining funding. Most of the DAH funding for HSS is allocated towards drugs, medical supplies, and health worker salaries. A summary of the 2020-2021 funding by the disease are is shown in Figure 12 below:

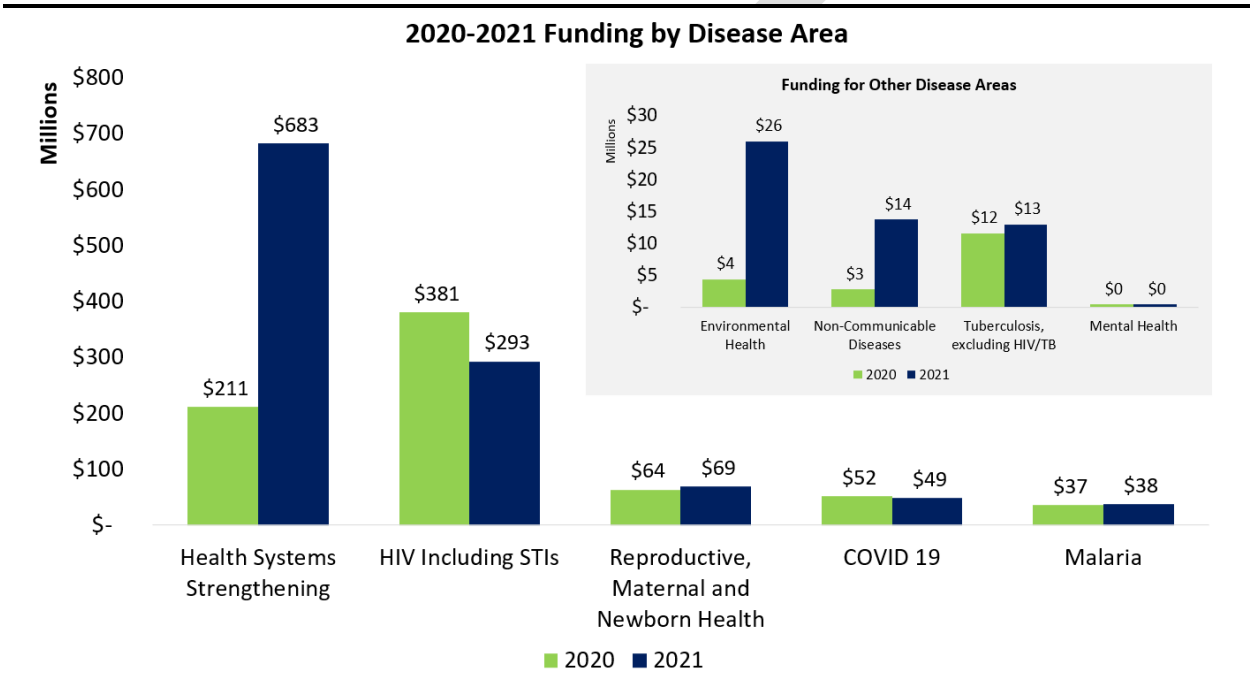

Figure 12: Total Funding by Disease Area

While both the GoZ funding for HSS and DAH funding for specific disease areas is complimentary, there is a need to ensure funding continues to adapt to the changing landscape of the health sector. With Zimbabwe facing a double burden CDs and NCDs, only 1% of total healthcare funding is allocated towards NCDs. This is despite the fact that NCDs are the leading cause of death in the country, with acute respiratory infections causing the highest mortalities. With HIV/AIDS receiving the highest among all CDs, this limits the ability to distribute available resources from donors in a manner that reflects the priorities of the GoZ and the overall health sector. For example, budget allocations to lower healthcare system levels have not reflected the population's specific needs. Distributions at lower levels have been biased towards hospital and curative services vs. primary and preventive services.

Overall, with the increasing and changing burden of disease in Zimbabwe, financial resources need to be mobilised efficiently. For example, HIV funding needs to consider interventions for the emerging co-morbidities, including cardiovascular, liver, and kidney-associated illnesses. With Zimbabwe in the process of defining an essential health benefits package (EHBP), there will be a need to sensitise all stakeholders

on the process. The package can guide the needs-based framework for resource allocation that will ensure equity in the usage of healthcare resources

4. COVID-19 Funding Analysis

4.1 Trend in COVID 19 New Cases and Deaths

When the COVID 19 virus was recognized as a Global Pandemic, the GoZ implemented an initial lockdown in March 2020. The country has since initiated various national lockdown measures to reduce the number of cases and deaths due to the virus. Statistics reveal that from March 2020 to February 2021, there have been 34,411 new cases recorded, with new waves coming in August 2020 and January 2021. The wave that occurred in January 2021 was the most significant, as it contributed to over 50% of the new cases recorded (19,521 new cases). A summary of the new cases of COVID 19 since April 2020 is shown in Figure 13 below:

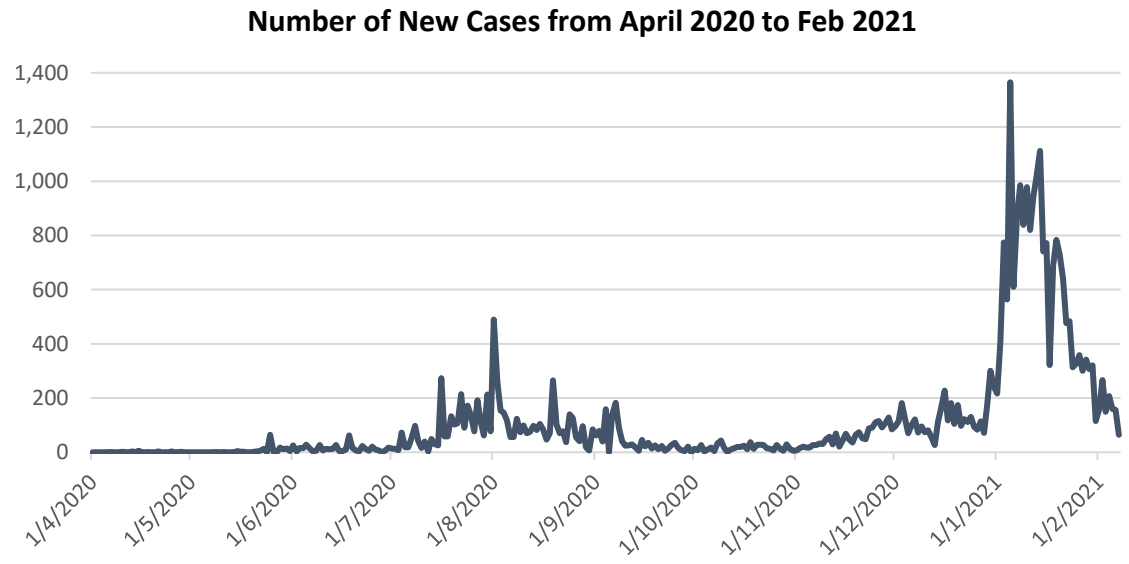

Figure 13: Number of New COVID 19 cases from April 2020 to February 2021

The number of COVID 19 deaths followed a similar trend to the number of new cases and have totaled 1,324 since April 2020. Deaths have mostly been constant over the April 2020-February 2021 period and peaked during three distinct periods. These periods were in August 2020, which recorded 135 deaths; January 2021, which recorded 854 deaths; and February 2021, with 109 deaths. A summary of the number of COVID 19 deaths is shown in Figure 14 below:

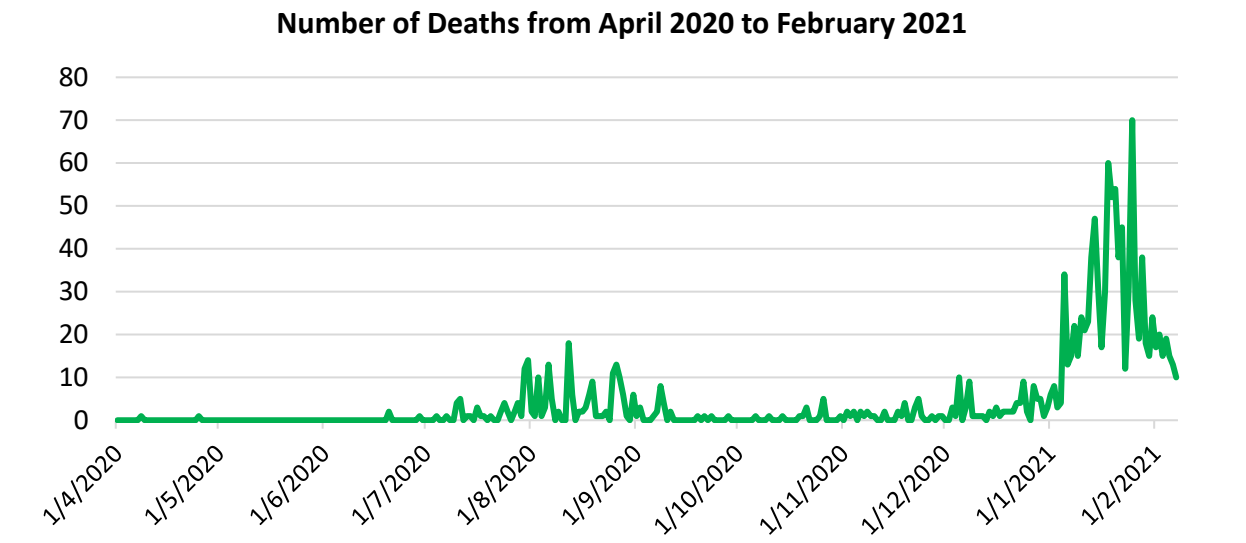

Figure 14: Number of COVID 19 Deaths from April 2020 to February 2021

In response to this pandemic, the Ministry of Health and Child Care established a multisectoral coordination framework. This framework comprised eight pillars that guided the COVID 19 response across all ministries and stakeholders involved in the response. This framework's total budget amounted to $325 million and was tabled by the MoHCC to the MoFED and Development Partners. A summary of the COVID 19 National response budget is shown in Figure 15 below:

National COVID-19 Response Budget	
Coordination	1,541,200.00
Surveillance	2,446,921.14
Rapid Response Teams	53,373,260.00
Case management	61,994,029.31
Risk communication & community engagement	1,350,748.00
Logistics	11,815,742.44
Infection Prevention and Control (IPC)	179,540,654.68
Laboratory Capacity	12,332,008.47
Points of Entry	467,870.00
	324,862,434.04

Figure 15: National COVID 19 Response Budget by Pillar

4.2 COVID 19 Financing

4.2.1 COVID 19 Budget by Source

For 2020 and 2021, funding for the COVID 19 pandemic is estimated to total $43 and $49 million respectively. In 2020, funding mostly came from the GFATM and the HDF, which contributed $19 million and $21 million. In

2021, the GoZ will be the largest funder with its contribution of $20 million, followed by the GFATM with $16 million and HDF with $10 million. External funding was mainly re-programmed from other disease areas, such as RMNCH, HIV/AIDS, and TB. Despite the fall in funding to these programmes, the pandemic opened opportunities to integrate activities with other programmes, promoting technical and allocative efficiencies. This was apparent with integrating COVID 19 interventions with existing community health programmes and Gene Xpert testing platforms for TB and COVID 19. A summary of the COVID 19 funding in 2020 and 2021 by the source is shown in Figure 16 below:

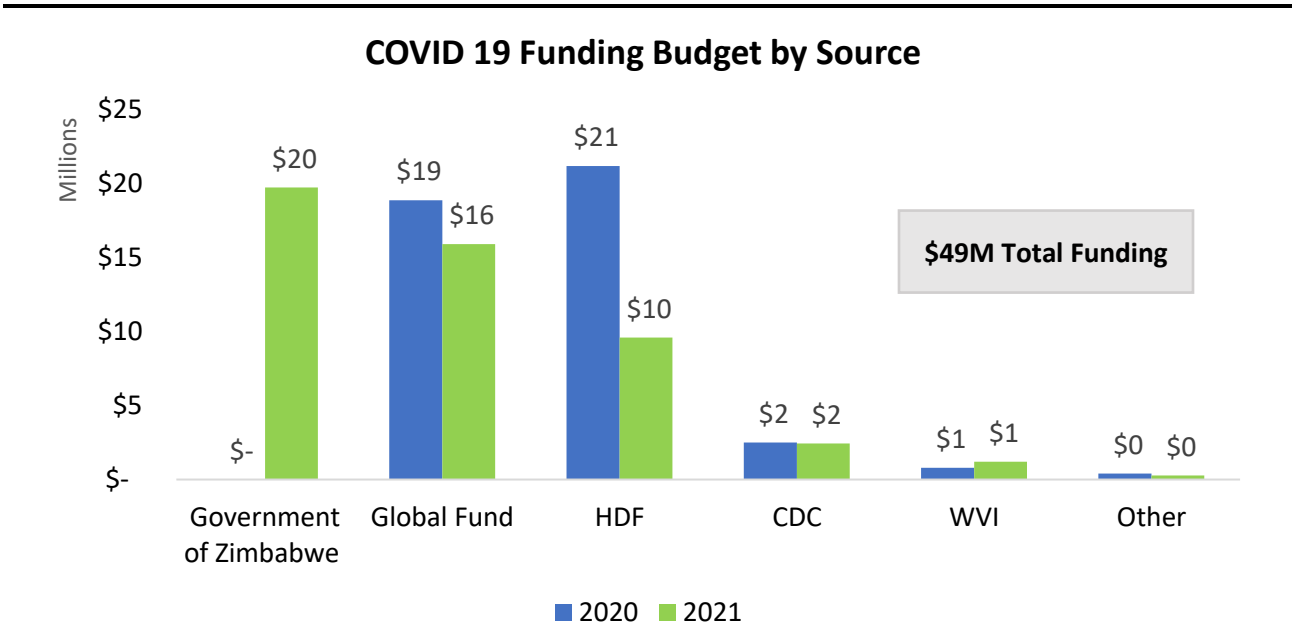

Figure 16: COVID 19 Funding by Financing Source

4.2.2 COVID 19 Budget by Pillar

Figure 17 below shows the total funding that was channeled towards the National Covid-19 response through the MOHCC and Development Partners by pillars. In 2021, most domestic funding is allocated to the Infection Prevention and Control and Laboratory Capacity pillars. External financing is mainly allocated to the Laboratory Capacity, Case Management, and Risk Communication and Community Engagement pillars.

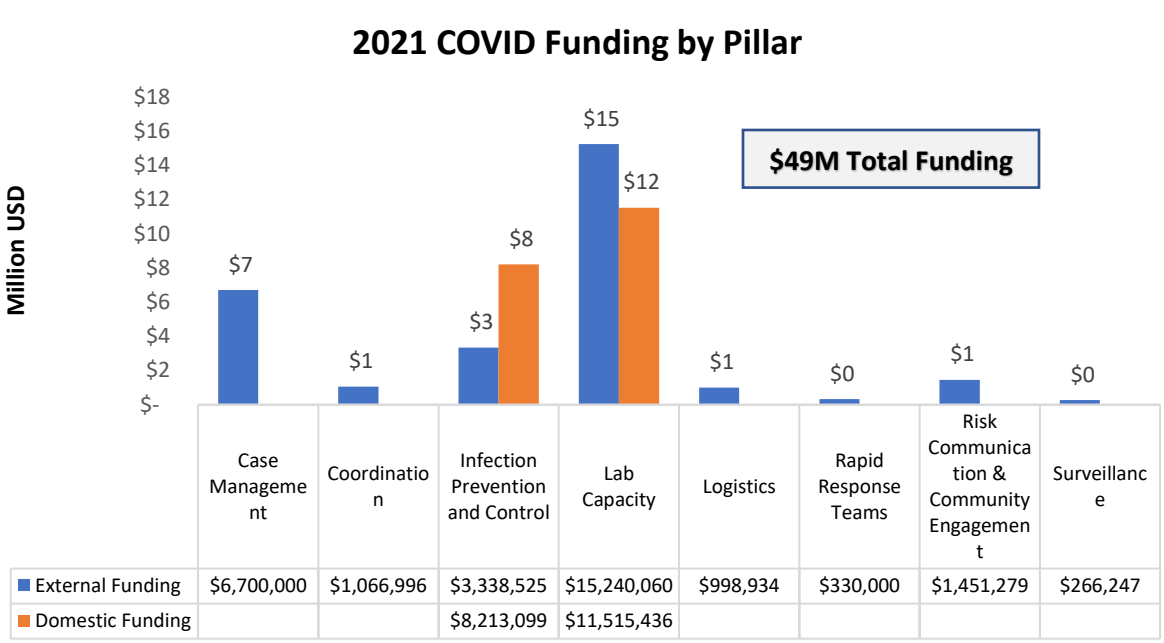

Figure 17: COVID 19 Budget by Pillar

4.2.3 COVID 19 Budget by Cost Category

Figure 18 below shows the distribution of the allocated Covid-19 funds by cost categories. Drugs, Medical Supplies, and Facility Operating Costs received the most significant allocations. For drugs and medical supplies, funding can be attributed to personal protective equipment, test kits, and other commodities used for case management. In response to the pandemic, the GoZ and development partners invested in constructing, refurbishing, and upgrading Covid-19 treatment and Isolation centers at Health facilities. To sustain the gains achieved so far in fighting against the pandemic, there is a need to invest more in research and development and public awareness campaigns to keep the public informed and educated.

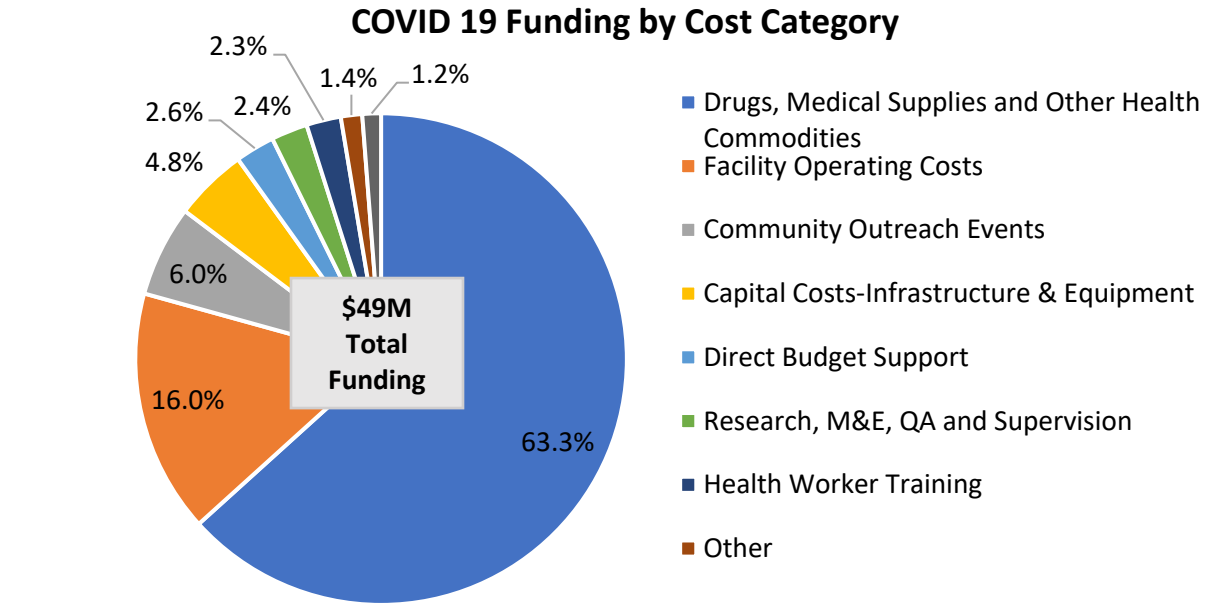

Figure 18: COVID 19 Funding by Cost Category

5. Community Health Funding

Community Health is one of Zimbabwe's most effective tools for achieving UHC, especially within the most remote and underserved communities. Following Zimbabwe's independence, the country shifted from an urban-based curative health care approach to a primary healthcare (PHC) approach that emphasized health promotion and prevention. As a result, the healthcare system's focus shifted from the urban minority to offering adequate healthcare to the majority rural population. As part of that shift towards PHC, the country launched the National Village Health Worker (VHW) Program in 1981. Since its inception, the VHW program has steadily grown, with the number of VHWs trained growing from 7,000 in 1987 to over 15,000 VHWs to date.

Despite the importance of community health in Zimbabwe, a situational analysis of the healthcare level reveals significant gaps. These gaps include fragmented service delivery, unevenly funded interventions, and the lack of a standard package of services. The funding landscape for community health is characterised by multiple health funders that operate in siloes and develop personalised community cadres to serve their priorities. Consequently, this has resulted in over 77 different community health workers (CHWs) in Zimbabwe that offer a diverse package of services in different geographic regions of the country. This vertical structure to community health has resulted in cadres that lack accountability to the communities they serve, with training remaining inadequate to provide a complete package of services. The absence of a coordination mechanism and varying remuneration levels has also made it difficult for these cadres to be formally integrated into the formal health system, making it difficult to monitor and supervise them.

The MOHCC launched the National Community Health Strategy 2020-2025 (NCHS) to address these challenges. This strategy aims to deploy a community-owned, well-trained, well-remunerated CHW cadre who has sufficient tools and adequate supervision to offer an integrated package of services to the most remote communities of Zimbabwe. Health interventions will be aligned to the comprehensive community health package (CCHP), which was developed as part of the NCHS.

5.1. Overall Funding for Community Health

The NCHS Costing Report reveals that $236 million will be needed to finance the strategy over the 2021-2025 period. For the years 2020 and 2021, approximately $13 million and $51 million will be required respectively in both years to finance the strategy. However, an analysis of community funding budgets using resource mapping data in both years shows budgets exceed cost by 515% in 2020 and 56.9% in 2021. The excess funding indicates that Zimbabwe has more than enough resources in 2020 and 2021 allocated towards community health, as shown in Figure 19 below:

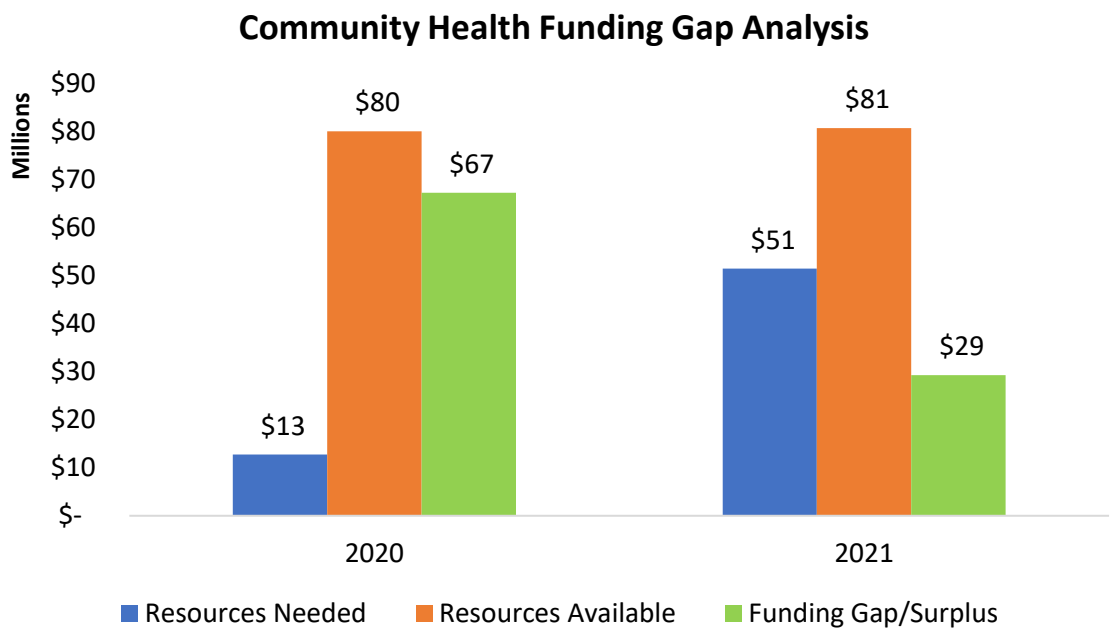

Figure 19: Resources Available vs. Resources Needed for Community Health

However, funding is not allocated efficiently across priority intervention areas, resulting in inadequate service delivery at the community level. This is due to the conflicting donor priorities and those of the GOZ, continued funding of parallel community health cadres or programs, and redundancies of services provided.

5.2 Community Health Funding by Source

Zimbabwe has several key development partners who work with the GoZ to streamline community health services. USAID (S$33 million in 2020 and $45 million in 2021) and CDC (US$12 million in 2020 and 2021) are the two primary funding sources for community health funding in 2020 and 2021. The two organizations source over 50% of community health funding for both years. Figure 20 below shows the available funding for community health by source in 2020 and 2021.

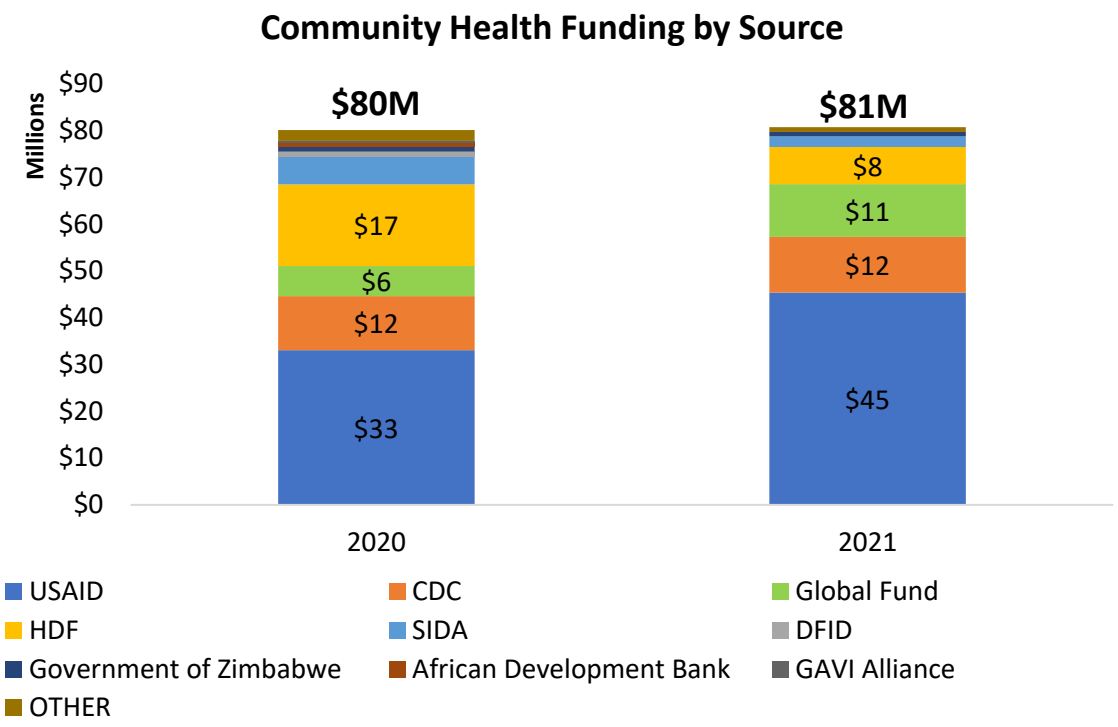

Figure 20: Community Health Funding by Source

The community health funders are heavily invested in HIV/TB and RMNCAH interventions. All six main community health funders contribute towards HIV/TB interventions, while four of the six contribute to cross-cutting activities. However, disease areas such as NCDs and Water, Sanitation and Hygiene (WASH) have been neglected. As shown in Figure 21, disease areas such as HIV/TB and Malaria have a funding surplus. Therefore, if the GoZ and its development partners collaborate, efficiencies can be unlocked, allowing surplus resources to trickle towards other neglected disease areas. Also, adopting the integrated approach of the CCHP means that funding sources for community health will be investing in a package that includes all disease areas indiscriminately. Therefore, the GoZ needs to advocate for coordination mechanisms in community health that are in line with the Health Sector Coordination Framework (HSCF).

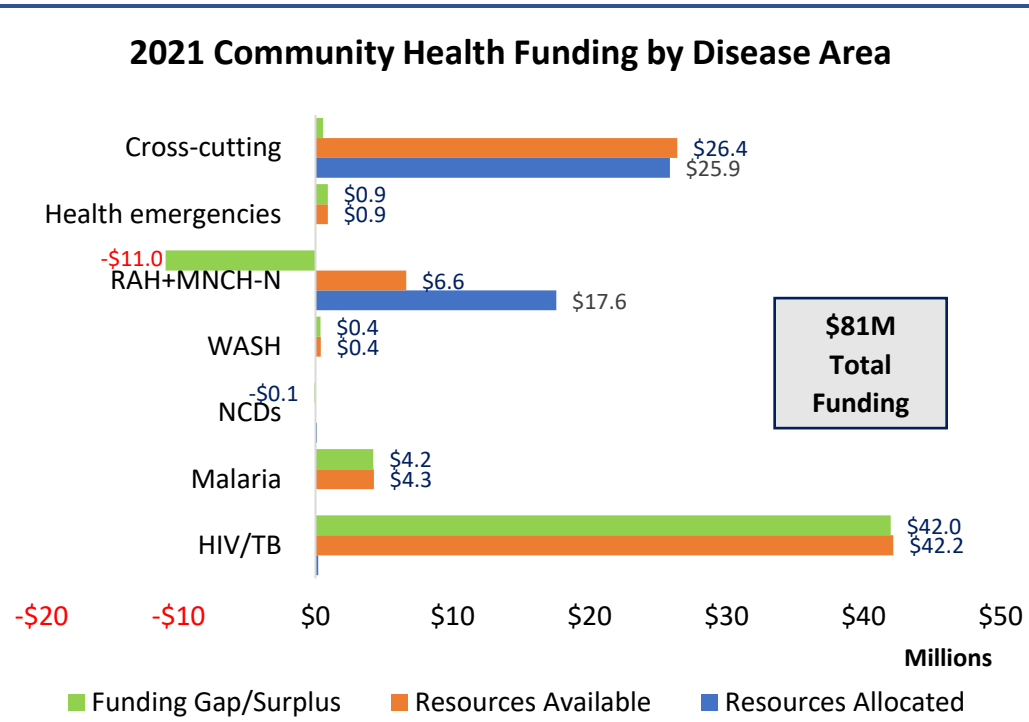

Figure 21: Community Health Funding by Disease Area

The lack of a community health coordination mechanism and parallel reporting structures leads to duplication of services, redundant administrative costs, and fragmented and inequitable service provision. This highlights the need to harmonise community health cadres, community structures, and community programs. Efficiencies can only be maximised once community health activities are coordinated from the national level downwards, resulting in an integrated approach to service delivery.

5.3 Community Health Funding by Cost Category

Although the overall resource envelope for community health exceeds the costed need, there are inefficiencies in funding allocations by cost category. Some cost categories such as VHW salaries, tools of the trade, medicines, and supplies are underfunded, while other cost categories such as management meetings and management salaries are overfunded, as shown in Figure 22 below:

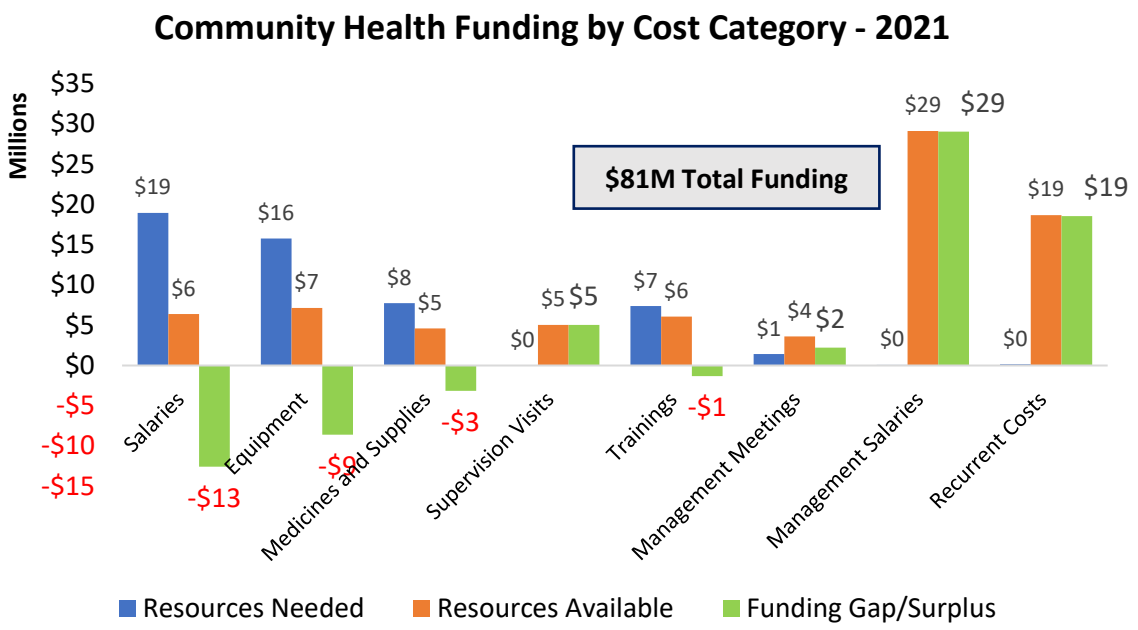

Figure 22: Community Health Funding by Cost Category

Inadequate funding for VHW Salaries can demotivate VHWs from implementing service delivery interventions and assisting communities. In addition, the lack of funding for tools of the trade, medicines, and supplies hinders the VHWs from providing quality health services to the most vulnerable. The GoZ and development partners need to coordinate their efforts at the community level to achieve synergies in allocating resources across cost categories. This will ensure an efficient allocation of resources, where coordinatized effort for costs like training and supervision can create cost savings that can be allocated to crucial underfunded cost categories like medicines and supplies.

5.4 Community Funding by Cadre

Although VHWs are the majority of the CHWs in Zimbabwe by number, the program only receives 8% of the funding available at the community level, as shown in Figure 23 below. This highlights the fragmented nature of the financing at the community level. This diversity of cadres at the community level that mainly focus on HIV interventions implies that cadres who focus on other disease areas will be left underfunded. Also, because cadres being funded may be concentrated in one geographic area, some areas will be left without the community health interventions they need. The variation in remuneration also means that volunteers will join some programs because of their incentives instead of their impact. If donors pool their funds together in support of the VHW program, funding will be focused on a national cadre that offers an integrated package of services.

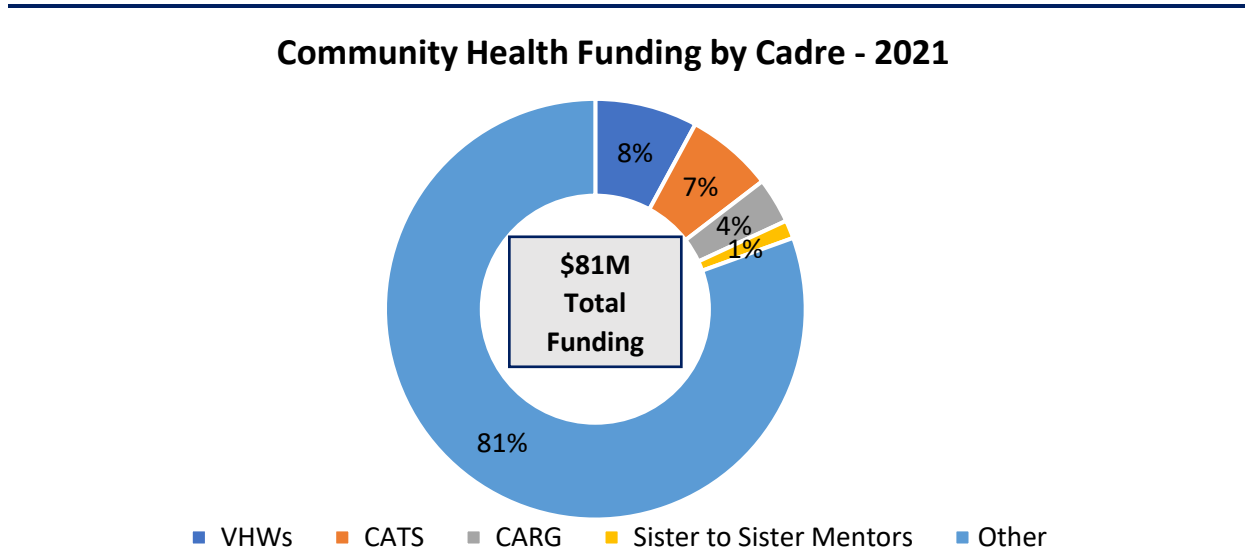

Figure 23: Community Health Funding by Cadre - 2021

VHWs, who are the most by number and provide the most comprehensive package at the community level to the most remote areas, should be the focal point of community health funding from which other CHW programs are aligned. In line with the HSCF and the National Health Financing Policy, the GoZ, and its development partners need to harmonize CHW cadres, create one virtual pool, and integrate their data systems to share information and leverage opportunities for partnerships. An integrated approach to training, support, and supervision of CHWs will ensure equal opportunities for capacity building for all.

5.5 Gap Analysis of Community Health Funding for Disease Interventions

Resources are not evenly distributed across different disease interventions at the community level, with HIV and TB receiving most of the funding (52%), as shown in Figure 24 below. NCDs and respiratory infections are the leading cause of mortality in Zimbabwe, yet HIV, malaria, and TB (which are now among the least causes of mortality) receive most of the funding at the community level. The recently launched NCHS emphasizes the life cycle approach in providing community health interventions by integrating health interventions and allocating budgets based on disease burden. HIV and TB are overfunded by over US$41 million, while other crucial disease areas such as NCDs and RMNCH are underfunded.

2021 Gap Analysis of Community Health Disease Interventions			
	Resources Needed	**Resources Available**	**Funding Gap/Surplus**
HIV/TB	$199,134	$42,180,671	$41,981,537
Malaria	$42,607	$4,265,117	$4,222,510
NCDs	$98,670	$24,112	-$74,558
WASH	$22,373	$393,622	$371,249
RAH+MNCH-N	$17,566,956	$6,611,412	-$10,955,544
Health emergencies	$0	$893,740	$893,740
Cross-cutting	$25,860,097	$26,399,632	$539,535
Total	**$43,789,837**	**$80,768,306**	**$36,978,469**

Figure 24: 2021 Gap Analysis of Community Health Disease Interventions

This uneven distribution of funds across disease categories means that the underprivileged will not receive vital health services, such as those for NCDs that are the leading causes of mortality among Zimbabweans. The GoZ and its development partners need to create a resource allocation formula based on the life cycle approach of the CCHP to ensure equity in health funding.

5.6 Efficiencies in Community Health Training

Although the new NCHS emphasizes the integration of services, the current funding landscape for training is heavily skewed towards HIV and TB services (64%). This implies that the cadres at the community level are primarily skilled in providing HIV and TB services but lack the skills to provide other services. Zimbabwe should invest in an integrated training approach that emphasizes the new integrated CCHP. An integrated approach would allow resources wasted in duplicate training of CHWs to be prioritised to other areas of need. Innovative training approaches for CHWs should cover multiple disease programs and be efficient, so less time is spent away from the communities they serve. Once the funds for training are pooled together, the MoHCC and development partners must invest the funds in efficient training approaches such as e-learning that will complement traditional classroom approaches.

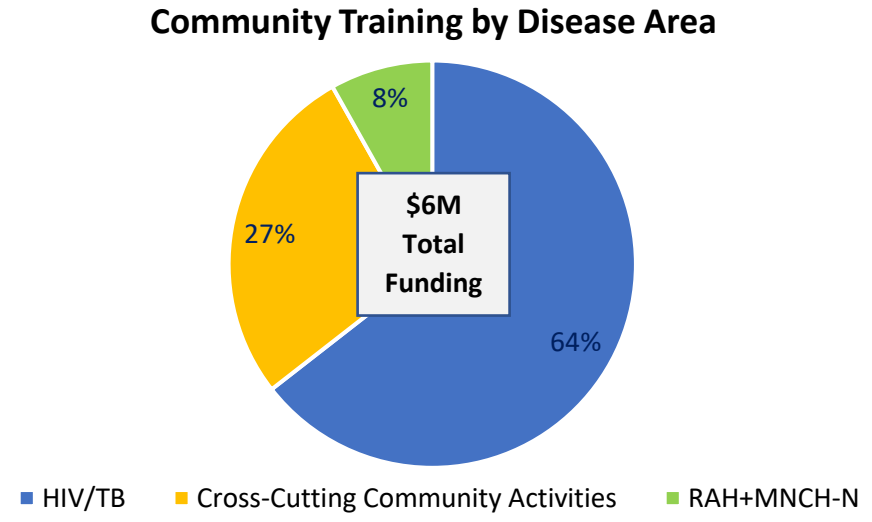

Figure 25: Community Health Training by Disease Area

6. Efficiencies with Healthcare Funding

Funding for health in Zimbabwe flows through three main funding pools. The largest funding pool in 2021 is the domestic funding pool comprising financing from the MOFED consolidated revenue fund (CRF), the AIDS Levy that flows through NAC, and funding from Local Authorities. The total resources within this pool totaled $669 million, with the CRF allocation comprising 99% of the funding within the pool. The second-largest pool is the donor pool that had a total of $447 million in funding, with the PEPFAR pool contributing $216 million (48% of the financing within the pool), the GFATM contributing $160 million (36% of funding within the pool) and the HDF funding pool with $72 million (16% of the financing within the pool). Funding from discrete channels totals $31 million and is targeted at specific projects for IPs. A summary of health financing by pool is shown in Figure 26 below:

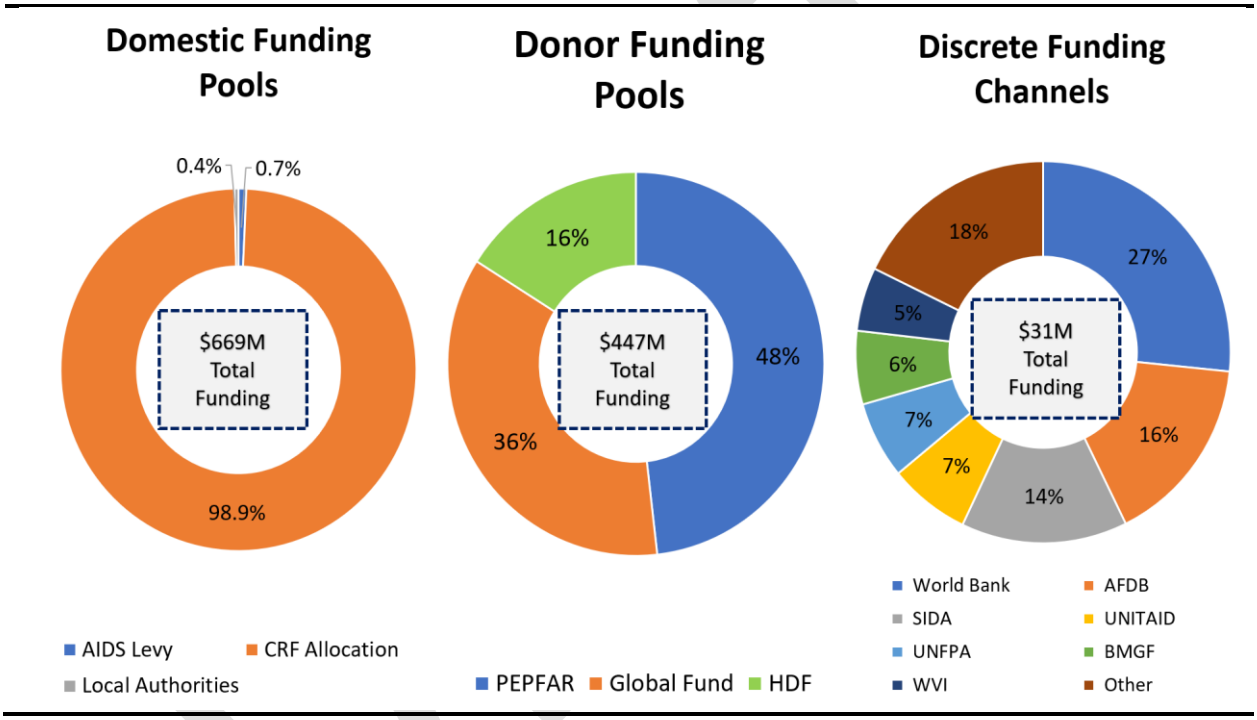

Figure 26: Health Financing for Resource Pools in Zimbabwe

6.1. The importance of Donor Coordination Structures

While domestic funding is managed at the central level through the PFMS, DAH funding is mainly targeted at specific vertical disease areas. By directing funding in this manner, this often leads to fragmentation and duplication in activity implementation, such as for training, support, and supervision. Fragmentation of activities also increases administration and transaction costs that redirect funding from the service delivery level where it is most needed.

To help maximise efficiencies with health funding, there is a need to enhance inter-ministerial, intra-ministerial, and multisectoral coordination across all stakeholders financing the healthcare sector. This is

in line with the three one's principle (one national plan, one coordination mechanism, one M&E framework) that will identify opportunities for coordinated planning and ensure funding mechanisms fall under one coordinating structure. To coordinate activities and financial contributions for DAH, the MOHCC must revitalise the Health Development Partners Coordination Forum (HDPCF), which aims to align DAH funding to national priorities and harmonise activities from stakeholders funding the healthcare system. The HDPCF must move the country towards a General Budget Support (GBS) model, where funding is under one structure and is directed towards national priorities instead of earmarked projects. By using the GBS system, funding will be more transparent as it will be disbursed through the GOZ's PFMS, thereby increasing transparency and accountability in resource use. To successfully operationalise multisectoral coordination, there is a need to generate high level political will ensure stakeholders are committed towards a common cause

6.2 Efficiencies in Health-Worker Training

To ensure quality service delivery, healthcare worker (HW) training remains a vital component of Zimbabwe's healthcare system. Like the vertical funding structure of program areas within the MOHCC, funding for health workers is also allocated towards vertical disease programs and totals $19 million in 2021. HIV including STI's receives the most funding ($6 million), followed by Reproductive, Maternal, Neonatal and Child Health (RMNCH) with $3 million. Malaria, Environmental Health, and HSS all have training funding of $2 million, with other disease areas having budgets of $1 million or less as shown in Figure 27 below:

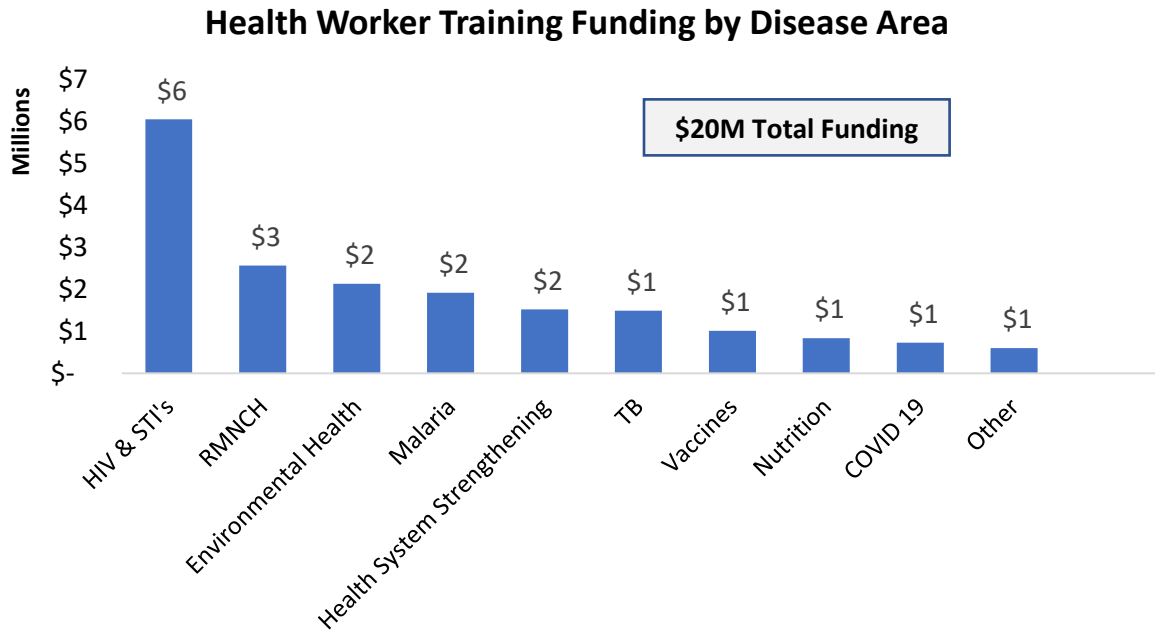

Figure 27: Health Worker Training Funding by Disease Area

To better utilise training funding within the health sector, coordination of training must be enhanced as it ensures that the HCW capacity is increased across more disease areas. Lessons can be taken from

training methods currently in place due to the COVID 19 pandemic, where COVID 19 training has been integrated within the training modules of other disease areas. Other innovative training methods must be implemented, such as blended and e-learning, since they offer a more cost-effective approach to HCW training. These will be especially important during the COVID 19 pandemic, where face-to-face training has been limited due to the various risks they impose. The implementation of innovative training approached will also avert excessive downtime by HCWs and ensure that less time is spent away from their respective service delivery platforms.

6.3 Efficiencies in Resource Allocation

As mentioned in the overall funding section, funding for health in Zimbabwe is characterized by complex funding flows involving the GoZ, donors, IPs, and other stakeholders. While having multiple implementing partners enables enhanced interpersonal communication with communities and a better understanding of their health needs, the consequence is increased administration and management costs. These administration costs channel funding away from service delivery interventions that ultimately benefit the patient. Since 2016, administration costs have equalled at least 13% of total funding for health, as shown in Figure 28 below:

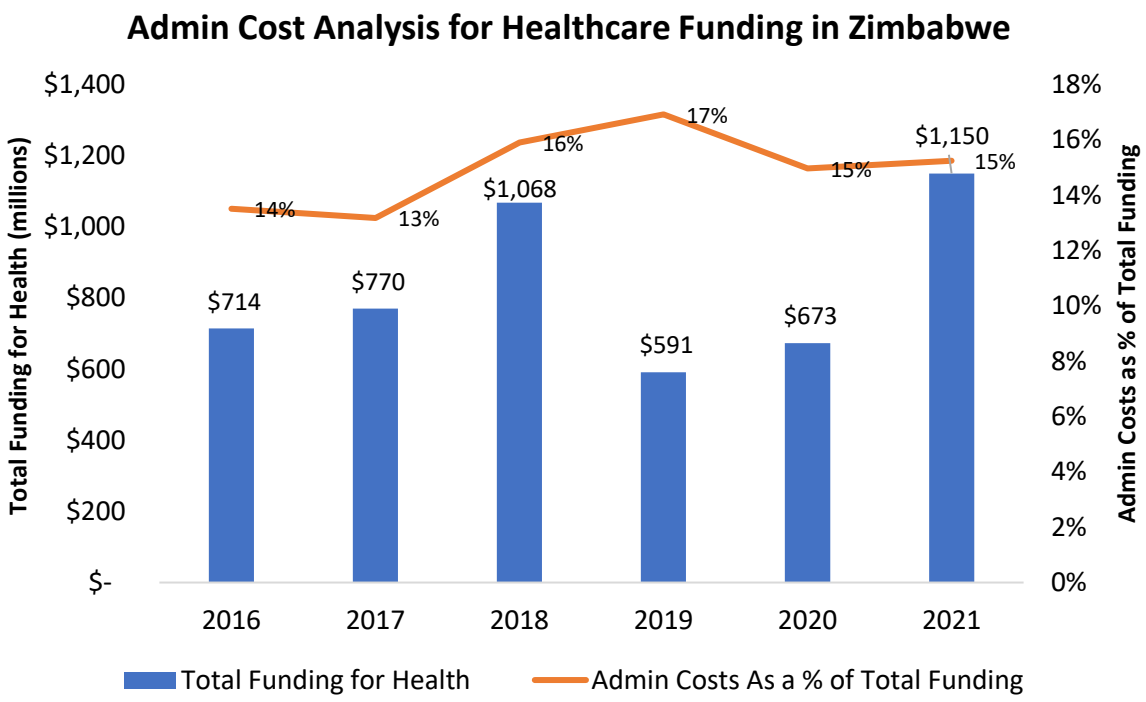

Figure 28: Administration Costs as a Percentage of Total Funding for Health

To help in the reduction of administration costs, partners should form consortiums and better coordinate their activities. Partners can leverage the HSCF, which will help them establish coordination structures at various healthcare system levels, thereby creating operational efficiencies in resource management. Virtual pooling of these funds will also help operational cost reduction for the health system since it will be more efficient in channeling resources. This is consistent with the HFS recommendation of developing

a virtual basket of all public and donor funds, joint accounting, monitoring, and reporting of resources and activities.

7. Funding for Specific Disease Areas

7.1 HIV Funding Analysis

7.1.1 Overall Funding for HIV

The MTR of the NHS revealed that despite HIV being allocated the highest amount of funding for disease areas across the 2016-2020 period, the disease area exhibited a funding gap across all implementation years. The most affected interventions included HIV Testing Services (HTS), unavailability of guiding documents & tools, and interventions for children & adolescents. Despite the gains made by the stakeholders in reducing HIV prevalence and incidence in the country, bottlenecks still exist in the service delivery for HIV. These bottlenecks include limited laboratory capacity to conduct STI aetiological testing and limited scale-up of innovations like the Electronic Patient Monitoring System (ePMS). Funding for HIV was financed mainly by external funding sources, as shown in Figure 29 below:

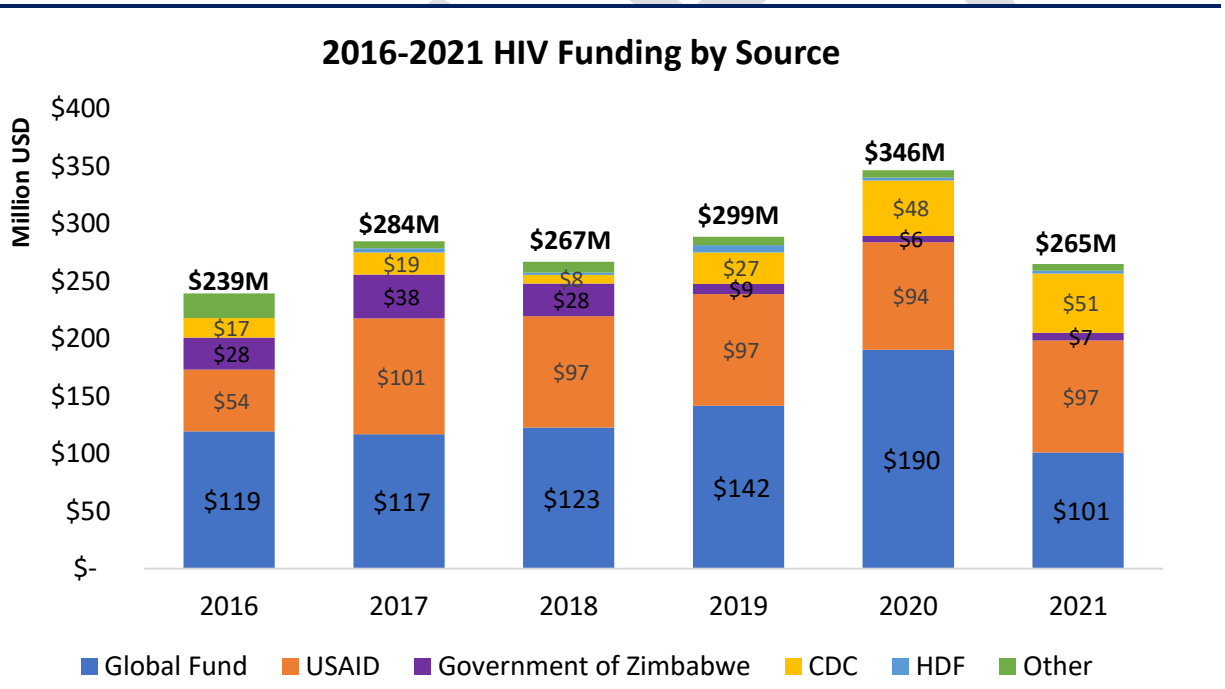

Figure 29: HIV Funding by Source

As Zimbabwe moves to implement the NHS 2021-2025, there will be a need to ensure that domestic funding is mobilized for HIV. Also, the revised NHS should ensure that interventions costed are prioritized and represent a realistic annual resource envelope funders can mobilise.

7.1.2 HIV Funding by Intervention Area and Implementing Partner

Most of the funding for HIV is allocated towards treatment ($91 million) and is mainly for the procurement of ART regimens ($79 million). As opportunistic infections continue to rise in Zimbabwe, there is a need to ensure that the HIV funding partners allocate funding towards them. Potential opportunistic infections include STI's, hepatitis, and especially NCDs that are causing the highest number of deaths in the country. Funding for HIV is distributed among 34 different implementing partners, with the United Nations Development Programme (UNDP) receiving the highest funding ($66 million). Other key implementing partners receiving funding for HIV include ZimTech with $49 million, Chemonics with $46 million, the MoHCC with $23 million, PSI with $20 million, and FHI 360 with $ 14 million. A summary of the HIV funding by intervention and implementing partner is shown in Figure 30 below:

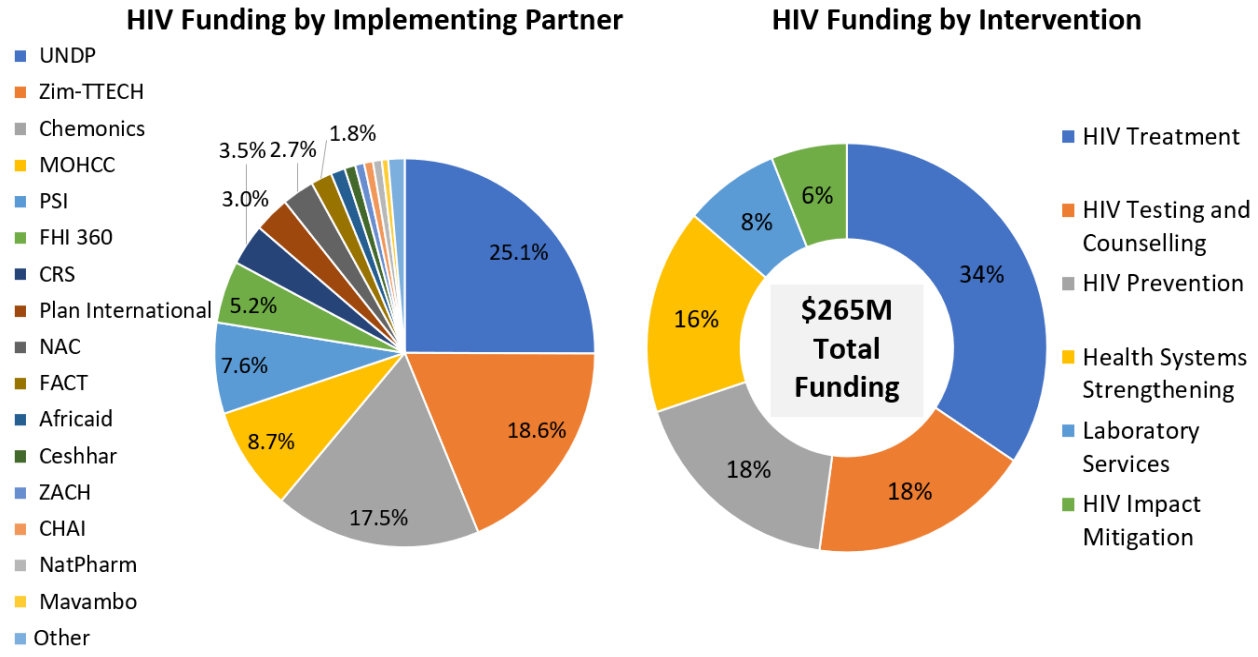

Figure 30: HIV Funding by Implementing Partner and Intervention Area

As Zimbabwe develops the overall NHS and specific disease strategies, it is vital to ensure that interventions within and across strategies align. In addition, there should be prioritization of interventions based on factors like disease burden and mortality ratios. For example, the Health Sector HIV and STI Strategic Plan has a costed need of $258 million in 2021, and total resources available total $264 million, giving a funding surplus of $6 million. A closer analysis of the strategic plan reveals that key cost categories like drugs and medical Supplies, capital costs, and policy meetings have significant funding gaps of $80 million, $14 million, and $7 million respectively. However, other cost categories like administration costs, technical assistance, and health-worker salaries exhibit funding surpluses of $40 million, $35 million, and $27 million as shown in Figure 31 below:

Gap Analysis of Health Sector HIV and STI Strategic Plan Needs in 2021			
	Strategy Costed Need	**Funding Available**	**Funding Gap/Surplus**
Drugs and Medical Supplies	$183,829,719	$103,982,846	-$79,846,873
Capital Costs - Infrastructure and Equipment	$18,763,700	$4,872,096	-$13,891,604
Planning & Policy Meetings	$11,267,524	$3,894,873	-$7,372,651
Facility Operating Costs	$5,786,580	$2,243,246	-$3,543,334
Health Worker Training	$9,514,825	$6,040,091	-$3,474,734
Communication costs (print, TV, radio)	$7,298,423	$5,886,997	-$1,411,425
Research, M&E, QA and Supervision	$8,659,949	$9,149,891	$489,943
Direct Budget Support	$1,639,500	$4,807,498	$3,167,998
Community Outreach Events	$3,030,844	$13,490,539	$10,459,695
Health Worker Salaries/Benefits	$4,676,933	$31,610,823	$26,933,890
Technical Assistance	$1,146,856	$36,431,704	$35,284,849
Administration & Management (incl. salaries)	$2,619,859	$42,203,967	$39,584,108
Total	**$258,234,711**	**$264,614,573**	**$6,379,862**

Figure 31: Financial Gap Analysis of the Health Sector HIV and STI Strategic Plan 2021-2025

To achieve technical and allocative efficiencies in resource allocation, virtual pooling, and coordination among the six implementing partners (UNDP, ZimTech, Chemonics, MOHCC, PSI, FHI 360) that control 83% of total resources for HIV must be implemented. Such a harmonized approach will ensure the attainment of the strategic objectives mentioned in the Health Sector HIV and STI strategic plan and other plans.

7.2 Funding for Malaria

7.2.1 Overall Malaria Funding

Over the 2016-2021 period, at least 92% of malaria funding has come from external funding sources. The most significant sources have been GFATM and USAID, contributing at least 50% of total financing for malaria per annum. Despite the marked increase in total funding for health by the GOZ in 2021, malaria funding only increased from $741 thousand in 2020 to $1.3 million in 2021. A summary of the total financing of malaria over the 2021-2025 period is shown in Figure 32 below:

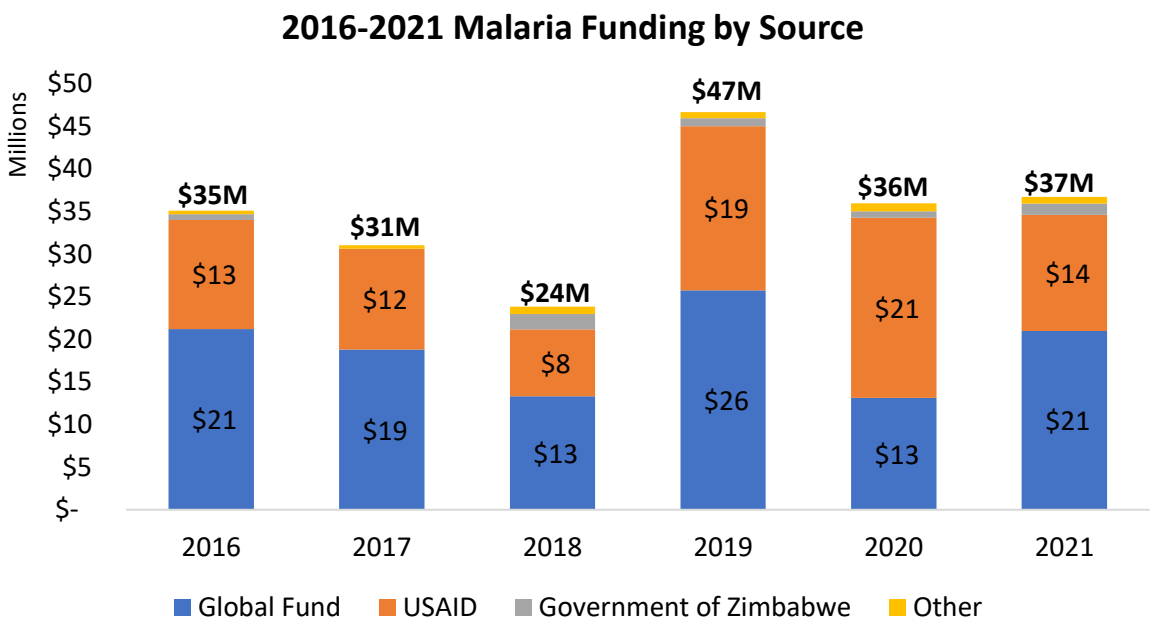

Figure 32: Malaria Funding by Source

7.2.2 Malaria Funding by Intervention and Cost Category

Similar to funding for HIV, funding for malaria needs to be re-prioritised according to the needs of the National Malaria Control and Elimination Strategic Plan 2021- 2025. In 2021, the strategic plan requires about $37 million in resources to conduct the necessary malaria interventions, consistent with the year's funding. As shown in Figure 33 below, 2021 malaria funding is mostly allocated towards prevention ($24 million) and HSS ($10 million). An analysis of the malaria funding by cost category reveals that $12 million in funding is allocated towards administration costs, highlighting the need for efficiencies in program implementation.

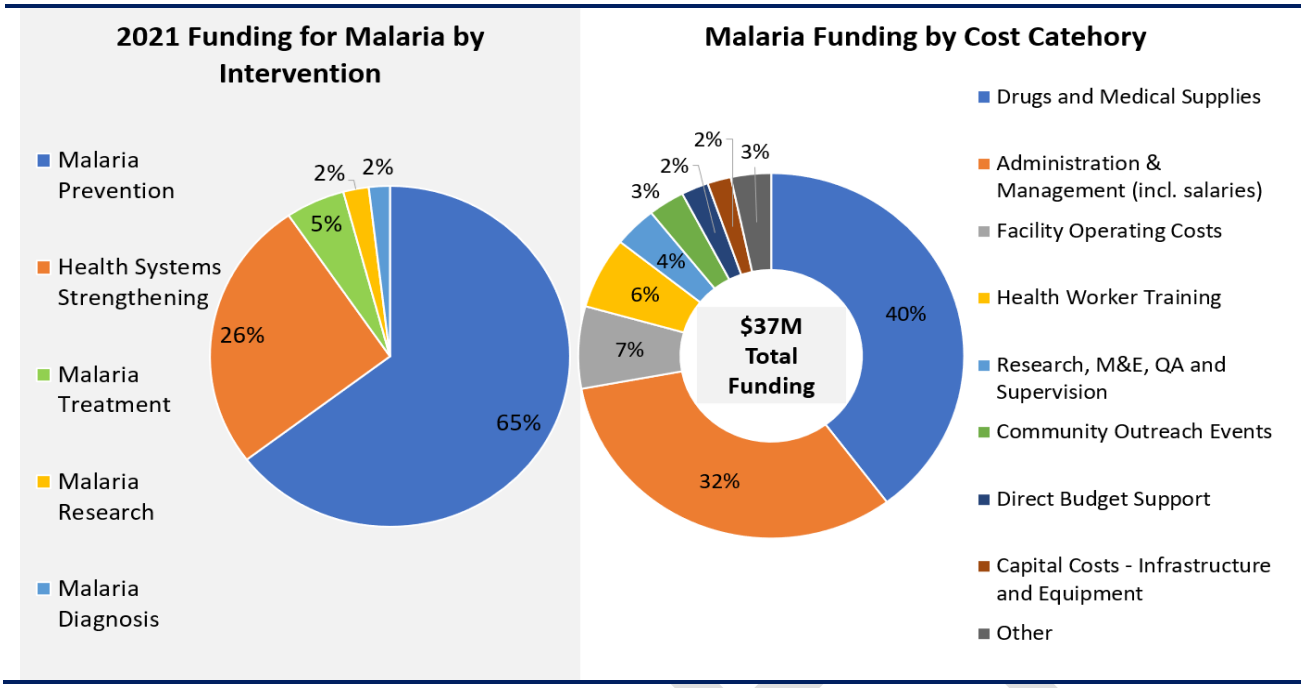

Figure 33: Malaria Funding by Intervention and Cost Category

7.3 Funding for RMNCH

7.3.1 Overall Funding for RMNCH

Over the 2016-2020 period, most of the funding for RMNCH has come from the HDF and the GoZ, with various external funders contributing towards disease areas within the program. However, 2021 saw a dramatic increase in GoZ funding for RMNCH, which increased from $3 million in 2020 to $32 million in 2021. Most of this funding was allocated for health worker training and salaries, ensuring that essential services for the most vulnerable populations continued during the COVID 19 pandemic. Other significant funders for RMNCH included the HDF with $18 million and the World Bank with $8 million. A summary of the funding for RMNCH is shown in Figure 34 below:

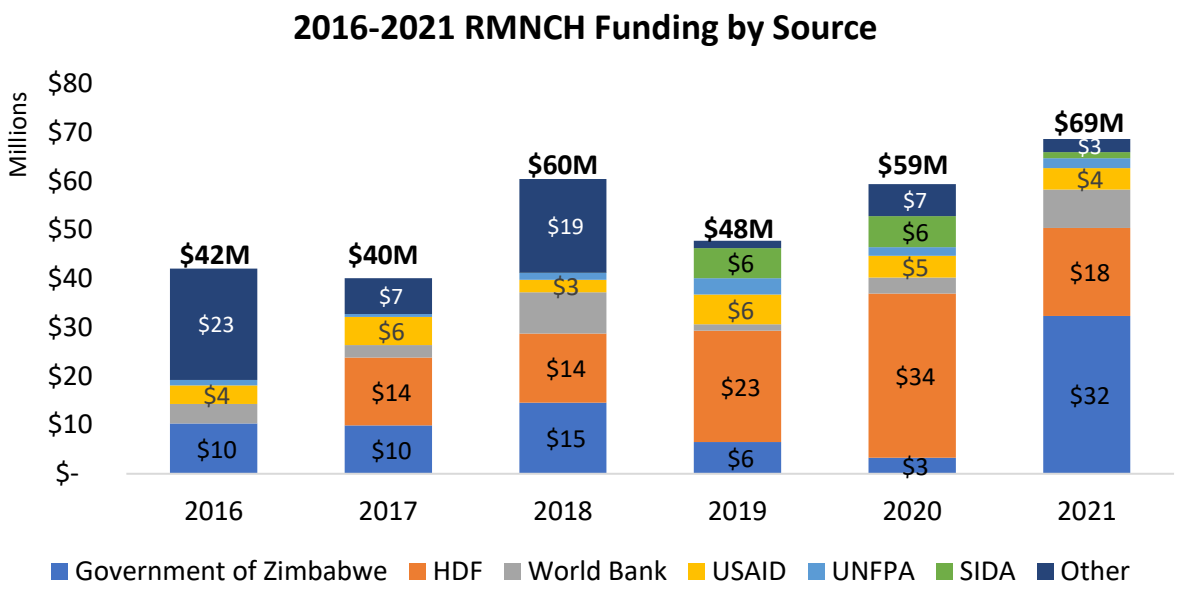

Figure 34: RMNCH Funding by Source

The issue of resource prioritization and the need for technical and allocative efficiencies resurfaces for RMNCH funding in 2021. According to the Zimbabwe Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition Strategy 2017-2021, approximately $69 million will be needed to implement the strategy in 2021. The funding available is close to this figure in 2021. Yet, funding gaps remain for cost categories like drugs and medical supplies ($33 million gap), health worker training ($10 million gap), and facility operating costs ($2 million gap). Yet, other cost categories show significant funding surpluses, such as health worker salaries ($22 million surplus), administration costs ($11 million surplus), and capital costs ($2 million surplus), as shown in Figure 35 below:

2021 Funding Gap Analysis by Cost Category for the Zimbabwe Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition Strategy 2017-2021			
	Resources Required	**Resources Committed**	**Funding Gap**
Administration & Management (incl. salaries)	$0	$11,290,583	$11,290,583
Capital Costs - Infrastructure and Equipment	$0	$2,442,479	$2,442,479
Facility operating Costs	$2,518,440	$377,023	-$2,141,417
Drugs and Medical Supplies	$45,137,894	$12,562,042	-$32,575,852
Health Worker Training	$15,318,475	$5,494,465	-$9,824,011
Planning & Policy Meetings	$784,550	$1,536,491	$751,941
Community Outreach Events	$1,727,729	$2,943,726	$1,215,997
Communication costs (print, TV, radio)	$206,830	$1,727,258	$1,520,428
Research, M&E, QA and Supervision	$3,248,300	$3,205,558	-$42,743
Technical Assistance	$0	$3,365,018	$3,365,018
Health Worker Salaries	$0	$22,317,911	$22,317,911
Other	$0	$1,441,323	$1,441,323
Total	**$68,942,219**	**$68,703,877**	**-$238,341**

Figure 35: Gap Analysis for the Zimbabwe RMNCH Strategy 2017-2021

8. Ways to Use Resource Mapping Data

Resource Mapping data are intended and designed to be used extensively beyond the high-level findings summarized in this report. Given the availability of the dataset, health stakeholders may independently carry out analyses to inform various activities. Section 4 describes several uses for RM data.

8.1 Prioritise the MOHCC Budget Bid from Treasury

After collecting resource mapping data from donors and partners in 2020, the data was converted into the MOHCC PBB format. This was to determine the external funding currently available for the various MOHCC programmes and sub programmes. After converting the data into PBB format, a prioritisation analysis was done to determine which programs needed additional funding based on external resources available. Once this analysis was done, the data were included in the MOHCC budget bid from the MOFED. Data indicated the MOHCC program areas that needed to be prioritised for additional funding based on external funding resources. This resulted in a MOHCC budget for 2020 that was more efficiently allocated across program areas. To promote a more equitable allocation and distribution of domestic resources, the RM team will continue to use and improve RM data in the MOHCC budget bid process.

8.2 Mobilize Additional Resources

With a constrained resource envelope and significant funding gaps, the GoZ and partners constantly seek ways to secure new funding and re-program existing funding to high-priority areas. RM data provides evidence to support financial gap analyses for existing or proposed projects, programs, or strategies. By comparing planned resources available (from RM) and costed resource needs (from the costing of a health sector or disease-specific plan), the resulting financial gap analysis can quantify funding availability and requirements for specific interventions. This process was applied to the overall sector costed NHS but has potential for sub-strategies developed by particular programs. Detailed strategy gap analyses are critical to adopting feasible strategies informed by directional estimates of available and future funding. Gap analysis results can then be used to make investment cases to mobilize additional resources, allocate new financing, or re-program existing resources from low-priority to high-priority areas. Some examples of MOHCC strategic documents that have had a funding gap analysis using resource mapping data include

1. HIV Testing Services Strategy 2017-2020
2. Zimbabwe Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition Strategy
   2017-2021
3. The Plan for the Elimination of Mother to Child Transmission of HIV/AIDS and Syphilis in Zimbabwe
   2018-2022
4. The Zimbabwe Child Survival Strategy 2016-2020
5. The Extended National HIV Care and Treatment Strategic Plan 2019-2020
6. The Health Sector HIV and STI Strategic Plan 2021-2025

8.3 Identify Inefficiencies and Overlaps in Funding

RM data can be used to identify inefficiencies or overlaps in funding. By providing a central repository of information regarding health stakeholders' budgets and projects, RM allows stakeholders to identify and quantify funding inefficiencies. Further analyses of RM data can provide detailed inputs for stakeholder negotiations, advocacy efforts, investment cases, and health policy analyses.

8.4 Enable Aid Coordination

After developing the HSCF in 2019, RM data can provide the tools for better coordination of external and domestic resources at national and sub-national levels. RM can isolate data on donors, implementing partners, and funded activities within each district and at the national level. Health stakeholders can then use this information to hold both government and donors accountable for their commitments and improve overall activity coordination. An application of RM at the program implementation level will also facilitate a coordinated implementation of activities based on the health sector's priority needs up to the district and facility level.

8.5 Inform Policy Change

RM can be used to inform and influence policy dialogue. By providing high-level policy briefs to stakeholders, RM can notify various officials within the GOZ of the current funding situation for the entire sector. Furthermore, summaries of funding gaps for government-prioritized strategies can be used to lobby for additional funding in budget hearings or to external stakeholders.

8.6 Integration of Resource Mapping, NASA and NHA Processes

The MOHCC has made significant strides in institutionalising the National Health Accounts (NHA), National AIDS Spending Assessment, and Resource Mapping processes. In 2020, the Resource Mapping and NHA teams worked together to compile data for the 2020 NASA and NHA results. With the three processes being complementary, RM data was used to input NHA and NASA data for the GoZ and NGOs. In contrast, private and household data were collected by the Zimbabwe National Statistics Agency. The integration of RM, NHA, and NASA processes helped fast-track the data collection process and reduce data collection duplications. In 2021, the RM team will continue to explore other health data collection processes to create a harmonized approach to national data management and resource tracking efforts.

9. Conclusion

As the GoZ continues developing and implementing the NHS 2021-2025, it should ensure that crucial implementation gaps identified during the MTR are adequately addressed. This will ensure that gains achieved to date are sustained, and key outcome areas are met. As the country moves towards the UHC agenda, the population will benefit from equitable, affordable, and quality healthcare services.

While the significant increase in domestic resources for health increased from $80 million in 2020 to $670 million in 2021 is encouraging, the GOZ should ensure that this funding level remains consistent and the MOHCC continues to take the initiative in both the funding and implementation of health reforms. It is vital for the GoZ and MoHCC to create a strong hedge against the dependency on external funding sources for health, especially given the fall in external funding from $584 million in 2020 to $480 million in 2021

As the country continues to fight against the COVID 19 pandemic, it is essential to ensure that funding remains flexible for program implementation. This is because the pandemic will continue to be unpredictable in the near future. Consequently, the MOHCC and development partners need to ensure that allocation and funding generation remain flexible to the changing needs. While the COVID 19 pandemic caused significant disruptions within the healthcare system, it also created some opportunities for establishing efficient use of resources. For example, at the community level, COVID 19 interventions were integrated with other disease interventions, such as with RMNCH. Integration was done to ensure that essential services for key and vulnerable populations continue despite the pandemic's presence. As the country continues to implement reforms at the community level, funding must be aligned to the NCHS's needs to maximise health outcomes for the population. This can only be achieved by reducing fragmented implementing arrangements and ensuring that a harmonised and coordinated approach to community health funding is undertaken by all stakeholders.

To take advantage of the increased resource pool for health in 2021, technical and allocative efficiencies must continue to be advocated for and maximised. This will reduce administration costs that divert funding from the service delivery level, ensuring optimal outcomes for persons who access healthcare services. The creation of virtual pools for integrated planning should be used to increase coordination and collaboration among stakeholders. To achieve such a harmonised approach to health funding, partners should leverage the HSCF at all healthcare system levels in Zimbabwe. By using this framework, partners can ensure that their funding is prioritised to the needs of the country’s disease-specific strategic plans. This is especially true for implementing the Health Sector HIV and STI Strategic Plan 2021-2025 and the Zimbabwe Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition Strategy 2017-2021. For both strategic plans in 2021, total funding levels are adequate to cover the cost of implementation. Still, both plans' allocation of funding needs to be re-prioritised to reduce gaps and surpluses in cost category allocation.