# POLICY BRIEF

FEBRUARY 2019

Zimbabwe Economic Policy Analysis and Research Unit

## Growth in Fragile and Post-Conflict States in Africa

# ZEPARU - AERC National Dissemination Workshop on Export Performance and Health Service Delivery

## 1. Introduction

The Zimbabwe Economic Policy Analysis and Research Unit (ZEPARU) and the African Economic Research Consortium (AERC) jointly held a half day national dissemination workshop under the theme 'Export Performance and Health Service Delivery in Zimbabwe: Challenges and Opportunities' on 4 February 2019 at Rainbow Towers Hotel. AERC commissioned country case studies under the global theme of 'Growth in Fragile and Post Conflict States in Africa' two of which focused on export performance and health service delivery in Zimbabwe. The national dissemination and validation workshop where the two papers were presented was attended by 50 participants drawn from diverse organizations including: government ministries, private sector, civil society organizations, academia and independent economists. This policy brief provides summaries of the key findings of the papers and policy issues that came out of the workshop.

## 2. Corruption and Firm Export Performance in Fragile Economies: Evidence from Zimbabwe, by Prof. Albert Makochekanwa and Dr. Godfrey Mahofa

### Background

The paper highlighted that most fragile and post-conflict countries are corrupt, and corruption tends to thrive in these countries because of weak public institutions. Corruption manifests in different forms including informal payments made to government officials to ease the day-to-day operation of businesses, embezzlement of public funds, externalization of funds, fraud, smuggling of goods, abuse of office, tax evasion, extortion and nepotism. The paper also provided evidence that suggest that corruption is now deep seated within socio-economic and political fabric of the Zimbabwean society including in both public and private institutions. The paper further argues that socio-economic indicators point to the fact that the country is fragile. This fragility affects firm behaviour in terms of its export business.

### Key issues

The paper also noted that corruption has both positive and negative effects to the economy. Some of its negative effects include low economic growth; investment and increased income inequality. It also noted that corruption dynamics are not unique to the Zimbabwean market alone but they straddle across national boundaries. For example, there have been economic cross border conflicts arising through indirect exports out of corrupt dealings, Zimbabwe's tobacco exports to South Africa being a case in point. Efforts have been made to fight corruption both at the national and regional levels. For example, Zimbabwe is a signatory to regional protocols aimed at stemming corruption but these are facing transposition (at the ratification levels) or implementation challenges.

Zimbabwe's exports are dominated by primary agricultural and minerals commodities. Exporters in Zimbabwe face serious challenges some of which include transfer of money from the importing company in the region; non-tariff barriers such as sanitary and phyto-sanitary issues, standards, export insurance, currency management issues; and the tariffs themselves. Some of these constraints promote corruption.

### Policy Recommendations

- Intensifying the ease of doing business reforms to create a more conducive export business environment.
- There is need for Government to take practical steps to stamp corruption through putting in place strong institutions and automation of government processes to reduce human conduct.

## 3. Service delivery in fragile states: The case of health sector in Zimbabwe, Dr. Rosemary Atieno, Prof. Theresa Moyo and Dr. Owen Nyang'oro

### Background

The main objective of the paper was on assessing the effect of fragility on the delivery of health services in Zimbabwe through three health outcomes, namely infant, child and under-5 mortality. Performance of the health sector influences the wellbeing and the quality of life in a country hence the effective and efficient functioning of the health system is important to ensure the quality of health services to the population. When the capacity of the state is diminished through factors such as declining economic growth, fall in revenues, conflict and destruction of infrastructure then its ability to deliver services is eroded. The state is responsible for setting policies, allocating resources and designing rules and systems for service providers. The country needs a strong state in order to perform effectively. The socio-economic decline registered in Zimbabwe which reached a peak in 2008 constituted to decay in health services. This affected Government funding to support the health sector through health infrastructure, health workers, medicines and commodities supply. The crisis also led to a massive brain drain of skilled professionals and this resulted in a near collapse of the public sector service provision, affecting health service delivery. As a result of the crisis, the delivery of health services has been erratic.

From 2009 the economy started to register economic growth. However, between 2009 to 2015 there was a sharp decline in infant, child and under-5 mortality but the rates are still too high. The capital expenditure to the health sector is very low.

Zimbabwe is regarded as a fragile state as indicated by the 2014 Afrobarometer. Two measures of fragility were used namely,

- Fragility 1 (trust in institutions - president, national assembly, elected local government, ruling party, police and courts); and
- Fragility 2 (perceptions on economic conditions – present economic conditions, present living conditions, and country's economic condition).

Hence, the paper analyses the state of fragility on health delivery using Zimbabwe as a case study. The rationale of the study is to address the gaps in the literature on policy responses to fragility in the context of health service delivery. While health service delivery is one of the six core pillars of the World Health Organisation (WHO) health delivery system, it is however, naturally dependent on the efficient functioning of the other five core pillars for its success.


## Key issues

The paper employed a qualitative and quantitative analysis. The quantitative analysis involved regression of three health outcomes (infant, child and under-5 mortality) against selected explanatory variables using a penalized likelihood approach. The explanatory variables used were the age of the mother, gender of the child, mother's work status, parity, residence, fragility index and mother's education level categorised as primary, secondary and tertiary education. The cross-sectional data from the Zimbabwe Demographic and Health Survey (ZDHS) for 2015 was complemented with data from round six Afrobarometer survey of 2014. The qualitative analysis involved key informant interviews with seven health institutions, two international agencies, two research institutions, two policy institutions and hospitals targeting health practitioners both from the public and private sectors. The sample included some funding agencies who have assisted the government in financing the health sector.

The study concluded that mother's education, residence, gender of the child, parity and mother's age are associated with infant, child and under-5 mortality. For child mortality, education has a negative effect on infant mortality with the former reduced by a factor of 0.6, 0.4 and 0.2 for mothers with primary, secondary and tertiary education compared to those with no education. Residing in urban areas reduces the odds of infant mortality by a factor of 0.75 which may be attributed to better and accessible health facilities. Male infants are likely to face higher mortality rates compared to female infants as mortality increases by 1.18. There is high level of infant mortality risk at higher than lower parity. The likelihood of infant mortality increases with age of the mother, but highest among women aged 35-44 years.

For child mortality the mother's education, age of the mother, gender of the child and parity are significantly associated to child mortality. There is a significant reduction in likelihood of child mortality for mothers with secondary and tertiary education, with the odds reducing by 0.48 and 0.08 respectively. Residing in urban areas reduces the odds of child mortality by 0.5. The likelihood of child death increases by 1.4 for working mothers. The likelihood of child mortality reduces with parity and the likelihood of child death increases with the age of the mother by a factor of 3 for mothers in age group 25-34 years compared to 5.5 for those in age group 45-49 years. The analysis of under-5 mortality also gave similar results.

The results show that fragility is not significant in determining the probability of child mortality irrespective of the measure of fragility used. This means fragility attracted more foreign investment in social services, hence the study concluded that fragility is not important in determining mortality in Zimbabwe. For instance, there was funding through the Health Transition Fund (HTF) and the Health Development Fund (HDF) which supported the

health system. However, reliance on donor funding is not a sustainable way of financing the health system since it is highly volatile. The intervention of donors is only meant to minimize the level of catastrophe but it is very dangerous to rely on donor funds which are very volatile.

Participants noted that while the conceptual framework and the methodology on the nexus of the health delivery system and fragility sounded reasonable enough, the model and the data inputs used for the analysis was at complete variance with the topic and objectives of the study. The paper looked more at the demand side variables (consumption function variables such as age, education, residence, etc) rather than the supply side variables (production function variables such as infrastructure, human resources, medicines, quality of care, etc.). The paper also did not show how fragility interacted with the other variables, rather fragility was entered in the model as one of the variables. This therefore did not align with the conceptual framework of health delivery system that the paper had initially introduced. These observations placed a caveat on the interpretation of the results from the paper.

## Policy Recommendations

Despite the impact of fragility being reflected in the paper as not being substantial, it was highlighted during the national dissemination workshop that the impact of fragility was reduced by the humanitarian support that the government received from donors which down played the impact of fragility.

- The key informant interviews recommended that the country should devise better health funding models to increase health financing, strategies to enhance preventive programs, engage in public-private partnerships in the health sector and address staff shortages and improving health staff retention.

- It was noted that the paper should have included a section on the situational analysis of the Zimbabwean health system tracing trends in infant, child and under-5 mortality and also information and trends in health financing. This would have revealed how fragility of the country resulting from constrained fiscal space among other factors impacted the health delivery system. A policy recommendation emanating from these observations is the need for timeous, robust and easily accessible data on the country's health delivery system.