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Exploring the Scope for Introducing Sin Tax to Finance a Universally Accessible National Health Insurance in Zimbabwe

A policy response to the national public health-financing crisis

1. Background and Rationale

The research project entitled; - "Exploring the scope for introducing sin tax to finance a universally accessible National Health Insurance in Zimbabwe; a policy response to the national public health-financing crisis.", is a multi-stakeholder research project designed to provide a national response to the national outcry against the imminent introduction of the statutorily compulsory National Health Insurance scheme by the country's social security services provider, the National Social Security Authority (NSSA). Contributions to the NHI shall be compulsory only for those in formal employment. According to the NSSA database, there are 1 200 000, predominantly urban-based employees, who compulsorily contribute to social security schemes. The private health sector is making representations at Government level against the introduction of the NHI ,arguing that it (the private health sector) was not consulted as NSSA designed its statutorily compulsory NHI and as a resulted it faces imminent collapse once NSSA introduces its NHI. To date, private medical aid schemes in Zimbabwe only cover an estimated 10% of the national population only.

Over the last seven (7) years, Zimbabwe has progressively deteriorated into a macro-economic, political and social crisis, as well as increasing poverty underpinned by a governance crisis that has assumed epidemic proportions, and has percolated the individual institutional-corporate levels as organizations invent unorthodox survival strategies, the spreading prevalence of HIV (and AIDS) whose sero-prevalence rate of 24.6% (in 2004) ranked the country as the third worst affected in the world. According to the Global Credit Rating Company (2006), as of December 2005, Zimbabwe's economy was 40% smaller in size than in 1998. This decline has left the purchasing power of an average Zimbabwean at levels last seen in 1953, while official unemployment is estimated to exceed 70%, and over 80% of the population now live below the poverty datum line (up from 35% in 1996). Per capita income levels are expected to diminish further on the back of a projection for real GDP to contract by an additional 4.7% in 2006 and geometric progression of the month-on-month inflation that had soared to an unprecedented 8 000% by mid-August 2007.

The challenges experienced in agriculture during the 1990 - 2005 land reform program's (land) ownership transitional processes witnessed the fall in maize and tobacco output which was once the economy's leading source of foreign currency (production by 86% and 60% respectively), Global Credit Rating Company (2006) Against this background, the Confederation of Zimbabwe Industries (CZI) report released in February 2006 announces that only 13% of the companies that were surveyed were operating above 75% capacity, with the clothing sector being the only sector operating optimally. The rest of the companies were reportedly operating well below 25% capacity.

Following the State's national clean up exercise in May 2005 that was meant to introduce sanity and the construction of better infrastructure in the small to medium enterprises (SMEs) sector, an opportunity was created to rationalize the informal sector and facilitate their participation in employment creation. This process has helped the informal sector to conduct business in an organized manner. For instance, electricity bills, water bills, telephone services and suppliers of goods and services have since extended well-structured systems of doing business to the informal sector. The challenge is that the construction of formal market stalls for this sector has not moved with the anticipated speed resulting in large numbers of players in the informal sector taking long to come back into business. The size of this organized informal sector is still small and the rest of those who operate from illegal sites have either gone out of business or have gone underground reducing the size and capacity of the traceable informal sector in the process. This

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situation has been compounded by political instability, unstable macro-economic environment, acute shortage of foreign currency with over Z$1 million currently being equivalent to US$1 on the parallel market in sharp contrast to the official exchange rate of US$1:Z$30 000, the proliferation of the parallel market, runaway inflation currently and conservatively estimated to be around 8 000%, acute shortage of goods and services and the decline in the public health sector expenditure. The economy registered a record negative economic growth rate of –14% by December 2005.

The governance and economic crisis have been particularly manifest in the public health sector. Patients and the public are concerned about the quality of care and the chronic shortage of drugs. Politicians are also concerned about spiraling costs of providing health care, and health professionals are concerned with the persistent shortage of medical supplies, health inequities and value for money. In the wake of these concerns, the public health sector has over the years suffered massive and unprecedented levels of brain drain as a result of the mass exodus of health professionals to regional and international countries seeking "greener pastures" According to a 2004 report by the Parliamentary Portfolio Committee on Health and Child Welfare, only 20% of all health professionals trained in Zimbabwe between 1990 and 2002 are still in the country, the rest, 80%, have left for "greener pastures".

The most economically productive 25 – 49 years age group is the worst affected by the AIDS pandemic. A UNAIDS survey in 2000, exploring the impact of AIDS related female mortality, revealed a devastating impact on the household and consequent reduction in school enrolment rates while studies in the business sector showed rising production costs attributable to AIDS-related morbidity and mortality.

A survey carried out in two districts in 1997 by the Zimbabwe Farmers' Union and the Friedrich Ebert Stiftung Economic Advisory Group, discovered a reduction of 50% in smallholder production in households with an AIDS death ranging from 29% for cattle ownership, 37% for groundnuts, 49% for vegetables and 47% for cotton to 61% in maize. This reflects the devastating effects of AIDS in rural Zimbabwe. In the same vein, Mutangadura (2000) in a survey conducted to assess the impact of adult female mortality in two rural districts in Zimbabwe found that 65% of households where the deceased female had lived were no longer in existence. Mutangadura (2000) also notes in the same survey that 31% of the rural households interviewed had a child who was not attending school after the death of a mother. These devastating effects of HIV and AIDS have to date been sustained.

The above-mentioned concerns have been further complicated by the possibility of the statutorily compulsory proposed NHI pushing the private health sector into extinction as it compels those already on private medical aid to contribute as well. The majority of the 1 200 000 in formal employment already have medical health insurance cover being provided by private health insurance agencies. Labor representatives, the Employers Confederation of Zimbabwe (EMCOZ), private hospitals and the private medical aid societies have confirmed these concerns during representations at the Parliamentary Portfolio Committee on Health and Child Welfare. Labor representatives and EMCOZ are arguing that workers and employers would inevitably sacrifice the voluntary non-compulsory medical aid cover than face double medical aid cover deductions from their salaries and wages;- one for the private medical aid cover and the other for the compulsory NHI. The imminent extinction of the private health sector would haveeffectively mean the collapse of the last bastion of quality health in Zimbabwe since the public health sector collapsed over seven years ago.

The NSSA's intention to selectively introduce the NHI when it was founded and financed by public funds in a country devastated by AIDS has received deafening condemnation and public disapproval. Health equity concerns are being raised against the morality of a NHI that has been designed by a State enterprise to cover only 1 200 000 mostly urban-based employees in the formal sector and excludes the rest of the population. About 90% of the 14 million Zimbabweans do not have health insurance cover, out of the 1 900 000 people living with HIV/AIDS only 29 000

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are on ARVs. NSSA admits that it does not have the means to enforce the collection of contributions for the NHI in the informal sector.

"What is ***national*** about a ***National*** Health Insurance that is selectively designed and is meant to serve a small fraction of a national population confronted by an historic health catastrophe?" livid critics are questioning.

Government's financial capacity to introduce a publicly funded universally accessible National Health Insurance Scheme is limited because of serious budgetary constraints that have to date restricted the State funded ARVs program to the country's five urban-based central hospitals against the background where the devastating effects of HIV and AIDS across the country are well documented. The publicly funded HIV and AIDS program was pioneered by Harare and Mpilo central hospitals before being rolled out to the other three metropolitan based tertiary health institutions. Given these limitations, NSSA can only rely on the database of the formal sector employees as the social security authority introduces the N.H.I.S..

Current proposals that the N.H.I. was supposed to beextended to indigents whose health insurance was supposed to bepaid for by the State through the department responsible for social welfare have their own challenges. Presently, public health institutions that have been providing health services to indigents under similar arrangements have huge indigent debtors ledgers that the Department of Social Welfare has been unable to honor because of serious budgetary constraints that the government has been experiencing over the past seven years. Considering the current budgetary challenges the State is experiencing, how the State was supposed to beable to marshal resources to pay for indigents' health insurance services when they are placed under the proposed national Health Insurance Scheme yet it encountered challenges under the current arrangements is a subject that demands further inquiry. This is because there are concerns by stakeholders that the problem of huge public hospitals' indigent debtors' ledgers that the State has not been honoring on time was supposed to betransferred to NSSA *voetstoots*.

In view of these challenges, the multi-stakeholder research project seeks to explore the means with which the sustainable financing of the NHI can be extended to all Zimbabweans. One option for designing an innovative universally accessible NHI is to explore the possibilities of introducing a "sin tax".

Parties to this innovative "sin tax" research initiative were inspired by;-

i. Sirico (2005), ***"The search for government revenue in fiscally tight times tempts legislators to raise revenue by imposing …excise taxes on cigarettes, liquor, gambling, and so on. This type of charge, often called a "sin tax," appeals to voters…"***

ii. Jones et al (2002) ***"The shadow of increased "sin taxes" won't curtail most Nevadans' appetites for alcohol and tobacco,….It's just like gasoline: When prices go up, we all scream and holler, but after a while we think nothing of (higher prices)".***

The realization that the utilization of some "sin products" as sustainable means of raising revenue in Zimbabwe is not novel, it dates back to the pre-independence era (pre-1980 era) when successive colonial governments developed and enforced statutory instruments and by-laws that mandated that the retailing of some selected "sin products" be monopolized by the State and local authorities as means of preserving dependable sources of revenue generation. ***"As early as 1914 Location (now Mbare) and beerhall profits for Salisbury (now Harare) were £516 and £330 respectively"***, Parry (1992) p125. Crush et al (1992) present a detailed account of the early profits that were registered by the Municipality of Salisbury (now Harare) up to 1930 and noted that ***"...the profits from the venture looked like they would support the whole of Native***

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Affairs expenditure, thus exonerating employers and ratepayers from all future financial responsibility...".

Following Zimbabwe's political independence in 1980, profits from liquor sales that had been part of the mainstay of local communities' development and maintenance budgets are now being enjoyed by individual beneficiaries of the liquor retail monopoly deregulation effectively paralyzing and dissipating local authorities' capacity to sustain the provision of public utilities like street lights, sewerage maintenance, maintenance of local authority funded schools and social services. The current unprecedented levels of infrastructure deterioration in most local authorities can to a large degree be traced to the systematic revenue dispossessions that local authorities suffered as a result of the deregulation of their previous monopoly of the retail of liquor and other related products (with the advent of independence in 1980).

The deregulation process was not informed by prior studies that could have projected the potential volumes of revenue that was to be lost, nor was it replaced by similarly sustainable local communities-oriented revenue generation systems that raise and retain revenue from these "sin products" to finance transparent equity-oriented local communities' public utilities. With the advent of independence, several political and anti-monopoly arguments that downplayed the economic justifications for the monopoly of liquor retail that were advanced were to a large extent fueled by the desire to rid the country of any traces of colonial repression in view of the bitter oppressive experiences that the black majority had endured during long years of colonial hegemony. The overarching concern was to do away with any policies that had a tone of repression and racism. In the process the economic arrangements woven into these colonial repressive systems were eliminated as they were to a large extent structured in a manner that ostracized the black majority. Parry R. (1992) notes that by monopolizing the sale of "sin products" successive colonial governments ***"…seized on the idea of a monopoly …and the sale of beer. The system promised a measure of social control… without the*** (colonial) ***administration having to draw on revenue from white taxpayers…."*** p. 125.

The realization that one of the areas that have consistently performed well and defied socio-economic odds in Zimbabwe is the consumption of "sin products" that is, (alcohol, cigarettes, horse betting, lotto, casino, etc).

Broad-based multi-stakeholder institutional strategy to secure the State's policy buy-in.

In the wake of the aforementioned challenges, it became apparent that innovative, holistic and sustainable national health insurance financing mechanisms therefore, had to be explored, probed, designed and implemented if NSSA is to ensure that a typically and truly National Health Insurance scheme that is underpinned by the principles of universal access and equity in both the supply and demand of these health insurance services to be offered are in place. In addition, the Consumer Council of Zimbabwe (CCZ) has, to date, been inundated with consumers' inquiries raising equity concerns against the accessibility and coverage of the N.H.I. that has currently been designed to cover only 1 200 000 mostly urban based employees in the formal sector (and their dependents) and excludes the informal sector and the rural majority. Consumers are raising questions about the morality of sustaining a national health insurance scheme that is selectively implemented.

In response, a broad-based multi-stakeholder steering committee comprising Government, Parliament, Local Authorities, apex representative structures of industry and commerce, the Consumer Council of Zimbabwe, Africa University's Institute of Peace, Leadership and Governance, the National Social Security Authority (NSSA) and others was set up to; -

i. use evidence and stakeholder review to support the need for a sustainable and innovative "sin tax"-based financing strategies to increase access to the National Health Insurance.

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ii. develop consensus amongst key stakeholders on the goals, mechanisms, principles and factors to be used in developing transparent, equity-oriented resource mobilization strategies to be used for the mobilization of "sin tax" to finance a universally accessible National Health Insurance.

iii. review the technical information and processes involved and to widen understanding on equity-oriented universal access to National Health Insurance.

2. The outcomes of the multi-stakeholder consensus building processes

This process involved the use of evidence and stakeholder reviews to support the need for a sustainable and innovative "sin tax"-based financing strategies to increase access to the National Health Insurance. As a result the following outcomes were achieved;-

i. A total to fourteen (14) Parliamentary Portfolio Committee on Health, Child Welfare and HIV & AIDS' public hearings on NHI were held at the Parliament of Zimbabwe's chambers. During these hearings, key stakeholders appeared before the parliamentary portfolio committee on health to register their concerns against imminent introduction of the statutorily compulsory NHI.

ii. The national social security services provider, NSSA, was dragged by stakeholders to appear before the Parliamentary Portfolio Committee on Health for a record nine (9) times as the haggling for and against the selective introduction of the NHI heightened. The challenge for NSSA to explore broad-based health insurance financing options to increase access to and coverage of the scheme took center stage at these hearings.

iii. In February 2007, a motion was set in Parliament and intensive debate on the NHI ensued. In the meantime, the national social security provider, NSSA, pressed ahead with nationwide road shows to increase public awareness on the need to introduce National Health Insurance with indications that the scheme would haveirreversibly be introduced in early 2008.

iv. A comprehensive literature review was undertaken to fully explore the local and international historic precedents on the mobilization of "sin products"-related revenues for development purposes.

v. A parallel broad-based national stakeholder consultative process was undertaken through thirteen (13) consultative workshops with primary and secondary stakeholders who belong to the following categories;-

(a) PRIMARY STAKEHOLDERS

Communities and their representatives:- Community Working Group on Health, Zimbabwe United Residents Association – ZURA, Women's Group (e.g. Women's Resource Network, etc), Youth Groups, Elected leaders, Traditional leaders, Churches, Farm Community Trust

Health providers:- Ministry of Health and Child Welfare, Local Health services, Non-Governmental Health providers, e.g. Red Cross, Private Hospitals Association, Traditional Healers, Zimbabwe Medical Association (ZIMA), Zimbabwe Nurses Association (ZINA), Environmental Health Practitioners Association (ZEHPA), Farm Community Trust, Association of Rural District Councils

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Health purchasers:- Consumers:- Consumer Council of Zimbabwe (CCZ), Community Working Group on Health (CWGH), Medical Aid Societies, National Association of Medical Aid Societies (NAMAS), Ministry of Health and Child Welfare (MOHCW), Zimbabwe Local Government Association (Zilga), International agencies, e.g. EU

Manufacturers of "sin products" National Breweries, Simba Beer, British American Tobacco (Zimbabwe) National Lotteries and Gaming Board, Mashonaland Turf Club, Tobacco Auction Floors, Chibuku Breweries, African Distillers (Afdis), Ingwebu Breweries, Pacific Cigarettes, etc

(b) SECONDARY STAKEHOLDERS

Public finance institutions:- Ministry of Finance – Fiscal Planning and budget Directorates, Zimbabwe Revenue Authority (ZIMRA).

Legislators/ Regulators:- Parliamentary Portfolio Committee on Health and Child Welfare, Parliamentary Portfolio Committee on Budget, Ministry of Local Government, Constituency Parliamentary Information Centers (C.P.I.Cs).

Public health advisory forums: Public Health Advisory Board

Research Institutions:- Government Analyst Laboratory, Blair Research Laboratory, the University of Zimbabwe's Department of Community Medicine

Other Cooperating Partners:- Care International, World Vision, UNFPA, UNICEF, UNDP, Save the Children (UK), Save the Children (Norway), Center for Disease Control (CDC Zimbabwe), USAID, UNAIDS, FAO, ICRISAT, WFP, Mvuramanzi Trust, CIDA, SIDA, etc

Technical Partners:- Institute of Peace, Leadership and Governance at Africa University, Select Research and Development Management, Consumer Council of Zimbabwe.

vi. **Public media talk shows and news coverage;-**on television, radio stations, as well increased coverage of the NHI debate in the print media. The general consensus that emerged from the ensuing public debate was that the limited coverage of the proposed statutorily compulsory and selectively designed national health insurance was insensitive to public health's equity demands and that urgent innovative national health insurance financing mechanisms be explored to increase its coverage. The need for a broad-based multi-stakeholder approach to compliment NSSA was also identified as a critical pathway in efforts to making the national health insurance truly national in its configuration and coverage.

3. Overall Aim/Purpose

The consensus by stakeholders was that the overall aim of this study is to explore the scope for the introduction of sin tax in order to raise revenue to finance a universally accessible National Health Insurance Scheme in Zimbabwe.

3.1 Main Research Questions

The main research questions were identified as;-

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Does Zimbabwe have a history of raising revenue from "sin products" for development purposes?

How was the revenue raised from "sin products" utilized?
When did the practice of raising revenue from "sin products" end?
What was the rationale for suspending revenue generation from "sin products"?
What were the effects of the suspension of revenue generation from "sin products"?
How long has the suspension of revenue generation from "sin products" for development purposes been in force?
Who is benefiting from the suspended revenue generation from "sin products"?
Is it feasible to seek alternative ways of re-introducing the concept of revenue generation from "sin products?
What are the projected levels of revenue to be generated from "sin products"?
What are the trends and current levels of production of each of the identified "sin products"
How would havethat revenue be collected?
Is it possible to generate "sin tax"-based revenue generation models?
How would havethe revenue collection be enforced?
How would havethe revenue raised from "sin products" be directed to the new development theme?
Who monitors proper and effective utilization of this revenue in the pursuit of the new development theme?
How would havethe beneficiaries of the revenue raised by "sin tax" be identified?

4. Objectives

The broad-based multi-stakeholder consensus building process resulted in the development of the following objectives:-

4.1 General Objective

To assess the feasibility of introducing a "sin tax" to finance the universal coverage of the National Health Insurance Scheme in Zimbabwe.

4.2 Specific Objectives

To establish the range of "sin products" consumed in the country.
To establish the volumes of production for each "sin product" that is produced in the country.
To establish the population of the national labor force that in benefiting from the social security schemes being administered by the National Social Security Authority (NSSA)
To establish the total population of the national employable labor force that is in the informal sector
To identify the opportunities and challenges confronting the National Health Insurance scheme in facilitating universal access and coverage that can make the insurance scheme truly national.
To develop revenue generation models for each of the "sin products" that can be taxed to raise revenue through "sin taxes".
To establish whether projected "sin tax" revenue was supposed to beadequate to finance national health insurance for the rest of the population.
To define expenditure models for each of the "sin products" that can be incurred in the provision of national health insurance.
To define the flow of resources in the financing the National Health Insurance scheme.

4.3 Concept Clarification

4.3.1 Variables to be measured

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Number (range) of "sin products" that is consumed
Consumption incidence rates for "sin products"
Volumes of each of the "sin products" that is produced in the country per month.
Number of employees currently benefiting from the social security schemes being administered by the National Social Security Authority (NSSA)
Number of people in the national employable labor force that is in the informal sector
Total number of indigents in the country.
National burden of disease
Current/planned national and sub-national coverage of the National Health Insurance Scheme
Estimating the potential beneficiaries of the H.I.S..
Revenue generation models for each of the "sin products" that can be
taxed to raise revenue through "sin taxes".
Estimating sin tax on a quarterly basis,
Estimating health expenditures;-(number of people covered x utilization rate x by average cost) can be estimated by type of service.

5. Methodology

The proposed methodology that was agreed on was to be informed by the following seven main steps, namely:

Inception briefing
Desk study
Presentation of inception report
Qualitative survey and quantitative survey
Data processing and analysis
Reporting preparation
Presentation of findings

5.1 Inception briefing meetings

The first steps were inception briefing meetings, workshops, multi-media publicity, and various other forms of raising awareness on the need to undertake the study. In addition, the study team met other key stakeholders such as NSSA and relevant sector ministries. All these initial meetings were guided by three main objectives: (i) to use evidence and stakeholder reviews to support the need for a sustainable and innovative "sin tax"-based financing strategies to increase access to the National Health Insurance, (ii) to discuss the scope of work that lies ahead, and (iii) to introduce the study team.

5.2 Desk study

The purpose of the desk study was supposed to be the reviewing of literature that exists on the sin tax studies that have already been carried out in other countries. In the wake of the successful conclusion of the multi-stakeholder consensus building process, the desk study team had just barely started to work on the literature review when the State's price control interventions fatally disrupted the supply side of the economy.

5.3 Presentation of inception report

The research team was required to prepare an inception report with details of the study background, justification, methodology and expected outputs.

5.4 Qualitative and quantitative survey

5.4.1 Research Design

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Key Informant Interviews and focus group discussions were supposed to be used to collect qualitative data from targeted respondents on production of “sin products”..

Following the briefing meetings, detailed interview guides were to be prepared and used to administer Key Informant Interviews to collect data on selected topics from stakeholders at national and provincial level. A cross-sectional quantitative survey was supposed to be used to determine the feasibility of introducing “sin tax” in order to raise revenue to finance a truly accessible National Health Insurance Scheme.

5.4.2 Sampling Frame

The sampling frame consisted of the following:
All manufacturers of “sin products”
All consumers of “sin products”
All potential beneficiaries of the NHI.
National Social Security Authority (NSSA)
Consumer Council of Zimbabwe (CCZ)
Ministry of Public Service, Labor and Social Welfare
Ministry of Health and Child Welfare (MOHCW)
Ministry of Finance (MoF)
Ministry of Small and Medium Enterprises Development
Department of Policy Implementation
Zimbabwe Revenue Authority (Zimra)
Employers Confederation of Zimbabwe (EMCOZ)
National Employment Council (NEC)
National Employment Council for the Transport Operating Industry (NECTOI)
Zimbabwe Local Government Authority (ZILGA)
Zimbabwe Congress of Trade Unions (ZCTU)
Zimbabwe Federation of Trade Unions (ZFTU)
Confederation of Zimbabwe Industries (CZI)
Non-State Actors’ Forum of Zimbabwe (NSAF)
Cross Border Traders Association (CBTA)
Farmers’ Unions

5.4.3 Sampling strategy to be used

A combination of purposive and stratified random sampling was to be used at provincial and national level. In each province the neighborhoods from where consumers of “sin products” reside and consume the products was supposed to be randomly selected from the provincial list of “sin products’” network of retailers. The study was required to stratify research subjects by province, and then pick our subjects purposively,

All the manufacturers of “sin products” were supposed to be included in the study. At each of the firms that manufacture “sin products”, clerical staff, middle managers and senior managers were supposed to be purposively sampled to select between 6 and 8 members who were expected to have reliable information on the production of particular “sin products”.

5.5 Data collection strategy

5.5.1 Collection of qualitative data

A checklist with open questions was being developed with a view to collect qualitative data from each target group. Research teams were supposed to conduct focus group discussions with potential beneficiaries of the National Social National Health Insurance. The size of each focus group was planned to be 6 to 10 members. The focus group discussions were required to be recorded with the aid of audio tape recorders while discussions were supposed to be guided by the use of an interview checklist.

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5.5.1 Collection of quantitative data

Data sheets were supposed to be designed to collect quantitative data from institutional records. A questionnaire with closed and open questions was supposed to be designed for each target group. Research assistants were supposed to be hired to administer questionnaires to sampled respondents and they would have also been trained on how to select respondents.

Secondary Data Collection was supposed to be undertaken at the Central Statistics Office from demographic health survey in terms of HIV prevalence over the years, at the National Breweries where sales volumes of liquor was supposed to be collected, and at the National Archives where data on literature review was supposed to be collected as well as from libraries and the internet.

6. Data processing and analysis

6.1 Data processing

Questionnaires from the field were supposed to be edited for completeness, accuracy and consistency. Open questions were supposed to be coded for efficient data entry. Data from the questionnaires was supposed to be entered into the computer using the Statistical Package for Social Scientists (SPSS) program. Data validation checks were supposed to be used in data cleaning.

6.2 Data analysis

Descriptive statistics was supposed to be used to analyze quantitative data in SPSS. Frequency distributions were supposed to be used to obtain numerators and denominators for prevalence rates and proportions. Graphs were supposed to be used to present findings and facilitate interpretation. A test for a difference between proportions was supposed to be used to test the hypotheses. Correlations between variables was supposed to be examined and subjected to statistical tests, that is, statistical inferences was supposed to be used to determine any significant differences between proportions. Time series models were supposed to be used to develop predictive models for revenue and expenditure.

6.3 Qualitative interpretation methods

Ordering of qualitative data was supposed to be done to ensure that all relevant data that belong to the same discussion topic or objective would have the same code. After ordering qualitative data, it was supposed to be summarized by listing the data that belong together. Matrix display of qualitative data was supposed to be used to order information and facilitate interpretation. That is, content analysis was supposed to be used to analyze qualitative data.

6.4 Methods to ensure validity and reliability of observations

The questionnaires and interview checklists was supposed to be pilot tested in a similar set ups that would have not been participating in the study. This would have ensured that the questionnaires are clearly understood by the respondents and they are capturing intended data. Questionnaires were supposed to be thoroughly edited for consistency and validity. The training of research assistants to administer the questionnaire would have also improved the validity and reliability of data to be collected. There was supposed to be double entry for every questionnaire by different data-capture clerks to ensure data validity.

6.5 Report preparation

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Report writing was supposed to be based on a format that would have address specific components of the TOR. Based on the comments from the various stakeholders including the study team and other stakeholders, a final report for the study shall be presented and the team was supposed to be flexible to present at as many fora as may be required by the study team at no extra cost other than for the travel and logistics only.

6.6 Presentation of findings

The findings of the study were supposed to be presented to key stakeholders at a workshop. The venue for the workshop for the venue was supposed to be decided upon in consultation with key stakeholders. The number of participants at the workshop would have depended on the final budget approved by key stakeholders.

6.7 Ethical considerations

Prospective respondents were supposed to be given detailed information on the purpose of the study and how the findings of the study were supposed to be beneficial to the nation. Respondents would have not been requested to divulge their names. All audiotape recorded focus group discussions were supposed to be stored in the strong room under lock-and-key. They was supposed to be disposed after five years, beyond which the findings of the study would have either have been implemented or was supposed to be outdated and therefore irrelevant. These tapes was supposed to be handed over to the National Archives of Zimbabwe who can either preserve them for posterity or dispose them as provided in the relevant national statues. It was supposed to be made clear to the prospective respondents that they were supposed to be free to choose whether to respond or not to respond to the questionnaires.

When the findings of the study were published, all the stakeholders would have to be given feedback on the study findings either though the media or through other effective means of communication.

Information from “sin products” manufacturers was supposed to be kept and used for this particular research purposes only. They were supposed to be disposed in the same fashion as mentioned above.

6.8 Limitations

There were no significant limitations to design, methodology and data analysis although there could be potential challenges in data collection. The challenge especially potentially lies in the collection of current production and output data of “sin products” from the private firms that manufacture these products.

Historical data might be readily available from the National Archives of Zimbabwe. The study demands extensive inquiries in the commercial activities of several manufacturers of “sin products” that are spread across the country. This presents potential logistical capacity limitations on the part of researchers to be able to exhaustively meet all the requirements that are detailed in the Study Design and Methodology.

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7. Disruption of the study

Following the State's directive that all manufacturers slash their prices by over 50% in May 2007, the manufacturing sector responded by scaling down the production of goods and services and in most instances ceased production altogether. Several reasons were advanced by manufacturers as justifications for ceasing production and effectively blocking the national goods and services supply chain. These included the following;-

- The economy was (and still is) reeling under unprecedented galloping inflation making it impossible for prices to be fixed to prices that were prevailing over a month ago.
- The State politicized the price control campaign and unleashed retributive reign of terror that witnessed the incarceration, humiliation, and criminalization of business leaders whose business transactions were deemed to have been in breach of a time honored long-forgotten pre-independence legislation that was conveniently invoked to penalize captains of industry and commerce who were being blamed for convening with the Western Governments to effect regime change in the country.
- The business sector felt that they were not consulted by the State prior to the unleashing of this populist but violent price control campaign and therefore had no option but to cease operations citing viability challenges, the imminent high expropriation risks that repeatedly became apparent with the shocking unannounced take-over of some blue chip companies like Olivine Industries.
- The already prevailing unstable property rights heightened industry and commerce's fears to resume production in the wake of what was widely criticized as populist price control political campaigns. The result was the complete disappearance of goods and services from virtually all shops' shelves across the entire economy.

Given the foregoing, the private sector, from which the study had drawn its study subjects in the form of companies that manufacture "sin products", suffered serious knocks in their production capabilities and cycles fatally discontinuing their initial pledge to participate in the study in the process. Manufacturers of "sin products" like beer and cigarettes have either scaled down production to trickle levels or have effectively suspended production citing several reasons, among them, the unviable prices set by the State as their reasons.

Current Project Status

With the further deterioration of the macro-economic environment, and the consequent capital flight from Zimbabwe, the manufacuturers of "sin products" like most firms are teetering on the brink of collapse and have increasingly become skeptical that the State might manipulate the outcomes of the study and effectively wreck their wobbling trickle level operations. The study that had been conceived of and had been basking in the assured support of non-traditional cooperating partners, that is, the private sector, the State, and other stakeholders, within the spirit of the Social Contract that had been signed by business, labor and the State fatally suffered from the loss of business confidence and like the Social Contract itself, was consumed by the political, socio-economic and macro-economic crisis engulfing Zimbabwe.

Conclusion

The dynamics surrounding the rationale for initiating this study in the face of mounting political and macro-economic crisis expose participants at the third Annual Conference on Development and Change to innovative broad-based multi-stakeholder collective strategies to fill in gaps created by deepening State incapacities to protect the vulnerable majority. It is also exposes, the ACDC participants to the difficulties encountered by moderate development-oriented coalitions

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operating in a state experiencing acutely shrinking democratic space. This paper enables its readership to ask themselves, "What could have been the outcome of such novel innovative strategies for both development and change, *ceteris paribus*, the economy was on a steady growth, favorable stable macro-economic conditions were in place and if the concomitant democratic space had collectively conspired with a broad-based multi-stakeholder initiative to increase access and coverage of a national health insurance in a developing country like Zimbabwe?"

NECESSITY IS THE MOTHER OF ALL INNOVATIONS.

THE END