Enhancing Healthcare Access for Poverty Alleviation: A Study on Zimbabwe and Zambia Healthcare Systems

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Received: 22 January 2026| Accepted: 18 March 2026| Published: 31 May 2026

Abstract

This research provided a comprehensive analysis of the structural and socioeconomic barriers to equitable healthcare access in Zimbabwe and Zambia, framing the issue as a critical determinant of poverty. Utilising a concurrent mixed-methods approach, the study synthesised longitudinal data from the Healthcare Access and Quality (HAQ) Index (1990–2024) with primary cross-sectional survey data from selected rural and urban districts. A regression model was employed to quantify the relationship between income, gender and medical insurance uptake. Results indicated profound systemic inadequacies: rural residents travelled an average of 18km to the nearest facility and over 70% lacked health insurance, resulting in a heavy reliance on catastrophic out-of-pocket expenditures. The analysis identified income as the paramount predictor of insurance coverage, while gender was statistically insignificant, underscoring the primacy of economic deprivation over other social factors in limiting access. The stagnant and declining HAQ scores for both countries revealed chronic underinvestment and systemic fragility. The study concluded that meaningful poverty alleviation was contingent upon targeted reforms in health financing and infrastructure. It recommended a tripartite policy intervention: strategic investment in last-mile transportation, the implementation of pro-poor, sliding-scale insurance schemes and the fulfilment of the Abuja Declaration pledge to allocate at least 15% of national budgets to health.

Key words: Healthcare, Health poverty alleviation, pocket payments, Health access and quality index, medical insurance

Introduction

Health is an important basic human right that should not be unjustifiably limited and access to it is essential to improve the productivity of a household and of the nation at large. Article 25 of the Universal Declaration of Human Rights states that everyone has the right to medical access and the right to security in situations of illness, disability, or other conditions that prevent them from earning a livelihood due to circumstances beyond their control. Third World countries still faced a great deal of struggle in providing better health services, as poor healthcare accessibility is one of the major causes of poverty in Africa (Health Affairs, 2018; Liao *et al*., 2022; World Health Organisation, 2023). These challenges were compounded by historical underinvestment, colonial-era health system legacies and contemporary macroeconomic instability, which, therefore, collectively undermined sustainable health financing and infrastructure development.

Zimbabwe and Zambia still faced serious health care access challenges, mostly because of the persistent economic crises, which negatively impacted the healthcare systems over time,

especially in the rural areas. Nearly 60% of the two populations respectively still lived in rural areas, where there were numerous obstacles to accessing timely and quality medical treatment. In these areas, falling critically or requiring urgent medical treatment might be like a death sentence. Long distances, the time it takes to get to medical facilities, financial limitations, a lack of infrastructure and a paucity of medical supplies and healthcare workers were some of the main stumbling blocks that were encountered daily. This research revealed that long travel times and distances to the nearest medical facilities were perceived to be the main hindrances to accessing timely medical care in Zimbabwe and Zambia. (Azevedo, 2017; Https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8804632/).

According to this study, unfortunately, the poorest groups in Zimbabwe and Zambia were more vulnerable to ill health. They tended to utilise healthcare facilities less frequently and socioeconomic disparities, including income inequality and poverty, significantly impact access to healthcare services (Liao *et al*.; 2022). The poorest groups, usually those in rural areas, often faced financial barriers, especially in the absence of medical insurance, making it even more difficult for them to afford healthcare expenses such as consultation fees, medications and transportation costs. Although the distribution of healthcare facilities such as hospitals, clinics and health centres was evenly spread across nations, a lot of hospitals and clinics, mainly in rural areas, lacked basic medical equipment and physicians, thus restricting medical access. Urban areas generally had better access to healthcare facilities compared to rural areas and this disparity in healthcare facility distribution contributed to differential healthcare utilisation rates among different geographic locations. (“Improving Healthcare Access in Rural Malawi,” n.d.; World Bank, n.d.). On the same note, geographical location in both countries substantially plays a role in impeding healthcare access as rural areas, where most of the population resided, face challenges resulting from poor infrastructure, substandard transportation systems and lengthy distances to healthcare facilities. (BMJ, 2020).

In Zimbabwe, most people did not have medical insurance; therefore, paid their medical bills "out of pocket", leading to unplanned expenses that negatively impacted a household's finances. Improving or enhancing medical access did not just mean making facilities available in an area but also making them affordable for the people. People should be able to go for medical checkups as frequently as possible without having to carry a huge financial burden or drop below the poverty line. With the intention of granting universal access to quality health services, Zambia passed the National Health Insurance (NHI) Act in 2018. The National Health Insurance Management Authority (NHIMA), a semi-autonomous organisation created by the Act, was responsible for collecting payments from citizens, procuring services from different healthcare facilities and granting beneficiaries' rights. This in future might increase medical access to all Zambians and curb the problem of lack of insurance in the long run. However, the quality of services had been negatively impacted by issues with finance and governance, especially in primary healthcare. Even though primary healthcare was "free," patients occasionally had to pay out-of-pocket because of a lack of supplies and medications. (https://zambialii.org/akn/zm/act/2018/2).

Moreover, while prior studies documented broad access challenges, a few integrated spatial, financial and quality dimensions into a single analytical framework, leaving a gap in holistic policy guidance. Previously, a lot of health-related studies were carried out in Zimbabwe and Zambia; however, none explicitly analysed the healthcare access and quality index of the two countries in detail. The HAQ was one of the most important tools among others used to measure health care accessibility and quality of any nation, yet no research in these two countries made use of this important tool. Medical insurance was a very important factor in discussing medical

accessibility; however, past materials in the two countries skipped its relation to income. This research gave important insight into using a multinomial regression analysis to show how income impacted medical insurance premiums paid.

Research Methodology

The first step was to separate rural from urban areas because healthcare accessibility in rural areas was completely different from that in metropolitan areas. Therefore, to better understand healthcare accessibility in the two countries, independent research was carried out on people living in rural areas and those in urban areas, meaning a total of four sets of data were collected and analysed differently. When studying the effects of distance on medical care accessibility, Zaka area was used to represent all other rural areas because of easier information gathering and more participants, allowing for better analysis. Furthermore, we analysed the HAQ index and checked trends since 1990. A regression analysis looking into the effects of gender and income on participants having medical insurance was also carried out.

Zaka district, a rural area in Zimbabwe, had a total population of 209,911 residents as of 2023 and has about 23 clinics and two hospitals, though most were not fully functional. Mufakose, representing urban areas, was a residential area in the capital with an estimated population of about 70,201. The area had three healthcare facilities registered under the Harare City Health Department. In Zambia, we targeted Chawama, a high-density suburb in the capital with a population of about 90,000 and Chama District in the northeast with a population of about 140,000.

Carefully designed questionnaires to gather demographic, health and socioeconomic data were administered randomly. In Zimbabwe, information gathering was faster due to more research assistance, compared to Zambia, which was mainly via online platforms. Random sampling was used to minimise potential sampling bias. For the regression analysis, questionnaires were sent to individuals separately. A few individuals in both countries elaborated more and gave suggestions, some of which were incorporated into the discussion. These methods enabled the gathering of information vital for measuring specific variables precisely: income, distance, waiting times, healthcare utilisation rates, transportation and insurance availability.

Sample sizes for each study area were determined using Cochran's formula. For all areas, a margin of error of 5% and a population parameter of 0.5 were applied. Zaka district utilised a 95% confidence level, while Mufakose, Chamaand Chawama utilised 90%. This differential approach reflected varying data collection feasibility, with Zaka's higher confidence level accounting for its use as a representative rural case study for distance analysis. The variables measured were: (1) HAQ index values and trends from 1990 to 2024, (2) Distance travelled in kilometres, (3) Time taken in minutes and (4) Monthly income, employment rate and health insurance premiums.

Healthcare accessibility in Zimbabwe and Zambia was mainly assessed through three different aspects. The first aspect targeted the quality of healthcare provided and this was done by looking at the HAQ. The other two dimensions focused on quantitative data collected in the research and focused on evaluating the physical accessibility of medical facilities.

We utilised the Healthcare Access and Quality Index (HAQ) to have a deeper understanding of the accessibility and quality of care. The HAQ determined the total accessibility of healthcare in each location by combining a few factors, including the presence of healthcare

facilities, the workforce in the field, health insurance coverage and geographic accessibility. We looked at the trends from as far as 1990 to see if the health systems of the two countries had improved and if not what the reasons could be.

We employed a histogram to have a better understanding of the overall data collected on distance travelled by residence especially in the rural areas. The questionnaire allowed us to gather information on the kilometres travelled by 400 Zaka residents in accessing their nearest functional medical facility. Using the SPSS software version 28 we then put all this together and came up with various statistical indicators such as the average distance travelled, mode and standard deviation between the results.

Fifty-one (51) respondents were examined to perform a regression analysis to further understand the effects of income and gender on the monthly healthcare premiums that they were willing to pay. Individuals in Zambia's Chawama area were sent a simple questionnaire requiring them to fill their gender, monthly income and how much they paid for medical insurance monthly. The information was collected and using the SPSS version 28, carried out a multinomial regression analysis to examine the relationship between them. We kept insurance as the dependent and Income and Gender as independent. Then looking at the coefficients table, it was then possible to determine the extent of impact of the two factors on insurance.

Results and discussion

This study employed a concurrent mixed-methods approach to assess healthcare accessibility in Zimbabwe and Zambia, with a focus on rural-urban disparities, physical and financial barriers and systemic quality trends. Primary data were collected via cross-sectional surveys in selected rural and urban districts, while secondary analysis examined the Healthcare Access and Quality (HAQ) Index from 1990 onward. Regression analysis further explored socioeconomic determinants of medical insurance uptake. The following sections presented and interpreted these findings in an integrated manner.

The HAQ Index

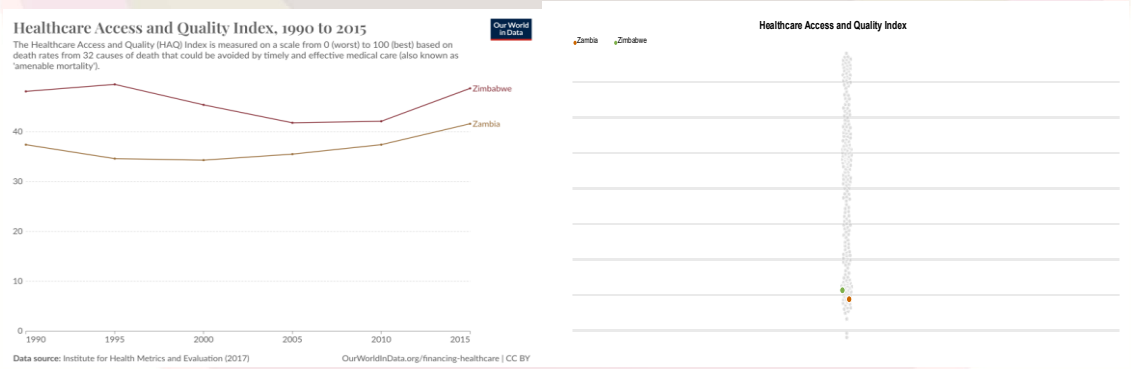


Figure 1 and 2: Showing the HAQ in the period from 1990-2015 and the current HAQ values for the two countries

The HAQ Index showed critical trends in the health system performance in both countries from 1990 to 2015. Zimbabwe's early post-independence gains peaked around 1995, followed by a sharp decline, a trend that might be interpreted as a direct consequence of deteriorating donor relations, reduced health financing and the outmigration of skilled health workers. Zambia's more gradual but stagnant progress suggested systemic resilience challenges linked to chronic

underfunding and infrastructure decay. This stagnation may be attributed not only to funding shortages but also to fragmented governance and insufficient integration of community health systems into the national health framework. The fluctuations in Zimbabwe's trajectory speculatively reflect policy instability, whereas Zambia's flat trend indicated persistent structural constraints. This could be traced back to the lack of funding in the Health Ministry since relations between the donors and the government soured. (https://academic.oup.com/bmb/article/121/1/47/2871224).

The main purpose of Zimbabwe and Zambia's health care systems was to serve foreigners and colonial officials in the past, with Africans receiving separate or secondary treatment. Zimbabwe embraced the idea of Equity in Health and Primary Health Care at independence in 1980 to address health disparities that had existed before then. This made the difference in health care between rural and urban regions less. (Chipunza & Nhamo, 2023); and "Socioeconomic Barriers to Universal Health Coverage in Zimbabwe," 2019). However, as time went on, there were increasing signs of disparities in health care and access, mostly due to changes in health policies and the economic structural adjustment policies. A contributing factor in the decline of Zimbabwe's health care industry, was the growing scarcity of skilled workers. Since 2000, the public sector has only employed 19% of its workforce. (Kidia, 2018; https://documents1.worldbank.org/curated/). Several highly skilled and proficient healthcare professionals continued to depart the nation due to the bad state of the economy and in search of greener pastures in Europe or nearby nations, such as South Africa. Zimbabwe's health system was functioning under a legal and policy environment that essentially disregarded the right to health. Since 1990, Zimbabwe had a better score than Zambia; however, but with so many fluctuations along the way as compared to Zambia. (Prust *et al*., 2019).

Zambia had significant economic challenges for almost twenty years and this clearly affected its score on the index. Lower salaries paid to healthcare personnel and a deteriorating social infrastructure, such as upgraded hospitals and equipment, were the result of this. Although there was a brief period of improvement in health condition following independence, development has been very slow since then and several indicators seemed to have gotten worse recently. (Https://documents1.worldbank.org/curated/en). Zambia had some of the lowest health metrics of any nation, even when accounting for its low GDP. All Zambians needed health care and the state assumed primary responsibility for this but could not provide it fairly or efficiently. An improvement from a score of about 38 to 41 in a space of about 25 years is very slow and much still needs to be done. There were significant changes underway to enhance the overall design and operation of the publicly funded health care system, but resources were few (Phiri et al., 2017; Chitah et al., 2018; Lehman et al., 2017).

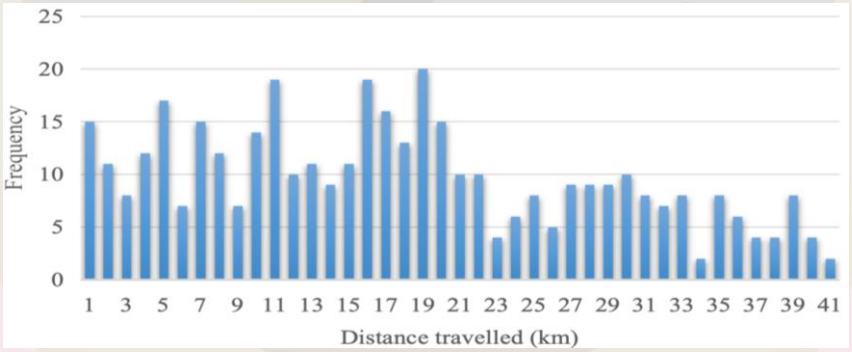
Zimbabwe and Zambia currently hold scores of 31 and 29, respectively, on the most recent HAQ index published by the European Commission in March 2024, as shown above. Long travel times and distances to the nearest medical facilities, which were typically impacted by inadequate road systems and transportation systems, contributed heavily, especially in rural areas. Moreover, lack of funds to pay for care, as well as the unavailability of medical supplies and skilled healthcare personnel, all had an impact on people's ability to access healthcare services. In Zimbabwe, residents of rural regions walked between 10 and 40km to go to the closest medical facility. The HAQ index level was determined by such factors and it, therefore, made sense why these two countries had very low values. (Mangundu et al., 2023).

It was clear that Zimbabwe's economic crisis resulted in a scarcity of medical equipment and supplies in public health institutions, which tremendously affected the treatment choices

available to professional nurses. (https://documents1.worldbank.org/curated/en). All these variables had a detrimental impact on the country's healthcare quality and access score. In 2002, African leaders agreed to allocate a 15% of the national budget to the health sector. Both nations failed to reach this target, with 2025's health sector share amounting to only about 11% of the total budget in Zimbabwe and Zambia. The government's deficit in health spending has been compounded by a major macroeconomic crisis, coupled with the coronavirus disease 2019 pandemic, which shifted priorities towards debt repayment. The health sector of Zimbabwe was underfunded. Johannes Marisa said, "The health sector budget is an improvement from last year but of course when you are benchmarking with the Abuja Declaration in 2002 you still realised that it fell short of the stipulated 15%" (World Health Organisation, n.d.).

The impact of distance on medical care accessibility

When asked what two major obstacles prevented them from getting timely medical care in Zaka, the most common response was distance, which was mentioned about 256 times by the 400 participants. The primary reason why respondents in Zambia's Chama area had difficulty receiving medical treatment was distance. Given that distance was not frequently cited in urban regions, it can be concluded that residents in rural areas experienced this difficulty more than those in urban areas. A closer look into the council plans showed that both countries had a distribution plan of clinics, which was fair; for instance, almost every ward in the Zaka district was supposed to have at least a medical facility. However, the problem was always the staffing of physicians and nurses, the availability of medicine, equipment and so on. Therefore, in some cases, residents of certain wards travelled to other wards within the same Zaka area but further away from their local clinic to access treatment.



Histogram showing distance travelled by Zaka residents

The survey data above shows that residents frequently travelled distances averaging 18km, with many reporting journeys even up to 20km to reach functional facilities. This substantial travel burden highlighted why distance remained the most cited obstacle in rural areas. These findings showed distance as the primary reported barrier in rural areas. However, when asked to prioritise interventions, respondents in Zaka chose improved transportation (256 mentions) over new health infrastructure (156 mentions). This suggested that rural residents saw transport as a more urgent and cheaper solution than infrastructural expansion. In contrast, Chama residents preferred new local services, possibly reflecting a more severe lack of facilities in the city. This difference invited speculation about contextual differences in local health geography and community trust in existing facilities. Such differences may also reflect varying levels of community engagement in health planning, suggesting that participatory approaches could enhance the relevance and effectiveness of access interventions. (Mhazo & Maponga, 2022).

Residents in rural areas take longer to get places than usual because of the low quality of the road infrastructure there. The 18km travelled, whether by walking or driving, was on poor roads that were filled with potholes, limiting drivers to very low speeds, especially during the rainy season. Due to a lack of commuter buses, people with severe medical issues who could not afford to walk for extended periods of time often waited for hours at bus terminals to receive medical treatment. Zimbabwe and Zambia were two very similar countries. They lacked dependable emergency transport services in times of medical emergencies or urgent situations, which frequently caused delays in getting to vital medical facilities in Chama District. This led to serious implications for patient outcomes and overall community health. Improved infrastructure was essential for connecting communities, facilitating trade and enhancing the overall quality of life (UNICEF, 2021).

Analysis of Income and Medical Insurance

A total of 700 Zimbabweans, both in the country's cities and villages, responded to the inquiry on their level of health insurance. Interestingly, 518 of them (327 in the rural and 191 in the urban) did not receive any kind of financial assistance. According to this, 74% of Zimbabweans paid their medical bills out of pocket, which was a huge population. In fact, according to some studies, only 20% of Zimbabweans had health insurance of any kind. Many Africans who resided in rural areas were impoverished and could not pay the premiums for health insurance. Most families placed a high priority on necessities like food, housing and education and were able to afford even the modest cost of insurance every month. 61% of the 650 respondents in Zambia (217 from rural and 117 from urban areas) did not have any form of health insurance, even in the presence of the universal health coverage system that was initiated in 2016 under the National Health Insurance Act. A sizable fraction of the rural population was employed in jobs like subsistence farming, which were not recognised as formal and did not offer official benefits like health insurance. Before evaluating the relationship between income and insurance, the table below served as the foundation for an analysis of Zambia's and Zimbabwe's income statuses.

Table 1: Employment and Monthly Income data of respondents

	ZIMBABWE				ZAMBIA			
	URBAN		RURAL		URBAN		RURAL	
Income (Monthly)	N=300		N=400		N=350		N=350	
less than US$100	12	4	19	4.75	20	5.7	28	8
US$100–250	71	23.6	72	18	43	12.2	98	28
US$251–500	151	50.3	278	69.5	170	48.6	164	47
US$501–750	92	30.6	31	7.75	117	33.4	43	12
Employment								
Self-employment	83	27.75	231	57.75	42	12	94	38
Full-time	135	33.75	84	21	154	44	95	25
Part-time	91	30.3	65	16.25	119	34	64	21
Remittances	21	7	20	5	35	10	47	16

The analysis shown in the table above of monthly income data revealed urban-rural disparities across both countries. In Zimbabwe, urban Mufakose residents (N=300) showed greater earning capacity with 30.6% earning USD501-750 in relation to only 7.75% in Zaka (N=400). Conversely, 69.5% of Zaka residents fell to an average USD251-500 bracket versus 50.3% in Mufakose. Zambia showed similar patterns with 33.4% of Chawama residents (N=350) earning $501-750, contrasting with 12% in Chama (N=350). Employment bureau further explained insurance disparities with 57.75% of Zaka residents being self-employed (versus 27.75% in Mufakose), creating income volatility that discourages regular premium payments. In Chama, 38% were self-employed, with 80% earning below USD500 monthly. These realities positioned insurance as a luxury good that only the formal sector urban employees could have. The data showed that income stratification directly determined financial capacity for health insurance, making poverty alleviation through employment generation a prerequisite for expanding coverage. The difference between urban and rural insurance coverage displayed the multidimensional nature of healthcare poverty. Rural economies dominated by subsistence agriculture provided intrinsic impediments to financial risk protection, while urban inhabitants benefited from formal work structures that frequently included insurance benefits. This structural gap implied that rather than using similar strategies across diverse populations, health funding solutions needed to be customised to specific economic settings.

Assessing the effect of Gender and Income on Insurance using Regression Analysis

Gender effects nearly all population-based outcomes of interest, according to a common belief in health research. This assertion was supported by the literature, which repeatedly demonstrated that men's and women's health, access to healthcare and use of health services differed. As a result, gender was frequently considered a variable that required consideration

in analysis. While several research identify the general determinants of health insurance and a typical source of medical treatment, including gender, few looked at how these characteristics varied between men and women. This was a major disparity because most data indicated that women were more likely than men to have access to a regular provider of treatment as well as insurance coverage. While full-time working men were more likely than full-time working women to have employment-based coverage, this trend may be due to married working women's preference to forego their own insurance in favour of their husband's. In fact, full-time working single women were marginally more likely than single men to have coverage through their jobs, mainly due to the different kinds of jobs that single men and women held. We performed a regression analysis and the results are shown below to further understand the significance of income on medical insurance.

Table 2: Regression Coefficients

Model	B	Std Error	Beta	Sig	95% C1 for B
Constant	-17.523	6.536		.010	(-30.665; -4.381)
Income	.104	.008	.858	.000	(.087; 0.121)
Gender	-3.59	2.868	-.093	.185	(-9.626;1.908)
a. Dependent Variable: Insurance					

For income, the p-value (mentioned under Sig.) is 0.000 (stated as p <.001), which is less than 0.05and the slope has a t statistic of 12.444. As a result, there was strong evidence against the null hypothesis, according to which the slope of income was zero. This, therefore, meant that income had a significant effect on medical insurance. A $1 rise in the income received by an individual resulted in 10 cents increase in the amount of medical insurance acquired. The slope for Gender had a t statistic of -1.345and the p value (given under sig.) was more than 0.05, at 0.185 (stated as p <.001). As a result, there was no strong evidence to refute the null hypothesis that there was no slope by gender. According to this research, it showed that Gender had no significant impact on medical insurance. The remaining two columns provided confidence intervals for the coefficients. A 95 per cent confidence range for the intercept accepted values between -30.665 and -4.381. Similarly, estimates for the slope of income within a 95 per cent confidence interval fell between 0.087 and 0.121. The fact that the confidence interval in this instance did not contain 0 meant that the null hypothesis, that the slope was zero, could, therefore, be rejected.

Assessment of Future Research Prospects

While this study identified distance, income and insurance as critical barriers, several areas warranted further investigation. Future research could (1) conduct longitudinal tracking of HAQ index changes post-2024 to measure policy impact. (2) Explore qualitative dimensions of transportation barriers through community-based participatory research. (3) Investigate the effectiveness of micro-insurance schemes in informal employment sectors. (4) Examine the specific impacts of health worker shortages and medicine stockouts, factors noted but not quantified in this study. Such focused inquiries would deepen understanding of the mechanisms driving healthcare inaccessibility and inform targeted interventions.

Conclusion and Recommendations

This study concluded that healthcare accessibility in Zimbabwe and Zambia remained affected by geographical, financial and systemic challenges. The integration of HAQ index analysis,

survey data and regression modelling revealed that rural populations bore a disproportionate burden, facing average travel distances of 18km to the nearest facility. Over 70% of the population lacked any form of medical insurance. Financial protection remained very weak, with out-of-pocket payments prevailing and income proving to be the primary determinant of the lack of insurance. The stagnant and low HAQ scores, particularly in the last decade, reflected a serious lack of investment and systemic fragility within both health systems. Based on these outcomes, this paper recommended that policymakers and health planners prioritise mobility and last-mile access, whereby governments should invest in rural transportation infrastructure and emergency medical transport systems as an immediate, cost-effective strategy to halve travel times. Furthermore, policymakers could design inclusive, sliding-scale financing models. This involved building on Zambia's NHIMA framework and was inspired by Rwanda's community-based approach. Both countries should develop and scale health insurance schemes with premiums calibrated to income, particularly for the informal and agricultural sectors. Subsidies should target the lowest income brackets to ensure true universality. In addition, fulfilling the Abuja declaration commitment was a non-negotiable first step towards systemic improvement for both governments to meet the pledged allocation of at least 15% of the national budget to health. This funding must be strategically directed to primary healthcare, human resources and medical supplies to correct the decline in HAQ scores. Moreover, employment should be formalised and integrated into health benefits by making broader economic policies aimed at job creation in the formal sector and should be linked to mandatory health insurance contributions. For the informally employed, simplified registration and contribution mechanisms were needed to bring them into the risk pool. A successful implementation of these recommendations required sustained political commitment and robust monitoring systems. Given the interconnected nature of health access barriers, isolated interventions were likely to yield limited results. An integrated approach that simultaneously addressed transportation, financing and workforce challenges would create synergistic effects. Regular assessment using both HAQ metrics and community feedback would ensure accountability and allow for course corrections based on evolving needs and contextual realities. Establishing inter-ministerial committees linking health, transport and finance ministries could ensure coordinated action. Additionally, partnerships between public and private sectors could mobilise resources for transportation infrastructure, while community health committees could improve accountability locally. Monitoring mechanisms should track not only insurance enrolment but also utilisation, focusing on reductions in catastrophic health expenditure as the ultimate metric of success. This research provided a cross-sectional representation of healthcare accessibility, utilising both rural and urban perspectives in two nations to offer a comprehensive diagnosis. One of the main limitations was the reliance on estimated incomes for many respondents in the informal sector, which affected the precision of the regression analysis. Furthermore, constraints in resources necessitated a 90% confidence level for some regional samples. Future research should go deeper into the qualitative dimensions of patient delay the specific impacts of the health worker and medicine shortages and the evaluation of pilot interventions aimed at improving transportation or community-based insurance.

Enhancing healthcare access in a country is not just a social imperative but an economic one. A healthy population forms the foundation of national productivity and development. The solutions seemed challenging; however, they were within reach through targeted investment, inclusive policy design and a commitment to health equity.

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