REPUBLIC OF ZIMBABWE

COMMISSION OF REVIEW INTO THE HEALTH SECTOR

REPORT

ABRIDGED VERSION

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CHAPTER ONE

INTRODUCTION, BACKGROUND, PROBLEMS AND PREMISE FOR CHANGE

1.1 Formation of the Commission

The Health Review Commission was formed to advise the Government on ways of arresting and reversing the deterioration and decline in the quality of health services. At Independence Zimbabwe outlined a policy for providing essential health care to all citizens. The policy under the tile of "Planning for Equity in Health" incorporated the basic principles of the Primary Health Care Approach namely: Community participation, Equity, Sustainability and Intersectoral Action for Health Development. Government expenditure on the health sector increased from 2% of GDP in 1980/81 to 3% in 1990/91 and from 5,3% of total Government expenditure to 6,2% in during this period.

The Policy, which put emphasis on community-based care and rapid expansion of basic infrastructure, was well implemented resulting in impressive and consistent gains in the first decade after Independence. Gains obtained included a rapid increase in access to health services and improvement in levels of health as measured by life expectancy, infant mortality rate and other indicators. For example, during this period, infant mortality rate fell from 100 per 1 000 live births to about 50.

Things changed dramatically in the 1990s. Budget allocated to the health sector has declined for a number of reasons, particularly the economic stagnation and the pressure to reduce spending under the Economic Structural Adjustment Programme. Health Expenditure as a percent of total Government expenditure declined from 6,2% in 1990/91 to 4,2% in 1995/96. Health activities have been severely affected by lack of sufficient budgets. Salaries of health personnel have decreased considerably in real terms with severe consequences on staff morale and retention. The period has in fact seen a worsening of several health indicators and loss of previous gains. The HIV/AIDS epidemic has been a tragedy. The epidemic has increased workload in the already overstrained health services and its impact on level of health is dramatic. For example, life expectancy, which rose from 56 in 1980 to 61 in 1990, would have been 64,9 in 1998 without the epidemic, but is now rapidly declining to levels below 40 years in the next decade!

The realization by the Government that in order to deal with current and emerging problems, the health sector required a transformation, which would also affect other sectors and the society as a whole, led to the formation of the Commission. The Commission was sworn in by the President on 23 December 1997. Annexes 1 and 2 contain the Terms of Reference of the Commission and a list of the members of the Commission respectively.

Methods of Work

The Commission used several approaches in its work. Firstly, the Commission, through radio, TV and the press appealed to the general public, professional associations and all interested parties to send written submissions on concerns they may have on health services and suggestions for improvement. The Commission received over 360 submissions from different parts of the country. Many of these showed a lot of reflection and concern.

Secondly, the Commission interviewed invited individuals and representatives of institutions.

Thirdly, the Commission visited all eight Provinces and the three major cities: Harare, Bulawayo and Chitungwiza. Discussions were held with Government, Local Authorities and leaders of NGOs and health staff at provincial, district and local levels. All facilities and institutions visited were inspected to assess their adequacy, maintenance and performance. At the local level, discussions were held with community leaders including traditional chiefs and traditional healers.

Fourthly, public hearings which provided an opportunity for individuals and the public to bring to the Commission concerns, grievances and suggestions they may have for improving health services, were held.

Fifthly, the Commission organized three consultative meetings on key issues. Besides experts from Zimbabwe, experienced individuals from a number of countries were invited to these meetings. Examples of experiences emanating from these meetings which were particularly useful to the Commission's work include:

- United Kingdom – Formation of a Cabinet Committee and Parliamentary Select Committee for Health to champion the cause for Health; Attempt to get rid of the regions but reintroducing them as outposts of the centre; The new Labour Policy of co-operation rather than competition in health care and separation of "planning" and "implementation " instead of the market jargons of "purchasing" and "provision".

- Zambia – Definition of new roles of Ministry of Health, establishment of Central Board of Health; Establishment of Hospital and District Management Boards and the elimination and later re-establishment of Provincial Health offices.

- Tanzania – The complete cycle of abolition of Local Authorities followed by period of centralization and decongestion of authority and more recently re-establishment of Local Authorities and the establishment of service contracts between Ministry of Health and Missions.

- Ghana – Establishment of Ghana Health Service, de-linked from Public Service Commission and re-structuring of Ministry of Health.

- Botswana – Decentralization of services to District Councils. Health staff were initially seconded and eventually transferred to Councils.

- Uganda – Hospital autonomy; establishment of an autonomous Health Service Commission, delinked from PSC and advisory to the President.

- Denmark – Decentralization within hospitals and the Twin Hospital Management Arrangement.

- Malaysia – Establishment of a National Quality Assurance Programme and improved performance and quality of public hospitals as an effective means of controlling the private sector.

- Quebec Field Visit – Accountability of Health Services and the operation of Community Health Centres.

- WHO – Global experiences in human resources policies/strategies; financing options; public policies towards the private sector.

Other important issues analyzed in the consultative meetings include: "User Charges, are they the best way to tap community resources?"; "Equity In Health and Health Care in Zimbabwe"; "Occupational Health and Safety"; "Health of Commercial Farm Workers"; "Revitalizing the Community Health Movement"; Implications of Decentralization to the role and structure of the MOH&CW at central level and intensifying the attack on HIV/AIDS. Finally the Commission organized three separate consultative meetings with Traditional Healers, Clinical Officers and Municipal staff.

The last approach used by the Commission was extensive analysis of reports, legislation and relevant papers by MOH&CW, NGOs, University, and Donor Agencies and other institutions.

1.2. What Zimbabweans Think of their Health Services

Zimbabweans were unanimous in their conclusion that Health Services were crumbling. While the opinion of the public and of health workers on issues behind the decline converged in most areas, it differed in a few.

Both the public and health workers feel strongly that health services are under-funded and the Government should give them much more priority in the allocation of resources. Concerns were also expressed about the allocation and use of available resources, most of which go to curative services and big hospitals with relatively little funds "filtering" to RHC/Clinics and preventive work. Management at hospitals was poor as evidenced by huge debts that have not been collected from Medical Aid Societies, Social Dimensions Fund (SDF), other institutions and individuals. There was agreement that a National Health Insurance Fund to which every citizen will contribute is an excellent idea.

Zimbabweans have heard from time to time that the Government is no longer able to provide free health services. Although they are willing to make a financial contribution, they hasten to add that those who promised free services need to go and tell them of the change in policy. Zimbabweans expressed a wish to be involved in decision making about their own health and in deciding on what changes should be made in health services. Certainly they do not want to play a passive role, just contributing additional funds and not even knowing how these are being used. They hear about decentralization of health services but do not understand what it means in practice. Will this improve Health Services? they asked. Finally, Zimbabweans are quite optimistic, saying emphatically that the deterioration in health services can be arrested and reversed if everyone, Government and citizens, play their part. "We should not just sit there", the Government should mobilize action.

The public's other concerns were the long distances that individuals in parts of the country have to walk to reach a health facility, poor facilities and quality of care, and a rising cost of health services.

HIV/AIDS has touched the lives of all Zimbabweans in one way or another. Regarding care, people with AIDS were being discharged from hospitals into home based care but no mechanism was in place to assist relatives of these patients in looking after them. The Government and Local Authorities were seen as not doing enough to improve the situation.

In urban areas, over-crowding, constantly breaking down sewer pipes which remain for long periods without being repaired, and uncollected refuse created a potentially hazardous environment for disease outbreaks. This situation was of particular concern to people residing in the high-density suburbs in the major cities of Harare, Bulawayo and Chitungwiza. The problem was compounded by the slow reaction of the City Health authorities and Central Government to address these problems, thus exposing the affected communities to prolonged risk of contracting communicable diseases which thrive in such environments.

Undoubtedly, the most serious concern of the public was the poor attitudes of some nursing staff, doctors and their aides, towards patients. The way these workers handled and treated patients was described as unprofessional and a negation of the ethics of the nursing and medical professions. Numerous serious allegations of malpractice by health workers were made. These ranged from lack of empathy, rudeness, and irresponsibility to negligence. Pregnant women especially bore the brunt of this ill treatment.

The state of health services from the health workers' point of view was demoralizing. Chronic shortages of essentials like drugs, linen, sundries and support services, made it difficult to provide the standard quality services expected by consumers. The conditions of service for professional health staff characterized by low salaries, poor allowances which are paid out erratically, unsocial working hours, no credit for years of experience, and poorly defined career development opportunities, were demotivating for health workers. The breakdown of the referral system has resulted in wards at most referral

centres being overcrowded. Frequent break down of hospital equipment, which then takes long to be repaired, exacerbates an already strained system and further compromises the quality of services available to people.

Other concerns expressed by health staff were the cumbersome system of resolving personnel issues, the Public Service Commission was repeatedly accused of being insensitive to concerns of health workers, absence of clear protection policy against TB, HIV/AIDS and lack of accommodation and clean water supplies in health facilities. Government was no longer honouring its obligation to reimburse Local Authorities 100% of their recurrent expenditure as per the 1976 Financial Agreement between Government and Local Authorities and Mission Hospitals were not getting adequate grants from Government. Finally, management within the MOH&CW Head Office was seen as top-heavy and unrepresentative. Some professions like nursing, environmental and reproductive health wanted more representation at top management level.

1.3 Historical Background, Developmental Landmarks and Current Situation

The situation at Independence was one with gross inequities. There was an elaborate UK standard hospital-centered service for the urban, mainly white community and a poorly developed rural health service to serve the mainly black population. Focus of development and funding was on curative services in the central and general hospitals in urban areas. It was left to missionaries to develop health services in those areas where they established their churches while Government from 1927 onwards provided grants. At Independence 80% of doctors were in Central Hospitals, 14% in General Hospitals, 6% in District Hospitals and practically none for rural areas. Over 60% of Government expenditure was in Central Hospitals, 21% in General hospitals, 10% in District hospitals and 3% to rural areas mostly as grants to Mission health services. The Public Health Act of 1945 provided policy guidelines for the provision and administration of health services. The Government set up the Rhodesia National Health Service Inquiry Commission (1945) and also the Commission of Inquiry into the Health and Medical Services of the Federation of Rhodesia and Nyasaland (1959). There has not been a structured assessment of the extent of the implementation of the Public Health Act and the recommendations of the two Commissions. Parts of the reports of the Commissions will be referred to later.

Post Independence: The First Decade

At Independence the new Government adopted the Primary Health Care approach. The Government developed a National Policy, "Planning for Equity" to ensure that all Zimbabweans have access to health care. As part of the policy, the Government built 246 RHC/clinics; refurbished and upgraded 450 existing RHCs and built 17 new hospitals. The Government decided that people in rural areas and those earning less that $150 per month would get free treatment. The Government also undertook to assist Missions with grants to cover 100% of approved staff, 80% of recurrent budget and 100% of drugs

purchased from Government Medical Stores. To meet human resource requirements, several new multidisciplinary programmes were established. A series of new training programmes were started e.g. X-ray Operators, Laboratory Assistants. Extensive PHC orientation programmes were organized for existing staff. Water and sanitation, nutrition and malaria programmes were expanded with considerable success. The new programme was a success story.

Large numbers of Village Health Workers (over 8 000) were trained. Although the target of 12 000 was not reached by 1990, VHWs played a key role in mobilizing community health action. The target of increasing immunization coverage to 80% by the year 1990 was achieved and killer diseases of children such as polio, diphtheria and tetanus virtually disappeared. The overall death rate fell from 10,8 per 1 000 to 9,4 in 1990.

1990 and Beyond: Pressures for Change

The nineties can be described as a time of economic hardship and declining budgets for Health, while the health needs were growing because of increased poverty, recurrent droughts and AIDS.

The current situation with regard to health and health service is summarized below.

Level of Health

- The HIV/AIDS epidemic and related TB epidemic are having an enormous adverse impact on health;
- Rapid decline in Life Expectancy from 62 in 1988 to below 50 in 1997;
- Increased IMR (Infant Mortality Rate) from 60 in 1990 to 89 in 1997;
- Increased MMR (Maternal Mortality Rate);
- Increase of Crude Death Rate;
- Gap in level of health between urban and rural areas, static or getting worse. For example the gap in IMR between urban and rural areas was 24 in 1978 and 26 in 1997.

Health Services

- Increased workload. Overcrowded facilities.
- Shortage of staff and essential equipment. Poor maintenance of equipment and physical facilities.
- Rapid growth of private health sector with minimal control.
- Inadequate management with multiple lines of communication and inadequate decentralization.
- Inadequate leadership due to continuous loss of key staff and other reasons.
- Dramatic decline in resources available to public health services.
- Inefficient use of available resources.

A transformation of the health system is essential to address the above issues. These and related issues are examined in more detail as follows:

Public Sector Health Services, Chapter 2.
Development and Deployment of Human Resources, Chapter 3.
Organization and Management, Chapter 4.
Financing, Chapter 5.
The Private Sector, Chapter 6.
Priorities, Conclusions and Way Forward, Chapter 7

CHAPTER TWO

PUBLIC SECTOR HEALTH SERVICES

The policy of GOZ is to ensure that all Zimbabweans have access to essential health care. In this chapter, the Commission examines the extent to which this policy has been implemented, problems encountered and ways of overcoming them. Promotive and preventive services will be examined first followed by clinical services.

A number of issues that are common to all types of services are summarized at the end of the chapter together with relevant recommendations. These issues are: quality of services, availability of drugs, laboratories and pathology services, essential equipment and maintenance, physical health facilities, staff accommodation, transportation and security. Other issues identified in the chapter such as shortage of staff, low staff morale, lack of adequate authority to make decisions by various institutions and shortage of funds are discussed in more detail in other chapters.

2.1 Health Promotion and Disease Prevention

2.1.1. Health Promotion

Although extensive knowledge has been acquired on what ought to be done to prevent important causes of morbidity and mortality, such as diarrhea, upper respiratory infections, malaria, HIV/AIDS, injuries and non-communicable diseases, action remains limited. A clear policy on Health Promotion and Health Education lacks sufficient priority. There is also no mechanism to coordinate activities of programmes involved in health promotion. Active involvement of communities, NGOs and other groups is considered essential for success. (See Section on Revival of Community Health Movement).

Village Health Workers (VHWs) were deployed in parts of liberated areas of Zimbabwe during the liberation struggle. The Programme was very successful and became a policy of MOH&CW after Independence. VHWs were elected and accountable to communities, MOH&CW provided training, basic medicines and later bicycles. Training schools were established in practically all districts. The role of VHWs was to promote health, provide simple treatment of diseases in communities and at the same time inform the health systems of needs and failures. Later VHWs were moved, despite objections by MOH&CW to the Ministry of Community Development and Women's Affairs where they received a higher allowance and became known as Village Community Workers (VCWs). As the name implies, VCWs are multipurpose and are involved in different types of community development activities. The Ministry of Community Development and Women's Affairs later became the Ministry of Community Development and Cooperatives and is now the Ministry of National Affairs and Employment Creation. What is clear to the Commission is that the programme of VCWs has been affected by these transfers and no longer has the central role in health care which it had when under

MOH&CW. There have been few training programmes since VHWs programme was transferred from MOH&CW and some VCWs have apparently been appointed without basic training. The VHW/VCW has also moved from being a mobilizer, selected by and accountable to communities to a government extension worker.

A number of other health programmes also deploy community-based health workers. Examples include the Zimbabwe National Family Planning Council (ZNFPC) which has deployed Community Based Distributors (CBDs) from the mid 1980s; the Farm Health Workers programme which was started in 1990 by MOH&CW with financial support from SIDA, the Health Task Forces and Peer Educators Programme started by the Bulawayo City Health Department in collaboration with the Residents Associations home care plan initially for AIDS patients but later extending to other chronic illness and health scouts in the City of Harare. The Commission is convinced that decline in the role of the VHWs is an important factor in the deterioration of the Community Health Movement started after Independence.

RECOMMENDATIONS

The Government should make a strong commitment and revitalize the programme of VHWs, selected by and accountable to communities. They should be retransferred to the MOH&CW.

To be successful, VHWs have to be responsible for few families, about 20-50. Workers who are responsible for larger numbers of families are essentially extension workers doing full time work.

The duties of these workers should focus on mobilizing community health action, health promotion, treatment of simple diseases and surveillance of health and disease.

A clear policy on Health Promotion indicating important elements in Zimbabwean context should be developed.

An intersectoral committee to foster health promotion should be formed. Membership should include MOH&CW, Ministry of Education and Culture, Labour and Social Welfare, Ministry of Local Government, Ministry of Higher Education, NGOs, Churches and Private Sector. The Committee might consider having standing subcommittees to deal with selected issues.

2.1.2. Communicable Diseases

As discussed in chapter 1, preventable communicable diseases such as malaria, TB, diarrhoea and HIV/AIDS are major causes of morbidity and mortality. A few of these diseases were reviewed by the Commission on the lined indicated below:

HIV/AIDS
The first case of HIV/AIDS in Zimbabwe was reported in 1985. It is now estimated that 1.4million people have contracted HIV infection since then and some 700 HIV/AIDS related deaths occur every week.

AIDS is affecting all families and communities ands every workplace. Funerals are the order of the day. Families see their breadwinners fall away and numbers of orphans are growing rapidly. At the workplace absenteeism is increasing and employers have to train large numbers of new replacements. Hospital beds are occupied in large numbers by AIDS patients, thus crowding out other patients who need treatment. Many AIDS patients are treated at home and are taken care of by relatives, friends and home care givers. The treatment conditions are often very indequate.

Zimbabwe has a sentinel surveillance system that provides a good estimate of HIV infection in different parts of the country, both rural and urban areas. Each of the eight provinces, plus Harare, Chitungwiza and Bulawayo have designated hospitals/health centres where blood samples from sexually transmitted disease patients and first visit antenatal care patients are collected and then tested for HIV/AIDS. Results from the sentinel sites indicate that around 25% of the adult population are infected with the deadly virus.

Groups most at risk of HIV infection are commercial sex workers, long distance truck drivers, members of the uniformed forces, prisoners and persons suffering from Sexually Transmitted Diseases. However, with such a high general prevalence rate, the whole population is now at risk.

A new cause of concern is the increase in the number of reported cases of AIDS in children 5-14years. Only 3 cases were recorded in 1989 and 349 in 1996. There has been concern that the development may be related to infection through breast milk or through rape by HIV infected men. A number of infected children survive beyond 5 years even into their early teens and with increasing numbers of HIV infected children, older children with HIV infection will be seen in greater numbers than in the past.

Around 30% of children born of HIV infected mothers are expected to be infected by their mothers during pregnancy, at delivery or through breast milk. Debate continues on whether HIV positive mothers should or should not be advised to stop breast-feeding. Those against advising stoppage of breast-feeding are concerned that most of the families involved are too poor to afford replacement feeding and death from malnutrition is almost certain.

It is noted from information at the Commission's disposal that females between 15-19 years are more than 4 to six times as likely to be infected as males in the same age groups. Young women tend to be targeted by older men who have had many partners. This renders the young women and girls particularly vulnerable to infection. Health promotion programmes that specifically target girls and young women should be established or strengthened.

The 1997 Zimbabwe Sexual Behaviour and Condom Use Survey showed very disturbing findings: although 100% of men and 99% of women were aware of AIDS, 15% of men and 26% of women did not know that a healthy-looking person could have the AIDS virus!

National Response to the HIV/AIDS Pandemic

There is an AIDS crisis in the country. The main features and impacts of the epidemic are summarized above.

There is sufficient knowledge available to indicate what to do and what can be achieved. In the absence of interventions, the HIV prevalence is expected to rise further. An effective blood-screening programme reduces prevalence only modestly. Condom promotion is more effective in reducing prevalence. Reduction of sexual partners has the greatest impact on HIV prevalence. When all measures are implemented simultaneously, it has been projected that prevalence would be approximately 55% less in year 2005 than it would be in the absence of such interventions.

RECOMMENDATIONS

The Commission supports the proposal to establish a National AIDS Council (NAC) which will ensure full participation of all sectors in the fight against HIV/AIDS.

All Government Ministries and departments should urgently integrate HIV/AIDS interventions, such as awareness, peer education and proper HR planning, into their plans at all levels. Periodic progress reports should be made. An overall Government HIV/AIDS Plan for different sectors and related issues should be formally considered by the Cabinet.

Sustainable strategies to mobilize resources, involving the private sector, NGOs, and religious organizations should be pursued actively. The efforts of different stakeholders need to be much better coordinated. The role of NAC is crucial in this effort.

The Commission further recommends that the HIV epidemic be declared a National Disaster in terms of the Civil Protection Act (Chapter 10.06). The said Act states as follows: "If at any time it appears to the President that any disaster is of such a nature and extent that extraordinary measures are necessary to assist and protect the persons affected, or likely to be affected by the disaster in any area within Zimbabwe, or that circumstances are likely to arise making such measures necessary, The President may in such manner as he considers fit declare that, with effect from a date specified by him in the declaration, a state of disaster exists within an area defined by him in the declaration".

In the Commission's view the facts that (i) over 20% of the adult population has contracted the fatal HIV infection where more are expected, (ii) at present 700 AIDS and HIV related deaths are occurring every week, (iii) there are more that 200 000 known "AIDS" orphans, (iv) the costs of HIV/AIDS to individuals and families and indirect

costs due to absenteeism or reduced work capacity creates a large impact on the economy, and (v) up to 70% of hospital beds are occupied by HIV related illness, form sufficient justification for declaring a state of National Disaster.

Gains & Risks of Declaring AIDS a National Disaster

Expected Gains	Possible Risks
▪ AIDS will receive prominence/legal status as a major national issue ▪ Involvement of other sectors is mandatory rather than optional. ▪ Multidisciplinary teams at grassroots and elsewhere will be required to play an active role. ▪ Easier for Government sectors and NGOs to access donor funds. ▪ It will immensely increase awareness among all levels of society. ▪ It will help to overcome present state of apathy, complacency, "adjusting" to HIV/AIDS as inevitable. HIV/AIDS illness or death is now often attributed to "long-illness". ▪ New tools for effective health promotion.	▪ A declaration may send the wrong signals and some sectors of economy, such as tourism, may suffer a down turn. However, most tourists and tour organizers know well which countries have high prevalence of HIV and measures to prevent HIV infection. A declaration of disaster is unlikely to make much difference to the tourist industry. ▪ The declaration is usually a short-time intervention and would need to be reviewed every 3 months unless the President makes it open-ended. ▪ The declaration may give the false impression that the problem can be solved in a short time. ▪ The Disaster Act recognizes the Minister of Local Government as leader for action and not MOH&CW. One should be able to overcome this formality.

Local communities should be involved in the formulation and implementation of HIV/AIDS activities. HIV/AIDS should be an integral part of the Community Health Movement. Health Education messages and strategies should focus on local determinants of behaviour. In this regard, health educators need to acknowledge that the approaches used to date have not worked in changing behaviour. There is now need to "go back to the community" and to work closely with local residents in formulating messages with practical local context.

Voluntary HIV testing and counseling as a tool for preventing the spread of HIV/AIDS has not been used much. While HIV testing facilities are generally available, there is a serious shortage of counselors. Large numbers of people, including religious and other local leaders can play this role well, they should be trained and mobilized. HIV Testing should be a requirement in settings such as premarital, long courses of training and sensitive jobs. This would act as an incentive to remain uninfected as well as send a message on the seriousness of the problem.

The existing policy of confidentiality needs to be reviewed and that a policy that is protective to both the individual and the public be developed.

On the dilemma of breast-feeding and HIV infection, the infant feeding policy guidelines of UNAIDS, WHO and UNICEF should be adopted as far as is practicable. All women should be kept optimally informed about the risks of HIV transmission through breast-feeding and have access to voluntary counseling and testing to find out their HIV status. All mothers need support to undertake safely the option they choose i.e. breast-feeding or replacement feeding.

The greatest risks to be borne in mind are: (i) the high cost of replacement feeding which might lead to death through malnutrition and (ii) the high likelihood of contamination of replacement leading to deaths from diarrhoea. (iii) The worst outcome of all is the possibility that fears about HIV transmission through breast milk may undermine breast-feeding in the general population. This would lead to widespread malnutrition, diarrhoea and high infant mortality.

The moral dilemma of anti-retroviral HIV treatment is one which the nation has to resolve. Drugs that can prolong life considerably are now available in the open market. At a cost of over $20000 per month such medicines are not financially accessible to the majority of persons infected with HIV. **To facilitate decision, comparative costs of the universal use of anti-retroviral treatment against medical, economic, social and financial costs of the status quo need to be worked out.**

It is now accepted that the risk of transmission of HIV from mother to child can be reduced significantly through medication. The cost of such a scheme would be much less than universal treatment. Here again, an assessment of cost of prevention versus the cost of looking after HIV infected children needs to be carried out. Removal of customs duties on these drugs might lower the costs but they would still remain high.

Home-based care has become crucial in the management of AIDS patients. The large number of terminally ill AIDS patients who could occupy all available beds in hospitals necessitates the emphasis on home care. Caregivers should be given appropriate training and support. Suggestions have been made for establishment of centres where patients can be admitted for a few days, to provide relatives for some break. **This and other options should be actively pursued.**

Baseline surveys should be carried out for all programme components in all sectors so as to design appropriate and relevant interventions whilst ensuring that the relevant process and performance indicators are set.

Tuberculosis (TB)

There has been a phenomenal increase of approximately 748% in numbers of reported new cases of TB between 1987 and 1997. The TB epidemic is closely linked to the

HIV/AIDS epidemic. The great majority of TB patients is HIV positive. The leading cause of hospital stay in the country is TB.

The Commission notes with concern the very poor treatment outcome. The overall cure rate is 35%. The main problems are treatment defaulting (11%) and erratic drugs supply particularly Rifampicin. A new approach, Direct, Observed Treatment Short Course (DOTS) has been hailed as a breakthrough. This strategy which requires patients to go to a health facility and be "observed" taking treatment is difficult in rural areas where distances to clinics are too far for patients to walk daily. A recent study shows that there may be little difference in cure rate between "DOTS" treatment patients and those who take medicines "unobserved" after adequate explanation.

The case of TB illustrates well the size of the challenge to MOH&CW and Government and the need for fundamental change: as a consequence of the AIDS epidemic the annual number of TB patients will rise from 43,000 in 1998 to well over 100,000 by the year 2002. The Health Sector is hardly coping with the present number of TB patients and in its present format it will be totally unable to cope with the number projected for 2002. Such a large prevalence of TB poses a threat to all people of Zimbabwe, both for the HIV-positive and the HIV-negative. More involvement of the communities will be needed in the prevention of TB and implementation of DOTS. In the chapters on organizational structure and human resources, the Commission will recommended the revitalization of the Community Health Movement and the reinstallation of Community Health Workers.

RECOMMENDATIONS

The Commission recommends that the fight against TB be much intensified using different strategies with emphasis on empowering individuals, families, communities and local leaders.

The fight against the HIV/AIDS pandemic will ameliorate the TB epidemic in the long run.

The Commission recommends that there should be adequate supply of anti TB drugs available at all times supplies of which have been noted to be erratic. These drugs should continue to be supplied free of charge.

Education campaigns should be intensified to increase public awareness of the disease.

Malaria

Malaria is one of the leading causes of mortality (16% of all deaths) in Zimbabwe. In the worst affected province, Matabeleland North, in 1996 close to 50% of the population was affected, and malaria was responsible for up to 40% of deaths in the province in that year.

In Zimbabwe, malaria is largely seasonal, clearly predictable in onset and distribution and is highly amenable to prevention. It is also readily curable. The high annual toll is therefore not justifiable. It seems to the Commission that the problem has not received adequate priority. For example, there is no specific financial allocation for malaria at provincial and district levels but minimal effort has gone to mobilizing community involvement.

RECOMMENDATIONS

Malaria should be given higher priority and prominence than at present.

Funds for malaria control to districts should be based on the extent of the problem and specifically allocated for this disease.

Local community participation should be a priority. Consideration should be given to communities and individual households doing their own spraying where this is possible.

Health Education regarding prevention at community level emphasizing use of bed nets, vector control including the use of chemicals, removal of stagnant water, proper use of anti-malaria drugs including chemo-prophylaxis and the need to seek early treatment is advised and should be channeled through the VCW or other community-based workers.

2.1.3 Maternal and Child Health

Women of child-bearing age 15-49 years of age constitute 23% of the total population while children under 15 years constitute 45%. The large number of the two population groups justifies the rapid expansion of services to mothers and children since Independence. At Independence not only was the coverage of these services inadequate, they were piecemeal and inconvenient to the use of clients. For example, an expectant mother would walk a long distance to bring a toddler to a child welfare clinic and in two days cover the same distance to get her pregnancy examined, often by the same nurse. Or a mother would take a child to the clinic and then have to cover the same distance to obtain advice on family planning. MOH&CW in the early 1980s changed this pattern of services, which was essentially organized for the convenience of health staff, to the "Supermarket Approach" whereby all major services for mothers and children were delivered at the same time. In this section the Commission looks at the health status of mothers and children and then assesses the performance of MCH services.

Available data shows that in 1987, 62 maternal deaths occurred in health institutions for every 100 000 children born in the country. The figure of 62 rose to 150 in 1994. These figures do not include maternal deaths that occurred at home. The 1994 Zimbabwe Demographic and Health Survey (ZDHS, 1994) established that the Maternal Mortality Rate (MMR) was 283 per 100 000 live births. The Commission is particularly concerned with this high level of mortality for two reasons. First, any death of a mother during

pregnancy or childbirth is a tragedy with serious family and community consequences. Secondly, over 75% of maternal mortality is due to direct obstetric causes, including haemorrhage, sepsis, eclampsia, obstructed labour and unsafe abortion all of which can be addressed by improving health services. Maternal mortality is a sensitive indicator of the standard of health care in the country. Unlike infant mortality rate, maternal mortality is not as directly dependent on major socio-economic changes such as nutrition and living conditions.

The Commission is concerned with the inadequacy of information on maternal mortality and the main causes. It is the policy of MOH&CW that all maternal deaths are notified on an official form. However, the policy is largely ignored and there seems to be no effort to enforce it. In 1996 only 78 deaths were notified out of the 524 deaths known to have occurred in institutions. The Commission believes that surveillance and control of maternal deaths should be carried out in all communities. The community and local leaders should be involved in establishing a culture of safe motherhood whereby every mother is expected to attend ANC and any maternal death is investigated. VCWs/VHWs and community leaders should inform RHC/clinic staff of all maternal deaths and circumstances to enable the staff to make an "oral autopsy" to establish the cause of death and decide on how identified failures of the health system could be avoided in future.

ANC coverage fell from 90% in 1988 to 74% in 1996. Institutional deliveries also fell from 54% in 1988 to 50% in 1996. Matabeleland North and South, which have the most dispersed population compared to other provinces, have the least coverage. Matabeleland North has a coverage of 60,4% ANC and 34,7% institutional deliveries. The corresponding figures for Matabeleland South are 67,2% and 49,8%.

A considerable proportion of deliveries is carried out at home. More understanding of the circumstances relating to home deliveries and their outcomes are essential. One of the major reasons for this is lack of transport to bring expectant mothers, particularly those at risk or with difficult labour to hospital. Waiting shelters where expectant mothers, particularly those at risk can stay should be made more readily available. The Commission understands that some shelters have been built around RHC/clinics. The Commission feels strongly that such a measure should be discouraged unless the RHC/clinic has reliable transport to take a patient to hospital should problems arise during labour.

RECOMMENDATIONS

The Commission recommends that the notification policy on maternal mortality be enforced and that it be mandatory that all maternal deaths are fully investigated and accounted for. A form of inquiry should be conducted into every maternal death, and a plan of action is put in place to reduce the chances of further occurrence wherever possible. Such a plan should have specific targets so that they can be evaluated at regular intervals.

A system of active surveillance of maternal deaths be set up at community level, as a basis for preventive action. Commission believes that mechanisms can be set up in local communities, at minimum cost, to provide more accurate information on maternal death. One such mechanism is to strengthen the Community Health Movement and to more effectively deploy and utilize community health workers.

Further investigation be carried to be out in order to ascertain the extent and outcomes of home deliveries. This will assist in policy formulation regarding the strengthening of the skills of Traditional Births Attendants and policies towards facilitating institutional delivery.

In every community, the District Health Team and the local leadership should establish a system of ensuring availability of transport for emergency purposes. This would be in addition to the existing arrangement of pregnant mothers' shelters at maternity centres.

Family Planning

The Zimbabwe National Family Planning Council and the MOH&CW programme are one of the most successful in Sub-Saharan Africa. Total fertility rate fell from 6,5 in 1984 to 4,3 in 1994 while contraceptive prevalence rate rose from 38,4 to 48,0 during this period. The Commission understands that donor support for the Council, which accounts for ¾ of the budget, is to end soon. Senior officials in the organization have left and its future is not clear. A number of options, including the possibility of integrating the programme with Reproductive Health are apparently being reviewed.

RECOMMENDATIONS

The Commission understands that this programme is in financial distress. Continued donor support is required to ensure that whatever form the programme takes, its success is maintained. It is hoped that donors will work closely with MOH&CW to ensure sustainability of the Council.

2.1.4 Child Health and Child Welfare

The National Programme of Action for Children was developed in 1992, with a Secretariat Unit in the MOH&CW. Thereafter the Ministry was known as MOH&CW to reflect this new responsibility. A focal Persons Committee was formed with representatives from all government departments, non-governmental organizations and International agencies that deal with children.

The immunization and nutritional programmes have realized remarkable achievements with the near elimination of polio and neonatal tetanus, and reduced incidence of

blindness from measles and Vitamin A deficiency. Health education to promote health and prevent disease was heightened and the country benefited enormously from all these efforts resulting in reductions in infant mortality as well as childhood morbidity and mortality.

The HIV/AIDS pandemic and problems associated with the implementation of Economic Structural Adjustment have had a negative impact on child health. Those most affected by these adverse factors are the children of the poor. Poverty related diseases, such as malnutrition have increased. Prevalence of childhood malnutrition is fairly high, 16% of under-5s are malnourished overall and 30% of under-5s in drought prone provinces are undernourished. Fewer mothers are able to pay for antenatal care and as a consequence, the prevalence of unbooked deliveries, premature and other neonatal complications are rising. Furthermore, the onset and rapid progression of HIV infection in infants has meant a more dramatic change in disease patterns and an increase in clinical load without increase in human resources.

In the area of education the major goals were to increase access to early-childhood education and care, universal access to primary education, to improve quality and relevance of educational experience. There are, however, still a significant number of children who are not attending school due to various reasons but mostly because of economic hardships in some rural, mine and farm areas. In some schools corporal punishment remains a stumbling block to the education of children without fear.

The National Plan of Action defined children living in especially difficult circumstances (CEDC) as "those children living on the streets, orphans, refugee children, abused children, abandoned children and children in institutions". Their protection is imperative, as is the prevention of situations that result in children having to live in these difficult circumstances.

Child Welfare Forum was established in 1993 to ascertain and monitor the circumstances under which the children are growing under in order for the appropriate interventions to be carried out. The Child Welfare Forum is therefore the voice of these children and has operational committees at ward, district and provincial levels throughout the country.

Poverty, orphanhood, child abuse and abandonment have led to an escalation of the number of children in the streets. Street children are the most visible of the children living in especially difficult circumstances.

Press reports give gory details of some of atrocities being committed against children. It was reported that in Harare alone, between January and September 1998, the Family Support Unit at Harare Hospital attended to over 560 new cases of sexually abused children. Many cases go unreported as families try to keep the abuse within the family.

Child Welfare programmes are now established at district and provincial levels countrywide. Workshops are held on children's rights, infringements thereof and training on helping children to avoid potential abuse situations.

The increasing community awareness of child abuse is one reason for the increase in a number of reported cases. The Victim Friendly Courts Act now enable the child victims of sexual abuse to testify away from the perpetrator to enable the law to take its proper course.

Many people in the society and civic leaders are coming forward as defenders of children. Most towns and cities have developed their own plans of action for the children in their areas of jurisdiction to meet the basic needs of children and uphold their rights.

Besides the efforts by government and NGOs, the traditional leaders, the chiefs have established orphan care programmes in their areas supporting the children from the Zunde ra Mambo harvests (Chiefs Granaries).

The laws of this country as well as the Constitution guard children against the abuses, but the implementation and monitoring of these provisions has been problematic, as most of these abuses happen within the family unit and thus are difficult to monitor closely. Furthermore, lack of public debate before ratification of the CRC has led to difficulties in the implementation of the National Plan of Action for Children (NPAC). Society has the wrong perception that these rights undermine their authority and responsibility over their children.

The NPAC major limitation in addressing the CRC is that preventative strategy is dependent on donor funds. The NPAC secretariat within the Ministry of Health is under resourced both in human and financial resources and has no effective powers to enable it to be the focal point of all activities targeted at improving child health and welfare.

The Commission notes that child welfare involves social issues which are not the `core business's the MOH&CW and involves many stakeholders. Although there is an Inter-Ministerial Committee to monitor the implementation of the CRC, the work is fragmented with no one being held accountable. Possible solutions suggested were:

- The creation of a separate agency with responsibility for co-ordinating all child welfare issues and overseeing the implementation of the convention.

- Merging the Department of Social Welfare and MOH&CW. Many countries have combined social welfare and health under one Ministry. This move would remove the apparent friction between the two and facilitate smooth functioning in those areas that require both medical and social welfare inputs. This would enable proper planning and co-ordination of activities in such areas as child abuse, drought relief and malnutrition, poverty alleviation, hospital fees and exemptions which require both social welfare and health care input.

- Expand the NPAC Secretariat Unit and ensure it work closely with the department of Social Welfare. The unit will then be the central co-ordinating body for all efforts by

Commission further recommends that MOH&CW introduce a programme of health promotion and education on healthy lifestyles. The programme should be decentralised and incorporated into local community health-promotion programmes, together with other health promotion activities such as HIV/AIDS education, sanitation and malaria prevention, child health and others. Specific topics to be emphasised to include nutrition, exercise, stress, tobacco smoking, drug and alcohol use and abuse.

In order to ensure that non-communicable diseases are not lost sight of in the country's preoccupation with communicable diseases and other diseases of poverty and underdevelopment, Commission recommends that prevention of non-communicable diseases be an integral part of Primary Health Care.

It is noted that voluntary organisations and NGOs are already deeply involved in the running of support as well as control programmes for various types of non-communicable diseases. Such experience could form a strong basis for nation-wide programmes. Commission therefore recommends the strengthening of and collaboration with existing associations and non-governmental organisations.

Factors that contribute to the causation of most non-communicable diseases have a broad base in society. Therefore comprehensive control of these diseases will require a multisectoral approach. This should include the ministries of Finance, Education, Information, Industry, Labour and Social Welfare, Agriculture, Transport and Home affairs. It is noted that this need for collaboration with other sectors applies to most health programmes and not only non-communicable diseases. The Commission therefore wishes to emphasise and endorse the need for intersectoral collaboration in health care programmes.

2.1.6 Environmental Health

The Ministry of Local Government and National Housing is the coordinator of the Integrated Rural Water Supply and Sanitation Programme which involves four ministries and NGOs.

The role of MOH&CW focuses on technology development, training and regulation. A National Sanitary Inventory conducted in 1998 showed that 79,5% of the rural population has access to safe water. In some Provinces, Manicaland and Matabeleland South access is even over 100%. The current standard of coverage is 250 persons per borehole, 150 persons per deep well and 50 persons per shallow well. This standard gives a false sense of security, particularly in sparsely populated areas. The Commission thinks that a standard that takes distance into consideration is more realistic. Field workers have suggested a distance of 400 metres from a water point and the Commission finds this to be reasonable and practical. In some provinces like Masvingo, large numbers of water sources are unprotected. Water protection requires only modest resources and with environmental staff available in most districts, considerable improvement is feasible.

The National Sanitation Inventory showed a low coverage with Blair latrines of about 37,5%, ranging from 16,3% in Matabeleland to 39,7% in Manicaland. It is estimated that approximately 600 000 households require toilet units. At 1998 prices these will cost in total approximately Z$12 million (about US$400 000).

School sanitation coverage nationally, using the ratio one toilet unit per 25 students, is 89,4% for boys and 95,6% for girls, which is commendable.

Many households indicated that they would like to have toilets but costs ($2000 per unit) were prohibitive. Funding is predominantly through donor money and Government assistance. It is reported that the majority of donors will stop their support in the year 2001. This is highly regrettable given the present low coverage.

RECOMMENDATIONS

The poor levels of sanitation coverage in the rural areas are a matter of great concern. The Commission feels that this requires priority attention.

A strong awareness programme needs to be put in place and local traditional and political leadership should lead this. Health workers should concentrate on forging partnership with the communities to work out local programmes for the provision of toilets, refuse pits, pot racks and the protection of drinking water sources.

It is recommended that it be made a legal requirement that every household shall have a toilet facility. This requirement to be enforceable by the local traditional leadership.

Mechanisms for funding the universal provision of toilets could include the use of the Health Service Fund. Commission considers that this is an important and justified use of the fund. A participatory system on the lines of the "food-for-work" and the grain loan scheme could be introduced. Such an approach would have the advantage of creating ownership of the project and enhance further appreciation of the importance of toilet facilities.

The Commission has noted with concern that the donor community may abandon this very worthwhile and cost-effective project in the next few years. It is recommended that the MOH&CW pursue further discussions with relevant donors with a view to having the project completed.

The Commission recommends that teachers be encouraged to use the medium of their school children to spread the message about the need for sanitation, hygiene, and toilet facilities in the homes.

Urban Environment

Shortage of water is perpetual in Bulawayo and has recently affected Harare. The Commission was informed that the main factors for the shortage are inadequate finance and technical personnel (Engineers & Technicians).

Pollution of water, air and land is mainly due to industrial waste both chemical and solid particles and to ineffective sewage systems.

The Department of Natural Resources (DNR) has worked on a project to improve management of industrial waste. A 1993 assessment showed that the practice of many local authorities in the management of industrial waste was very unsatisfactory. Another assessment was carried out at the end of 1997, while the results were better than 1993, serious deficiencies remain.

Refuse removal has been inefficient in most cities and towns. There is no regulation or guidelines for safe handling of waste. Although all urban authorities have a high coverage of water borne sewage systems, many of these lack maintenance or are inadequate for the population served. Breakdowns are frequent.

RECOMMENDATION

The Commission recommends that there be clear guidelines on environmental protection and minimum standards to be observed in all urban authorities. The responsibility of formulating these guidelines should be shared among MOH&CW, Ministry of Mines and Environment and Tourism, Ministry of Local Government and Local Authorities.

2.1.7 Occupational Health and Safety

A joint ILO/WHO Expert Committee defined the aim of Occupational Health as "the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations, the prevention among workers of departures from health caused by the conditions; the protection of workers in their employment from risks resulting from factors adverse to health, the placing and maintenance of the workers in an occupational environment adapted to his equipment and to summarize the adaptation of work to man and each man to his job".

In Zimbabwe, NSSA is responsible for Occupational Health and Safety (OH&S) but its activities do not cover civil servants. There are many Acts and Regulations administered by about six Ministries involved in the area of OH&S. There are many laws and the agencies which administer them create fragmentation in the management of Occupational Health and Safety.

The Zimbabwe Occupational Health and Safety Council (ZOHSC) in the national OH&S Council is comprised of 6 members each from Government, employers and workers. MOH&CW departments, which should have input in OH&S, are Environmental Health, Epidemiology, Government Analyst Laboratory, Provincial Medical Directors, Injury Control, Communicable and Health Institutions. The Commission was informed that there is no effective collaboration on the ground among the various bodies to deal with issues of OH&S.

RECOMMENDATIONS

Harmonization of various legislation dealing with OH&S is needed in order to consolidate and reduce the number of Acts and Regulations.

The MOH&CW and its relevant departments be more involved in OH&S in collaboration with NSSA and establish a focal point in the Ministry to co-ordinate research and other activities.

The Public Service Commission must put in place clear regulations governing all aspects of OH&S in the public service work place. Public service workers should be insured against occupational injury and procedures for claiming compensation should be clarified. The Commission views with concern the fact that civil servants do not subscribe to NSSA.

2.2 Clinical Services

2.2.1. Community Level

Village Health Workers (VHWs), mentioned in the first part of this chapter, also play an important role in curative care by assisting in early case detection and providing simple treatments for common illnesses.

2.2.2 Primary Level, Rural Hospitals, RHC/Clinics

These facilities are expected to provide preventive and curative services as the first back up of community based workers. Rural hospitals/RHCs/Clinics are also expected to function as health development units. The number of RHCs and clinics has increased enormously. The distribution is also now more equitable between provinces. Population per clinic ranges from 7 826 in Mashonaland East to 13 119 in Mashonaland West.

The physical infrastructure of rural hospitals most of which were built in 1930s and 1940s are dilapidated and in a poor state of repair. Most of the clinics especially those run by urban local authorities in Harare, Chitungwiza, Bulawayo, Marondera, Mutare were better maintained than those owned by RDCs, Missions and Government. Many centres had problems with availability of electricity, water supply, communication

facilities (telephone, radio) essential equipment, sanitation facilities, security and staff accommodation.

Staff in most primary level facilities was overworked due to shortage of staff and increasing workload. The issue of staff shortage will be analysed in the section on Human Resources. Recommendations will be made on measures to enhance retention of nurses and the introduction of a new cadre, the primary health care technicians, who will be appropriately trained to carry out many of the activities of RHC/Clinics. The workload at a number of busy clinics in some remote parts of the country like Dotito, Mushumbi Pools require additional staff. These clinics should be upgraded to Rural Hospitals. At the same time the Commission noticed that access to services remains a problem to some hinterland populations who have to walk many kilometres to the nearest RHC/clinics. The size of the population and hence the workload in these communities may be too small to meet the criteria to establish a RHC/clinic. While the possibility of using regular mobile clinics in such sparsely populated areas should be explored, the Commission thinks that a more viable and sustainable option is the provision of small facilities (health posts) with lower staff levels than the standard rural health centre. Each household should have an individual file at RHC/Clinic with key data and information on each member of the family.

On capacity building the Commission noted that most staff at RHC/Clinics had recently attended workshops on different problems like immunization, HIV/AIDS etc. However there was no evidence of a systematic programme of continuing education of workers. Secondly, there was no linkage or complementarity between the different workshops, all of which are meant for the same cadre. It was also clear that training programmes were not addressing important gaps in particular improvement of skills in clinical areas, working with communities and management of health centres.

The Commission was concerned by the relative neglect of RHC/Clinics, which had higher status and visibility in the 1980s. These units together with VHWs were seen as health development units that spearheaded the successful Community Health Movement of the 1980s. It was not possible for the Commission to obtain data on trends in allocation of Government resources to RHC/Clinics. The impression the Commission had was that the portion of GOZ expenditure to RHC/clinics was at most static, but more likely declining.

The structure and operation of today's RHC/Clinics has essentially remained unchanged from yesterday's 'clinics'. There were few innovations to see in the field. Organization of work needs to be reviewed so that RHCs provide effective support to VHWs and the Community Health Movement. Outreach and Community support activities should be carried out in their own right and not just when time can be spared. To restore hospitals to their rightful role, RHCs should be strengthened.

Each RHC/clinic should have a plan with objectives, targets, activities, monitoring and evaluation.

Workers in Primary Health Care Units owned by RDCs expressed a wish to have the same basic conditions of service as those in Government institutions. This was prompted by perceived inequalities between government and RDC workers in terms of salary, promotions, working conditions, and conditions of service. **The Commission feels that this is a fair request that should be seriously considered.**

The staffing situation is much better in municipal clinics than in government clinics and staff are more motivated. While most primary level centres made achievements the QA is weak and urgent measures are required to rectify the situation. It was suggested in several places that some municipal clinics should remain open during the night. This measure would serve the public better and reduce congestion at hospitals. Availability of drugs varied a great deal.

RECOMMENDATIONS

Skills at some RHCs with high workload should be upgraded to the same level as rural hospitals.

The Commission was depressed by the state of physical structures it visited many of which are in urgent need of repair. Problems with electricity, water supply, communication, security and staff accommodation need to be addressed.

Health Managers, particularly PMDs and DMOs through a process of learning-by-doing should introduce appropriate innovations in selected RHCs and monitor and evaluate implementation. Such a learning process is essential for improving performance of RHC/clinics. There is little evidence of this periodic assessment of quality taking place in the field.

2.2.3 District and Mission Hospitals

The district is the basic implementation unit for PHC in Zimbabwe. The Government Plan is to have one District Hospital (52-140 beds) per district of 140 000 people. Considerable progress has been made to construct or upgrade District Hospitals in rural areas particularly through the Family Health Projects but there are no District Hospitals in urban areas. This situation has resulted in Provincial and Central Hospitals being used as first referral centres leading to congestion and a fall in the quality of services offered. The demand for additional beds is there and is increasing. At Harare and Mpilo Central hospitals, it is estimated that about 75% of patients presenting are self-referred. This in itself is indicative of the gross inappropriate use of resources in the health sector.

It was depressing to note the poor maintenance of health facilities. Examples include Rusape District Hospital, Mutare Provincial Hospital, Concession District Hospital, Sakubva Hospital Psychiatric Unit, Filabusi District Hospital, Gwanda Provincial Hospital and Kwekwe General Hospital.

The ownership of health facilities as well as with other public buildings is with Ministry of National Housing, which is responsible for their maintenance and receives the relevant Vote. A number of reports in the field emphasize the importance of various ministries working closely with communities. At Concession District Hospital the Commission was informed that a building funded to house and safeguard the generator by the local community had to be pulled down on the instructions of the Ministry of Public Construction and National Housing because it was sub-standard. At the time the Commission visited the hospital the motor of the generator had been stolen. The Commission is pleased to learn that the Maintenance Vote will henceforth be allocated to MOH&CW.

Mission Hospitals play a big role in the Health Services. Donations, both financial and in kind have dwindled to very low levels since Independence, and unless they are rescued they may collapse completely. An example is Chidamoyo Hospital in Hurungwe, which is only able to provide limited services, and the infrastructure is in a deplorable state. Currently there are no formal contracts between GOZ and Mission Hospitals. Many local leaders and communities were not aware of the conditions under which Mission Hospitals particularly designated district hospitals operated. The Commission feels strongly that a clear definition of the responsibility of each partner would improve management and performance of the hospitals.

District Potentials Unrealized

The District is also the basic planning and management unit for the provision of care. The District is the first referral level for RHC/Clinics and provides training, particularly continuing education to district health staff. Issues of staff shortage and poor infrastructure, on the lines indicated above, rightly came out in briefing by health staff. Data on hospital activities such as number of admissions and outpatient attendance, and information on what is being done on preventive programmes were readily available. Information on performance issues such as maternal mortality in the districts, services for expectant mothers at risk, HIV/AIDS activities,occupational health risks, health of commercial farm workers, mental health, environmental sanitation and supply of safe water, tactics to improve the services, the unit cost of services at different facilities and the quality of the patient/health worker relationship was scanty and piecemeal. The Commission observed the deficiency of such information at all levels. This information is crucial. The district team, which is near the population, is best placed to "count" and "account" for failures and successes of health services. Deficiencies in MCH and Environmental Health services are particularly worrying. A number of RHCs and clinics do not provide basic maternity care due to shortage of Midwives.

The Commission is convinced that leadership in districts needs to be strengthened. Strong leadership to link different programmes with one another and with overall District Planning and Management is a must if the potentials of District Health Systems are to be realized. Few comprehensive District Health Plans are available. Many DMOs have not had public health management training. Capacity development programmes for DMOs and district management teams should be a priority. Leadership for district health work

should also be open to suitable health workers with post-graduate training in public health.

RECOMMENDATIONS

In view of the fact that the traditional financial base of the Mission hospitals has dwindled substantially over the years and considering the magnitude of their contribution to the delivery of health services in the rural areas, the Commission feels that funding of recurrent expenditure of Mission hospitals by Government and staffing should be at the same level as that of comparable Government hospitals.

The Commission recommends that there should be formal contracts between the MOH&CW government and churches clearly defining the relationship between the two. The contract should be reviewed at least once every two years. Local leaders, communities and the public in general should be informed of the provisions of the contract. Contracts should include the establishment of Hospital Management Boards.

MOH&CW should give priority to the maintenance needs of institutions. The funds allocated for maintenance should be broken down to institution level so that each institution can plan the priorities of its maintenance needs. Each central hospital and provincial hospital should have a maintenance department. At district Hospital level an efficient handyman unit would be adequate. Excellent examples of how well such a unit can function were seen at St. Michael's Mission Hospital in Mashonaland West Province and at Karanda Mission Hospital in Mashonaland Central Province. A well-trained carpenter, plumber or builder would be the most suitable person to employ for this type of job.

District Hospitals should be built in Harare and Bulawayo in the first instance and with time in other major urban centres. To minimize the cost of developing such infrastructure suitable polyclinics that lend themselves to easy upgrading can be identified. Good examples of such polyclinics visited by the Commission are: Mbare Polyclinic in Harare, Pelandaba Polyclinic in Bulawayo and Sakubva Council Clinic in Mutare.

2.2.4 Provincial Level

Prior to Independence the role of Provincial Medical Officer of Health (PMOH) focused on prevention of disease. After Independence their title was changed to Provincial Medical Directors (PMD) and their role was expanded to include curative and administrative responsibilities. Some public health workers at one of the consultative meetings, organized by the Commission, regretted the extension of the role as this had adversely affected quality of public health and community health work.
All the provinces have a provincial hospital except Matebeleland North. Chitungwiza hospital is not regarded as a central hospital. Most of the provincial hospitals are old except Chinhoyi Provincial Hospital.

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The responsibilities of PMDs at present include:

- Planning, Monitoring and Evaluation of the health delivery system within the Province.
- Supervising of the District Health Teams.
- Organizing training.
- Coordinating health related activities of other sectors including Non-Government Organizations (NGOs).
- Providing adequate logistical and technical support to the district health teams.

The role of the provincial level in carrying out the above responsibilities and strengthening district teams has been carried out well. Many districts now have capacity to plan and manage their services and some people believe that the provincial level may have worked itself out of a job. The provincial hospital should provide specialist services to the districts but currently only one provincial hospital has near adequate number of specialists. The rest of the provincial hospitals do not have any specialists at all.

RECOMMENDATIONS

The Commission recommends the establishment of a provincial hospital in Matabeleland North Province.

The MOH&CW should address the question of shortage of specialists at provincial hospitals.

The Commission recommends that for planning purposes the MOH&CW should regard Chitungwiza Hospital as a provincial hospital. As the population of Chitungwiza continues to grow there will soon be a need for a District hospital which will act as the first referral level. The construction of such a hospital will relieve congestion at Chitungwiza hospital.

Chinhoyi Provincial Hospital is a big, expensive and ultra modern facility, which is grossly under-staffed and under-utilised. The Commission strongly recommends the expansion and upgrading of the other provincial hospitals. It is felt, however, that with the country's limited resources, it is not realistic to use Chinhoyi Provincial Hospital as a model for all the provinces. It is much better to have modest facilities, which function well than expensive facilities, which may prove difficult to maintain. In upgrading these hospitals the bed capacity should be determined by the workload. Special attention should be paid to certain departments, which are totally inadequate at present. The departments include Pharmacy, Laboratory, X-ray department, Rehabilitation department and Mortuary. There is need to explore ways of ensuring that Chinhoyi Provincial Hospital is fully utilised to train all grades of health personnel.

The critical shortage of accommodation for both staff and student nurses at the Provincial Hospitals should be addressed.

2.2.5 Central Hospitals

The central hospitals are the referral centres for provincial hospitals. Except for Ingutsheni psychiatric hospital, the other four central hospitals have teaching status and are affiliated to the University of Zimbabwe Medical School.

It is estimated that 75% of patients presenting at Harare and Mpilo are self-referred. A number of important infrastructure deficiencies exist in the hospitals. The facilities at Harare Central Hospital, Mpilo Central Hospital and United Bulawayo Hospitals are old and poorly maintained. Mortuary facilities are inadequate at Parirenyatwa, Mpilo and Harare.

Problems reported for provincial hospitals, particularly shortage of staff, equipment and over-crowding, also exist at central hospitals.

RECOMMENDATIONS

The infrastructure at Harare Central Hospital, Mpilo Central Hospital and United Bulawayo Hospitals is old and poorly maintained. These institutions are in urgent need of refurbishment. Although Parirenyatwa Hospital is a relatively new institution the effects of poor maintenance are beginning to take their toll. Rehabilitation of these hospitals should include extension of mortuaries at Harare Central Hospital, Mpilo Hospital and Parirenyatwa Hospital and the construction of a Laboratory of UBH and waiting facilities.

All central hospitals should have management boards and these boards should be empowered to hire, fire and discipline staff.

The Commission observed that there are major structural defects in the new Paediatric Hospital and the new Outpatients department at Harare Hospital. These defects which could have been prevented through good tendering award of contracts and supervision should be rectified as a matter of urgency. The Commission hopes that the proposed construction of the new paediatric hospital at Mpilo Hospital will be adequately supervised to avoid similar problems to those at Ingutsheni Hospital.

As a special institution with specific needs, the budget allocation of Ingutsheni Hospital should be fully discussed with the hospital management so those subvotes are adjusted to meet the needs.

Because of the intensive nursing requirements of the patients at St. Francis Home, in Ingutsheni hospital, staff working at this Home should be given a special remuneration package.

2.2.6 Specialized Hospitals and Services

Specialized Hospitals

There are three main categories – Psychiatric Hospitals/Units, Infectious Diseases Hospital and Institutions concerned with the care and rehabilitation of the disabled. The infrastructure at Ngomahuru Psychiatric Hospital is old and unsuitable for psychiatric patients. It is a truly forgotten place. Ngomahuru requires a new psychiatric hospital with new and appropriate accommodation for staff.

At Sakubva District Hospital, the 37-bedded Psychiatric Unit was in a deplorable state. It was depressing to see the broken windows, missing floor tiles, broken door locks, broken furniture, leaking roofs and blocked toilets. **This unit should either be condemned or refurbished as a matter of urgency. It is unfair to expect patients to be treated in such an environment or health professional to work there.**

Ruwa Rehabilitation Centre is run jointly by the MOH&CW and Department of Social Welfare. Ministry of Health runs the 52-bed National Rehabilitation Hospital. The hospital specialises in the treatment of spinal cord injuries, head injuries and cerebral vascular accident patients. The department of social welfare is in charge of the rest of the facilities in the centre, which includes the Orthopaedic Workshop.

The designation of the centre is not clear. It is neither a district nor is it a provincial hospital as it receives patients from all over the country.

In the category of Infectious Diseases hospitals the Commission visited Beatrice Road Infectious Diseases Hospital (270 beds) and Wilkin's Hospital (50 beds) in Harare. The physical infrastructure at both hospitals was in a satisfactory condition. Each of the hospitals had a modern purpose-built mortuary. Although Beatrice Road Infectious Diseases hospital was almost always full, it seemed to be coping. On the other hand, Wilkin's Infectious Diseases hospital was over-subscribed due to its limited capacity. To cater for this increased demand a new block with 50 beds is under construction. The new Genito-Urinary Centre at Wilkin's hospital was mainly designed for training of health workers in the management of Sexually Transmitted Infections (STIs).

RECOMMENDATIONS

A Psychiatrist or at the very least a Government Medical Officer should be appointed to Ngomahuru hospital as a matter of urgency. The absence of a Psychiatrist impacts negatively on service provision. As a consequence certain statutory requirements are not being met, for instance completion of Section 42 forms.

This Hospital has other serious problems. Many of its structures should be condemned. There is need for laboratory to do basic blood tests at Ngomahuru. Currently the Advisory Board does not function. A new Advisory Board should be appointed

To attract staff to a hospital in such a area as Ngomahuru, special incentives should be put in place.

The Commission recommends that the position of Ruwa Rehabilitation Centre be reviewed in order to regularize its functions as a national centre.

The Dental Services

Government, municipalities and private providers provide oral health care in the urban areas. In the rural areas MOH&CW and mission hospitals provide the services. Care is provided in the main by qualified dentists and dental therapists. Dental assistants assist dentists.

There are 149 registered dentists of whom 11 are in public service with 3 posts vacant. All of these have been trained abroad, while the University of Zimbabwe will provide its first qualified dentists in the year 2000.

Twelve dental therapists and 4 dental technicians are provided each year and 170 therapists have been trained since 1983. However there are only 44 posts in Government service (of which 38 are filled) so that most are servicing the private sector.

Dental assistants of whom the 33 establishment is full have no formal training.

The provision of equipment and materials is the responsibility of the GMS. As has been noted elsewhere there have been considerable difficulties in the supply of materials through this channel.

RECOMMENDATIONS

Creation of additional posts and creation or improvement of career structures are required at all levels – Dental Officers, Dental Therapists and Dental Technicians

Dental Assistants should have one year of formal training.

There should be proper consultation between the Department of Dental Services and the GMS before any dental equipment or materials are ordered.

Dental equipment should only be services and maintained by specialised dental equipment maintenance personnel.

Transport must be made available for school dental programmes.

Ophthalmology

There are around 80 000 people who are blind from cataract in Zimbabwe, and an estimated further twenty thousand blind or partially sighted from other causes ranging from glaucoma, through conjunctivitis to injury. Cataract however is the most disabling, yet, despite enormous efforts, the health services have not managed to make any impression on the number of afflicted persons, which has remained stationary over many years. The Commission understands that the treatment of cataract by the surgical removal of the affected lens is now a straightforward technical procedure, and its replacement either by a plastic lens or the provision of glasses restores effective sight. He or she who had to be led around, becomes self-sufficient once again. It is clear to the Commission that the number of ophthalmologists currently in training in Zimbabwe or abroad will be insufficient to make a serious impression on this problem over the next ten years.

The Commission proposes the development of a Clinical Officer (ophthalmic) grade similar to that of the Clinical Officers proposed for general duties. Such persons will be specifically trained for medical ophthalmic work and for cataract surgery. A large number of these officers will be required if this problem is to be attacked successfully and each one will require a support team which it is suggested would consist of a theatre sister/assistant, a nurse aide and driver/general handyman. Teams could tour the area to which they were attached operating in district and mission hospitals where there was an operating theatre, but would bring their own equipment with them. A two-year training program is envisaged for them.

Mental Health Services

The Mental Health Services in Zimbabwe are governed by the Mental Health Act 1996. Over 200 000 visits are made to outpatient departments by the mentally ill annually. The mentally ill persons receive treatments at rural health centres, district hospitals, provincial psychiatric units and at central hospitals.

Some of the problems in Mental Health services include: shortage of nurses and Psychiatrists, delay in processing prisoners who are mentally ill, absence of provincial psychiatric units in Mashonaland Central Province, Matabeleland North and Matabeleland South Provinces. There is no facility for the admission of children with mental health problems.

RECOMMENDATIONS

At least two child psychiatric units need be established in the country to cater for the growing number of abused children and those who are mentally ill from other causes.

Regarding mentally ill prisoners, the Ministry of Justice Legal and Parliamentary Affairs and the Ministry of Health need to form a Committee to come up with proposals to ensure timeous processing of persons in special institutions and in the courts.

There is need to establish Provincial Psychiatric Units in Mashonaland Central, Matabeleland North and Matabeleland South.

There is need to establish two secure psychiatric hospitals for the mentally ill prisoners.

Physical Facilities, Staff Accommodation, Essential Equipment and Transport

The Commission is concerned with the poor condition of physical facilities. Detailed findings of the Commission are outlined in the report. Facilities at rural hospitals and some of the district hospitals visited such as Rusape and Concession need extensive rehabilitation. Specialist hospitals, including Ngomahuru Psychiatric Hospital and Sakubva Psychiatric Unit, most provincial hospitals and central hospitals also need improvements and extensions. The state of some facilities like Gwanda and Masvingo need technical reviews to decide whether rehabilitation or new buildings are needed. Facilities are particularly inadequate for the following functions; pharmacy, laboratory, x-ray and laundry.

The deficiencies reported by the Commission do not constitute an exhaustive list. Secondly the Commission is convinced that some of the health facilities that were not visited are likely to be in as poor condition as those visited and thus need urgent action to prevent deterioration. MOH&CW does not have basic skills to deal with health facility issues. The Ministry relies almost exclusively on Ministry of Construction for technical advice.

Accommodation needs of health personnel has not received priority in the massive development of health infrastructure throughout the country. Lack of accommodation is a major disincentive for staff to accept posting to areas outside the main urban areas. The Commission has developed a document summarizing the outstanding needs of accommodation for mission and government facilities. It is hoped that this document will be an input to discussions with interested parties with a view to obtaining necessary funding.

Equipment is generally inadequate and where available is poorly maintained and supplies such as linen, furniture are worn and in urgent need of replacement. Models of equipment are also quite varied resulting in problems with users due to unavailability of accessories and long down time. The training programme for hospital equipment technicians has been stopped since 1992. Thus there is a serious shortage of trained staff to maintain health equipment.

Availability of transport is a major handicap to the delivery of health services. Many facilities have inadequate fleet of vehicles. Donated vehicles were of different makes resulting in difficulties in their maintenance and repair by CMED.

RECOMMENDATIONS

MOH&CW should give greater priority to rehabilitation and maintenance of health facilities.

MOH&CW should acquire adequate skills to spearhead a programme for maintenance of health facilities and provision of staff accommodation. MOH&CW should have a team of civil engineers and architects at Head Quarters.

MOH& CW should carry out a technical assessment of its health facilities at all levels and develop a plan of action for rehabilitation and maintenance. The plan of action should be developed urgently so that it can be considered along with others in the proposed forum on revitalisation of the health sector to be attended by donors and other partners.

MOH&CW should start an extensive construction programme for staff accommodation. The programme should start at primary care facilities in remote areas and move from there up the referral chain.

There should be a clear equipment policy in the MOH&CW covering essential elements such as procurement, maintenance, upgrading, replacement, inventory and disposal.

MOH&CW should develop a plan for staff development in the area of maintenance of equipment.

The vehicle fleet in the MOH&CW should be standardized to include selected models. The MOH&CW should ensure that adequate funds for transport commitments are allocated to institutions.

2.3 Health Services for Special Groups

2.3.1 The Disabled, Elderly and Other Minority Groups

The Commission reviewed submission from welfare organisations associated with the disabled including: Council for the blind; Epilepsy Support Foundation of Zimbabwe; the Association of the Deaf and the Albino Association of Zimbabwe. The Commission also interviewed representatives of the Albino Association of Zimbabwe and visited rehabilitation centre Southerton and the Homefields in Mount Hampden in Harare and

two homes for the aged (B S Leon in Monavale and Bumhudzo in St Marys Chitungwiza). The Commission finds that the associations are making considerable effort to represent interests of their members.

Problems common to the groups include: inadequacy of funds compounded by delays in disbursement; dwindling of funds from donors; shortage of human resources; drugs, equipment, appliances, transport and accommodation; delays in Customs and Excise department and lack of clear (GOZ and MOH&CW) policy response to address these issues.

RECOMMENDATION

The financial position of many of the institutions is inadequate and GOZ support to some of the institutions needs to be increased substantially. There appears to be no direct coordination between MOH&CW and these institutions on health issues.

The need for a mechanism to coordinate activities of MOH&CW and those of other sectors is discussed in Chapter 4.

2.3.2 Health Care for Commercial Farm Workers

About 20% of Zimbabweans live on Large Scale Commercial Farms (LSCFs). The following issues emerge from the Commission's analysis of health and health care of Commercial farm workers:

A Social Dimensions of Adjustment Survey in 1993 revealed that 12.2% of under fives in LSCFs were moderately to severely undernourished compared to 9.5% in communal areas and 5.7% in urban high-density areas. Diarrhoea is also more common in LSCFs; HIV, TB, Malaria, Injuries and poisoning by agricultural chemicals are important sources of morbidity and mortality in the farms.

Health facilities and schools are few in LSCFS. The mid-term evaluation of the Farm Health Worker (FHW) programme in Mashonaland Province (1995) showed that 61% of farm workers lived more than 20 km from a health facility. Malaria control, water and sanitation and child supplementary feeding programmes concentrate on communal and resettlement areas.

Weak coordination among various actors that provide health services on the farms. MOH&CW, through SIDA funding is responsible for training FHWs but support on the ground is weak. RDCs who are supposed to provide health services on farms lack transport and outreach immunisation services suffer. RDCs can claim for mileage costs incurred on outreach programmes from PMDs. Vaccines are provided by MOH&CW. Some NGOs do work on farms but liaise little with MOH&CW. More recently the Agricultural Labour Bureau (ALB)– a body that represents employers of Agricultural Labour has initiated the Agricultural Workers Welfare Plan which seeks to provide better

housing, water and sanitation facilities, schools and paid health workers on the farms. The implementation of the plan runs until 2007. Finally CIMAS has also proposed to ALB a basic medical aid package for farm workers.

The Commission notes that as of December 1997 commercial farm workers were granted the right to vote in local government elections and can now vote for representatives of their choice. **Inclusion of Councilors from CFAs in the RDCs sub-committee on health and social welfare should be encouraged to enhance better understanding and action on health problems of CFWs.** Other recommendations of the Commission are summarised below.

Future planning by MOH&CW for RHC/Clinics and programmes such as reproductive health, water and sanitation, health education, occupational health and control of communicable disease should address needs of CFWs more seriously.

MOH&CW should play an active role in the development of plans and activities to improve health of CFWs.

GOZ should revise laws that hinder government investment in social services on LSCFs. GOZ should also consider introducing legislation to encourage commercial farmers to be more involved in the provision of health facilities and services.

2.3.3 Substance Abuse

A number of studies indicate that drug abuse is a problem in Zimbabwe. A retrospective study on mentally ill people admitted to Harare Psychiatric Unit showed that in 1980 11% had a final diagnosis of drug dependence. The corresponding figures rose to 21% and 25% in 1982 and 1985 respectively. Another study (1983) on sixth form and UZ students showed that 75% took alcohol regularly and this was also associated with use of cannabis. A larger study on secondary school students in seven randomly selected schools showed that the following main drugs in descending order were abused: alcohol, tobacco, inhalants, amphetamines and cannabis. Existing structures that deal with substance abuse include: The Zimbabwe Resource Centre for Drug and Alcohol Problems funded by Ministry of Social Welfare and ILO; Hospitals and Psychiatric units and NGOs e.g. Alcoholics Anonymous. There was no reported abuse of opium, cocaine, heroin or mandrax.

The Commission thinks that the present structures and activities are inadequate to deal with the increasing problem of drug abuse and that the activities are fragmented and not coordinated.

RECOMMENDATIONS

Health Education and Promotion programmes regarding drug abuse should be started nationally.

Establish/strengthen a coordinating mechanism among various players especially those who have a direct interest in this area including:

Department of Social Welfare
MOH&CW
Ministry of Home Affairs
Ministries of Education
Local Authorities and
Non-Government Organizations
Ministry of Justice and all other Ministries

The Drug Resource Centre should be adequately funded and supported to enable it to decentralize its activities to all provinces and major cities.

2.4 Ensuring Availability of Drugs

The Commission examined three issues namely:

- Availability of drugs and related mechanisms;
- Procurement, Supply and Distribution of drugs;
- Ensuring affordability of drugs.

2.4.1 Availability of Drugs

The Commission found the availability of vital drugs to be 30-50% at RHC/clinic, 50-70% at district hospitals, urban clinics and Mission hospitals. Drug supplies at provincial and central hospitals were better, 80-90% of vital drugs. The Directorate of Pharmacy Services has carried out annual surveys on availability of essential drugs at randomly selected facilities. Findings of the Commission are almost identical to those from the 1998 surveys, with the exception of RHC/clinics where the survey figures are on the higher side, 70%.

The *Zimbabwe Essential Drugs Action Programme* (ZEDAP) which was established in 1984 with the objective of establishing a drug supply system to ensure rational use and availability of essential drugs at all levels of services has had considerable success. A baseline survey done in 1987 identified training needs for health personnel at rural health center level and at the same time the need for reference materials and books was identified. A training manual of 15 modules aimed at improving drug management, clinical skills and utilization of drugs was produced. DANIDA supported development of ZEDAP. In the first phase of ZEDAP 1986-1991, over 5 000 workers were trained using these modules. The Commission feels strongly that ZEDAP is doing a good job and deserves continued support to address persistent and new problems hindering universal availability of drugs.

Zimbabwe has a strong National Drug Policy (ZNDP) consolidated in 1994. The overall goal of ZNDP is to improve and sustain within available resources, the health of the population of Zimbabwe by treating, curing, reducing or preventing diseases and conditions through the use of safe, effective, good quality and affordable essential pharmaceutical products.

The National Drug and Therapeutics Policy Advisory Committee (NDTPAC) developed the Proposed Essential Drugs List (PEDLIZ) in 1981and in 1985 the Essential Drugs List (EDLIZ) and a revised list in 1994. It is currently working on a list for 2000.

The Drug and Toxicology Information Service (DaTIS) was established as a unit of the Department of Pharmacy in the Faculty of Medicine at University of Zimbabwe to provide information service on medicines, drugs and poisons on a 24-hour-7-days-a-week basis. Medical staff and any person in Zimbabwe can request information on different aspects of drugs such as economy in the use of drugs and treatment of poisoning.

The Medicines and Allied Substances Control (General) Regulations prescribe categories for distribution of medicines. There are Dangerous Drugs or Narcotics, Prescription preparations (available on prescription of Medical or Veterinary Practitioner), Specially Restricted Preparations (only available from 7 public hospital pharmacies laid by regulations), Pharmacist Initiated Drugs, Pharmacy Drugs, Household Remedies, Prohibited Drugs and Veterinary Medicines. There is now need to review the classification in light of the expansion of health services to allow more access of health facilities by the community.

The Medicines Control Authority of Zimbabwe (MCAZ) has the responsibility to ensure the availability of safe and effective medicines on the market for human and animal consumption. This is achieved through the control of the manufacture, distribution, storage and dispensing medicines. All drugs imported and used in Zimbabwe must be registered. The process can take 3-12 months due to staff shortage and poor quality of information supplied for registration. MCAZ has developed a corporate strategy and business plan, which addresses management and operational weaknesses.

Pharmacy Services in MOH&CW: Following a policy decision to commercialize Government Medical Stores (GMS) –a decision which the Commission fully supports-- and the creation of MCA with authority to recruit and pay their own staff, it is essential to redefine the role of the Directorate of Pharmacy Services. There is a serious shortage of Pharmacists in MOH&CW. For example, the Ministry planned to have 198 Pharmacists by 1997, but now they have only 59 established posts out of which only 37 are filled.

The Commission finds that Zimbabwe has good National Drug Policies and appropriate mechanisms to enhance implementation. Zimbabwe also spends a high portion of its public health expenditure on drugs. The Commission is convinced that staffing, management and procurement problems are the main causes of drug shortages.

2.4.2 Procurement, Supply and Distribution of Drugs

The Government Medical Stores (GMS) has the responsibility for purchase, storage and supply of medicines and other products to public health institutions and other approved institutions. The Commission found a number of issues at GMS, including shortage in number and capacity of staff in all departments, delays in the audit of accounts and continuous computer breakdowns.

The process of procurement by tender has problems at practically all stages. Accurate quantification of the amounts of drugs needed is difficult because of the ever increasing consumption due to the AIDS epidemic and lack of morbidity data in a format that can be used by GMS. Data on drug needs of institutions is often inadequate. Other problems include the length of the bidding process, length of time needed to register drugs which have been awarded a tender, delays in payment of local suppliers and the limit of Z$150,000 for informal tenders which is too low for GMS and health institutions. On the payment of suppliers, the Commission was informed that external suppliers are paid 90% of the contract price on shipment of goods and in hard currency, whereas local suppliers are paid in local currency and only after delivery, sometimes as late as over 120 days. The Commission agrees that the current procedures discourage local industry from supplying GMS. The commercialization of GMS may improve its efficiency.

RECOMMENDATIONS

GMS staff should be systematically trained in the use of the International Competitive Bidding (ICB) and other procurement procedures.

GMS should develop a database in which information on performance for each supplier is systematically archived. A supplier with poor performance, with regard to the quality of the product or with regard to delivery, should be disqualified for participation in future tenders and should be informed of such a decision. Monitoring of companies is crucial, particularly if the restricted tender with pre-qualification system is adopted.

The Commission recommends that as per the recommendation of a management consultant, a GMS Procurement Committee should be established which would take over the activities and the responsibility of procurement from the GTB in order to reduce the lead times significantly. This committee would comprise GMS board members, staff members and relevant professionals, whose numbers and levels of involvement would depend on volumes and frequency of purchases, number of suppliers, and the types and efficiency of systems in place.

Government Tender Board (GTB) should revise its tender document to define well who qualifies for domestic preference. GTB should increase the domestic preference under its tenders. This may stimulate local industry.

GMS should be allowed to request bids from all bidders in any stable currency.

A local agent who bids for a tender must have a letter of authority from the manufacturer. The GMS tender document must include a clause, which requires a bid security.

2.4.3 Ensuring Affordability of Drugs

Prices of drugs have increased considerably, more than double in some items in 1998. The massive drug price increases seen during the life of the Commission have been mainly due to the devaluation of the dollar. The Commission analyzed a number of measures that can be taken to ensure that the price of drugs remains affordable.

- Generic prescribing and dispensing leads to economic savings. ZEDAP policy is that generics should be prescribed where possible, but reinforcement of the policy is minimal. In fact, non Essential Drug List in Zimbabwe (EDLIZ) prescribing seem to be allowed for some public sector institutions like the Army. Generic prescribing in the private sector is not widespread.

- Mark-ups are currently determined by market forces. The levels at present are manufacturers 25-80%, wholesaler 20-35% and retailer 40-50%. Anti-retrovirals have only a 10% mark-up (but still the cost-to-end-user is exorbitant). The mark-ups need to be reviewed from time to time by all involved.

- Customs duty is levied on supplies to the private sector and not on those for the public sector. The Commission's view is that drugs and medicines on EDLIZ, HIV drugs, ostomy and related products that replace or augment body functions should be duty free. This measure will reduce the average price to end-users by about 18%.

- Some multinationals insist that their finished products be sourced from one country only, often South Africa. The same product, which would have been charged duty and levies in South Africa, will be charged duty again in Zimbabwe when re-exported from South Africa. Some of the medicines can be procured at half to a third of the current landed costs if imported directly from the source of manufacture.

- Registration fee with (MCAZ) for imported drugs is US$1 000 and yearly retention fee is US$600. The corresponding charges for locally produced drugs is Z$1 200 and Z$800. The registration and retention fee is apparently considered high, particularly with "orphan drugs" whose sale is slow and therefore some multinationals end up de-registering the product. These products when needed later have to be procured at a higher premium through a wholesaler.

RECOMMENDATIONS

The Commission recommends that all drugs and raw materials for drugs in EDLIZ be exempt from customs duty and that the Secretary for Health Code (SHC)

number for exemption be re-introduced for those drugs not in EDLIZ and for other essential products e.g. ostomy and orthopaedic products.

There should be more dialogue between MCAZ and NPCZ and the Dept. of Pharmaceutical Services on drug registration costs and retention fees for "orphan" drugs to ensure the continued availability of these products.

Mark-up policies and practices should be reviewed regularly.

The Commission subscribes to and fully supports the privatization of MCAZ. However there is a need to ensure that the skills and the quality of personnel are adequate.

There should be dialogue and negotiation between doctors, pharmacists, clinical officers, HPC, MCA, nurses and other stakeholders to define parameters for the quality control and dispensing of drugs. Nurses in private homes should only prescribe and dispense drugs that they are legally allowed to do so.

The Commission recommends that where possible MCAZ should encourage companies to register more than one source of supply of their drugs, so that the best possible price can be obtained.

CHAPTER THREE

HUMAN RESOURCES

The backbone of any Health Service is its staff. Most staff interviewed by the Commission felt that the ongoing Health Sector Reforms being carried out by MOH&CW are concerned with organizational and financing issues but paid little attention to staff.

The main findings of the Commission are summarized below under the following headings:

- Availability of information
- Staff Supply
- Conditions of Service
- Personnel Management
- Training
- Ethics/Discipline among health workers.

3.1 Availability of Information

The Commission was very concerned about lack of readily available accurate information on the health workforce. Occasionally, the Commission had to resort to contacting Provincial Medical Directors and individual hospitals to obtain data that should be readily available. The Commissioners spent considerable time trying to verify and make sense of the data provided, but it is possible that a number of errors still remain in the data included in the report. The Commission could not find centralized data for staff in local authorities and the private sector. This data is of vital importance for planning, both within the MOH&CW and in the health sector as whole.

RECOMMENDATIONS

The Commission recommends that MOH&CW utilises available staff/posts in Personnel Department, of which there are 26, to install an efficient Personnel Information System and invests in suitable computer hardware and software and provides appropriate training for staff.

The MOH&CW should collect accurate statistical health information from the public sector, local authorities and the private sector to facilitate monitoring of the entire health field.

3.2 Staff Supply Pool and Planning

The number of professionals registered by the Health Professions Council (HPC) has increased over the years. For example, the HPC Register shows that nurses have

increased from 9533 in 1985 to 16 407 in 1997 and Medical Practitioners from 1058 to 1634 during this period. The MOH&CW in its Health Human Resource Master Plan 1993-97 established staffing norms for each category of staff for all health facilities and institutions) and then worked out yearly targets for all staff. Table 3.1 shows the 1997 targets for four cadres namely doctors, nurses, pharmacists and dentists.

Table 3.1. Total number of health workers on register (1997), approved posts in MOH&CW, filled posts, and % target posts filled.

	Number on Register	MOH&CW Target (1997)	Approved posts	Filled posts	% Target Posts Filled
Doctors	1634	1851	676	551	28,7%
Nurses	16 407	14 251	7923	7923	55,6%
Pharmacists	524	198	59	37	18,7%
Dentists	148	43	14	14	32,6%

A number of conclusions can be reached from the table. Firstly, not only have the 1997 targets in relation to the recommended posts not been achieved but there are vacancies in established posts. Secondly, even the total pool of registered doctors (1634) was insufficient to meet the targeted needs of MOH&CW (1851). At the same time, there were only 676 established posts and only 551 filled. This reflects the inability of Government to provide adequate posts and of MOH&CW to attract and retain doctors. Thirdly, the table confirms the Commission's observations in the field that there are serious staff shortages. For example, while the staffing norm for RHC/Clinic is given as four nurses, one environmental health technician, two nurse aides and two general hands, the Commission found a number of clinics with only one nurse, or staffed entirely by a nurse aide. The Master Plan had envisaged that 60% of all newly qualified doctors would be sent to provincial and district hospitals until all posts available are filled by Zimbabweans. Data for 1998 is not available but by 1995 over 60% of doctors working in provincial and district hospitals were expatriates.

To understand the extent of staff shortage, which is no doubt one of the most serious concerns of MOH&CW and the public, the Commission looked at adequacy of the projected numbers of staff, using nurses as a benchmark. The Commission then looked at the adequacy of the current planning process and plans for tackling the problem of staff shortage. Prior to 1992, there was an annual output of 550 SCNs and 360 SRNs. In 1992 the training of SCNs was discontinued. By 1997 the SRN training schools had increased to 14. As a result there was a significant increase in the intake of students in the SRN training schools. However estimates indicate that despite the increased intake, shortage of nurses will continue and only 53,7% of the nurse requirement will be available by the year 2008. The Commission considers that in the context of such a scenario, the cessation of the SCN training course before adequate replacement by SRN training capacity reflects a serious error in planning on the part of those responsible.

The Commission learnt in the field that the training programme for laboratory technicians had been abolished and that the training programme for X-ray operators was threatened with abolition. At one Mission hospital, the Commission was told that blood transfusion could not be carried out because the only laboratory technician available to do cross matching had gone for upgrading and was unlikely to come back. The hospital could not get a replacement as the training programme was abolished. The Commission fully understands the desire and pressure of professional associations to improve the lot of their members, but the MOH&CW and PSC should ensure that in responding to these desires, the needs of the public are fully safeguarded.

Staff Mix

Next the Commission looked at the staff mix in Zimbabwe. A good staff mix is one that is able to achieve maximum improvement on health services and level of health at a given cost. The Commission was informed that current plans do not indicate what proportion of doctors should be specialists/consultants in MOH&CW. Within the MOH&CW, the ratio of doctors to nurses is 1 to15. Whilst, there is no accepted "standard" this ratio is high compared to other countries. For example the ratio for Africa is 1to5 and 1 to 1,5 globally. If the 1997 targets had been achieved the ratio between doctor and nurses would have been 1 to 8, but they were not. These figures provide further evidence of the serious shortage of doctors in MOH&CW.

The main finding of the Commission in the area of staff mix is that there is need to increase the pool of doctors. Other measures proposed by the Commission include increasing the intake of nurses as much as possible and strengthening the role of clinical officers and nurse aides (see later).

The Commission believes that priority in human resource development should be given to meeting needs of district health systems, in particular the communities and RHCs. Failure at this level means failure of the totality of the health system. A new cadre, the PHC worker to strengthen work at this level is proposed. The VHW plays a crucial role in promoting health at this level, and their activities were discussed in the previous chapter.

Nurse aides

Nationwide the ratio of nurse aides to nurses is approximately 1:5. It has been shown above that over the next years the output from the nursing schools will not be adequate to maintain numbers as they are at present and with the expected increase in the number of patients attending hospital, the imbalance will become greater. The Commission has been informed that the nursing profession is proposing that the nurse aide be known as a care assistant. Traditionally, nurse aides were recruited from the ranks of the general hands and given "on-the-job" training. The Commission feels that this is not satisfactory particularly since the grade of state certified nurse no longer exists. It has been noted that the "Red Cross" is producing numbers of young persons with a three-month course and the possibility of these young people, with appropriate orientation, moving in to alleviate the staff shortage should be examined among other options.

RECOMMENDATION

The grade of nurse aide will have to be greatly expanded and the training formalised with the goal of reaching 1 nurse aide to 3 nurses. This means that the establishment of nursing aides must be increased accordingly.

Primary Health Care Technician

The Commission devoted much thought to the staffing of the rural and urban clinics and to the necessity of ensuring that they are adequately serviced. Throughout the health service there is a severe shortage of medical personnel. During the field visits the Commission observed that this shortage was critical at the RHCs/Clinics. The shortage of trained staff at this level of care deteriorated further when the SCN training was discontinued in 1992. As a result the RHCs/Clinics are now heavily dependent on the Registered General Nurse. This cadre is in great demand, there being a shortfall of 1800 vacancies on the RGN establishment at present.

Although steps are being taken to increase the production of RGNs, the Commission realises that given the demand for this cadre on the market it will take a long time for the training institutions to satisfy the requirements of the public health sector. The Commission has also observed that like other more highly trained health workers, RGNs are not willing to work at Rural Health Centres/Clinics. **In view of these problems and the fact that the work at the RHCs/Clinics requires a specific set of skills of promotive, preventive and curative care rather different from the skills of the more clinically trained RGN, the Commission proposes the introduction of a new grade of health worker to be called the Primary Health Care Technician whose job will be mainly related to Rural Health Centre/Clinic and outreach work. A two-year course of training is suggested. The Commission feels that the MOH&CW should aim to produce at least 2 000 such personnel in a relatively short time.**

Clinical Officers

Owing to the shortage of doctors a considerable amount of medical work in rural areas has had to be undertaken by nursing staff for which they were only partly trained. Clinical officers have received additional medical training needed to provide a wider range of treatment to patients. The Advanced Clinical Nurse course was commenced at Mpilo Hospital in 1976. The title of Advanced Clinical Nurse was changed to Clinical Officer in 1980. The Commission understands that at present there are 76 such qualified persons. The Commission identified a number of issues that needed urgent action. These include lack of career structure, lack of proper legal recognition of their status and the small number of Clinical Officers in relation to need. On the latter, **the Commission believes that intake should be increased to produce adequate numbers of Clinical Officers for district, mission and rural hospitals.**

Staff Distribution

Table 3.2 shows that distribution of staff between different levels is very much based on tradition. In 1981, 66% of doctors were in central hospitals and 13% in district hospitals. The corresponding figures for 1998 are 67% and 15%. The Commission understands that there has not been a systematic review on the allocation of staff to central, provincial and district hospitals.

Table 3.2. Distribution of Staff by Level of Service, 1981 and 1998

	1981	1998
% Doctors at:		
Central Hospitals	66%	67%
Provincial Hospitals	13%	10%
District Hospitals	13%	15%
% Nurses at:		
Central Hospitals	34%	38%
Provincial Hospitals	21%	16%
District Hospitals	15%	26%
RHCs	17%	13%

The Commission considers it essential that such reviews, which will enhance efficiency and equity in the allocation of resources, be undertaken.

The Human Resources Master Plan has not been taken seriously. For example, monitoring and evaluation of its implementation accompanied by the introduction of corrective measures has not been done. Training is haphazard, often based on reaction to vacancies. The Commission believes that this unsatisfactory situation is due to weakness and low priority given to human resource planning and management. There has not been a manager for human resources for long periods. There is now a human resource manager recently appointed, but this is a donor-funded post for 3 years only. Consultants have been deployed on several occasions to provide advice on a number of issues but lack of a strong Programme Manager in human resources to directly work and follow up on recommendations has limited their usefulness.

RECOMMENDATIONS

The Commission recommends that MOH&CW should develop a realistic and costed Master Plan for Human Resources Development as a matter of urgency in order to address the manpower and skills mix required in view of the current staff shortage. Staffing norms should be based on locally developed standard workload as well as task analysis and assignment of roles and responsibilities at various levels.

The Commission further recommends that MOH&CW should strengthen its work in planning and management of human resources. The programme should be much more visible and headed by a suitably trained, experienced and competent manager. Posts for the manager and supporting staff should be established.

MOH&CW should increase intake of nurses as much as possible, create more vacancies for RGN training schools and maximize the use of available manpower. The Commission recommends that the current programme for upgrading SCNs to RGNs be reviewed, so that it is focused to fill the gaps that existed in the SCN training programme. It is further recommended that a system of residential sessions for theory be combined with relevant practical attachments. This system will ensure that a student continues to work at her/his station during the upgrading exercise.

The MOH&CW should consider expanding the number of clinical officers and making more use of this cadre at district and rural hospital levels. It should also revisit the existing policy concerning the role of the clinical officer and ensure that the career structure and status is clearly defined throughout the service.

A new grade of health worker to be called the Primary Health Care Technician should be introduced in the health service. The activities of this cadre will be mainly related to rural health centre/clinic and outreach work.

The MOH&CW should increase the number of nurse aides in the hospitals to relieve the shortage of nursing staff and to take responsibility for tasks that could be delegated. The Commission suggests that a ratio of one nurse aide to every three nurses would be a reasonable balance. The MOH&CW should also review the current job description for nurse aides and develop a standard national curriculum for this category. Training of the nurse aides should be conducted by individual hospitals with the District hospital taking responsibility for the training of nurse aides to work in the health centres.

The MOH&CW should reinstitute a training programme for laboratory technicians aimed at preparing them to work at district hospitals, mission hospitals and some rural hospitals.

The Commission strongly recommends that the course for X-ray operators should be considerably expanded to meet the needs of the mission hospitals and district hospitals. It is further recommended that a proper establishment and career structure for this cadre should be worked out by the MOH&CW and proposed Health Services Commission.

The Government should take urgent action to increase the pool of doctors by having an effective recruitment and retention policy, enhancing the capacity of the current Medical School and establishing a second medical school in Bulawayo.

Right skills mixture is needed to create well-balanced teams for patient care, financial management, information system management, data analysis and administration. However, the achievement of the right skills mix of professional

staff is dependent on the ability of the MOH&CW to offer competitive remuneration packages.

The Commission recommends that MOH&CW establishes an Advisory Board with representatives from training institutions and individuals with skills and experience in human resource development and management to oversee the packages of recommendations. The proposed Health Services Commission or its Sub-Committee could carry out this function.

3.3 Conditions of Service

During the Commission's consultations with the various health employees, poor salaries, inadequate accommodation, poor conditions of service, bad personnel management and a non-conducive work environment were cited as contributory to the current poor morale in the public health sector and causing the high attrition rates of professional staff and making it even difficult to attract staff. It soon became clear that many of the problems are beyond the immediate control of the MOH&CW. All employees of the MOH&CW are currently public servants and are subject to conditions of service determined by the PSC, which controls the establishments of posts, defines salary scales, allowances, advancement and promotion opportunities. Budget allocations are defined by the MOF. This limits the ability of the MOH&CW to introduce practices which might encourage recruitment and retention of staff and improve efficiency. It is for these reasons that the Commission has recommended in Chapter 4 that the above functions should be decentralized to MOH&CW and Health Service Commission.

In a recent survey, over half of the staff who had left MOH&CW gave poor salaries, allowances and conditions of service as the reason for leaving. About half of MOH&CW staff who have considered leaving gave the same reasons. The decline of salaries in real terms and the inability of Government to provide other incentives and allowances have led to low morale among the workforce and little desire to serve beyond the normal duty.

The Commission has examined current and proposed salaries for the medical school at the University of Zimbabwe; salaries for health workers in neighbouring countries, such as South Africa, Namibia and Botswana, as well as cost of living and the income of health workers in the private sector in general. The Commission found that the salaries in the public sector were grossly uncompetitive. For example, in South Africa a newly qualified doctor earns more than the most senior doctor in Zimbabwe does. The Commission believes that the salaries of all health workers should be reviewed upwards and has made recommendations to that effect.

In 1996-97 the Public Service Commission conducted a Job Evaluation exercise for all civil service staff to determine an appropriate grading system in the service. The resultant grading exercise left some staff groups disgruntled and feeling that their worth was not properly evaluated.

Staff expressed concern about the level of allowances, particularly for night duty. Common sources of income supplementation for health workers are in the form of allowances such as on call, standby, uniform, housing, travel and night duty allowances, which are considered inadequate and are a major cause of dissatisfaction among the health workers. Furthermore, long delays in the payment of allowances was a constant complaint and non-payment of transport and allowances for journeys on duty within a 20km radius of the base was a continuing source of annoyance. The Commission feels that levels of allowance should be reviewed upwards.

Overtime, part-time and locum working arrangements are not allowed for many health workers by PSC regulations. At one poorly staffed district hospital, the Commission was told of loyal staff members who from time to time have no-one to replace them at the end of their duty period. These members of staff remain on duty until someone comes to take over, yet overtime pay was not even possible in these extraordinary circumstances. The idea that "time off" could be taken in its place is not valid because it is the lack of staff, which provoked this situation in the first place. It was hard to understand how the PSC regulations could be so narrow as to prevent remuneration for this generous act. The demand for the right to do "locum or overtime duties" was a constant one. Some staff felt that rather than go to do entirely different work, nurses should pursue the profession for which they are trained by doing "locum" duties in the hospital in which they work in or any hospital of their choice when extra staff is needed. The question at issue is whether the health service is willing to employ its own staff part-time or sessionally.

The Commission considers that granting of this permission would be of benefit both to the hospitals and the staff concerned. Other countries have such schemes whereby they have a "Pool/Bank" of staff they can call on when needed. If these mechanisms are explored they may alleviate some of the staff shortages in critical times. This is allowed for doctors who supplement their salaries with private practice or locum duties. While the Commission feels that this should be permitted in the short term, there needs to be recognition that staff should not be allowed to work excessively long hours.

Health workers have been complaining about administrative delays in the processing of their papers and the decision making process. Some of the delays relate to the processing of grievances, salary adjustments, allowances and promotion or advancement. This situation is made worse by the inefficient information management system within the MOH&CW and also the communication problems between the stakeholders especially PSC, Salary Service Bureau and the MOH&CW. In addition, the administrative workers are not provided with adequate resources and training for them to efficiently and effectively execute their duties.

Nurses complained of not having flexible working arrangements so asto spend time with their families, especially nursing mothers. Unsocial hours put staff at risk especially those travelling home at night and the Ministry has no provisions of transport for staff. There have been reports of nurses being assaulted whilst travelling to and from work at night.

In terms of recruitment, promotion and dismissal, the Commission was informed that PSC had delegated the responsibility for recruitment and dismissal of all staff below the level of Assistant Secretary to the Ministry. There was, however, very little evidence of this happening in the field as various managers complained of staff shortages and blamed PSC for not having given permission to recruit staff. This indicated lack of clarity on the recruitment policy.

Staff in the field complained to the Commission of unfair practices in terms of appointment and promotion. Promotion opportunities are limited because promotions tend to be within professional categories. The current practice of promotion based on length of service is not necessarily the best way of getting the right person for the job. Rehabilitation technicians and environmental health technicians stressed the lack of any career path for them. Laboratory technologists cited the very small number of senior posts in their field in MOH&CW.

RECOMMENDATIONS

From this extensive review, the Commission is able to propose realistic salary increments that will be able to attract and retain staff. The table shows the present salary scales and those recommended by the Commission.

Table 3.3. Recommended Basic Monthly Salaries for Health Workers in Grades IV to XVIII (July 1998).

Grade	Current Basic Salary (ZWD)	Proposed Basic Salary (ZWD)
IV	16 274	40 050
V	15 439	35 910
VI	14 101	30 673
VII	12 973	26 520
VIII	11 488	23 205
IX	9 748	20 443
X	8 450	18 255
XI	7 012	14 222
XII	5 491	9 116
XIII	4 798	6 030
XIV	4 212	4 548
XV	3 203	4 171
XVI	2 284	3 140
XVII	1 848	3 018
XVIII	1 462	2 301

The Commission recommends the urgent review of the grading system and evaluation of personnel by an appropriate authority taking into account the peculiarities of their functions and responsibilities.

The Commission recommends that the night duty allowance, which was considered a compensation for all staff and other allowances should be reviewed in line with market levels and be paid timeously.

The Commission recommends that the Ministry should make suitable transport arrangements to and from their place of work for staff members who work unsocial hours and be gender sensitive and allow flexible working arrangements for nursing mothers and fathers in special circumstances.

The Ministry needs a comprehensive and transparent recruitment policy which covers all aspects of recruitment including clear procedures to be followed from the time the position becomes vacant until a person has been appointed. Promotions should be based on performance and the ability to do the job and should not be based on length of service only or on inappropriate criteria.

3.4 Personnel Management

Many complaints were received by the Commission on the management style of MOH&CW, particularly regarding communication, performance management and industrial relations. **The Commission believes that the challenge for the Ministry is to create an open consultative management style that establishes relationships of trust among health workers, service users, institutions and their managers. Participation of health workers in the planning and decision – making process will give legitimacy to the objectives and priorities of the service and will stimulate the desire to work towards a common goal.**

Management at various levels of health services is weak due to poor conditions of service and inadequate management skills. Granting of permission to civil servants to engage in private practice has worsened the situation because nobody seems to be accountable to anybody and there is no effective supervision.

It is increasingly difficult to attract and retain senior experienced or well-qualified staff at MOH&CW-HQ due to low salaries. There has been a rapid turnover of senior doctors at HQ, many leaving to join international organizations where conditions of service are much better. The Commission is convinced that this rapid turnover leading to lack of continuity and loss of experienced staff at a time when MOH&CW is facing serious problems is one of the key reasons for the current decline in health services.

Hospital authorities do not exercise effective supervision of professional staff – nurses, doctors, pharmacists, physiotherapists, dentists, radiographers and others. At central hospitals, many consultants and specialists from both MOH&CW and the Medical School spend more time doing private practice than government work. According to PSC, doctors are only allowed to do part-time private practice outside working hours and during agreed working hours for some. Most medical superintendents and heads of 0departments do not exercise their supervisory powers adequately. Most of them are

engaged in private practice themselves. Not only do they not provide adequate supervision but some even go as far as employing junior staff as locums in their private surgeries. Other doctors, private practitioners and consultants engage in the same illegal practices. The absence of consultants at the central hospitals also affects service delivery. For example people referred from the districts to see consultants end up seeing a junior doctor who may be less experienced than the one who referred the patient.

Some junior doctors who do not have Open Practicing Certificates and therefore cannot do private practice nonetheless leave hospitals during their normal working hours to do locums elsewhere. Besides reneging on their primary responsibility they render such service illegally and without adequate training. Poor supervision and the lack of good role models have caused this. In the teaching hospitals teaching and supervision of students is compromised.

The Commission has received several allegations regarding the misuse of hospital services:

- Abuse of theatre lists where surgeons include a majority of private patient specimens at the expense of non-private patients.
- Abuse of laboratories where technicians will examine private patients specimens and pretend that the tests were done at a private laboratories and collect payments for themselves.
- Disappearance of drugs from pharmacies, loss of equipment and other irregularities in other departments.

Many of the problems encountered at the head quarters are also found at provincial level. The PMD's offices have been accused of sluggish decision making, slow processing information and ineffective supervision.

At the district level there is also inadequate supervision. The DMO doubles up as district medical officer and superintendent and hence may have difficulty in supervising staff at the hospital and the periphery effectively. Some District Medical Officers are increasingly being attracted to private practice often at the expense of public health services. In one district the public complained of a DMO who was supposed to be in-charge of services in the district and the hospital, but was hardly ever available in the hospital. Apparently the only way to be sure of seeing him even during normal working hours was to go to his private clinic. The PMD is not able to monitor daily activities in the districts.

Furthermore, the roles between matron of the district hospital, community sister and district nursing officer are not clear. In many hospitals there is confusion as to who is in charge of the district nursing services when the DNO is on leave. The chain of command needs to be clarified.

At the RHC/Clinic level, there is lack of effective supervision by the DMO, DNO and community sister due to lack of transport. The staff at the RHCs make their own duty

rosters and there are reports of some staff covering up for each other whilst they take unauthorized leave days.

In making recommendations on these matters, the Commission observed that many of the current managers do not have management qualifications and skills. The Commission is convinced that to revitalize health services new leadership and a management culture that enforces discipline and takes accountability seriously has to be created.

RECOMMENDATIONS

The Commission recommends that a core of key administrative, professional and senior technical staff be identified and adequately remunerated. These will work full time for the MOH&CW and not do private practice at all. It should be appreciated that the needs of individual institutions and departments will not always be the same. The definitive number of core posts in each institution will be worked out by the local administration in consultation with the MOH&CW and the proposed Health Services Commission (see Table 3.4).

Any private practice by full time employees of the MOH&CW who are not occupying one of the key posts can only be done outside working hours and with the express permission of the Hospital Administration/Management Board who will reserve the right to withdraw such permission if the priviledge is abused. Adequate mechanisms to monitor such private practice should be put in place.

In the clinical departments, a head of department will be appointed from among the core group of specialists. The head of department will get an extra allowance for carrying out administrative duties and supervising both full time and sessional consultants and maintain discipline in the department.

All health workers who form part of the core group should be employed on a performance contract of 4 to 5 years. A worker who fails to meet the obligations of his/her contract will be informed by the hospital administrator of the intention not to renew the contract 6 to 12 months before the contract expires.

Adequate remuneration packages should be put in place for sessional consultants or part-time specialists who work in public institutions. The head of department and the clinical director will closely monitor the activities of sessional consultants in central hospitals. Similar mechanisms should be worked out at the provincial hospitals.

The MOH&CW should ensure that every health worker (including those already in service) signs a specific contract on a specified date to ensure compliance and any breach leads to disciplinary action and possible termination of employment. In the past the system relied on honour, respect, good will and integrity. The situation has changed so dramatically that now a clearer legal instrument is required.

Table 3.4. Suggested List of Core Workers

Institution Level	Key Personnel		Number
PMD	Provincial Medical Director		8
Provincial Hospitals including Chitungwiza (N= 9)	3 Administrative staff (Superintendent, Matron and Administrator) 2 Specialists (Surgical and Medical) 4 Support staff (Pharmacist, Radiographer, Physiotherapist and Lab Technologist)		81
Central Hospitals (N=5) Harare Central Hospital	**Administration (5)** **Support staff** Chief Executive Chief Pharmacist Clinical Director Radiographer Financial Director Director Operations Physio./Rehab. Matron Chief Laboratory Technologist	**Specialists*** Medicine (2) Surgery (2) Radiology (2) Paediatrics (2) Pathology (2) Obstetrics (2) Anaesthetic (2) Psychiatry (2)	27
Mpilo	As for Harare (-1 Psychiatrist, +1 Radiotherapist)		27
Parirenyatwa	As for Harare (-1 Radiotherapist, +1 Ophthalmologist)		29
UBH	As for Harare (-1 Psychiatrist, +1 Ophthalmologist)		27
Ingutsheni	3 Administrators Superintendent Matron Administrator	1 Specialist 1 Pharmacist 1 Physio/Rehab	7
Dental Services	1 Director 1 Deputy 1Bulawayo 1 Harare 8 Provinces		16
Districts (N= 57)	1 DMO DNO Matron Lab	1 Chief Executive Pharmacy X-ray	110
Total			**332**

*In those departments where distinct specialities exist, the local administration in conjunction with the MOH&CW and the Health Services Commission should appoint core personnel accordingly.

Injury and Sickness Sustained on Duty

The Commission was concerned about the responsibility of employing authority for its servants who are injured or sustain an infection while on duty. It was observed that not only was there inadequate knowledge about reporting procedures to be followed in cases of injury, but also a clear policy in relation to infection was lacking.

The Commission recommends that a well-laid out policy to be followed by any person who has suffered a possible infection or injury in the line of duty must be formulated and publicized for all staff to see. If a staff member chooses to ignore the protocol then he/she would abrogate the right to compensation. The protocol and open acceptance of responsibility for disease contracted on duty must be widely acknowledged and publicized so that all staff members know their rights and responsibilities.

The Commission recommends that a clear communication policy for the Ministry be devised. There should be regular production of Lifeline magazine (MOH&CW magazine) as a means of keeping staff informed of developments and a channel for staff to make contributions. Information from the centre should be distributed systematically to reach all staff. MOH&CW should ensure that all staff has access to information on conditions of service.

The Commission recommends that the Ministry should have a performance evaluation/appraisal scheme relevant to the health work force. This would be based on regular planned supervision sessions between the employees and their managers to review progress, difficulties and achievements and records of such meetings kept. This would ensure that there are proper records of an employee's performance especially in cases where performance related pay is involved, or in cases of poor performance and/or disagreements.

The Commission recommends that the Ministry should have clear and non-threatening grievance procedures and initiate health workers committees so as to involve workers in the decision making process. Complaint mechanisms should be established at all institutions to deal with staff grievances locally through a disciplinary and workers committee.

3.5 Training

While the quality of basic training was acknowledged, concern was expressed by a number of professionals that important components of medical care, such as ethics, disease prevention and holistic approaches to care are weak in the curricula. Other important gaps identified in the curricula include gender sensitivity and domestic violence, child abuse, and training in information technology e.g. use of computers.

On funding – MOH&CW pays full costs for all health care students in its schools. Students fill established posts and therefore recruitment is limited to posts available. Student nurses get a salary, accommodation and uniform allowance; this is compensation because they spend considerable time in wards. Other students get a living allowance. Medical students who are not self-financed are expected to contribute 50% of fees and subsistence. It is understood that this year (1999) students are expected to pay 100% of fees and subsistence directly or through a loan.

On training of nurses, the Commission was concerned with shortage of tutors and instructors at a time when the country needs an increase in intake of student nurses. The production of 8 new tutors annually is at least needed to maintain the ratio of 1 tutor to 18 students. Shortage of teaching aids, computers and textbooks was reported by a number of schools. Student nurses requested that they should be given an opportunity to evaluate their tutors and supervisors. The issue of change from in-service nurse education to classroom-based university was also raised. Two other concerns --poor premises and the need of nursing schools to be cost centres-- are discussed elsewhere.

On young doctors, the Commission notes with concern that many are opting to work outside the country once they have completed their two-year housemanship. While it is true they cannot obtain a Practicing Certificate or post-graduate training until they have completed a third year practicing in Zimbabwe, possession of a full registration allows them to practice in other countries. The Commission understands that there are 125 medical cadet posts and felt that this system in which a doctor is supported throughout his training and is then bonded for an equal period for which he has received financial support could attract staff to the MOH&CW. **The Commission feels strongly the cadet system needs to be reviewed and if deemed appropriate made effective**, although it is understood that the MOH&CW has had difficulty with the system in the past.

The Commission is very concerned with the attitude of many of the young doctors and medical students, who in their spare time go to doctors in town and practice for them. This reflected badly on the GPs as well as the HPC and teachers, the role models of the junior doctors. The young doctors indicated they could not come out on their salaries. This is particularly so after Ministry of Education decided to deduct a high portion of their salary ($2 000) as repayment for loans on their education. The level of deduction needs to be reviewed by the Ministry of Higher Education but it is no excuse for the illegal practice by students and junior doctors, which may endanger the health of the public. **The Commission feels that salaries and conditions of services of young doctors need urgent review.**

With regard to post-basic training the Commission notes several problems. Many staff complained of lack of transparency in awarding scholarships and attendance at workshops and seminars. Mission staff complained that selection was very much biased against them.

The present salary cut of 50-75% for the duration of a training is restrictive to those wishing to pursue further studies. There is often no link between continuing education and established posts, those returning from training may have to go back to old posts.

Lack of clarity by MOH&CW on the position of doctors who wish to enroll for M. Med. degrees was brought to the attention of the Commission. Following the introduction of the M. Med. degree, staff enrolling for it had to resign from health services, but took their post with them when they went on training. These posts carried with them the right to enroll for M. Med. degree. Later 36 training posts were introduced in Harare, although

similar posts remained at Mpilo and Parirenyatwa Hospitals. The policy remains unclear at the moment.

After the SCN course was discontinued in 1992, SCNs who qualify undertake one-year conversion course to become SRNs. The courses are run by 17 Schools, which formerly trained SCNs, mainly Mission schools. The Commission has recommended that these schools be used for training of the proposed primary health care technicians, to meet the urgent needs of RHC/Clinics. Alternative arrangements would therefore have to be made. The Commission feels this upgrading should be conducted mainly in the hospitals where these candidates are employed.

On in-service training, the Commission noted that many programmes are uncoordinated even though they are meant for the same cadre. These programmes are organised top-down and often disrupt local plans and priorities. The Commission feels that effort should be made to base continuing education programmes on local needs and to integrate or link such programmes.

Below the Commission makes broad recommendations relating to cadres in the health sector. More detailed and specific recommendations on individual professional groups will be found in the main document.

RECOMMENDATIONS

The various professional education committees need to review their training curricula in order to address the current health concerns and changing disease patterns. Especially an effective response to the HIV/AIDS epidemic requires new skills.

All health-training institutions reassess the training of their students to ensure that appropriate emphasis is placed on child abuse and the impact of domestic violence on the health of women with special attention paid to training in the identification and management of these cases.

All professional training syllabi should place great emphasis on ethics and professional code of conduct and have a "customer care" component as all health workers deal with members of the public. This should also be extended to those already working in institutions as part of "in-service training".

Selection of candidates to health training institutions, medical school, schools of nursing and other training institutions should not be solely based on the highest academic qualification as is the case at present. Entrants to these schools should attain a minimum agreed pass in order to qualify to attend a selection interview. The panel among other things will base their final decision on other factors such as the school report on behaviour, community service and performance at the interview. Those who satisfy the selection panel may be admitted to training institutions. During the training more time should be allocated to ethical and

disciplinary issues in lectures and practice in an attempt to change attitudes, improve ethics and professional code of conduct.

The control of postgraduates be removed from the MOH&CW and returned to the care of suitable committees in the four teaching hospitals.

For all students use of computers should be part of their training in order that they may realize the full benefits of modern technology and be on par with their counterparts worldwide.

Finally, some members of staff complained that they received no significant increase in salary after attending additional training. For example nurses who undertake the diploma in anaesthesia receive a monthly increment of only $6.00!

3.6 Reviving Discipline and Ethics

Introduction

Health Care delivery is the prime objective of any health institution and draws on a professional culture that promotes recovery from illness. This comes from the commitment of health workers who should have special personal qualities and attributes of compassion, empathy and high ethical standards that go beyond the call of duty.

In the early 1980s, Zimbabwe achieved health gains that were the envy of the rest of Africa through the dedication and good will of its work force. At hospitals and clinics there was a high level of respect for patients and there was an enviable code of conduct by health workers. As a result the public had trust and respect for the service and staff.

During the Commission's visits and public hearings, there were overwhelming complaints by consumers about the rude and derogatory language used by health staff, disrespect of patients and shunning of HIV patients in particular. The whole health care system is now perceived as insensitive to the needs of patients. As a result, the public has lost trust and respect for the service and only attends because it has no choice. The complaints were leveled against health staff across the board.

Factors contributing to unprofessional culture

(i) Conditions of service. There are several factors, which have contributed to the current situation. The buying power of the health workers salaries has declined and the government has not been able to sustain monetary and other non-monetary rewards. This, together with the conditions of work and management systems has led to the destruction of morale of the workers, loss of commitment, especially the willingness to serve beyond the call of duty. The mass mobilization of the 1980s, has been replaced by apathy in all categories of professionals, individualism and pre-occupation with

remunerative packages, characterised by non-accountability and an "I don't care" attitude. This has contributed to a culture of indiscipline and unprofessional behaviour.

(ii)Management. At the central level the situation has been allowed to develop to the current unacceptable levels because of lax leadership and poor management. It appears that senior managers have completely abrogated their responsibility to manage, epitomised by lack of effective supervision and transparent disciplinary mechanisms at all levels of the service. In cases where individual stations have taken action against bad behaviour of staff there are delays by the Public Service Commission or in actioning recommended disciplinary measures from stations. Some workers have been reported to have died or retired before any action had been effected. It was reported that at times Head Office has intervened to thwart disciplinary measures instituted by hospital authorities.

The management style of the MOH&CW is considered non consultative and non participatory which irks staff who then feel dictated to, without being involved in the decision making process. The lack of effective supervision of staff means the objectives of the organisation are not achieved and quality service is compromised and patients are dissatisfied.

The failure by management to foster the concept of health care teams for holistic care resulted in the disappearance of the traditional team spirit among health workers. Each profession has gradually improved academically and tends to feel they 'know it all' and that they are the only important group in the health services. This undermines other professions. The interdependency of all health professional groups has been ignored.

At the institutional level, lack of role models exacerbates the situation. Doctors play a defining role in the maintenance of professional culture and for this reason the current deterioration in the professional conduct of public sector doctors has a negative impact on all health workers.

The Commission was informed that hospital authorities do not have effective control in the supervision of key health professionals such as, doctors, pharmacists, physiotherapists, dentists and radiographers and so cannot effectively monitor their activities and movements. Some medical superintendents have not exercised their supervisory powers adequately and some of them are engaged in private practice leaving little time to supervise the rest of the professional staff. At times, some of them compromise their administrative positions as they employ junior staff as locums in their private surgeries.

Consultants and other senior doctors set bad examples by coming late or not at all to ward rounds, outpatient clinics and theatre lists. Some junior doctors disappear from the wards to do private practice during working hours and some work without a practicing certificate. Other doctors do not respond timeously when required by nurses and other staff for emergencies.

It has been reported that at a central hospitals there are inconsistent disciplinary measures by medical superintendents and consultants in respect of junior doctors. At times, offending junior doctors are reprimanded by consultants and are then conveniently transferred to some other institution by the supervisor without any disciplinary action being taken. This erodes the authority of those who wish to maintain discipline.

The Commission was also informed that this uncaring attitude permeates all levels of the service. There are reports of nurses who leave patients lying on the floor when they are not able to get up and of hospital hands and nurse aides who do not feed very sick patients who require assistance in feeding. The same workers then come back on their next round to remove untouched food from hungry patients. Health workers of different professions who sell various items or commodities such as eggs or vegetables while on duty, to the detriment of patient care are still paid a full salary.

RECOMMENDATIONS

The Commission recommends that strong action be taken against transgressors at all levels. Doctors who defraud should be dealt with not only with the appropriate rigour of the law, but also with strong action by HPC, which may even remove their names from the register. Other health workers who transgress should be dealt with in similar fashion.

The methods of selection of those who enter a caring profession must be reviewed. Selection of candidates should be based not only on academic qualifications but also on proven interest and compassion for fellow human beings, through social work, debating, etc.

The teaching of ethics must be included in all curricula of health workers.

CHAPTER FOUR

ORGANIZATIONAL CAPACITY AND ACCOUNTABILITY IN THE PUBLIC SECTOR

In this chapter the Commission examines interrelated organisational issues that are behind some of the deficiencies identified in the previous chapters – Public Health Services and Human Resources Development and Deployment in the Public Sector. Firstly, the Commission considers a number of key decisions in health care are beyond MOH&CW and at times it is not clear who is responsible for what. Secondly, decentralisation of appropriate level of decision making to hospitals, districts and communities is lacking and finally, definition of the role and structure of MOH&CW in a decentralised system is inadequate. Lack of clarity on organisational arrangements and roles of different institutions weakens efficiency and accountability. Similarly, inadequate decentralisation and lack of clarity on leadership arrangements weakens organisational capacity and accountability.

4.1 Roles of Public Service Commission and Ministry of Finance in Key Decisions

PSC controls the establishment of posts and defines salary scales and allowances, and promotion opportunities for all staff of MOH&CW. This limits the ability of MOH&CW to introduce measures that might encourage recruitment, retention of staff and efficiency. The PSC aims to maintain some conformity between different sectors and has not been able to take due cognisance of the special needs of the health sector.

Numerous examples of frustrations and low morale among staff, due to delays in appointments, promotions and institution of disciplinary decisions were presented to the Commission. Health staff felt strongly that PSC did not have adequate knowiedge or experience of what was happening in health services and their special needs. Health workers, including most decision makers in MOH&CW and others with whom the matter was discussed, agreed on the need for authority on health workers' issues to be vested in a body that is able both to appreciate and to respond appropriately to the special needs of the health sector. It is believed that such a move will enhance:

- development of conditions of service that are based on and respond to specific needs of health services;
- promptness of decisions;
- transparency in appointments and accountability;
- good management in general.

The Commission agrees with these views, and further notes that the National Health Services Inquiry Commission of 1945 was of the same view. The body should have the

responsibility currently held by the PSC, of advising the President on human resource matters.

This Commission believes, on the basis of local findings and international experience, that a possible mechanism for delegating responsibilities for health staff matters is through the formation of a Health Services Commission (HSC). What is important is agreement on the functions to be carried out by the proposed Health Services Commission

The Ministry of Finance (MOF) plays a major role in the management of the MOH&CW budget. The Ministry decides on use of planned budgets, for example salaries, and influences the freezing of posts or establishment of new posts. Given that the total budget of the Ministry is approved by Parliament, serious consideration should be given to providing a global budget to MOH&CW. MOF should also delegate the authority and management of donor funds to the MOH&CW. The desirability of authority transferred from MOF being vested in the HSC should be examined.

There is widespread dissatisfaction with the services of CMED, which is charged with the maintenance and replacement of MOH&CW vehicles. Crucial services including vaccination, TB and HIV control are in jeopardy due to transport problems resulting from poor maintenance and other problems. Similar problems exist with maintenance of health facilities and equipment by the Ministry of Local Government and National Housing. The Commission is convinced that placing ownership of assets and maintenance responsibilities with the MOH&CW will alleviate the situation.

RECOMMENDATIONS

The Commission recommends the formation of a Health Services Commission.

The Commission recommends that the Health Services Commission should start with delegated personnel responsibilities together with any others that can be agreed on, with the possibility of other responsibilities being added in due course. The board shall consist of a chairman and 9-12 members including representatives of health care partners (professional associations, missions, PSC, LAs, NGOs, private sector, teaching institutions and other sectors). In appointing members of the Commission, consideration will be given to gender balance. The President, on the advice of the Minister of Health, shall appoint the chairman and other members of the Commission. Details of structures and other issues – tenure of office, meetings, allowances for members, appointment of staff, secretary to the Health Services Commission, sub-committees (e.g. appointment and promotions and disciplinary) should be decided after consultations among interested parties.

The Commission strongly recommends that the authority, responsibilities and relevant resources of PSC, the Ministry of Local Government and National Housing and Ministry of Finance in setting conditions of service for public health staff, the maintenance of health facilities and equipment and management of health budget respectively should be decentralised/delegated to the MOH&CW. The Commission

is pleased to learn that decisions have already been made to transfer responsibilities from the first two of the three Ministries. The MOH&CW itself should develop internal management and control mechanisms to take on these responsibilities.

4.2 Decentralization

Level of decision making in hospitals.

Government policy and MOH&CW strategy documents emphasise the need to create Hospital Management Boards in hospitals. These mechanisms should have delegated authority from MOH&CW to make most management decisions. Of the four Central Hospitals, only Parirenyatwa has a Board of Governors. The Board has been vested with considerable powers but it does not have authority to hire and fire staff. That authority remains with PSC.

The Commission would like to point out that the main objective for granting hospital autonomy is to improve management, efficiency, quality of care and public accountability. It is not just to reduce Government. budgets for hospitals and allow the hospitals to raise money.

RECOMMENDATIONS

Parirenyatwa Hospital and each of the other four hospitals: Harare Central, Mpilo Central, United Bulawayo Hospitals and Ingutsheni should have a Board whose powers include hiring and firing of staff. Hospital Management Boards should be established in all provincial, district and designated district hospitals. Responsibility of the boards will vary in the different types of hospitals.

The process of creating Hospital Management Boards should be gradual and phased so that information obtained from monitoring and evaluation can be used to introduce and expand changes.

A working group be established by MOH&CW to review the current staffing norms of health facilities and make recommendations on future standards taking into consideration the need to achieve maximum improvement of health services for all Zimbabweans with available resources. The working group should also make recommendations on how the monitoring of the impact of the delegation of authority on health care objectives should be carried out.

Decentralisation to Districts

The Commission is shocked by the lack of information among health workers and the public in general on the Government policy and plans on decentralisation. In the circumstances, practically all health staff was not in favour of decentralisation to district

councils because of their bad record in management of schools and health facilities. Some councillors felt that MOH&CW should not be allowed to hand over problems that it has failed to solve. The Commission notês that MOH&CW has started two initiates, creation of District Health Executives (DHE) and the Health Service Fund (HSF) on which the process of decentralisation can build. The Commission believes that caution is needed in the decentralisation of health services. Decisions need to be made on which services should be decentralised and which should not. This has not been yet done. The decentralisation of health services needs to be carried out in stages with each stage backed up by experience gained, and with clear definition of the roles of each level.

RECOMMENDATIONS

The Commission recommends a gradual process of decentralisation to districts that will avoid much the same unnecessary disruption of services. The process should begin with deconcentration to an expanded District Health Executive. The DHE should be expanded to a District Health Management Committee/Board through increasing its membership by adding representatives of local authorities, missions and communities. District health management committees/boards will, like hospital Management Boards, report to MOH&CW. The gradual decentralisation approach will provide an opportunity to assess the proposed decentralisation arrangements through practical experience, and to decide which services would be better decentralised further to local authorities and which would not.

The Role of the Province

The Commission was made aware of GOZ policy for a two level MOH&CW, essentially eliminating the province. The Commission believes that while the functions and strength of provincial level needs to change after decentralisation, its abolition at this stage may affect the performance of MOH&CW adversely.

RECOMMENDATIONS

The Commission recommends that the functions and staffing of the provincial level should be reviewed. The work of the provincial level should focus on capacity building, monitoring of progress towards attainment of set targets at provincial and district levels, enhancing quality assurance in public and private services and other responsibilities assigned by MOH&CW. The provincial level should be classified as an extension of MOH&CW headquarters.

Revitalising the Community Health Movement.

Immediately after Independence, Zimbabwe adopted the PHC approach with its focus on community mobilisation for health. After an initial period of spectacular success, the

momentum of the movement slowed down and many community programmes are now piecemeal and poorly coordinated.

The Commission is convinced that major emphasis on preventive services and the community-based approach were fundamental to the extensive achievements of the 1980s and that major health gains will be achieved through reviving the Community Health Movement. The HIV/AIDS pandemic, whose control and management can be greatly enhanced by community-based approaches and activities provides an opportunity and underscores the timeliness and urgency for such revival.

RECOMMENDATIONS

To revive the Movement, the Commission recommends that the role of VHWs/VCWs should be strengthened. Local surveillance of health and health care should be reinforced and the role of RHC/Clinics should be strengthened and transformed. Government and donor resources should be made available to support the revival and sustenance of the Community Health Movement. Communities should be empowered to manage local funds and aspects of RHC/Clinics. The orientation of RHC/Clinics should give increasing role to communities in planning and management of activities.

The name of RHC/Clinic should change to Community Health Centre. The change in name should be accompanied by appropriate reforms, including provision of appropriate continued training to increase clinical and community mobilisation skills of staff and Village Health Committees (or similar mechanisms) to manage local health action.

The MOH&CW should appoint a focal point for the movement in the Ministry.

MOH&CW should set up an inter-ministerial technical working group on revival of the Community Health Movement that will include relevant decision-makers and experienced field managers of community based programmes and workers. The working group should also include a representative of the Ministry of Public Service, Labour and Social Welfare (which is focal point for three important programmes namely: Social Development Fund, Poverty Alleviation Programme and Community Action Project), Nutrition and District Environmental Action Planning. The working group should develop guiding principles on different aspects of the movement. This will include guidance on link workers – types, training, remuneration.

A reasonable portion of the Health Services Fund should support activities under the Community Health Movement.

A Village Development Committee will manage funds at village level. Village Health Committees should be informed of funds available and be supported in developing relevant projects.

4.3 The Role and Structure of MOH&CW

The Commission agrees in principle with the functions of the new MOH&CW as outlined in the Ministry's Strategy Document after decentralisation. And recommends only slight modifications. The Commission addressed in some detail six priority functions, which it feels should feature more prominently in the new MOH&CW. These are: enhancing health action in other sectors; enhancing equity; quality assurance and inspection; statutory and regulatory provisions in support of health; enhancing high quality research and strengthening the structure of MOH&CW at central level.

Enhancing Health Action in other Sectors

Important partners for health improvement, besides MOH&CW include individuals, families, communities, NGOs, Government as a whole, other ministries, local authorities, teaching institutions, private sector and donor agencies. Revitalising health services demands a very wide-ranging and radical strategy involving all partners. There is no doubt that spearheading and nurturing this partnership is the biggest challenge that the Commission is recommending to MOH&CW. All the imagination and initiative skills of MOH&CW will be needed for success. An example of an innovative initiative is the concept of health promoting companies, which can enhance health action in the private sector. Enterprises, which adopt the concept, take action at four levels: (i) promoting positive health at work place through increasing awareness on healthy environment, healthy lifestyles, hazards of smoking and alcohol; (ii) minimising health hazards of business through pollution control and reduction of unsafe operations, (iii) promoting health in the community of employees; (iv) optimising the health impact of products.

RECOMMENDATION

The Ministry of Health should obtain commitment from different partners to support the revitalisation of health services and the health strategy in general. The commitment should indicate principles and code of co-operation and contribution to be expected from each partner to achieve the objectives of the strategy. The partnership should be formalised as a National Health Co-ordinating Council (NHCC) chaired by the Minister of Health. The Ministry should consider establishing a charter (or a social contract) on these lines. The charter and its signing are seen as enhancing direct social and political accountability. Partners might also consider meeting at least once a year to review progress in implementation, agree on changes in strategies and to renew their commitment.

Enhancing Equity in Health and Health Care

At Independence, Zimbabwe had dramatic inequities in health and health care between whites and blacks. After Independence, Zimbabwe formulated a policy of "Equity in Health" aimed at improving equity between different population groups and geographical areas. Zimbabwe has made substantive progress in expanding access to health care and improving levels of health. Allocation of resources between provinces as measured by expenditure per capita, population per clinic or per bed is fairly equitable. However this does not take into consideration the long distances that people in sparsely populated areas have to travel to reach a health facility. Disagregated data on utilisation of services and of levels of health care in different socio-economic population groups both within and between districts are not available. At risk groups include the poorest households in rural areas, the unemployed and low wage earners in urban areas and the semi-employed in commercial farms.

With the rapid growth of private practice in recent years, political and value issues that are of great relevance to equity have been sidelined. The health system and policy is now at crossroads and it is critical for the Government to decide on the way forward. In one route, the better off and employed Zimbabweans are encouraged to make their own health care arrangements while the Government provides health care for the poor. This is the "Safety Net" route. One serious adverse effect of this route is the creation of a two-tier system, one of high quality for the better-off and one of low quality for the poor. A second route, which is the one the Commission recommends, focuses Government policy on the health risks and needs of the whole population and resources available. It uses its powers to guarantee access to health care for everyone, but those who can afford additional care can do so. This is the "Escape Valve" route.

It is obvious that where there is solidarity and available resources in the country are viewed as a whole as in the second option, the quality of care for the total population will be higher than in the first route. The second route requires a clear Government policy on equity, adequate funding of the public health sector, measures to ensure that the growth and operation of the private sector does not harm the public sector and that marginalized population groups are encouraged to play an active role in planning and delivery of their health care. A number of people asked: "if private medicine pays for itself and takes a middle-class load off the Government budget, what is the problem"? Response to this important question is provided in the third recommendation below and is discussed further in the chapter of health financing.

RECOMMENDATIONS

MOH&CW and Government should reaffirm its policy for equity in quality of care, and develop appropriate targets and strategies to enhance its implementation.

Surveillance for equity should be strengthened at local level – Community, RHC/clinics and other levels, through identification of population sub-groups among whom disease and risk are concentrated and targeting corrective action to them. The MOH&CW should play a central role for monitoring equity. Special studies and surveys to supplement data from surveillance and routine monitoring should be carried out as necessary.

The Government needs to exert some regulation on the growth of the private health sector. For example, unregulated growth of private hospitals will result in a decline of the quality of services in public institutions. Private hospitals will attract staff from public institutions, which already have a serious shortage of staff, by offering them better salaries and other conditions of service. Three major private hospitals can absorb as many nurses as those needed to staff six District hospitals or over 100 RHC/clinics. The Government might consider vetting all such new projects for need and appropriateness and not just approving all such projects. The Commission has recommended staff retention packages, which should improve availability of staff in public institutions, but there is always the likelihood that the private sector will be able to be more attractive financially.

MOH&CW should make efforts to empower population groups that are underprivileged so that they themselves can demand better access to health services and support for reducing health risks. Strategies for such empowering include assembling and disseminating relevant data to the groups concerned. Data on inequities in health and health care, for example data on infant mortality rate, birth weight, attendance at ante-natal clinics, immunisation coverage and cigarette smoking rates by different socio-economic population groups or geographical areas should be made available and be made public.

Other strategies that need to be considered, include construction of additional rural health centres and clinics to under-served areas; construction of "health posts" in remote areas with populations that are too small to qualify for a clinic or a health centre, as discussed in Chapter 2; provision of subsidies to poor districts; extension of the Social Dimension Fund and enacting appropriate legislation to reinforce equity oriented measures. An example is legislation requiring employers to ensure that basic health care is provided for their workers.

Quality Assurance (QA) and Enforcement

The Commission notes that health workers often associate quality with high cost and sophistication. This is wrong as quality refers to compliance with defined standards of performance and is thus relevant at all levels of health services. Development of health services in Zimbabwe has been concerned with the quantity while quality issues have tended to be left to individual professionals, professional associations and HPC. These arrangements are inadequate to deal with the current increasing concern with quality by the public and health workers. While many organisations have mandate on issues of

quality, MOH&CW should be a central coordinating mechanism. MOH&CW should establish a programme on QA, possibly through expanding the role of the Department of Epidemiology and strengthening it. The programme should also assess new and available technology and disseminate findings. The point of departure for the programme is that it should play not just a promotive role, but active enforcement as much as possible, within the mandate of MOH&CW. Additional resources and skills should be mobilised.

RECOMMENDATIONS

The Commission recommends that the MOH&CW establish a National Programme on Quality Assurance (NPQA) as soon as possible.

Given below are some suggestions on objectives, organisation and some of the activities that could be undertaken by the programme. The objective of the Programme is to ensure that appropriate quality care is accessible to all Zimbabweans within available resources. The word "all" is important, as high quality care for a small minority when the rest of Zimbabweans have practically no care at all is inappropriate nationally. Thus an effort to widen access is part and parcel of the national programme on QA. The process of QA will centre around obtaining and assessing information on the performance of an activity, taking action to improve care and to verify the effects of that action on performance.

Standards of good performance in various programmes and activities for example the reduction of maternal mortality, management of head injury, diabetes etc. need to be defined and agreed on before hand.

The programme will work closely with organisations working on different aspects of QA including professional associations and facilitate the exchange of information.

The QA programme will also spearhead and co-ordinate work in the technology assessment as well as development and enforcement of health legislation. A central focal point where information and guidelines can be prepared should be established. The programme could build on elements of work being done by the Department of Epidemiology and Disease Control such as "bench marking". The focal point will also need legal and “inspection” skills.

A steering committee chaired by the Secretary for Health and involving keyplayers in QA should be established to initiate and spearhead the programme. Sub-Committees of the steering committee will be responsible for development of indicators and standards for different programmes. The steering committee with support from relevant institutions should prepare strategies for the programme.

Training programmes in QA initially should aim at developing a critical mass of professionals with appropriate skills within the system. QA should also be introduced or strengthened in all basic and other training programmes for health workers. Training materials guidelines and computer-based packages should be prepared.

PMDs Teams should play a leading role in the development and implementation of QA activities in their Provinces. QA focal points should also be appointed at different levels of health services and in various institutions.

Considerable additional resources, particularly for start up of the programme will need to be mobilised.

Statutory and Regulatory Provisions in Support of Health

The Commission reviewed a number of key laws to assess their effectiveness in support of health. The Medical and Dental and Allied Professions Act, 1971 established the HPC to register professionals and institutions and to control training and practice standards. The inspection function is poorly carried out, mostly due to inadequacy of resources. The annual renewal of registration is automatic on payment of a fee; evidence of attendance of a continued education programme is not necessary. The Act itself does not recognise that health workers including Clinical Officers and Nurses carry out important medical interventions that are the responsibility of Medical Practitioners.

The Medical Services Act, 1998, which recently passed in Parliament, is an important tool for regulating the private sector.

The Commission observes that there is no provision in the Constitution of Zimbabwe guaranteeing the right of Zimbabweans to receive a reasonable standard of health care. Regulatory legislation is piecemeal and scattered in numerous Acts. Finally, the Commission is concerned about the inadequacy of legal technical skills in MOH&CW at a time when the volume of work requiring such skills in such areas as formulating contracts, new legislation (like the revised Public Health Act) and enforcement is on the increase. The Commission considers that exclusive reliance on support from the AG inadequate.

RECOMMENDATIONS

The Medical and Dental and Allied Professions Act, 1971 should be reviewed to provide legal recognition to medical interventions carried out by Clinical Officers and other health workers.

The Commission welcomes many components of the Medical Services Act. The Commission believes that fixing of fees should involve MOH&CW and all partners.

In the long terms the right to health care should be introduced in the Constitution of Zimbabwe. This will strengthen the Government's commitment to health for all Zimbabweans. In the short term, financial commitment should be indicated in GOZ Budget Policy on the following lines: "The Government will ensure that the burden of financing essential health care is equitably distributed and will allocate at least $ .... per capita in real terms of its budget to health care". The 1990/91 budget figures per capita constitute an appropriate target in the short term.

Existing legislation should be consolidated and updated. This is a mammoth task but Zimbabwe can build on the experience of other countries.

MOH&CW should have at least two staff with legal skills located in the proposed QA and Inspection Programme.

Enhance High Quality Research

The Blair Research Institute, founded in the 1930s has carried out distinguished research, particularly in the areas of malaria, schistosomiasis, sanitation and water. The Commission identified three issues. First is fragmentation of research activities. There is no overall research strategy with a clear indication of expected output. Such a framework would also be of use for donors in identifying priority areas for support. The Medical Research Council (MRC) essentially reviews and approves research projects. It does not fund projects. A meeting organised by MRC in 1995, under the theme of "Essential National Health Research" drew a list of 25 priority areas of research. The Task Force on ENHR established after the meeting could have built on the deliberations of the meeting and developed a research strategy, but apparently has not been operational. Secondly, co-ordination of Health Systems Research (HSR) is weak. Thirdly, the Commission was pleased to note that over 400 health cadres from provincial, district, municipality and NGO teams had received HSR training. These cadres could help solve many of the health service problems the Commission saw in the field through research. It is not clear if this group continues to carry out HSR after their training periods, but there was little evidence of such work in the field.

RECOMMENDATIONS

MOH&CW and MRC should develop an overall Health Research Strategy as soon as possible.

A Health Systems Research Advisory Committee chaired by the Permanent Secretary (or his representative) should be formed. The Committee should include representatives from the University, Blair Institute, PMDs, PNOs, DMOs, Community Action Group, Public Health Advisory Board, Missions and interested donors.

The capacity building in health research should be strengthened. MOH&CW, Hospital Management Boards, PMDs and DMOs should support training of staff and research activities.

The role of MRC and its financing should be reviewed with a view to enabling it to play a more active role in promoting and supporting health research.

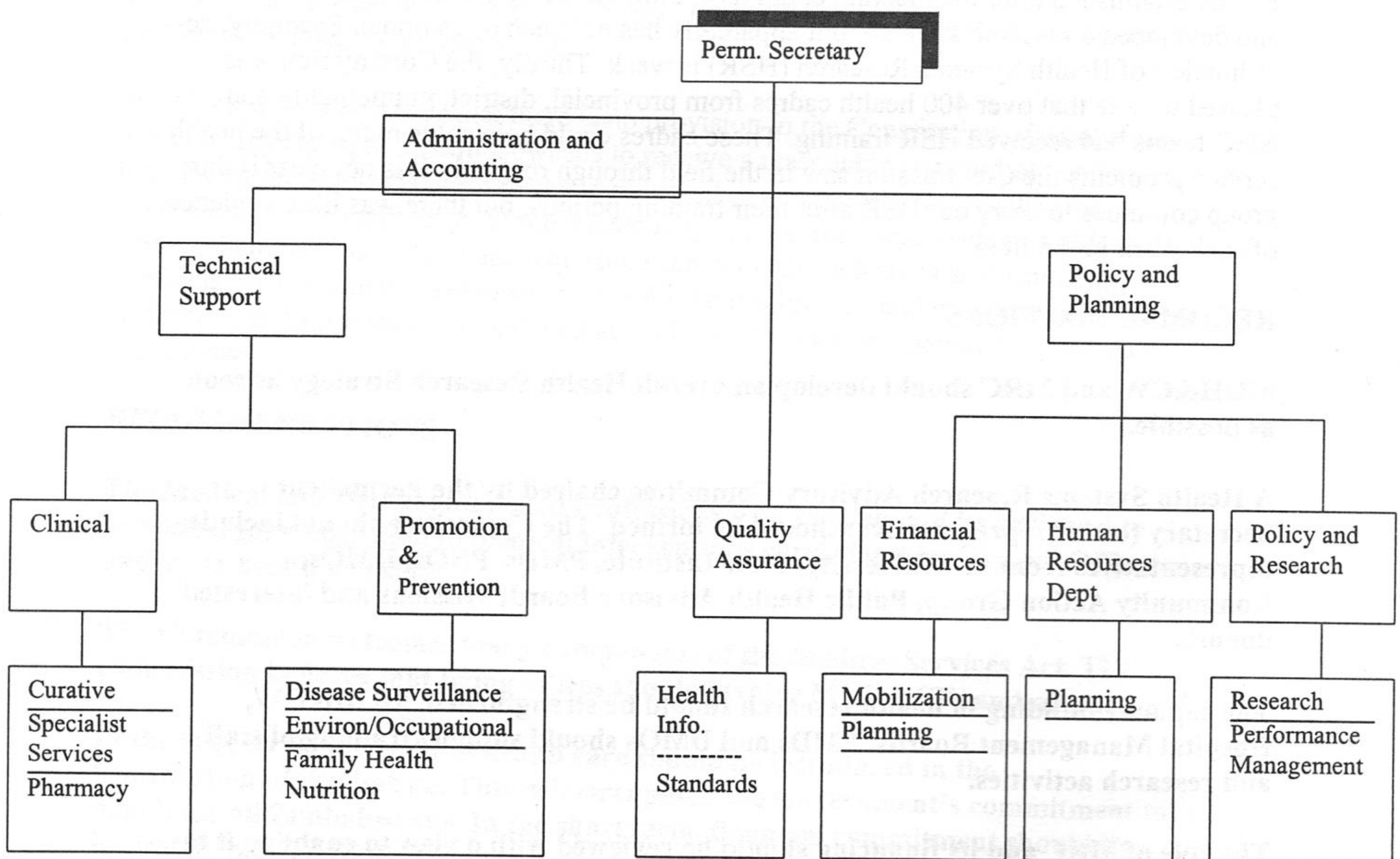
Strengthening the Structure of MOH&CW at Central Level

The Commission believes that restructuring of MOH&CW should address the following issues:

- MOH&CW should move away from delivery of services to policy, strategy and tool development and provision of technical support;
- Need to avoid centrally managed vertical programmes, which enhance duplication;
- Need to separate financial analysis from accounting;
- Need to strengthen planning, financial control, human resource development, quality assurance and community-based activities;
- Need to organise work based on functional rather than professional lines.

The figure below shows the proposed new structure for MOH&CW.

Fig 4.1: Proposed New Structure of MOH&CW



RECOMMENDATION

The Commission recommends that a task force be formed to rethink the fundamental structure of MOH&CW on the above lines and oversee its implementation. Clearly piecemeal changes with the structure will not do. A critical step in the process is the detailed identification and decision of skills and posts required at H.Q. Overall, the MOH&CW is under-established at the periphery and resources that will be released at H.Q. should be transferred to districts.

CHAPTER FIVE

HEALTH FINANCING

Many of the problems discussed in preceding chapters including inadequacy and poor maintenance of health facilities, shortages of equipment, accommodation and drugs and above all low staff morale and staff shortage are essentially due to underfunding of the health sector. Thus implementation of many of the recommendations made by the Commission in the previous sections to address these problems will require additional resources. The Commission examined ways of (i) increasing resources from all partners involved; (ii) using available resources more efficiently and effectively to achieve better health outcomes, greater equity and more consumer satisfaction, and (iii) filling the resource gap between available and required resources to revitalize health services.

5.1 Increasing Resources From Partners

The main sources of funding to the health sector are Government (MOH&CW, other ministries, Local Government), missions and other NGOs, donors, health insurance, employer based care and individual direct payments. MOH&CW was the largest contributor in 1987, providing 42% of health expenditure. Individual direct payments were 10%. The corresponding figures for 1994 were 29% and 30% showing that the burden of financing health expenditure has shifted considerably from Government to individuals.

Governments Contribution

Government health expenditure increased steadily in the first decade after Independence to reach 3.1% of GDP and 6.2% of Government expenditure or US$23.6 per capita in 1990/1991. Since then the trend has reversed with only 2.2% of GDP and 4.2% of total Government expenditure going to the health sector in 1995/96. The approved MOH&CW budget of Z$3.7 billion for 1999, is less than US$10 per capita, which represents an alarming decrease.

Cuts in Government health expenditure have been particularly felt in the health sector for three reasons. First there has been considerable increase in workload to MOH&CW as evidenced by increased attendance for various services and above all the HIV/AIDS epidemic and TB which have placed new and extensive demands on the already over-stretched sector. Secondly, the cuts have made it difficult for MOH&CW to fund and retain additional staff. Thirdly the burden of financing health services has shifted considerably from Government towards individuals who are feeling the burden. The Consumer Price Index (CPI) for medical care has risen faster, over 50%, than the overall CPI. In fact, this CPI for medical care rose much faster than any other component of CPI.

Decisions on how services should be financed and the level of Government contribution are basically political. Members of the public, the health staff as well as practically all Government and political leaders consulted submitted strongly to the Commission that the Government should give greater priority to the health sector in the allocation of resources. The Commission is convinced that to revive health services, the decline in resources allocated to the health sector should be reversed urgently.

Governments additional contribution should come from reallocation of resources from other sectors to Health; increase in general taxes especially by improving tax collection; earmarked taxes, tax exemptions for products that serve public health goals or benefit particularly the poor; and tax deductions for donations to the public health sector. Unhealthy products and habits such as alcohol, tobacco and traffic offences increase illness and hence the cost of health services. Earmarked taxes in these areas are a form of compensation to the health sector.

RECOMMENDATIONS

The Commission recommends that in the short term the Government should increase its contribution to the health sector to at least the level of real per capita allocated to health sector in 1990/91 i.e. US$23,6 per capita, while in the long term further increases will be required.

The Commission recommends that the possibilities of increasing funding for health through earmarked taxes, tax exemption and deduction be studied in depth. The impact and possibilities of contributing additional funds to the health sector need to be carefully examined in consultation with interested parties.

Health Insurance

Private, National (Social) and Community Insurance enables large groups of people to pool their resources to provide coverage for catastrophic illness and injury.

Private Insurance

Compared to many other countries in Africa, private health insurance is well established in Zimbabwe. There are about 30 Medical Aid Societies covering about one million people. Membership is growing at 5 - 6% annually. It is estimated that 20% of Zimbabweans could be enrolled in health insurance. This is doubling of the present number and would mean a freeing of considerable funds of Government of Zimbabwe to take care of the poor.

Societies operate a range of schemes to cater for different income levels, ranging from a scheme of basic treatment in government and municipal facilities to executive's schemes providing generous benefits. Schemes of basic treatment are relatively cheap since the public sector does not charge full costs of services to medical aid societies.

The Commission did not go into issues of profitability of the different packages, but was informed that the advent of HIV/AIDS has increased costs to medical aid societies and the survival of a number of them is apparently on balance. Two other issues emerged in the review of the work of the medical aid societies. (i) First, when private patients are admitted to public hospitals, because of inadequate (low) fee schedules, delays and sometimes non-billing and non-collection of charges the public sector ends up subsidizing the private sector. Dependants of insured people are often treated free in rural facilities, medical aid societies are not charged, and thus the public sector once again subsidizes the private sector. (ii) government policy towards medical aid societies needs to be strengthened. From the perspective of government policy, the objectives of health insurance are to increase health sector revenues and reduce financial barriers to those that are insured. The expansion of medical aid societies should lead to people switching from public to private payment of services, thus freeing government resources, which can be directed to the poor population. Government policy should enhance efficiency in the medical aid societies, as achievement of its objectives will depend on how well these societies are operated. Employer contributions to medical aid schemes are tax- deductible (and are tax-free benefits for employees). These tax-free benefits constitute Government subsidies to a relatively well off segment of the population. The Government might consider using this subsidy as a tool to enhance efficiency in medical aid societies. For example, tax deduction can be used as incentive to provide schemes which are affordable by many people; encourage medical aid societies to be cost conscious and to explore alternative and efficient means of paying providers, avoiding fee for service, which causes rapidly rising costs because of the incentives generated to produce excess services as much as possible.

Finally the Government also needs to look at the impact of the growth of the private sector which is considerably induced by the expansion of insurance, on the availability and retention of human resources in the public sector. The Commission has made a number of recommendations on staff retention but excessive, unregulated payments by Medical Aid Societies to health providers may be a factor attracting public health staff to the Private Sector.

National or Social Health Insurance

Social Health Insurance is generally compulsory and organized by Governments with premiums partly paid by employees and partly by the employer. Practically every country in Africa says it is studying the feasibility of a social health insurance but this seems to be a long-term project. The Government commissioned a study on possibilities and options for establishing a National Health Insurance.

The Commission is also concerned with the high administrative costs. The Commission feels that the proposed National Health Insurance is important but it should be seen as a long-term goal. The same conclusion emerges from global experiences. In most countries that have achieved universal coverage with Social Health Insurance (e.g. German, Japan, Czech Republic and Costa Rica), the transition from partial to full coverage of the

population took between 40 and 100 years. The fastest country to make this transition has been South Korea, which did so in 12 years. This occurred in the context of a clear Government commitment to universal coverage, a strong local government system able to implement regular means tests to identify those in need of subsidies and a real per capita GDP growth rate that averaged more than 10% per year during this period. The Main issues for the establishment of a Social Health Insurance in a developing country like Zimbabwe include the large contribution that has to be made by the Government as premiums for the unemployed and peasant farmers with little income.

For the immediate future public health facilities, mostly financed by general taxes should be seen as providing "Insurance" to the majority of Zimbabweans who cannot afford Private Health Insurance.

Community Insurance

There is considerable global interest on mechanisms for sharing health risks among the rural and urban poor. There has not been a systematic analysis of such mechanisms in Zimbabwe. It would be useful for MOH&CW to review existing mechanisms and potentials for expansion.

RECOMMENDATIONS

The Commission recommends that Social Health Insurance be considered as a long-term goal for health financing as it cannot be achieved in the immediate future.

District Health Services must be strengthened as a matter of urgency by GOZ.

Health insurance should be made compulsory for all in formal employment and should be strongly encouraged for the rest of the population who can afford it. It is imperative that all employers including government, should pay their contributions to ensure the financial viability of Health Insurance Schemes. Insurance could best be provided through the existing medical aid societies, many of which already carry insurance packages which provide coverage for services at public facilities. Government should review with the Medical Aid Societies how best the membership for these basic packages can be rapidly expanded. Government can assist in increasing membership of the population in Health Insurance by active promotion of insurance for curative services and by installing a structure of user fees for those services. Non-Governmental Organizations, especially mission organizations, which have so much experience in the provision of health services, should be encouraged to become more involved in health financing schemes.

The Commission recommends that the Government (MOH&CW) should have more interest in and encourage good management and efficiency in medical aid societies. The Commission also recommends that present payment systems be reviewed by the health insurance companies in negotiations with the practitioners and that new payment systems be designed which will ensure quality and cost containment.

MOH&CW could facilitate such review by the two partners. Both parties and MOH&CW will have to set standards for quality of care.

MOH&CW should undertake an extensive analysis of the various community financing schemes, with a view to establishing their strengths, weaknesses, and ways of building on the findings.

A New Approach to User Charges (Fees)

User fees have generated heated debates in Zimbabwe, Africa and globally.
User charges have potential to: mobilize additional funds for health care; improve efficiency by moderating demand and containing costs; encourage appropriate use of first and referral levels through setting price differentials at these levels; enhancing provision of quality care and as a means of inducing people to go for insurance schemes. On the last point, it is obvious that where people do not have to make some payment for services, few will seek insurance. However, user fees have not been particularly successful in raising additional resources. For example, user fees raise less than 5% of the costs of public health in Africa. Secondly, experience in many countries show that user charges deter the use of services by the poor more than the rich and there is no evidence that those who are deterred from using services did not have a genuine need for them. While most countries with user charges have instituted exemption policies and mechanisms, implementation of such policies has proved difficult.

User charges have had a tumultuous history in Zimbabwe (see Box 5.1). Such sudden and frequent changes in policies are harmful to health services. Most of the people who made submissions or discussed the matter with the Commission, were convinced that health services should not be free at the time of use. The Commission agrees with these sentiments and recommends that everyone should be encouraged to contribute to health services. The Commission also notes that on this matter the Departmental Committee of the Parliament of Zimbabwe on Service Ministries concluded that either Zimbabwe should have a National Health Scheme or all patients should be required to pay a nominal fee when they visit health institutions.

Box 5.1. User Fees – Changes in Policies

1981: Abolishing of fees for those earning less than Z$150 per month.

1991: Strengthened enforcement of existing user fees at all levels.

1992: Increased the exemption level to Z$400/month.

1993 : The MOH&CW briefly abolished fees for rural facilities (January-June)

January 1994: Increased user fees at all levels by an average of 2.5 times in nominal terms, with the largest increases at tertiary levels and urban areas, and strengthened referral enforcement.

March 1995: Eliminated fees at Rural Hospitals and Rural Health Centres.

The Commission is very concerned about the danger of user charges deterring the poor from using health services. It is difficult for the poor to obtain necessary documentation. A number of studies have shown actual and potential negative impact of user charges on utilization of health services. The exemption system reaches a small percentage of the poor and has become distorted by patronage. Removal of fees in RHCs has helped the rural poor, but the urban poor face significantly high prices and significantly more strict fee enforcement. In addition, district hospitals often act a primary facility for surrounding catchment areas. The poor, living near district hospitals face a difficult choice between travelling many kilometres to visit a clinic or paying the district hospital fees. The same applies in urban areas in relation to town dwellers with major hospitals.

In view of the above problems and other considerations, the Commission recommends a new approach to user charges that is different from those currently being used in Zimbabwe. Essentially, the Commission recommends that the introduction and enforcement of user charges should be part and parcel of reviving the Community Health Movement. The Commission is convinced that empowering communities to collect and manage funds raised from user charges is the way forward. Communities through an appropriate Committee should be responsible for granting exemptions because they are more likely than outsiders to know those who cannot pay. Giving communities the authority to manage funds raised will be an incentive for them to collect as much as possible and promote a sense of ownership of the facility.

Reinforcement and better collection of user charges in hospitals will increase their revenue considerably. Funds collected at RHC/Clinics should support community health activities.

RECOMMENDATIONS

The Commission recommends that a fee be instituted for hospitals, RHCs and Clinics. No fees will be asked for under fives, preventive programmes such as MCH.

immunization and treatment of important infectious diseases. The fee will be inclusive of drugs. Exemptions for payment will be provided for those who cannot pay.

In rural areas, communities through an appropriate committee at the village will be responsible for granting exceptions, collecting and managing funds at RHC/Clinics. Once people are vetted by such a mechanism their certificate (identity card) should be valid for about a year and will be recognized by referral institutions. Exemptions for individuals and families should as a rule be provided before onset of illness. In case of emergencies, treatment should be provided free and exemption sought later.

In urban areas prospective exemptions will be provided by a committee consisting of local leaders including religious leaders, residents associations, municipalities and a social welfare worker. Exemption certificates will be issued on similar conditions to rural areas.

Department of Social Welfare and MOH&CW should work out appropriate exemption guidelines and mechanisms aimed at recognizing that some people who may have paid at RHC/Clinics may not be able to afford the high cost or charges at hospitals.

It is obvious that user fees will be subsidizes for all attendants but insured persons should pay a fee negotiated between MOH&CW, medical aid societies and local authorities.

Fees should go up for services at referral levels, thus providing disincentive to those who bypass first level.

Fees should be fully retained at the facility level.

MOH&CW should institute surveillance of the impact of user charges on access by the poor to services and equity so that policies can be modified in a timely and appropriate manner.

Funds from External Financiers

Donors form a major source of funds of the health sector. It is estimated that external contribution amounts to about 30% of MOH&CW budget.

Discussions with donor and lending agencies showed that most of them were familiar with the current problems of Zimbabwe and concerns of MOH&CW. Many are quite willing to continue or increase their support depending on strong MOH&CW leadership, good policies and strategies. MOH&CW is currently developing a strategic plan for the next decade. The strategy has potential for serving as a tool to enhance coordination of the activities of various donor agencies and MOH&CW in a sector-wide approach

(SWAP). GOZ should insist on a uniform reporting format for all donors. Considerable interest was expressed on the Health Services Fund (HSF) which mandates institutions to collect and use health care fees to supplement the health budget. The Act allows revenues collected to be retained by institutions and used to supplement any existing budget category, except salaries, depending on local needs and priorities outlined in the approved plan. The Commission considers the establishment of the fund as an important landmark towards decentralization.

RECOMMENDATION

MOH&CW should encourage more donor support. The support should ideally be given as sector-wide or budget support.

5.2 Efficient and Equitable Allocation of Resources

While availability of financial data was slightly better than in the case of Human Resources, there were gaps in some important areas. Data was particularly deficient in unit costs and trends of expenditure.

MOH&CW spends 42% of its budget on salaries and 30% on drugs. At a glance this would appear to be a very efficient use of resources, many developing countries spend over 60% of their budget on salaries leaving very little money for other costs. On the other hand, the low percentage of expenditure on staff is a reflection of the serious shortage of staff in Zimbabwe.

Disaggregated data on trend in allocation of resources to different programmes is piecemeal. It is clear however that in the first decade after Independence, Zimbabwe substantially increased investment of public resources on the elements of PHC, health interventions of high social returns, including MCH, Health Education, Food production/Nutrition, EPI, Water Sanitation, Control of Diseases and treatment of common diseases. Zimbabwe built one of the most effective Family Planning programmes in Africa. The District, which was seen as the Unit for implementing these interventions, was the focus for MOH&CW work and received extensive strengthening.

Data on distribution of total expenditure by level is available for a number of years. Spending on PHC seems to be declining from 39.4% in 1992/93 to 35.8% in 1994/95. This trend should be reversed.

GOZ expenditure and investment, per capita is more in provinces with low population density, like Matabeleland North and South. This is a good policy as delivery of services is more expensive in areas with dispersed populations.

At Independence, Zimbabwe used a very innovative approach to the allocation of resources between different levels. It was decided that growth of resources at RHC/clinics would be 185%; 139% at district hospital; 83% at specialist hospitals; 50%

at provincial hospitals and 9% at central hospitals. **The Commission recommends this approach to programming new resources. Extensive reallocation of available resources, at a time when most facilities are under-funded is not feasible.**

MOH&CW has been using mathematical formulas for the allocation of resources between provinces since 1992/93. The formulas are complex and are currently being revised.

On investments in technology the Commission notes that there is no mechanism to advise, let alone control procurement or enhance shared use of costly equipment. For example in 1997, Parirenyatwa Hospital commissioned a Magnetic Resonance Imaging Scanner at a cost of about US$1.5-2 million. The Scanner is massively under-utilized, currently about 15 examinations per week. There are two other MRI Scanners in Harare – shortly to be three!

RECOMMENDATIONS

In a constraint environment the public sector should focus more on priority health problems of the country where government money can have the biggest impact on improving the health status of the population and where Government has an appropriate role to play, such as delivery of services to the poor, delivery of services with benefits which go largely beyond the individual who receives the service, surveillance, regulation, monitoring and evaluation of services and health status.

Government and MOH&CW should improve its financial information system into a "National Health Accounts" to allow for monitoring of health expenditure and its compliance with stated policies.

The Cómmission recommends the introduction of a mathematical formula for the allocation of Government finances to the municipalities and Districts/RDCs to enable them to deliver a certain set of services. For districts, such a formula should give weight to relevant factors:

- **Number of people living in the district**. The factor makes that Government per capita expenditure should be equal for every person in Zimbabwe;
- **Reciprocal of population density in the district**. The factor guarantees that districts with a dispersed population receive relatively more Government funding, since these will be unable to deliver the services as efficiently as districts with a higher population density.
- **Poverty in the district**. The proportion of poor people living in the district or municipality should also be a factor in the allocation formula, since they (1) deserve to receive extra services from Government, (2) are less able to come up themselves with finances for those services, (3) have more health problems. If MOH&CW cannot find poverty data of acceptable quality a health indicator closely related to poverty, such as stunting among the under-fives or child mortality rate could be used.

The large hospitals, which have a national or provincial function, could receive Government funding based on a mathematical formula, which gives a weight to:

- **The number of beds in the facility.** This factor is important since it is a major determinant for the number of staff in the facilities, which is one of the largest components of the facility's budget.
- **The number of referrals to the facility.** The number should not depend on directly admitted patients or on all OPD patients, since the large hospitals are supposed to attend to referred patients only

However, as long as the major cities have no district hospital type facilities available, it will not be possible to fully apply the suggested allocation formula.

Less emphasis should now be put on building new facilities, than on making the existing infrastructure fully functional through adequate staffing, upgrading and maintenance, in order to obtain the level of equity as was intended by the rural investments. For under-served areas with a very low population density GOZ should consider to provide mini-health centers, staffed by a health worker with PHC and midwifery skills.

The issue of equity in distribution of human resources is discussed in Chapter 3.

5.3 Improve Financial Management and Cost Control

Decentralization of decision making to large facilities and the district health authorities, as discussed in Chapter 4, as a first priority has potentials for improving efficiency. Other financial management areas that need attention include budgeting, accounting and contracting out.

On budgeting, the Commission observed that Treasury's guidelines tend to encourage budgeting based on historic trends rather than on strategic planning. Certainly in a rapidly changing environment such as now because of the AIDS epidemic the present budgetary process tends to respond too late. The absence of a coherent implementation plan for health strategy may make it difficult for MOH&CW to prioritize and to fight for an increase in its budget and for MOF to evaluate the efficiency with which MOH&CW uses its resources. Capital projects such as the construction under FHP and FHP2 or the extension of Harare Central Hospital, are mainly funded through multilateral loans or bilateral donations. Chinhoyi hospital was mainly GOZ funded. Capital expenditure for health averaged around 9.7% of total health spending from 1990/91 through 1994/95, including 2.3% for furniture and equipment. These funds were mainly channeled through the Ministry of Public Construction and National Housing (MPCNH), now Ministry of Local Government and National Housing (MLGNH). The National Economic Planning Commission (NEPC), in the President's Office, plans capital investment and the annual phases of the 5-year PSIP and monitors monthly capital expenditure by Ministries. Given the wide range of projects and their sometimes technical complexity, MOH&CW should

ensure that they have adequate opportunity to provide briefing and justification to NEPC. This will reduce delays.

On recurrent budget several training institutions complained to the Commission that their budgets were part of hospital budgets which meant that the more urgent hospital needs will use training funds. The Commission is convinced that this is a valid concern.

Ascertaining trends in the share of investment that goes to different levels of care is not readily possible in the current MOH&CW accounting system. MOH&CW makes grants to "cost centers", which at the district level comprise a referral hospital (mission or district), rural hospitals (sometimes) and all affiliated rural or mission health centers. Assessing the cost-effectiveness of current investments requires separating the portion dedicated to primary care from total health spending. The standard categories in the MOH&CW budget are not amenable to functional analysis and, in some cases, do not accurately describe the expenditures they include. There is considerable overlap between Sub-vote II entitled "Medical Care Services" and Sub-vote III "Preventive Services".

MOH&CW Accounting Systems were designed to control cash, to safeguard assets and to summarize historical accounting transactions rather than to generate management information. The growing need to manage financial resources more effectively suggests that the existing account structures and headings be modified to track expenditure by responsibility center first and then by activity to allow for reporting by and comparison between managers and the resources allocated to them. Besides information on how much is being spent on salaries, wages and office equipment, people want to know how much Government is spending to improve the quality of their health services, fighting HIV/AIDS, malaria and other priorities.

It is clear that the present budget and financial control systems are in conflict with a policy aiming for decentralization. In fact, local authorities and districts are often uncertain of the amount of money they will receive, and central controls make local spending difficult. A review of expenditures suggests that budgetary allocations often do not translate into actual spending, especially where first and second level of care is concerned.

The GOZ has decided to contract out a number of non-clinical services to the private sector. Service contracting is seen as a strategy to improve the quality and/or increase the quantity of services that can be provided at specified cost. Experience to date is limited. The Commission was informed that MOH&CW received instructions on services to be contracted out – security, cleaning, maintenance, laundry and catering. Laboratory and dental services were to be considered later. MOH&CW was apparently given no time to study which areas were best contracted out and how. MOH&CW has found it difficult to achieve the PSC three monthly targets which are essentially about numbers of staff retrenched as a result of contracting out.

The MOH&CW realized early on that catering and laundry services could not be contracted out for the time being because the equipment in many hospitals is old and not

in good condition. The laundry equipment in Chinhoyi is an exception and laundry is in the process of being contracted out. PSC has provided training for staff in the Mpilo Hospital laundry with a view to eventually contracting the service to them. This at the moment seems difficult, as the laundry staff do not have adequate investment and management skills. It seems to the Commission also that there should be an element of transparent competition in awarding such contracts. So far, the experience with contracting out has not always been positive.

The main conclusion of the Commission is that MOH&CW should be encouraged to assess present experiences and carry out more studies in areas possibly suitable for contracting out, before moving ahead.

RECOMMENDATIONS

Provinces and districts should be able to make their work plans with the guarantee that they will receive at least a real budget increase to account for the population growth per year. Funds should be made available as an advance, not on a reimbursement basis. Operational staff should be involved in budget preparation, since they finally will be held accountable for management of their resources. Budgets should be provided as a lump sum, while virementing could be done at the local level of the district/institution.

Given that the total MOH&CW budget is approved by MOF and Parliament, consideration should be given to devolving the authority to virement budgets to MOH&CW. This would prevent many delays in utilization of funds.

Planning of capital expenditures needs to be done strictly on basis of technical arguments, such as equal access to clinical services per district or province. To ensure a more equitable distribution of capital funds between the various service providers there should be joint planning for capital spending by MOH&CW, local authorities and missions.

Budget discussions between the Ministry of Finance and MOH&CW should be based on a business plan of the MOH&CW rather than on historic data. The MOH&CW plan should clearly explain and justify the priorities of its program, and attach to this a multi-year expenditure framework. The Ministry needs to sharpen its analysis of the link between health expenditures and outputs by the sector. It should be able to show to MOF the impact of budget decisions on outputs of the health sector.

GOZ should work towards setting up contracts with the larger health institutions, such as hospitals and training institutions, and with the district health authorities. The contracted entities should be allowed to virement without further involvement of central offices. Payments should be made on an advance basis, rather than as a reimbursement.

MOH&CW and MOF should review with the involved institutions the appropriateness of the present division of cost centers. Under present arrangements training institutions are part of the same cost center as a hospital. This often means that the training budget suffers under the urgent unforeseen needs of the hospital. Budget to training institutions should be earmarked and protected.

The financial management system should easily reveal if Government's policies, procurement procedures and sectoral priorities are being complied with and the goals of the program are being achieved. Mechanisms to follow spending by level of care need to be developed.

It seems prudent for MOH&CW to move gradually with contracting out, assessing and evaluating services that are suitable for contracting out. MOH&CW should begin with relatively easier services before moving to complex services.

5.4 Closing the Financial Resources Gap

All partners, donors, NGOs, associations, the public and private sectors indicated willingness to be actively involved in a programme for revitalizing and improving health services. The main elements of such a programme which were discussed with them include: staff retention packages; essential equipment and its maintenance; staff accommodation; urgent rehabilitation of health facilities; reviving the community health movement; ensuring availability and quality of drugs; intensifying action against HIV/AIDS; TB and Malaria; establishing a QA programme; strengthening role of MOH&CW in human resource development (leading to a new master plan which is needed urgently), planning and leadership in MOH&CW. A number of these elements feature prominently in proposed areas of support in recent donor review reports.

The report of this Commission contains critical elements of such a programme for revitalizing and improving health services. The Commission recommends that after initial discussions with interested donors and adequate planning, high level donors meetings should be convened to agree on collaborative plan to fill resource gaps, ideally in a sector-wide approach.

The partners were clear and unanimous on one point – more transparency is needed in the health sector. The present accounts in MOH&CW make it impossible for donors to provide more integrated (=budget) support to the sector, since it is unclear how the moneys flow. There is need to set up a comprehensive financial information system -- such as National Health Accounts in which all finances and flow of resources for health from GOZ and other partners can be followed. All partners working together in the Health sector --MOH&CW, local authorities, missions, external finances, NGOs-- should have access to the financial information of the other party. This is the only way to provide a transparent overview of the contributions and expenditures of all parties and check if commitments have been followed by actual expenditures. These reports should

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be open to the public and press to guarantee transparency and promote community involvement. This transparency is a prerequisite for fair budget discussions. As a first step, the partners should meet once a year to share information.

CHAPTER SIX

THE PRIVATE HEALTH SECTOR

The private sector is involved in both the provision and financing of health care. Providers include private hospitals, private surgeries, pharmacies, ambulance services, traditional medical practitioners and natural therapists. Financiers are mainly the medical aid societies who finance most of the private health care expenditure.

The main problems and concerns regarding the private sector, as established by the commission, include lack of effective mechanisms for co-ordination, the rapidly escalating cost of health care, and lack of regulation. The Medical Services Act, *1998, which recently passed through Parliament,* aims to regulate these activities but appears to have left out some important areas.

Of the approximately 1 600 registered medical practitioners, an estimated 40% work full time in private practice and only 625 (39%) are employed by Ministry of Health. Of the over 15 000 nurses registered with Health Professions Council only about 7000 (47%) are employed by the Ministry of Health.
About 50% of the total national expenditure on health is private spending by the approximately 30 Medical Aid Societies - whose membership is about 1million (10% of the population), and individual cash payments.

Private Health Care Services

The sector is an important partner in health care but its uncontrolled growth is of concern to the Commission.
Since the early 1990s there has been a steady growth in the provision of private facilities, which range from relatively small industry-owned clinics to large institutions with highly sophisticated facilities.
Recently there has been an "explosion" of small facilities such as general practitioner (GP) surgeries due to an increased demand, economic deregulation and relaxation of PSC regulations. A number of large private hospitals are currently under construction.

In Harare there are three private hospitals with a total of 365 beds. Three other hospitals are under construction in the same city with a total of 384 beds. These hospitals will be operational within the next 6 to 24 months and will have serious manpower implications for the public sector. The Commission urges the MOH&CW to make contingency plans for the inevitable drainage of large numbers of health personnel from its hospitals.

In Bulawayo the only major private health institution is Mater Dei Hospital. The hospital has a capacity of 150 beds, but is to be extended to 200 within the hospital's current

refurbishment programme. A new private eye hospital is nearing completion and a major private hospital is due for construction in Bulawayo in the near future.

Pharmacy Services in the Private Sector

It is estimated that about 10% of the population purchase their drugs from the private sector. There has been an "exponential" increase in the number of registered pharmacies. This rapid growth of the private sector, with insufficient numbers of professionals trained, has caused a severe shortage of pharmaceutical personnel in the public sector. The private pharmaceutical sector is able to provide much better salaries and are therefore more attractive to pharmacists than is the public sector.
Pharmacy services in the private sector seem to work better than in the public sector and there are much less reports of drugs shortages.

The Quality of Private Service Provision

The Commission notes that in general the public considers private facilities provide better quality care than public institutions. However studies show that many private practitioners do not follow standard treatment protocols and often employ under-qualified staff. It has also been reported that private doctors might be guilty of over supply, and not providing value for money. There is a more serious risk that in an imperfect market, quality compromising short cuts might be taken to keep costs and prices down.

The current regulatory mechanisms are recognised as inadequate to monitor or enforce any minimum standard of quality in the private sector beyond structural concerns. Quality concerns are investigated reactively, and the lack of standards makes assessment difficult.

RECOMMENDATIONS

The Commission recommends the formation of a standing public/private health sector committee. The committee will report to the National Health Coordinating Council which has been proposed in Chapter six. Part of the responsibilities of the committee should be to draw up mechanisms for effective co-ordination of the private and public health sectors in the planning and delivery of health services in the country.

The Health Services Act, 1998, contains provisions for the regulation of, among others, the registration of medical aid societies, establishment of private hospitals, keeping of records and provision of information and admission of private patients to government hospitals by private practitioners. The Commission supports these provisions, but recommends that they be extended to cover the establishment, functions and activities of, and where appropriate, the qualifications of health personnel engaged in: nursing homes, X-ray facilities, ambulance services, emergency and trauma centres, laboratories, surgeries (including a limit on the

number of surgeries an individual may operate) and other health-related facilities. There should also be provisions to ensure the affordability of drugs.

The MOH&CW should establish a technical committee to regularise the stocking, prescribing and dispensing of drugs in various settings and to establish conditions under which different health professionals - pharmacists, doctors, clinical officers and nurses - may deal in different types of drugs. This Committee should include MOH&CW, statutory regulatory bodies, professional associations and other relevant bodies. This Committee will make recommendations to the Minister of Health who may propose relevant legislative and operational changes.

With regard to problems raised by the private pharmaceutical sub-sector the commission makes the following recommendations.

Market forces currently determine the mark-up on drugs. The levels at present are manufacturers 25-80%, wholesaler 20-35% and retailer 40-50%. The mark-ups contribute to the very high cost of drugs and need to be reviewed by all involved, including the Ministry of Health.

Local companies should be given incentives to increase the value of local content of their products. GMS could increase the domestic preference regulations in its tendering procedures.

With the privatisation of the Government Medical Stores, the private and public sectors should work together on a formula for purchasing essential imported products through collective buying. This will reduce the overall cost to be borne by the consumers in the formal sector.

There should be more dialogue between MCAZ and NPCZ on drug registration costs and retention fees for "orphan" drugs to ensure the continued availability of these products.

MCA should increase its focus on market surveillance.

In co-operation with ZEDAP and the medical aid societies a survey of prescribing practices in the private sector should be carried out to evaluate if the public's interests are now best served.

Traditional Medical Practice

Traditional medicine is the original medicine of Zimbabwe and it has survived the political social and technical pressures by modern culture and technology. It is estimated that there are about 50,000 traditional healers at present (1998) and it is clear to the Commission that traditional medical practice is very popular and is utilised by a large section of population. Some people use both traditional medicine and conventional

medicine, depending on existing circumstances such as lack of access to conventional medical care or type of illness or pressure from family members. It seems quite clear to the Commission that traditional medical practice has a large following, and certainly has a role to play in health care.

In 1981 the Traditional Medical Practitioners(ZTMP) Act was enacted which made it a legal requirement that all traditional medical practitioners be registered. The Act also established a Traditional Medical Council with the main function of registering traditional practitioners, and supervising and controlling the practice of traditional medicine. This task seems to the Commission to be near impossible and not enforceable. As a result the registration requirement is largely ignored and it seems that the majority of traditional practitioners are not registered.

Before the promulgation of the ZTMP Act traditional healers had formed themselves into an association, the Zimbabwe National Traditional Healers Association (ZINATHA). This is a powerful association and the name ZINATHA has become synonymous with traditional medical practice. Since the enactment of the Act there has been increased confidence among the TMPs and calls for further recognition. In particular there were calls for collaboration between traditional medical practitioners and allopathic medical practitioners. There have also been calls for TMPs to be allowed into government hospitals to assist in the treatment of patients. There has been hardly any progress on this matter of collaboration because of professional incompatibility between the two systems.

In the private sector there has been some progress towards collaboration. A clinic has been operating in Bulawayo since 1991, which offers both traditional medicine and conventional medicine in the same premises. This practice has apparently not spread beyond this one clinic.

The Commission has had some in-depth look into the subject of collaboration and integration between traditional and allopathic medicine. The president of ZINATHA made a formal presentation to the Commission on the whole subject of traditional medicine. In addition a special consultation meeting was held with 15 provincial representatives of traditional medical practitioners.

In the area of herbal medicines there is general appreciation that some herbal medicines are efficacious; what is required is adequate refinement of the medicines, hygiene in preparation and dispensing, and attention to dosages and safety. There is also agreement on the need for more extensive research on traditional herbal medicines.

RECOMMENDATIONS

In the light of the above observations the Commission makes the following recommendations.

There is deep-seated misunderstanding and mistrust between traditional medical practitioners and allopathic doctors. Consequently the Commission believes that it

would serve no useful purpose to attempt to forcibly integrate the two systems. It is recommended instead that resources be put towards improving the quality of care offered by both types of health systems. Monitoring of traditional medical practice needs to be strengthened. This is more likely to be achieved through ZINATHA and local community action than through legislation.

It is further recommended that the dialogue that has developed between practitioners of the two systems in recent years be encouraged and promoted. This will assist in the better understanding of each other and help built a relationship of confidence and trust in due course. This can probably best be done at the local level by organising regular joint meetings.

Systematic research into herbal remedies and a review of patent laws in relation to herbal remedies should be developed and sustained through official financial support by government. It is hoped that this research could lead to large benefits not only for the health of the population but also for the economy of the country, since there seems to be a large national and international demand for effective traditional medicinal products. Plans should be made to ensure that plants that have been proved to be medicinal are both preserved and propagated for the benefit of posterity.

The subject of traditional medical practice is too large and complex to be exhausted within the Commission's terms of reference. The Commission therefore suggests that certain aspects of the subject be investigated separately. Specific areas for research to include:

* Re-examining the extent and reasons for the current popularity of traditional medicine in the country, with the aim to improve quality of service in both the traditional and formal system;
* The role of spiritually based traditional practitioners in providing health care;
* Professional relationships between the biomedical trained and the traditional practitioner, especially regarding policies designed to integrate traditional medicine into the formal health sector;
* Evaluation of interventions of traditional healers and the potential public health benefits from better understanding of traditional medical practice;
* Assessment of the community's opinion concerning a possible role for traditional medicine in basic health care.

Alternative Medicine

There are two main types of alternative medical practice namely Natural Therapy and Complimentary Health practice. These are represented by the Natural Therapists Council of Zimbabwe (Act 31 of 1981) and the Association of Complementary Health Practitioners of Zimbabwe (ACHP) respectively.

Natural therapists undergo formal training to become homeopathic practitioners, osteopathic practitioners, chiropractors, naturopaths, aupuncturists or ayuverdic practitioners. They all undergo a five-year full time training programme in approved Schools and Colleges in South Africa, United Kingdom, United States of America and India, and a one-year internship. The overall contribution of natural therapy to health care in the country appears to be very small; for example the Commission was informed that only 15 homeopathic practitioners are registered to practise in the country.

The group of Complementary Health Practice consists of practitioners who need no formal qualifications to practice. Qualification is usually by experience and training from other practitioners. The aim of complementary health practitioners is not to be an alternative but to complement the work of the medical profession in general by adding to the healing process from a different angle.

RECOMMENDATIONS

The Commission notes the existence of alternative medical practices and the need to respect patients' freedom of choice. The Commission is of the opinion that alternative medical practitioners should set up their own institutions and facilities, separate from the existing conventional medical practice.

The Commission notes that legislation is already in place to regulate the practice of alternative medicine that excludes those that are not qualified. It is recommended that those groups who feel that they are not recognised should endeavour to get registered under the relevant Acts such as the Traditional Medical Practitioners Act.

The Commission recommends that the curricula of health professionals should contain some concepts of alternative medical practice in order to raise awareness for alternative forms of treatment.

CHAPTER SEVEN

CONCLUSIONS, PRIORITIES AND WAY FORWARD

7.1 Conclusions

The Commission's analysis of the Zimbabwe Health Services shows a mixed picture of positive and negative findings. **On the positive side**, Zimbabwe has clear objectives and policies for the development of her health system. A large increase in coverage by health services has been achieved through: construction of new RHC/Clinics and hospitals; training of large numbers of staff; deployment of hundreds of VHWs; provision of grants to mission hospitals to enable them to provide free care to poor clients; abolition of user fees at RHC/Clinics and creation of the SDF which pays hospital costs for poor patients among other things. Resources to the public health sector were increased considerably in the first 10 years of independence. For example health expenditure as % of total government expenditure rose from 5.3 in 1980/81 to 6.2 in 1990/91 (US$23.6 per capita). The Zimbabwe Essential Drugs Action Programme ensured availability of drugs to a large extent. During this period utilization of services increased considerably, for example immunization coverage increased from 25% in 1982 to 77.6% in 1996. The expansion of health services contributed to considerable improvements in health during this period. For example IMR rate decreased from 83 per 1,000 live births in 1979/80 to 60 per 1,000 live birth in 1990. Life expectancy rose from 57 years in 1978/80 to 61 in 1988. The final positive finding is that, although health has been deteriorating in the nineties, there is a sense of optimism among the public, health workers, NGOs, donors, private sector, MOH&CW and the government that the current deterioration of the health service can be put right and all groups are ready to play an active part in the process.

Some of the data on the **negative findings** are alarming. For example: IMR rose from 60 per 1,000 live births in 1990 to 89 in 1997; Life expectancy decreased from 62 years in 1988 to below 50 in 1997; Maternal Mortality rate remains high, 283 per 100,000 live births in 1994 and is probably increasing; Antenatal coverage fell from 90% in 1988 to 74% in 1996 and deliveries carried out in health institutions fell from 54% in 1988 to 50% in 1996. Deficiencies in health services have contributed to the deterioration in health. MOH&CW budget fell in 1999 to its lowest level since Independence (less than US$10 per caput). The Commission's recommendations to correct health service deficiencies are organised under four main headings namely: delivery of services; human resources; organisation and accountability and financing of health services.

On **delivery of health services** the Commission finds that national response to key threats, namely HIV/AIDS, TB and malaria are inadequate and makes practical recommendations to intensify the fight against them. The measures recommended include: declaring HIV/AIDS a national disaster and mobilization of all sectors and communities to participate actively in the fight.

A number of progammes, such as those dealing with health care for commercial farm workers, occupational health, health of prisoners and control of non-communicable diseases are relatively neglected and recommendations are made on how each should be strengthened. The Commission is very concerned with the high maternal mortality rate and spent considerable time working out possible solutions. The Commission's recommendations on this issue focus on enhancing local surveillance of maternal mortality and improving quality of MCH services. The Village Health Worker programme, which at Independence was the pride of MOH&CW and central to the Community Health Movement, is now at a low ebb. Urgent action to revive the movement is needed and recommendations of the Commission include re-transferring the VHW/VCW programme to MOH&CW, which has the infrastructure to expand and strengthen it.

Other programme issues addressed include low coverage with Blair latrines (only about 37.5% of households at present); unsatisfactory management of industrial and domestic waste; ineffective referral system; child health and substance abuse. On infrastructure, the Commission makes recommendations to improve the poor state of health facilities particularly in rural and provincial hospitals; shortage of essential equipment and inadequate maintenance and staff accommodation. Remedial measures are recommended. Availability of essential drugs was fairly good at most hospitals but inadequate at RDC health centres and clinics. Recommendations for improving procurement and enhancing affordability of drugs are made. Recommendations are also made on measures to improve laboratory, pathology and other support services.

Three broad issues namely: the need for MOH&CW to develop clear health promotion policies, lack of coordinating mechanisms between MOH&CW and health related sectors and enhancement of gender sensitivity are also addressed. A coordinating mechanism that will be concerned with health promotion, revival of the community health movement and substance abuse and related issues is proposed. On the last point the Commission feels strongly that the role of women at all levels of MOH&CW should be strengthened, particularly at higher levels of decision making.

On **Human Resources**, the Commission addresses five issues. Firstly, the Commission is very concerned about lack of readily available accurate information on health workforce and recommends that MOH&CW should install an efficient personnel information system.

Secondly, there is a serious shortage of health staff and the current Human Resource Development Plan is not an effective tool for change. For example, the Human Resource Master Plan has a target of 1 634 doctors working for MOH&CW by 1997. But in practice there are now (1999), 676 posts and only 551 are filled. The Commission recommends measures to attract and retain doctors, increase intake in the medical school and establishing a second medical school in Bulawayo. In the case of nurses, the Commission notes that if current trends in training and attrition persist, only 53.7% of the requirement of nurses will be available by 2008. In this respect, the Commission regrets the abolition of the SCN training course. The Commission recommends that intake of

nurses in training programmes be increased, that the role of nursing aides and clinical officers be strengthened and that a new cadre, the Primary Health Care Technician, with appropriate training to carry out most tasks at RHC/Clinics as well as at mission and district hospitals should be established. MOH&CW should strongly resist pressures to abolish the X-ray operator training programme and seriously consider reinstituting the training programme for laboratory technicians. The Commission also recommends that MOH&CW should develop a realistic and costed Master Plan for Human Resources Development as a matter of urgency.

Thirdly after reviewing the current conditions of service for public health workers as well as those prevailing in private practice and neighbouring countries, the Commission recommends what it considers to be a realistic package of conditions of service to retain staff (as of June 1998).

Fourthly on personnel management, the Commission is surprised by the weakness of leadership and management at various levels of health services. A good example is the almost lack of enforcement of PSC conditions related to private practice by public health workers. The Commission recommends two measures, strengthening leadership and management skills at all levels and provision of allowances to key staff in lieu of private practice.

Finally, the Commission addresses and makes recommendations on training programmes of various cadres.

The Commission dealt with three **organizational issues**. First, a number of key decisions in public health care are beyond MOH&CW and at times it is not clear who is responsible for what. PSC controls establishment of posts and defines salary scale and allowances, limiting the ability of MOH&CW to introduce measures that might encourage staff retention. The Commission recommends the formation of a Health Service Commission with authority to carry out the functions of PSC in the public health sector. The Commission also recommends that authority and responsibility for ownership and maintenance of vehicles and maintenance of health facilities and equipment be transferred to MOH&CW from CMED and Ministry of Local Government and National Housing respectively. The Commission is happy to note that the maintenance budget for these activities is now with MOH&CW.

Secondly, hospitals and districts do not have adequate authority. The Commission recommends that all hospitals should have Management Boards with specified but varied levels of responsibility. The Commission recommends a gradual process of decentralization to districts. Initially DHEs should be expanded to a District Health Committee bringing in other major health stakeholders in the district. Such a gradual approach will provide an opportunity to assess the proposed decentralization arrangements through practical experiences and decide on which services are better decentralised further to Local Authorities and which should not. With increasing decentralization the Commission recommends that the functions and staffing at provincial level should be reviewed. The work of the provincial level should focus on capacity

building, monitoring and enhancing quality of services in public and private institutions. The Commission is concerned with the danger of decentralization getting stuck at the district level and recommends a number of measures to revitalize the community health movement.

Thirdly, the Commission feels that MOH&CW at Headquarters should focus on policy, strategy and tool development and provision of technical support. Further the Commission addressed in some detail six priority functions of MOH&CW at Central level: enhancing health action in other sectors; enhancing equity in health and health care, QA and enforcement, enhancing high quality research; statutory and regulatory provisions in support of health and strengthening the structure of MOH&CW at HQ.

On **Health Financing**, the Commission discussed three issues. First, the Commission examined ways of addressing the dramatic decline in resources available to health services. The Commission recommends that in the short term, the Government should increase its contribution to the health sector to at least the level of real per capita allocation to health sector in 1990/91, while in the longer term further increases will be required. The possibilities of increasing funding for health through earmarked taxes and tax exemptions should be studied. National Health Insurance should be considered as a long-term goal, which cannot be achieved in the immediate future. Public hospitals, particularly district hospitals should be strengthened and will for a long time serve as insurance mechanism for the majority of Zimbabweans. Private insurance mechanisms should also be encouraged. The Commission recommends a new approach to user fees, the point of departure being that exemption, collection and management of user fees at RHC/Clinics will be carried out by local communities. On efficient use of available resources the Commission recommends, (a) review and simplification of the mathematical formulae for allocation of resources between provinces; (b) more emphasis being put on improving functioning rather than putting up new buildings and (c) rationalization of "cost centres".

Thirdly, on closing the gap in financial resources, the Commission recommends that MOH&CW uses its strategy document as a basis for enhancing partnership and establishing global funding of programmes (sector-wide approach). MOH&CW should make every effort to increase donor contribution.

7.2 Priorities for Action

Recommendations of the Commission are closely interrelated and constitute a package. Thus talking about priorities is not in the sense of deciding what should be done and what should be excluded – the issue is the extent of implementation of individual recommendations. For example, the Commission's recommendations on organizational reforms are unlikely to succeed without provision of additional funding and vice versa. Appropriate mechanisms and enabling legislation will also be required. However, the extent of implementation of recommendations such as those dealing with decentralization may be partial at least initially.

The most important recommendation that the Commission is making is that to rehabilitate and revitalize health services, MOH&CW and Government as a whole need to make a number of fundamental changes. Piecemeal superficial changes will not help. Foremost, MOH&CW needs to open up to health partners: communities, donor agencies, NGOs, health workers, professional associations, private sector, teaching and other institutions and trade unions. MOH&CW and Government must be prepared to tell partners what is happening in the health services and foster a commitment, a social contract for joint action and monitoring. Many partners called for more dialogue, transparency and accountability within the health sector. Success of the Government and MOH&CW in this endeavour (resulting in improvement in health services and health) could serve the nation as an example of what partnership can achieve even in the context of adverse economic situations. The Commission recommends the establishment of a National Health Coordinating Council (NHCC) chaired by the Minister of Health and involving the major partners. The Council should have a number of standing committees such as on SWAP, public/private coordination and others.

A number of priority areas that cut across the Commission's recommendations emerged from discussions with various partners. These include: staff retention packages; essential equipment and its maintenance; urgent rehabilitation of health facilities; staff accommodation; reviving the community health movement; intensifying action against HIV/AIDS, TB and malaria; establishing a national QA Ppogramme; strengthening the role of MOH&CW in human resource development and equity in health and health care.

The severity of the present crisis in the health of the people certainly asks for a concerted effort in many sectors.

7.3 The Way Forward

Recent health reforms in many countries have often swung from one position to another. Fundamental policy changes are made to correct dissatisfaction with the existing situation. After a short period, often only a few months, when problems and dilemmas are encountered in the new position a move is made back to the original position and the cycle is repeated. To avoid such to and fro movements which often disrupt and have an adverse effect on operational health services, the Commission recommends a gradual process in the implementation of the reforms in such areas as decentralization of authority to hospital management boards and districts; revitalization of the community health movement and in the approach to user charges. Such an approach through which lessons from experience are used as inputs to the further extension and expansion of reforms is the way forward.

Most of the recommendations made by the Commission focus on the process of revitalizing health services. Many of these processes, which are re-organization and financing, may not be visible to the general public immediately. The Commission believes that it is essential for "products" emanating from implementation of its

recommendations to be clearly identified and monitored. In terms of the process, visible products will include rehabilitated health facilities, improved staff accommodation, availability of essential equipment and appropriate maintenance of services, revitalized community health movement, increase of staff, improved environmental sanitation and the establishment of a QA and inspection programme. In terms of impact, the commission would expect to see increased quality of care, community and health worker satisfaction and close monitoring of maternal mortality with corresponding action to deal with preventable causes being undertaken.

The successful implementation of the recommendations of the Commission, if approved, will require quick action, high level of co-ordination between changes in policy, organization, management, financing the delivery of programmes and strong leadership. The Commission would like to make three specific suggestions to enhance follow up. First is the formation of an Implementation Committee that will spearhead the process. Secondly, the Report of the Commission along with the strategy being developed by the MOH&CW should be used to facilitate dialogue and mobilization of financial resources and support from donor agencies. Most donor agencies expressed interest and enthusiasm in supporting the implementation of the recommendations of the Commission and the Health Strategy. Finally, the importance of monitoring and evaluation of the implementation of the recommendations cannot be over-emphasized.

In the late 1980s and early 1990s, the Health Services in Zimbabwe were the envy of many countries. The Commission strongly believes that if its recommendations are implemented this will revitalize the health services and make it one of the best in Sub-Saharan Africa.

ANNEX 1

Terms of Reference

The Terms of Reference of the Commission were to inquire into and report upon:

- The extent and role of government's involvement in the provision of health services in Zimbabwe.

- The provision of an organised, cost effective and efficient health care delivery system that is both affordable to government and accessible to the most vulnerable and yet addressing the nation's health priorities.

- Achieving an appropriate framework and managerial process for the public health delivery system with particular attention to organisational, administrative, financial and legislative provisions necessary to provide such a health delivery system.

Further, the Commission is to address more specifically the following issues:

- Organisational Capacity and Accountability

  Examine the organisational structure, responsibilities and roles within the public health system with specific reference to the Government's decision to decentralise functions.

  To review the existing structural relations and responsibilities between the MOH&CW, missions, local authorities and the private medical sector including the financial arrangements currently in place.

- Health and Disease Problems and Priorities

  To elicit detailed information on the major health and disease problems of the nation, priorities needing special attention and action and consider how these could be addressed, with special regard to equity and the National Plan of Action for Children.

- Service Quality.

  To evaluate the quality and maintenance of health infrastructure, the availability of essential drugs and the prioritisation of preventive over curative services, through primary health care, including factors contributing to the quality of care at public health institutions and in the community.

- To review the role of Professional Associations namely:

  Health Professions Council of Zimbabwe (HPC)
  Zimbabwe Medical Association (ZIMA)
  Zimbabwe Nurses Association (ZINA)
  Zimbabwe College of Primary Care Physicians: (in setting professional standards and maintaining discipline amongst the professionals.)

- Financing the Health Sector

  In the light of a decline in public health expenditure by Government, to address the problem of mobilising additional resources to deal with priority health problems, including sustainable alternate sources of community based funding, such as property tax and hypothecated levies.

  Examine the policy on cost recovery safety net for the poor, flexibility in non-salary budget, financial management and accountability.

  Examine the relative contribution and relevance of private medical and other (including life) insurers in the overall care of the Zimbabweans.

  Consider the planning and national resource allocation systems, decentralisation and capacity of rural district councils.

- Human Resources Management Systems

  To look into staff shortages and high attrition rates, poor attitudes and low morale among professional staff and how quality care and productivity gains can be achieved.

  To investigate the priviledge of private practice.

  To assess the competitiveness of salaries, recruitment and conditions of service for health professionals.

  To review local decision making processes in relation to personnel management and implications for a decentralised health delivery system.

  To review the role of the Public Service Commission in the recruitment, appointment, promotions and determination of conditions of service for professionals in the public health system

Members of the Commission

Chairman

Dr E. Tarimo, Public Health Specialist, Former Director of the Division of Analysis, Research and Assessment, World Health Organisation.

Members

Dr. F. B. Chikara, Consultant Psychiatrist and Honorary Lecturer, University of Zimbabwe Medical School.

Dr C. P. E. M. Kostermans, Senior Public Health Specialist, World Bank.

Professor Dr L. F. Levy, Professor of Neurosurgery, University of Zimbabwe Medical School.

Rev. Dr C. C. G Mazobere, Minister of Religion with wide knowledge and experience in pastoral and social activities.

Professor Dr G. I. Muguti, Associate Professor of Surgery, University of Zimbabwe Medical School.

Mrs C. S. Nondo, State Registered Nurse, Chairperson and Lecturer, Department of Adult Education, University of Zimbabwe and President of Zimbabwe Nurses Association.

Dr B. B. Nyathi, Public Health Specialist and former Director of Health Services, City of Bulawayo.

Mr R. D. Nyenya, Executive Secretary, Zimbabwe Association of Church Related Hospitals.

Mrs M. P. Torongo, Pharmacist in the Private Sector, Past President of the Pharmaceutical Society of Zimbabwe.

Secretary

Mr F.G. Chibuda, Under Secretary-Administration, MOH&CW.

Commission Secretariat

1. T. Chitemere	Health Planner
2. D. Madhina	Medical Research Scientist
3. N. Dzumbira	Health Administrator
4. P. P Mwazungunya	Health Services Administrator
5. S. Mlauzi	Typist/Stenographer
6. A. Guchu	Typist/Stenographer
7. U. Kangoya	Senior Driver
8. O. Gogo	Driver
9. T. Nyahodza	Driver
10. S. Sachinda	Driver
11. J. Chibi	Office Orderly

List of Abbreviations

ACHP	Association of Complementary Health Practitioners
AG	Attorney General
AIDS	Acquired Immune Deficiency Syndrome
CEDC	Children Living in especially difficult Circumstances
CMED	Central Mechanical Equipment Department
CRC	Convention on the Rights of the Child
DHE	District Health Executive
DMO	District Medical Officer
DNO	District Nursing Officer
DOTS	Direct Observed Treatment Short Course
ENHR	Essential National Health Research
EPI	Expanded Programme for Immunization
ESAP	Economic Structural Adjustment Programme
GDP	Gross Domestic Product
GOZ	Government of Zimbabwe
HIV	Human Immuno-deficiency Virus
HPC	Health Professions Council
HSC	Health Services Commission
HSF	Health Services Fund
HSR	Health Systems Research
IMR	Infant Mortality Rate
LA	Local Authority
LSCFAs	Large Scale Commercial Farming Areas
MCAZ	Medicines Control Authority of Zimbabwe
MCH	Mother and Child Health
MLGNH	Ministry of Local Government and National Housing
MMR	Maternal Mortality Rate
MOF	Ministry of Finance
MOH&CW	Ministry of Health and Child Welfare
MPCNH	Ministry of Public Construction and National Housing
MRC	Medical Research Council
MRI	Magnetic Resonance Imaging
MSc	Master of Science
NAC	National Aids Council
NEPC	National Economic Planning Commission
NGO	Non-Governmental Organisation
NHCC	National Health Coordinating Council
NPAC	National Plan of Action for Children
NPCZ	National Pharmaceutical Council of Zimbabwe
NPQA	National Programme for Quality Assurance
OH&S	Occupational Health and Safety

OPD	Out-Patients Department
PHC	Primary Health Care
PSC	Public Service Commission
PSIP	Public Sector Investment Programme
RDC	Rural District Council
RGN	Registered General Nurse
RHC	Rural Health Centre
SCN	State Certified Nurse
SDA	Social Dimensions of Adjustment
SDF	Social Dimensions Fund
SIDA	Swedish International Development Agency
SRN	State Registered Nurse
TMP(Z)	Traditional Medical Practitioners of Zimbabwe
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USD	United States Dollar
VCW	Village Community Worker
VHW	Village Health Worker
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic and Health Survey
ZEDAP	Zimbabwe Essential Drugs Action Programme
ZINA	Zimbabwe Nursing Association
ZINATHA	Zimbabwe National Traditional Healers Association
ZNFPC	Zimbabwe National Family Planning Council
ZTMP	Traditional Medical Practitioners of Zimbabwe
ZWD	Zimbabwe Dollar

Printed by the Government Printer, Harare.