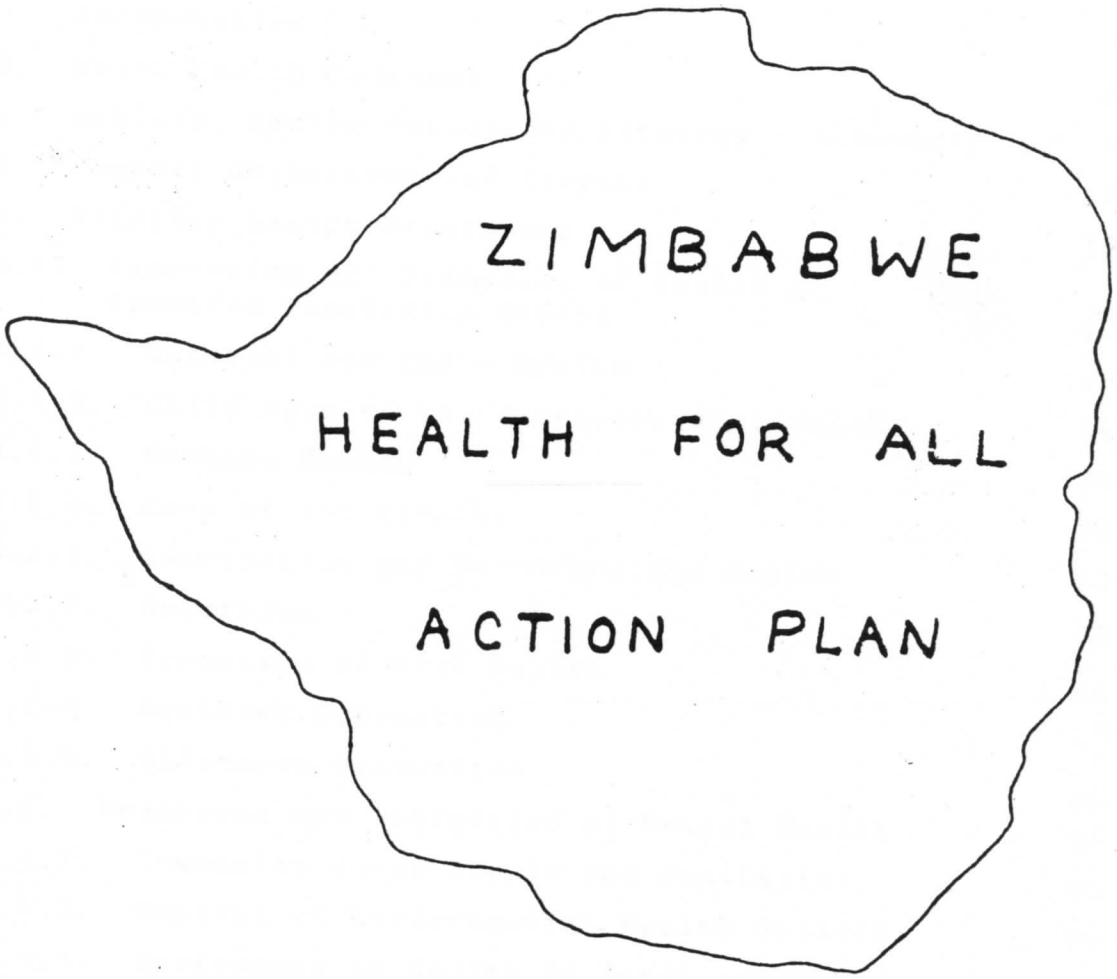

HEALTH FOR ALL

ACTION PLAN

FOREWORD

Health improvement is a goal that should be desired by one and all as it contributes largely to socio-economic development.

Having been deprived of social justice for so long, our main preoccupation following our struggle for Independence, was the establishment of social justice in health for the betterment of life of our previously oppressed people. Our first major task in the health sector was to correct the gross inequalities in Health Service provision, to which the masses had been subjected. The national health policies which were formulated in the White Paper 'Planning for equity in health' expressed the desire and determination of our people to fight yet another struggle, this time against disease and disability in order to see a better and healthier future.

In order to translate our national health policies into realities, within the framework of our economic and other limitations, there is a need to have a sense of direction in which we must harness our energies, efforts and resources over the years to come in order to bring to reality our dream of a healthy and prosperous nation. Having chosen primary health care as the best approach to reach our goal, the Health for all Action Plan, answers to this need of a sense of direction in that it provides guidance for the long term evolution of the health sector. The various programmes that will lead to health development are based on the primary health care approach. The objectives, targets and plan of action of each programme are spelt out along with the infrastructural development they entail.

Our success in attaining Health for All by the year 2 000, will depend largely on our following the guidelines laid down in the plan. In fact the tremendous success we have already achieved since Independence in the health sector has been due to using many of the strategies laid down in the plan. The adoption of the Primary Health Care Approach, entailed changing the paternalistic attitudes of health professionals, and making them more receptive to the realities of health development in our country. This change of attitude and approach has seen an upsurge of activity at the community level in the rural, periurban and urban areas.

A reorientation from the former curative, cost heavy, urban biased service, to a comprehensive health promotive and preventive approach aimed mainly at the rural masses, has occured. The community through the setting up of appropriate socio political structures now has the opportunity to participate fully in the planning and implementation of health programmes. The Village Health Worker (Community Development Worker) programme has emerged as the community's major contribution to help solve its own health problems and establish the vital link between the health professionals and the community. The building of Rural Health Centres all over the country ensures accessibility of health care to people even in the remotest of areas.

The strengthening of District and Provincial hospitals allows them to play the vital supportive role to the Rural Health Centres and thereby create an efficient two way process which is crucial to the development of effective primary health care.

Emphasis on the development of appropriate technical and managerial capacities at each level of the health care delivery system will provide the necessary expertise, and skill, to health workers operating at the various levels of care, right down to the Community level.

I must emphasize that the success of any plan of action does not just rest on manpower, infrastructure development, or availability of financial resources. It is the involvement of the community in all aspects of health development that plays the decisive role in the success of any programme. It is very relevant that community participation is enlisted all through the various phases of programme planning and implementation. The health professionals assured of ample community support will be the torch bearers for the health development we cherish for our people, which is vital if all our people are to contribute meaningfully to National Socio-economic development.

Seneramye 18th April, 1986

Dr S.T. Senanayake

1. INTRODUCTION

The Zimbabwe Health for All Action Plan has been prepared to give effect to the national health policy and strategy outlined in the White Paper, 'Planning for Equity in Health'. While this plan is for the period 1985 - 1990, the overall policy directions given in the White Paper have been reflected which will be valid for a long term period up to the year 2000.

The Plan provides guidance and direction for the development of the country's health system. It incorporates the health programmes addressing the priority health problems of the population. For each of these health programmes, specific health improvement objectives, related targets, the technologies to be used, the main lines of action and the resources required have been considered. An estimated timetable for their implementation and the means for their monitoring and evaluation have also been included.

The Action Plan also outlines the way the health system will be organized based on primary health care together with the managerial processes required to develop the health system. It also points to the areas where legislative modifications may be required.

An attempt has been made to estimate the resources, including physical, human and financial, required for the implementation of the Plan. The projections will no doubt have to be refined and revised when more precise information becomes available.

It is important to emphasize that the Plan is based on available information on health problems and health resources. This information is deficient in quality and quantity. The need to improve the information on health situation and trends and information support for management of health system has been emphasized. Measures to ensure that the available information is used in detailed programme development, monitoring and evaluation have to be instituted. Furthermore, specific problem-oriented health research will be encouraged to find the most appropriate solutions to resolve them.

Finally, it is essential topoint out that this Action Plan itself may have to be further refined and modified in the light of resources actually available and the potential progressive increase of these resources. As the Plan is progressively implemented, constant interaction will be required with on the one hand, technical levels involved in detailed programming and running of programmes, and,

Furthermore, as this Plan only extends up to 1990 at the most, it will require a careful review and updating to eventually target it up to the Year 2000. Continuing monitoring and evaluation of the Plan will be important to adjust and incorporate any policy or strategic change and to ensure that it remains always relevant, adequate, effective and efficient with respect to the concepts and strategies for Health for All through Primary Health Care.

2. MAJOR HEALTH CONCERNS

In common with the people of other underdeveloped countries the people of Zimbabwe suffer particularly from nutritional deficiencies, communicable diseases and conditions related to pregnancy, childbirth and the new born.

These health problems are inter-related. Malnutrition and infection are bound in a vicious circle. Malnutrition in girls and women leads to problems in pregnancy and childbirth for both mothers and babies, increasing the risk of maternal death and the incidence of low birth weight and neonatal death. The persistently high infant mortality rate, at about 83/1000 live births, promotes the desire for frequent and numerous pregnancies, which in turn destroy the mother's health and her ability to feed her children. The malnourished infant and child are particularly susceptible to infections.

The past history of Zimbabwe has meant that there is a great variation in the distribution of health problems. The most marked characteristics of the health sector up to Independence were the inequitable geographical distribution of services and discrimination in access to some. The preventive and promotive aspects of health services were sacrificed to provide selective high quality curative care for the few. This maldistribution is reflected in the present health patterns in Zimbabwe. This is particularly true of the burden of ill health in rural areas.

Present evidence suggests that up to one-third of children aged 1-5 years in rural areas are malnourished, as are a quarter of suburban grade one pupils. Malnutrition, which occurs even in commercial farming areas from which food is exported, is the major basic health problem in Zimbabwe. Its solution lies with political and economic changes as well as with active promotion of good feeding practices and provisions of treatment and rehabilitation through Primary Health Care.

Infection takes an enormous toll in disease and death in Zimbabwe, especially among the young. Together with malnutrition, infections account for most infant and child deaths. Among the most important are diarrhoea, pneumonia and other acute respiratory infections, measles, neonatal tetanus, malaria and tuberculosis. Most of the deaths and much of the illness due to these infections are preventable.

Infections are not restricted to children. Tuberculosis and Malaria are still common in adults. An estimated 1% of the adult population is blind, at least half of them as a result of infections. There are at least 10 000 cases of leprosy in the country.

Many of the communicable diseases are associated with insanitary living conditions, and the lack of an adequate supply of safe water and an excreta disposal system. This is particularly the case in the rural areas where less than 20% of the population has access to such facilities within a reasonable distance.

The maternal and child health problems arising from malnutrition are compounded by a lack of care of women during pregnancy and childbirth, leading to avoidable deaths of mothers and their babies both from obstetric causes and from subsequent infection.

The problem imposed on the society by mental illhealth and handicap is only now being recognised. Changes in society are creating difficulties for the young in particular which must be tackled by a sensitive and active mental health programme in conjunction with political, social and economic programmes. The nutrition and infection problems in the country have led to a large number of mentally and physically handicapped children and adults who need care and rehabilitation. Special attention must be paid to alcohol abuse, which is becoming recognized as a major problem.

Living and social conditions as well as the growth in road transport contribute to making accidents at home and on the road a major cause of mortality and morbidity, particularly among children.

Although Zimbabwe, has not yet passed through the so-called 'epidemiological transition', the incidence of cardiovascular, degenerative and neoplastic diseases is high enough to cause concern. These problems arise from environmental conditions and unhealthy living practices, and will become more prominent as the expectation of life rises in the years to come. The solutions to the present major health problems lie only partially with technology. Health for

Zimbabwe depends on the recognition that many of the major health problems have their roots in the living conditions and habits of the people, and that these must be the main targets of action for the achievement of health for all.

3. NATIONAL HEALTH POLICY AND STRATEGY - A SUMMARY

In 1984, the Government of Zimbabwe approved a White Paper 'Planning for Equity in Health'. This White Paper outlines the health policy consistent with the economic policy embedded in 'Growth with Equity', which seeks to establish a socialist, egalitarian and democratic society in Zimbabwe. It seeks to achieve equality in health status and health care in Zimbabwe and demands that the rural population be cared for first. It advocates the adoption of the Primary Health Care (PHC) approach whose key components are appropriateness, accessibility, affordability and acceptability of the care provided. It calls for a conscious acceptance by the community of the responsibility for its own health. Health is identified as development issue. It thus demands concerns from other sectors and clear political commitment, a marshalling of adequate resources and a clearly defined strategy with set goals and targets.

To formulate this Health Policy and strategy, the Ministry of Health undertook a rapid but intense study of the health sector. This revealed the existing inequalities in health status as well as parallel inequalities in the broader social arena. The review also showed inequalities in the allocation of health care resources stemming from the present system. These findings, thus, formed the basis for the new health policy, which is characterised by the primary health care approach. A broad strategy to implement this policy through restructuring of the health care system, re-orientation of health manpower, and preferential allocation of health resources was outlined and priority areas for action were identified.

Main thrust of the Health Strategy

3.1 Primary Health Care approach

Primary Health Care has been adopted by the Government of Zimbabwe as the most appropriate approach for meeting the urgent health needs of the people. The PHC approach embodies three basic ideas:

- that the promotion of health depends fundamentally on improving socio-economic conditions, and on the elimination of poverty and under-development;

- that in this process the mass of the people should be both major activists and the main beneficiaries;
- that the entire health care system should be structured to support health activities at the primary level, which respond to the mass health needs of the people.

3.2 Health and Development - an integral approach

The Government has spelt out its socialist development strategy in its policy statement, Growth with Equity. Within the Government, there will be a conherence between development and health policies, plans and actions. It will be a priority for the government to strengthen its institutional mechanisms for integrating development and health planning, and for co-ordinating the work of the agencies responsible for health-related sectors, notably: health care, water supply and sanitation, local government and housing, rural development, agriculture, community development and women's affairs and education.

3.3 Broadening the Social Base of Health Activities

(a) The tradition of community involvement in health will be preserved and carried over in a developed form. Some of the main activities for health promotion can be performed best - and sometimes only - by the people themselves, collectively or individually. Among such activities are those in connection with:

production of appropriate foodstuffs;
- correct feeding practices for young children and mothers;
- construction, protection and hygienic use of wells and latrines;
- control of insect vectors of diseases;
- personal hygiene;
- mobilisation of attendance for preventive health care (immunization, MCH care, health education);
- case-finding of communicable diseases (tuberculosis, leprosy, trachoma, venereal disease).

Locally organised health education, linked with practice and sometimes in the form of campaigns will be promoted to ensure that people understand fully their role and purpose of their actions.

Community will also play an active role in the local rural health centre. It will play a part in decision-making about health in the locality. In the planning and execution of community health actions, and in the functioning of the local health service.

At the village level, intersectoral co-ordination will be especially promoted.

(b) Another aspect of co-ordination to be developed is between the 'modern' health system and traditional medical practitioners. These practitioners constitute a large corps of people who are recognized, respected and trusted by the community in their activity. With the passage of the Traditional Medical Practitioners Act, 1981, and the establishment of the Zimbabwe National Traditional Healers Association, there is now the necessary recognition and legal framework within which traditional practice can be regulated, supervised, up-graded, and investigated scientifically.

(c) Democratisation in the health service

The principle of mutual respect and dialogue is at the heart of the new relationship to be created between the health service and the community. This new relationship will be promoted at all levels of the health service. Opportunity will be provided through appropriate mechanisms for active participation of the public and the health workers in discussions and decision-making.

3.4 Restructuring of the Health Service from the Base Upwards

The PHC approach involves a profound re-orientation of priorities within the entire health service from top to bottom, or rather - as it is being planned - from bottom to top. First priority will be given to meeting the urgent health needs of the masses, and the higher levels of the service will be developed as a function of their support to the priority work at the base of the system. Priority allocation of resources will be given to providing a 'package' of basic promotive, preventive and curative activities, accessible to all the people, and closely linked with the actions of the community and of health-related agencies. This primary level care requires systematic support from the highest levels of the health service, which must provide material supplies, technical information and supervision,

administrative back-up, training facilities and referral hospitals. The allocation and use of resources at the district, provincial and central levels will therefore be planned in these terms.

3.5 Re-orientation of Health Workers

Implementation of the Government's health policy will require not only a rapid increase in the number of health personnel but also a substantive re-orientation of the staffing structure. The government will plan to develop a cost-effective health team with the correct quantitative proportions between the different cadres, at the same time improving the quality of each member of the health team.

As the Zimbabwe PHC system is implemented, new roles and responsibilities of the doctors and nurses will emerge for which they must be adequately prepared. Revision of their curricula which must incorporate adequate training in the rural areas will be required. New categories of health workers as well as modification of the functions of some of the existing categories of health workers will be introduced to support the PHC implementation especially at the Community level and in the rural areas.

These changes call for substantive efforts in training. Development of appropriate personnel policies including career structure will also be required.

3.6 Preferential Allocation of Resources

The Ministry of Health will institute a new system for the planning of resources to support the primary health care approach. An essential component will be a revised budgeting system. A special budgetary system will be developed to ensure the priority channelling of funds to primary level activities, while allowing a controlled development at the higher levels of the health services. Criteria for expansion will be the reduction of health care inequalities through the provision of an integrated health service with an appropriate mix of the different levels of care.

The procedure for compiling the budget estimates will be brought into line with the Ministry's approach of centralization of policy-making with flexibility of implementation at the periphery. A continuing process of monitoring the use of funds will be carried out. Progress will be measured against the goals set for reducing inequity, which in the present phase means increasing the proportion of funds going to the district health services.

4. OVERALL OBJECTIVES AND TARGETS

The main objective of the Health for All Action Plan is to ensure that all the people of Zimbabwe have access to comprehensive and effective health care which will ensure their highest possible level of health and which will allow them to participate fully in the socio-economic development of their country.

Specific Objectives

4.1 To redress past and existing imbalances, anomalies and inequities in the health sector through the development of a comprehensive and integrated health service, that aims at reaching all the citizens of the country. The Health service based on the philosophy of Primary Health Care will focus mainly on preventive measures, especially in the rural areas, where most problems encountered are preventable.

4.2 To establish a National Health Service that is appropriate to our economical circumstances and disease pattern. The National Health Service to be developed and strengthened at 4 main levels.

(a) The Primary level which is operative at the grassroots and dependant for the most part on Village Health Workers. This level also incorporates the first point of contact between the people and the formal health sector, the Rural Health Centre.

(b) The Secondary (or District) level which offers support and supervision to the primary level.

(c) The Tertiary (or Provincial) level which co-ordinates and directs health sector activities at the district level.

(d) The Quarternary (or Central) level where the National referral centres are, as well as the Ministry of Health, Head Office, which translates Government policy in the health sector centrally, for implementation peripherally.

4.3 To redress the current imbalance of health services in the country, by increasing health facilities in the rural areas. At the same time it is recognised that for the rural health programme to be effective and successful, it has to be integrated with other rural development programmes,

e.g. education, water supply, improvements in sanitation, food production, etc.

The various components of Primary Health Care will be developed through appropriate health programmes which, over the plan period 1985-90, will help achieve the global strategy of health for all by year 2000.

4.4 Village Health Worker and Rural Health Centre Programme - launched in 1982 provides the essential link between the community and the formal health services. Village Health Workers are villagers who are chosen by each community from amongst its midst. These villagers undergo formal training in preventive, promotive, curative and rehabilitative interventions, which are targetted against the most common, easily preventable health problems in their communities, after training, they work in their community mainly as agents of health promotion and health education, who also provide a very basic curative service e.g. treating minor injuries, diarrhoea, malaria, scabies and other minor ailments.

The programme aims at producing one Village Health Worker for every 500-1000 population. In each of the fifty five districts, there is a village health worker training school. 4500 have already been trained an by 1990, 12 000 are expected to have been trained.

4.4.1 The Rural Health Centre provides the support and supervision for the Village Health Workers. This is the most peripheral unit of the Health Services Delivery System i.e. the Primary level facility. The RHC provides basic but comprehensive preventive, promotive, curative and rehabilitative care. Eacn RHC is to cover a population of 10 000 and should be accessible to the community.

There are over 500 such units functioning presently and the full complement of 766 is expected to be completed by 1986/87.

The RHC is ideally to be staffed by two medical assistants of whom one is a maternity assistant, and one health assistant.

4.4.2 The District (Secondary) level provides the support and referral for the Rural Health centres. Each district has a district hospital whose role is vital in providing supervision and support to

the rural health centres. Strengthening of the RHC and District levels will be crucial to the successful implementation of the action plan.

A phased upgrading of existing hospitals and building of 6 new district hospitals over the plan period is provided for.

4.4.3 The Provincial (Tertiary) level co-ordinates and directs health sector activities. This decentralisation is essential for implementation of programmes. Each of the eight provinces will be strengthened, with upgrading of the provincial hospitals, building of multi-disciplinary schools, medical stores, maintenance workshops etc. over the plan period.

The Central (Quartenary) level with the national referral centres and policy making machinery will be strengthened and adapted to play its productive role fully.

4.5 Maternal and Child Health Programme (including E.P.I.) - has to cater for 70% of the population and is the largest user of health services. The main objective of the programme is to provide comprehensive and effective maternal and child health care at all levels of the health service delivery system.

The target set for 1990 is;

(i) To reduce overall maternal and child morbidity;

(ii) To reduce mortality rates -

(a) Infant mortality from 83/1000 to less than 50/1000;

(b) Childhood mortality from about 40/1000 to less than 20/1000;

(c) Perinatal mortality from about 40/1000 to less than 20/1000;

(d) Maternal mortality from about 200/100 000 to less than 100/100 000.

(iii) Health Services Indicators

(a) To increase deliveries which are attended by trained personnel, traditional midwives included, from the current level of 66% to 90%;

(b) Increase the percentage of fully immunised children in the community from the current 42% to 80%;

(c) To ensure the percentage of mothers fully covered by tetanus toxoid to 100%;

(d) To increase the percentage of children above the 3rd centile line weight for age from 80% to 100%;

(e) To cover all women at risk with adequate antenatal services;

(f) To ensure that all women have access to child spacing and Family Planning Services, as well as adequate knowledge of their importance and the methodologies used.

4.6 Nutrition Programme

Reduction in the prevalence of malnutrition especially among children under 5 years and pregnant and lactating mothers is aimed at so that by 1990:

(i) All children under 5 years will be over the 3rd centile;

(ii) Ninety per cent of all newborn will have a birthweight of over 2500 grams;

(iii) Reduction in the prevalence of Protein Energy Malnutrition among children under 5 to less than 10%;

(iv) Reduction in the morbidity due to lack of micro nutrients of anemia, goitre, pellagra.

4.7 Water and Sanitation Programme

(i) The promotion of protection of water supplies country-wide and construction of primary water supply points through materials subsidy and the generation of community participation;

(ii) The promotion of rural sanitation through the construction and use of Blair latrines;

(iii) Hygiene education to back up both (i) and (ii);

(iv) The target is to construct 70 000 latrines and 7 000 primary water supply points yearly.

4.8 Health Education Programme

This programme complements the activities of all the other programmes. Health education officers are deployed at all levels of the health care

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7. ORGANIZATION AND DEVELOPMENT OF HEALTH SYSTEM

7.1 ORGANIZATION OF HEALTH SYSTEM BASED ON PRIMARY HEALTH CARE

A. Situation Analysis

The Government of Zimbabwe has inherited a fragmented health care system. Five sub-sectors predominate in the provision of 'modern' medical care; The Ministries of Health and Local government, mission, industrial medical services, and the private medical sub-sector. Various voluntary organizations also make contributions to health care, mostly in specific problem areas. Each provider has its own character, structure and system of financing, and there has been little co-ordination among them. The most marked characteristics of the health care sector of Zimbabwe have been the inequitable distribution of facilities geographically, and the discriminatory access to care. The system has ensured excellent standards of care for the few, while seriously neglecting the mass of the people, especially in the rural areas. The curative care has been stressed while the preventive aspects of health care have been weak.

1. The Ministry of Health is the largest provider of health care. In addition to operating much of the health sector itself, it transfers funds to municipalities local councils, missions and other voluntary organizations.

The Government hospitals have been in four categories by level of care central, provincial, district and rural. The system is supported to provide a chain of increasingly sophisticated facilities so that patients with more complex conditions can be referred up the line. In practice the referral process functions poorly as the facilities in the rural areas are very inadequate. Specialized services such as maternity care, care of mentally ill, and dental care are available mainly in the urban areas. Their preventive aspects have been neglected. While over the years, the preventive services of the Ministry of Health have broadened their responsibilities, the success of rural preventive activities has been very limited. The low budget and the 'vertical' and mobile character of these services has limited the effectiveness.

2. The Local Government Health Services are provided through district, rural and town council clinics. They have not been developed according to an overall national plan. Many of these clinics are rudimentary inadequately staffed and poorly equipped and in many rural areas there is not even one of these clinics within walking distance of the population. In 1980/81 these services accounted for 4 per cent of national expenditure on health care.

3. The Army Medical Service has substantially increased since Independence, employing approximately 1000 medically-trained personnel including doctors, SRN's, Medical Assistants and Health Assistants as well as pharmacy, dental and laboratory staff. There is presently little co-ordination of the work done within this service with that of the Ministry of Health.

4. The missions continue to play an important role in providing medical care to the rural population and their services vary from sophisticated hospitals to primitive clinics. There are no laws regulating the practice of medical missions, and the result is a wide diversity of standards of care and a lack of co-ordination of service, both among missions and with neighbouring government institutions. Previously, the size of the Ministry of Health grant to a mission facility was based on the services it provided and on average it covered a third of the cost, Mission facilities have suffered from serious under-financing in relation to their role as the major source of medical care in rural areas. In 1980/81, it spent about 3 per cent of the national health care expenditure.

5. The Industrial Medical Services provide health care to the workers in mining, farming and other industrial sectors. In 1980/81, the total expenditure by this sub-sector accounted for 4 per cent of national health care expenditure. The quality of care provided by these as well as the standards for prevention of occupational hazards vary greatly. The Ministry of Health has the statutory responsibility to monitor these institutions.

6. Private medical sub-sector provide services mainly in the two major cities, Harare and Bulawayo. It is financed mainly by insurance through the medical aid societies. The government contribution to the private care (through allowing use of government hospital beds to private patients at lower fee) amounts to a subsidy of over $4 and a half million per year. In addition this sub-sector also benefits from the investments that the Government has made in developing hospitals and in training health personnel.

In addition to the above large sub-sectors, a number of voluntory organizations are involved in health-related activities. In some fields their contribution has been significant, for example, in relation to the blind, the disabled, the aged, and those affected by leprosy or tuberculosis, the Fertility and Child Spacing Association. The Ministry of Health gives subsidies to these organizatio There has been no effective co-ordination of their activities and little opportunity for popular representation.

Recognizing the existing inequalities in access to health care especially by the rural population and the poor, inadequacy of preventive health service for a large majority of the population and the fragmentation of health care system resulting in low efficiency in the use of available scarce resources, the government adopted the Primary Health Care approach as the most appropriate approach in meeting the urgent health needs of the people.

Government has already begun to implement the primary health care approach by expanding the health care base at the community and rural levels. The redesigned health care system consists of four levels.

Primary Level

The principal components are the Village Health Workers (VHWs) and the rural health centres. VHW are the key links between the organized village community and the local health service. The role of VHWs is fundamentally promotive, educative and preventive, mobilizing the community and the individuals to preventive health activities. They are also first line health workers for treatment of simple conditions, disease surveillance and for backing health information system. On-going technical supervision of VHWs is provided by the regular staff of the rural health centres, which keeps the VHWs supplied with medicines and equipment at government expense. At present there is 1 VHW for a population of around 2000.

The Rural Health Centres (RHC) provide basic but comprehensive promotive, preventive, curative and rehabilitative care, concentrating on mother and child health, including antenatal care, delivery of uncomplicated births, child spacing, child health and nutrition, routine immunizations for children, and anti-tetanus immunization for women of child-bearing age, environmental sanitation, especially in relation to small-scale water supplies and excreta

disposal systems, control of communicable diseases, other special problems, including mental illness, eye diseases and physical and mental handcap, general curative care, care including basic dentistry. Health and nutrition education form a routine part of all the above activities. At present there is an average of one RHC for every 13000 population, which is inadquate as in many places people need to travel more than 10km to reach a centre.

Secondary Level

The secondary level is the district level where preventive and curative services have been intergrated under a simple District Health Services Authority. The main functions of this secondary level of care is:

- to support, supervise and upgrade the PHC activities in the entire District.
- to provide district hospital care, mainly for patients referred from the rural health centres.

While at present there are district hospitals in most districts, they need considerable strengthening and upgrading to function as a first freferral hospital.

The District Health administration also requires considerable strengthening.

Tertiary Level

The tertiary level is at a Province level where all preventive and curative services are being intergrated under a single Provincial Health Services Authority. The main functions of the tertiary level are;

- to support, supervise and upgrade the health activities in the entire province.
- to provide provincial hospital care, mainly for patients referred from the district hospitals.

The facilities in the provincial hospitals also require considerable strengthening to enable them to cope with most medical and surgical problems.

Quarternary Level

This level consists of central and special referral hospitals, and the head office of the Ministry of Health. There are four central hospitals, two each at Harare and Bulawayo. In view of the inadquate referral services at district and provincial levels, these hospitals direct much of their resources to the provision of basic in-patient care at high cost. The head office of the Ministry of Health directs all activities in the health service. It establishes national policies centrally and lays down general guidelines while allowing for flexibility in implementation peripherally. The adoption by the government of the PHC approach involves a great expansion of rural health care, a change in the structure of the health service, and a transformation of health workers training and attitudes. This will require considerable strengthening of the managerial and technical capacity of the Ministry of Health.

B. Overall Objective

To progressively reorganize and strengthen the above four graded levels of health care, each engaging in an appropriate mix of promotive, preventive and curative activities, with the higher levels providing support, supervision and referral facilities for the levels below, so that all citizens will have access to a comprehensive and integrated health service.

Specific Objectives

1. To provide an efficient base for the delivery of health services at the community level and in rural areas, the principal components of this base to be the Village Health Workers (VHW), supported in the first instance by the Rural Health Centres (RHCs), equitably distributed throughout the country.

2. To progressively strengthen the referral services starting at the district level by upgrading district health services or constructing new facilities as required, providing adquate material and human resources, and improving their management capacity.

3. To establish links between these health services levels and the corresponding structures in the socio-political system, to ensure political and community inputs and intersectoral collaboration with health-related agencies.

4. To develop effective mechanisms of co-ordination among the various sub-sectors of the health care system in order to rationalize health service organization and to achieve standardised care on a cost-effective basis.

C. Targets

1. To provide 1 VHW for every 50-200 families

2. To establish 1 RHC for every 10.000 population so that no person is more than 8 kilometres of walking distance of a RHC

3. To ensure one fully equipped and functional district hospital in every district, through strengthening, upgrading of 47 existing district hospitals and construction of 6 new district hospitals

4. To have one well defined referral hospital centre in each electoral province

D. Plan of Action

1. It is intended, through the medium of the Public Sector Investment Programme (PSIP), to put up most of the buildings over the years 1984 to 1990. Specific details of the physical facilities expansion programme appear in chapter 8.

Organization of Primary Level

2. Appropriate training, upgrading of the skills of the Village health workers (VHWs) will be carried out along with the strengthening of ongoing technical supervision of VHW by regular staff of the local rural health centres.

3. Norms for the prevention, diagnosis treatment and management of different conditions to be carried out by Rural Health Centres will established. Health Workers of varying degrees of specialisation will be trained or re-trained and adquate supplies will be organized. All of the PHC components will be programmed through the levels of health service to support the work at primary level.

4. To provide for a community input to the functioning of the RHC and to co-ordinate local health activities generally, a health centre committee will play a part in the supervision of VHWs, debate local health priorities on an intersectoral basis, promote popular mobilisation for health related activities and provide a channel for the feedback of the people's views on the work of the health centre.

5. Organization of the Secondary Level

At the district level, District Health Services Authority (DHSA) will be strengthened both through provision of adquate staffing and managerial skills.

6. District hospitals will be progressively strengthened to have facilities for paediatric, obstetric, surgical and medical care. Mission hospitals and clinics while remaining under their present ownership will be expected to work under the technical direction of the DHSA and for this, suitable co-ordination mechanisms will be established.

7. The District Health committee will be a key body for providing local political control on health activities, for intersectoral co-ordination between the DHSA and other district health-related agencies, and for stimulating community health involvement.

Organization of the Tertiary Level

8. The preventative and curative services in a province will be integrated under a single Provincial Health Services Authority (PHSA). The technical and managerial capacity of the PHSA will be strengthened.

9. The Provincial Health Committee will be a sub-committee of the Provincial Authority. This committee will provide local political control and intersectora co-ordination of the health-related activities of the province.

10. The management structures in provincial hospitals will be strengthened. Mechanisms for the involvement of staff, and of members of the local community in the functioning of the hospital will be gradually introduced. Each hospital will be provided with the necessary staffing and resources to deal with most of the specialized medical and surgical services, and provide the support and supervision to district level.

Quarternary Level

11. The management structures of the central and special hospitals will be established similar to those for the provincial hospitals, hospital management boards will be responsible directly to the Ministry of Health.

12. The overall capacity of the Ministry of Health for planning, implementation and monitoring and evaluation of health services and its technical capacity for each of the main PHC component area will be strengthened.

Co-ordination Mechanisms

13. Institutional mechanisms will be established for intersectoral co-ordination and for co-ordinating health related activities with other development activities. These mechanisms will complement at the highest level the various arrangements for political intersectoral and community inputs to the health service already described for the lower levels.

14. Mechanisms will be developed for close collaboration between the army medical service and the Ministry of Health at all levels, especially in the area of preventive services.

15. The Ministry of Health will monitor the standards of health care provided by the Industrial Health Services and in co-ordination with other relevant ministries will review and monitor the standards of safety at work with an emphasis on prevention of occupational hazards to the workers.

16. No further expansion of private sub-sector will be permitted at this stage and a system of licensing premises for private medical practice will be introduced.

17. A close colloboration will be established between The Ministry of Health and the voluntary organizations so that their valuable work can be integrated effectively with that of the government health service.

18. Relationship and collaboration with the mission health services will be strengthened with the government having representation on their management bodies. At the district level, the mission health services will function in close collaboration with the government health services and will be under the technical direction of the District Health Authority.

19. The financial, legal and administrative issues arising out of these reorganization actions will be reviewed and necessary measures including the required legislative measures will be gradually introduced.

E. Resources Requirements

20. The bulk of the resources required will be for the upgrading/expansion of physical facilities and for the provision and training of adquate staff expecially at the primary and secondary levels. These have been detailed in chapter 8. The government will mobilize its own national resources and also seek external resources in support of these committments.

F. Monitoring and Evaluation

Detailed plans of action will be developed at district and provincial levels on the basis of which the programme's progress will be monitored. The main criteria will be accessibility and quality of health care available to the population.

7.2 MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT

A. Situation Analysis

Implementation of the national policy and strategy for achieving equity in health will necessitate the development of managerial skills and the introduction of the managerial process at all levels of the health delivery system. Good management is a valuable resource in itself as it permits optimal utilization of the existing and often scarce resources. As has been mentioned in the previous chapters, the Government has already begun to implement the primary health care approach, which involves restructuring of the health care system, expansion of the health care base at the community and rural levels, and a transformation of health workers' training and attitudes. This will require considerable strengthening of the managerial and technical capacity of the Ministry of Health.

Action along this line has already been initiated by the Ministry of Health. The re-organization of the health services into four graded levels of care has begun, each level engaging in an appropriate mix of promotive, preventive and curative activities, with the higher levels providing support, supervision and referral facilities for the levels below.

The central level of the Ministry of Health has been re-organized and strengthened in some areas. At the provincial and district levels respectively, Provincial Services Health Authorities and District Services Health Authorities have been established.

In order to ensure political and community inputs and intersectoral collaboration each of these levels have links with the corresponding structures in the socio-political system.

Nevertheless, health management has yet to be established as a continuous process of planning, programming, budgeting, implementation, monitoring, evaluation and re-programming. The financial, legal and administrative issues arising out of the re-organization have to be studied in depth and resolved. Functions and relationships of different units and levels of the Ministry of Health need to be clearly defined to achieve maximum efficiency. Managerial skills of health workers at all levels have to be developed or strengthened. Strengthening of the managerial capacity of Ministry of Health is thus crucial to the implementation

B. Objectives

Overall Objectives

To achieve an optimum managerial capacity of the Ministry of Health for developing and operating the national health care system with maximum efficiency and effectiveness.

Specific Objectives

1. To progressively strengthen the national planning, implementation and monitoring functions at central levels of the Ministry of Health.

2. To develop and implement mechanisms for continous and permanent links for for the planning-implementation, monitoring-evaluation functions among the four levels of health care system.

3. To develop and implement support sub-systems for the efficient management of resources including financial, personnel, physical and material resources.

4. To progressively increase the management skills of the relevant health workers at all levels of health care system.

C. Targets

1. To complete Health for All Action Plan by July 1985.
2. To train provincial and district level senior administrative staff in management with a view to facilitate detailed programming by October 1985.

3. To complete detailed programming for implementation of Action Plan at district and provincial level by the end of 1986.

4. To review and strengthen the structure and functions of the Ministry of Health with the aim of ensuring permanent mechanism for planning, implementation, monitoring and evaluation of Action Plan at Central level by the end of 1985.

5. To review and strengthen the structure and function of provincial and district health offices with emphasis on increasing their capability in programme implementation and monitoring by the end of 1986.

6. To review and develop accordingly the existing information system so that it will be capable to support efficiently programme implementation by the end of 1986.

7. To train all key staff from all levels in management skills by the end of 1986.

D. Plan of Action

1. Reorientation of the attitudes of health workers from the former curative, urban based approach to the more productive comprehensive rural health care approach. This is achieved through reorientation workshops at all levels of health care and is an ongoing activity for all categories of health staff.

2. Setting up of a permanent planning unit at the headquarters of the Ministry of Health with appropriate links with the provincial and district levels. The unit will serve the acute need for programme planning, implementation, monitoring and evaluation of the rapidly expanding health services.

3. To strengthen the health information system so as to provide the support needed by management in planning, implementation, monitoring and evaluation of programmes.

4. Strengthening of the managerial skills of health cadres responsible for management at all levels of the service.

5. Development of teaching materials to suit the socio-cultural and economic context of Zimbabwe, which will be useful in the introduction of instruction in management into health manpower training programmes.

6. Introduction of management instruction in the training programme of all grades of health workers from the medical practitioners to the village health workers.

7. Strengthening management at district levels by training district health administrators and ensuring that each district is provided with such a cadre.

8. Establishment of a programme of continuing education for all categories of workers at the various levels. This will ensure upgrading of knowledge and expertise and provide a more efficient and effective service.

7.3 INFORMATION SUPPORT FOR THE HEALTH SYSTEM

A. SITUATION ANALYSIS

At Independence the health information system provided only institutional data for less than half of the whole country, and even these date were inadequately used for planning and management. The pre-independence system of data collection was deficient in quality and failed to reflect adequately the urgent needs of the rural masses, especially in a form which lent itself to effective and systematic action. To correct this deficiency in the health information system the Ministry of Health undertook rapid but intense study of the health sector so that government could formulate policy in this area in a systematic manner backed up by relevant health information.

The implementation of government's new health policy based on the primary health care approach, necessitates strong health information support in order to provide for efficient planning, implementation and monitoring of programmes.

In order to improve the collection, analysis, distribution and use of health information the Ministry of Health instituted in 1984 a review of the existing system. Following widespredd investigations and discussions and a national workshop, recommendations were made which form the basis of the plan of action for this programme.

B. OBJECTIVES

To ensure that relevant health information needed for planning and management including monitoring, evaluation and research are readily available at all levels of the health service.

C. TARGETS

1. By 1985 the information required for the planning and management, including monitoring and evaluation, of the health system in implementing the Health for All Action Plan will have been defined.

2. By 1987 a national health information system will be operating throughout the country which will be providing to health workers, planners and managers the disease surveillance and operational data required for their work. This data and information will arise from the activities of the health sector.

3. By 1987 a community-based vital registration system will have been developed and implemented in all provinces.

4. By 1987 a system of co-ordination will have been developed at Central Provincial and District levels to identify information needs common to other health related sectors or ministries and to facilitate sharing of this information.

5. By 1987 practical training in the use of information for management will be incorporated in the curricula for in-service training for district and provincial managers, and will be a part of the basic and in-service training for health workers in health centres and in the community.

6. By 1989 the capacity for using surveys and other special methods to obtain essential data which are not obtainable through the routine system will have been strengthened by co-operative action by the NHIS, the Epidemiology Unit, the Central Statistical Office, the Blair Research Institute and the University of Zimbabwe, and by the appropriate training of managers and specialist personnel.

7. By 1989 the epidemiological support to specific disease control programmes will have been strengthened at Central, Provincial and District levels by appropriate in-service training of health staff.

D. PLAN OF ACTION

1. N.H.I.S. Trial Run

The proposed revisions to the N.H.I.S. concerning the collection of data from the rural and district levels are being tested and the findings of these trial runs will be used for future action.

2. Structure of National Health Information System

i) Rural Health Centre Level

a) The medical assistant at the Rural Health Centre will have the responsibility for data collection, compilation and analysis.

b) Reporting by Village Health Workers should be reduced to a minimum. They will keep a diary and record all activities and events covering such areas as environmental work, health education, treatment given etc. They should then discuss their monthly information with the health centre staff.

c) Health assistants activities should be submitted in the form of monthly reports recording details of new water supplies, latrines, home hygiene and inspections, health education coverage etc.

ii) District Level

As data and information handling at this level will be considerable a health information office, with an appropriate clerical cadre (health information officer), will be established in each district.

The health information officer will be responsible for:

- training, support and supervision of staff in health centres, clinics & smaller hospitals in this field
- compilation and analysis of monthly, quarterly, and annual data
- feeding data to district health team as well as reporting to the province and national levels
- feedback to all units who submit reports.

iii) Province Level

In view of the increased workload, a provincial information office on the same line as the one at the district level, but with adequate office space and appropriate equipment will be set up under a senior health information

iv) Central Level

a) To effectively develop and maintain the NHIS, the functions of statistics and epidemiology will be combined under one department which will be appropriately strengthened both regarding equipment and manpower. This department should be responsible for:

- The collection, analysis, storage and dissemination of health information. This is to be achieved by the coordination of the activities of the health information system right from the rural level, through the district, province to the central level
- Implementing the various standard procedures and mechanisms for collecting and processing data
- Close coordination with other sectors handling health related information particularly the Central Statistics Office whose role in training health information staff, providing vital statistics, conducting special surveys for generating health information is important
- Meeting international commitment concerning health information.

3. National Coordination

A NHIS Committee will be established as a permanent body within the Ministry of Health, reporting to the Secretary for Health and working closely with the department of statistics and epidemiology.

The Committee be appointed by the Secretary and consist of 7 members: One Provincial Medical Director; one Provincial Health Services Administrator; one Provincial Health Inspector; one District Medical Officer or Medical Officer of Health, one Community Sister, one representative of a City Health Department and one representative of the M.C.H. or E.P.I. Departments. In addition advisors from the Statistics and Epidemiology Department and the Health Planning Unit would sit with the Committee and it would coopt other persons from time to time if considered necessary.

The Terms of Reference of the N.H.I.S. Committee to be:

i) Carry out revisions to the National Health Information System, (including planning and implementing a trial run of these revisions), to develop its comprehensiveness, usefulness for health management at all levels, accuracy, reliability, timeliness, and cost effectiveness.

ii) Provide ongoing planning, organizing and evaluation of the National Health Information System

iii) Review all proposals and forms for gathering health information for the Ministry before they are adopted, and make recommendations on them to the Secretary for Health

iv) Ensure coordination in the gathering, analysis, presentation and distribution of health information at all levels in the Ministry of Health and with other ministries and departments (particularly the Central Statistical Office)

v) Encourage and assist all levels in the health services to use health information in management and administration

vi) Ensure that gathering health data disrupts the other work of health staff as little as possible.

4. Manpower Training

Staff to man the health information services will be trained locally. In currently organised in-training service programmes for management staff, appreciation of health information systems will be included.

E. RESOURCES

Office accommodation has not been costed because existing space will be utilised at Central, Provincial, and some District levels. Additional office space requirements will be met by the general upgrading programme.

1.	Equipment costs Typewriters Photocopiers Printing of forms etc. Micro computers and computer terminals	Sub-total	$700,000
2.	Salaries - central, provincial & district	300,000	
	Training of staff	92,000	
	Sub-total	392,000	392,000
	Grand Total		$1,092,000

F. EVALUATION

The success of the health information support programme will be assessed on the quality and relevance of information available to the managers and the extent to which they react to them. The dissemination of relevant health information down to the operational levels at reasonable time intervals will serve also to monitor the efficiency of the system. A formal evaluation of information support to management is proposed for 1988 or 1989 at which time a complete review of information needs, supply, mechanism and use will be undertaken by the Information Unit.

7.4. HEALTH RESEARCH PROMOTION AND DEVELOPMENT

A. SITUATION ANALYSIS

Research facilitates the achievement of a health programme by providing the necessary knowledge and insights, the lack of which often impose severe constraints to the progress of the programme. Zimbabwe's commitment to the HFA/2000 strategy using Primary Health Care as the key approach, dictates the need for developing and promoting research on a national basis. Research activities at present are not organized in a coordinated structure. The Blair Research Institute conducts research related largely to communicable diseases and environmental sanitation. There exists several research activities linked to the various health programmes viz. Nutrition, Maternal and Child Health, Cancer, Traditional Medicine, etc. A major constraint to research is the dearth of trained manpower and appropriate facilities and a proper sense of direction which ensures that research is not undertaken for the sake of research but to find solutions to health problems.

The need for research activities is immense and in view of the social, behavioural and economic determinants which influence health, a multidisciplinary approach to research is indicated. Following this concept the programme will have to provid for epidemiological, behavioural, environmental and health systems research.

B. OBJECTIVES

Overall Objectives:

The development and promotion of an appropriate research potential in a multi-disciplinary and organized way to find solutions to the health problems of the country.

Specific Objectives:

1. To strengthen existing research capability and develop a multi-disciplinary health related approach
2. To develop a mechanism for the flow of information between research programmes and operational programmes.
3. To set up a coordination mechanism which will:
   - i. define national research policies
   - ii. set priorities for research
   - iii. ensure application of research findings in health programmes