

AFRO-MEMORANDUM

FROM: Dr L Arevshatian *LA* TO: Dr E M Samba
WR/Zimbabwe Regional Director
WHO/AFRO

DATE: 20 October 1995

Our Ref:

Att.

Originator:

SUBJECT: JAPAN INSTITUTIONAL COOPERATION AGENCY'S (JICA) SUPPORT
TO AFRICA - ZIMBABWE HEALTH BRIEF

Thank you for your essential fax message on 13 October 1995 on expected collaboration of JICA with African countries and particularly with Zimbabwe.

We are pleased with your support and close follow up of this resource mobilization potential. Please find attached requested brief on the health situation in Zimbabwe to facilitate your discussion with the JICA representatives.

We have copied the "Brief" to Dr Y Kawaguchi, DIR/INA/HQ who has shown a similar interest towards Zimbabwe support in his earlier communications to us for which we are thankful to him.

Best regards.

COPY FOR INFORMATION TO:

Dr N Kawaguchi, DIR INA/HQ: With the above mentioned document attached.

LA/cms

06 NOV 1995

Received 7 NOV 1995

**A BRIEF ON
THE HEALTH SITUATION IN
ZIMBABWE**

1995

WHO OFFICE IN HARARE

1 GEOGRAPHIC, ECONOMIC, SOCIAL AND POLITICAL CONTEXT

1.1 INTRODUCTION AND GEOGRAPHY

Zimbabwe is a landlocked, relatively small, country with an area of 390 756 sq km in Southern Africa. It lies between the Zambezi river in the north and the Limpopo river in the south. It is bordered by the People's Republic of Mozambique in the East, South Africa in the South, Botswana in the West, and Zambia in the North and Northwest.

Geographically, the country has a distinctive plateau, "the high veld" that runs from East to West and is about 650 km wide. This high veld has a well developed infrastructure such as roads and railway lines. It also includes most commercial farms, major cities and most of the industrial activities. The climate on the plateau is cool. The country slopes to the north-west into the Zambezi Valley and in the south-east into the Limpopo valley. The valleys are hot and arid. Broadly speaking, the country can be said to have three climatic regions, namely:

Cool and wet in the eastern highlands.

Dry and hot in the west and in the valleys of the Zambezi, Limpopo and Sabi rivers.

Moderate in the high veld.

The main rainy season stretches from November to the middle of March. The eastern highlands and the high veld receive most of the rain which, under normal circumstances averages 125 cm or more, while the extreme southern and western parts of the country have an average only of 40 to 65 cm per year.

Zimbabwe boasts one of the most diversified economies in independent Black Africa, ranking second only to South Africa as an industrial power.

Except in periods of drought, the country is self sufficient in food and has traditionally been a net exporter of food.

1.2 HISTORY

It is thought that the African population entered what is now Zimbabwe during the 15th and 16th centuries. These were later followed by successive invaders, who included the Portuguese and Arabs, from about the mid-19th century.

The latest were white settlers who established themselves in what was then called Southern Rhodesia in 1890. Despite opposition from the African population, they established rail communication, mining and farming settlements, mainly along the high veld. This indicated that they intended to stay. In the 1920s the country was annexed by the British. In 1930 a "Land Apportionment Act" was passed, which reserved half of the land area to the whites, despite their tiny numbers in relation to the African population.

From 1953 to 1963 Southern Rhodesia (as Zimbabwe was then called), was part of the Federation of Rhodesia and Nyasaland. The federation was dissolved when calls for independence by the three countries became stronger and each went their own way, with Zambia (Northern Rhodesia) and Malawi (Nyasaland) gaining independence earlier.

In Southern Rhodesia, opposition to white rule by the African majority always existed right from the beginning. The first uprising against white occupation occurred in the 1890s (1893 in Matabeleland and 1896 in Mashonaland). These were brutally suppressed, and things were relatively quiet until the unilateral declaration of independence (UDI) by the whites in Southern Rhodesia in 1965. During UDI the whites declared the country to be theirs forever. After this the struggle for African majority intensified, accompanied by an armed struggle. The war for independence eventually forced the whites to negotiate a settlement (the so-called "Lancaster House Talks"), which led to the true political independence of Zimbabwe under majority rule in 1980.

1.3 MAIN DEMOGRAPHIC INDICATORS

The last population census in Zimbabwe was done in 1992. This showed a total population of 10,412,548 people, with a male to female ratio of 95 to 100 and a population density of 27 people per square kilometer. The population density increased from 13 per square kilometer in 1969 to 20 per square kilometer in 1982 to the present 27 in 1992, making it higher than the average for Africa (which was 16 in 1982).

The population growth rate was estimated at 3.1%, which is very high. At this growth rate the population is expected to double in 23 years. This high growth rate has resulted in a relatively young age structure. Forty five (45) percent of the population was under 15 years and 3 percent above 65 years, showing a high dependency ratio.

Ninety nine (99) percent of the population was of African descent in 1992, compared to 95% in 1969. This has been due to a decline in the population of European descent.

The table below shows some of the main demographic indicators for Zimbabwe (1992 census)

| | |
|------------------------------------|------------|
| Total population (1992) | 10 412 548 |
| Sex ratio (males/100 females) | 95 |
| Percent living in urban areas | 31% |
| Percent living in rural areas | 69% |
| Population density (persons/sq km) | 27 |
| Age composition (Percent) | |
| under 15 years | 45 |
| 15-64 years | 51 |
| 65+ years | 3 |
| Percent African origin | 99 |
| Crude birth rate (indirect method) | 44 |
| Crude death rate (direct method) | 9.5 |
| Infant mortality rate (1990) | 66 |
| Child mortality rate (1-4 years) | 26 |
| Life expectancy at birth (1990) | 61 |
| Population growth rate (percent) | 3.1 |

Figure 1 : Population pyramid for Zimbabwe (1992 census)

1.4 THE ECONOMY

Zimbabwe is potentially a rich country. Mineral resources include: gold, asbestos, coal, nickel, platinum, copper and precious stones such as emeralds.

The economy is diversified, with relatively developed commercial, industrial, mining and agricultural sectors. Major industries include: food production, construction, chemicals, textiles, wood and furniture, transport and paper printing.

Main agricultural exports are: tobacco, maize, cotton, sugar and groundnuts. The agricultural sector has a well developed commercial component, co-existing with a subsistence communal sector.

Soon after independence, the main priority of the government was to redress some of the social imbalances that had been suffered by the African majority. In 1981 the government issued an economic statement with long-term national objectives.

The economy in the 1980s was dominated by the state. There was also heavy emphasis on improvements in the social sectors such as health and education.

By the end of the 1980s Zimbabwe's social indicators compared favourably with those of other developing countries. Infant and under-five mortality were greatly reduced, access to safe water and sanitation greatly improved, malnutrition reduced and life expectancy improved, as shown below:

Selected Key Indicators

| | Zimbabwe | | Sub - Sahar a Africa | All Developing Countries | |
|---------------------------------|----------------|------|-------------------------------|--------------------------------|-----|
| | 1980 | 1990 | 1990 | 1990 | |
| Life expectancy (years) | 56 | 64 | 52 | 63 | |
| Infant Mortality / 1000 births | 86 | 53 | 103 | 71 | |
| Under 5 Mortality / 1000 births | 128 | 87 | 175 | 106 | |
| Immunization (%) | 25 | 80 | 49 | 80 | |
| School enrolment | -Primary | 83 | 117 | 49 | 104 |
| | - Secondary | 8 | 50 | 68 | 61 |
| Adult Literacy (%) | " | 67 | 50 | 63 | |
| Access to potable water | -urban (%) | " | 99 | 68 | 88 |
| | -rural (%) | " | 14 | 26 | 68 |

However, these policies had other effects on the economy as a whole with some sectors of the economy showing signs of stress. For example, the budget deficit greatly increased and foreign currency reserves were reduced. The private sector had also been almost squeezed out of the economy and unemployment increased. Overall economic growth also slowed down. Because of this, in 1991 the government embarked on an Economic Structural Adjustment Programme (ESAP) in order to increase investment and stimulate growth in the economy.

Agriculture provides 70% of total formal employment and 40% of merchandise export. Unfortunately, the start of ESAP also coincided with the worst drought in this century (1991-92). This drought caused a decline in output of 6%. Another drought has occurred in 1995, further delaying economic recovery.

As a result of all this, financing of the health sector has become precarious. It is estimated that the health sector budget has declined by at least 30% in real terms since ESAP began. The consequence of this has been a general decline in health services. This has resulted in loss of skilled personnel, drug shortages, inadequate supplies and lack of maintenance of buildings and medical supplies. The early decline of infant and child mortality evidenced in the 1980s has levelled off. Maternal mortality has been rising since the start of the 1990s.

2 COUNTRY HEALTH SITUATION

2.1 MORBIDITY

2.1.1 Top causes of outpatient attendance

Morbidity figures are available for 1993 only. No figures for the early 1980s are available to make a comparison.

Because of the way the data is coded, AIDS does not seem to feature among the top causes of morbidity even though it is known to be a big problem. AIDS statistics are collected separately, since the disease was recognised after the National Health Information System had already been developed and the data collected forms already printed. Therefore a separate section on AIDS and HIV infection has been included in this profile.

| <u>Under five years age group</u> | <u>Above five years age group</u> |
|-----------------------------------|-----------------------------------|
| Acute respiratory infections | Acute respiratory infections |
| Diarrhoea | Sexually transmitted diseases |
| Skin diseases | Injuries |
| Clinical malaria | Clinical Malaria |
| Injuries | Diarrhoea |
| Eye diseases | Skin diseases |
| Scabies | Eye diseases |
| Malnutrition | Bilharzia |
| Measles | Scabies |
| Bilharzia | Hypertension |

2.1.2 Incidence of specific diseases

2.1.2.1 Immunization Coverage Trends

| Year | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | |
|------|------|------|------|------|------|------|------|------|------|------|------|----|
| BCG | 89 | 80 | 91 | 86 | 89 | 87 | 73 | 76 | 93 | 79 | 90 | |
| OPV3 | | 75 | 67 | 80 | 84 | 79 | 83 | 76 | 78 | 81 | 73 | 80 |
| DPT3 | 79 | 71 | 82 | 85 | 79 | 83 | 77 | 78 | 81 | 72 | 80 | |
| Meas | 77 | 72 | 79 | 80 | 76 | 79 | 75 | 74 | 81 | 77 | 77 | |
| PCC | 42 | -- | -- | -- | 66 | 64 | 68 | 72 | 72 | 67 | 66 | |

The EPI programme was launched soon after independence in 1981. Baseline data in 192 showed a PCC of 255 which had risen to 42% by 1984. The programme gathered momentum throughout the 1980s, reaching a peak in 1989. Funding for the programme in the 1980s was not a problem, both from the government as well as from donors.

However, in the 1990s funding became a problem due to ESAP. As funding to the social sector was curtailed in real terms, EPI coverage began to fluctuate.

2.1.2.2 Polio

| Year | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 |
|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| No. | 28 | 8 | 3 | 4 | 65 | 92 | 5 | 4 | 1 | 0 | 0 | 0 | 1 | 2 |

The incidence of poliomyelitis had been dramatically reduced by 1989-90, with no cases been notified during 1990 to 1992. This was mainly due to the high coverage which had been attained. It could also be due to poor reporting.

The country has committed itself to eradication of poliomyelitis by the year 2000, as recommended by WHO. In light of this, polio surveillance was intensified in 1993. All cases of AFP were urged to be reported to the health authorities and investigated. Mainly as a result of this increased surveillance cases of poliomyelitis started being reported again in 1993.

2.1.2.3 Neonatal Tetanus

| Year | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 |
|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| No. | 114 | 428 | 85 | 74 | 154 | 358 | 11 | 21 | 58 | 16 | 28 | -- | -- | 23 |

Zimbabwe had committed itself to neonatal tetanus elimination by 1995, as recommended by WHO. WHO has defined neonatal tetanus elimination as an incidence of less than 1 case per 1000 live. With 23 cases reported in 1994, the incidence of NNT in 1994 was 0.05 per 1000 live births. Zimbabwe thus has achieved NNT elimination. It is hoped that this status can be maintained.

2.1.2.4 Measles

| Year | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 |
|------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| No. | 36253 | 22929 | 22290 | 20388 | 17675 | 49812 | 47509 | 13728 | 24090 | 16134 | 32337 | 33855 |

According to the World Summit for Children goals, to which Zimbabwe is a signatory, measles incidence should have been reduced by 90% from the pre-immunization levels. Using 1993 as the base year, then Zimbabwe is a long way from achieving this goal.

2.1.2.5 Leprosy

| Year | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 |
|-----------|------|------|------|------|------|------|------|------|------|------|
| New Cases | 162 | 146 | 135 | 106 | 140 | 102 | 71 | -- | 73 | 54 |

There has been a steady decline in the number of new cases recorded in the country since 1985. This can be attributed to the case-finding and treatment programme launched since independence.

2.1.2.6 HIV Infection and AIDS

Zimbabwe was one of the first countries in the world to recognise the AIDS disease and offer protective measures. In 1984 the Blood Transfusion Service in Zimbabwe started screening blood for the HIV virus to protect recipients. In 1987, AIDS cases began to be reported to the MOHCW, and 119 cases were reported. The number of reported cases has rapidly increased since then and as at the end of 1994 there were 38552 cumulative cases of AIDS. However, the National AIDS Coordination Programme (NACP) considers this figure an under-estimate and that the true number of cases is above 100,000. AIDS has thus become the number one health problem in Zimbabwe.

Sentinel surveillance for HIV positivity shows that 17-25% of antenatal patients were HIV positive in 1993.

The table below shows the age distribution of the cumulative AIDS and AIDS-related complex (ARC) cases in 1994.

| Age group | ARC cases | AIDS cases |
|-------------|-----------|------------|
| 0-4 | 3419 | 5609 |
| 5-14 | 318 | 327 |
| 15-19 | 502 | 763 |
| 20-29 | 5643 | 10922 |
| 30-39 | 5612 | 11438 |
| 40-49 | 2555 | 4839 |
| 50-59 | 817 | 1827 |
| 60+ | 323 | 638 |
| unspecified | 873 | 2189 |
| Total | 20062 | 38552 |

2.1.2.7 Tuberculosis

Tuberculosis is a serious public health problem of growing importance in Zimbabwe. Since 1989, the number of tuberculosis cases has almost increased fourfold. Tuberculosis mortality has also increased tremendously. There is no doubt that the most important reason for this rise is the AIDS epidemic. It is estimated that 40% of the adult tuberculosis cases are infected with the HIV virus. The most affected age groups match those affected by HIV/AIDS i.e 30-54 years followed by 15-29 years. About 20% of the cases are relapses, inpatient absconders and defaulters.

Reported Tuberculosis cases and deaths 1989-1994

| Year | Cases | | | Deaths | | |
|------|-------|--------|-------|--------|--------|-------|
| | Males | Female | Total | Males | Female | Total |
| 1989 | 4324 | 2488 | 6812 | 513 | 359 | 872 |
| 1990 | 5620 | 3299 | 8919 | 808 | 495 | 1303 |
| 1991 | 7702 | 4428 | 12130 | 1123 | 736 | 1859 |
| 1992 | 9255 | 5982 | 15237 | 1683 | 1180 | 2863 |
| 1993 | 11619 | 8506 | 20125 | 2067 | 1468 | 3535 |
| 1994 | 14088 | 9871 | 23959 | 2103 | 1446 | 3549 |

2.2 MORTALITY

AIDS is now the number one cause of death in Zimbabwe. A separate section on AIDS has therefore been included in this profile.

2.2.1 Life Expectancy at birth

The life expectancy at birth (1992 census) for both sexes was 57 years in 1978 and 61 years in 1992.

2.2.2 Mortality trends

2.2.2.1 Trend in infant and child mortality

Strict comparisons between 1983 and 1993 lists is not possible because of differences in the classification of the conditions between the the two periods.

| | 1978* | 1988** | 1990* | 1994** |
|-----------------------------|-------|--------|-------|--------|
| Infant Mortality Rate | 83 | 53 | 66 | 53 |
| Child (1-4 years) mortality | 37 | 24 | 26 | 26 |
| Under-five mortality | | 75 | | 77 |

N.B: * = Census Results

** = Demographic and Health Survey (DHS) results

The DHS estimates mortality directly, whereas the census uses indirect estimates. This may explain the differences in the level obtained.

Perhaps because of the health strategies put in place soon after independence, mortality in children had decreased to its lowest levels towards the end of the 1980s. It seems to have levelled off in the 1990s, and no further declines seem to be occurring. Part of the explanation could be the increasing AIDS epidemic in the country. Another explanation could be declining funds, in real terms, available to the health sector as part of ESAP.

2.2.2.2 Top Causes of Infant Mortality, 1983 and 1993

N.B: Ranked according to frequency of occurrence

| <u>1983</u> | <u>1993</u> |
|--|------------------------------|
| Perinatal conditions | Perinatal conditions |
| Intestinal infections | Acute Respiratory infections |
| Respiratory infections | Intestinal infections |
| Measles | Nutritional deficiencies |
| Meningitis | Ill-defined conditions |
| Congenital anomalies | Viral diseases |
| Nutritional deficiencies | Malaria |
| Signs, symptoms and ill-defined conditions | Diseases of nervous system |
| | Tuberculosis |

The classification/definition of diseases was not the same in 1983 as in 1993, making it difficult to make a strict comparison. However, it can be noted that measles was prominent as a cause of infant mortality in 1983, but no longer features in the 1990. Tuberculosis appears among the top ten in the 1990s, due to significant association with HIV/AIDS.

2.2.2.3 Top causes of mortality in children (1-4 years)

| <u>1983</u> | <u>1993</u> |
|-------------------------------|--|
| Measles | Nutritional deficiencies |
| Nutritional deficiencies | Intestinal infections |
| Intestinal infections | Malaria |
| Diseases of lower resp. tract | Viral diseases |
| Meningitis | Endocrine, metabolic and immunity related diseases |
| Diseases of upper resp tract | Tuberculosis |
| Malaria | Ill-defined signs and symptoms |
| Pulmonary Tuberculosis | Other respiratory diseases |
| | Diseases of nervous system |
| | Diseases of digestive system |
| | Diseases of blood-forming organs |

Measles was the number one killer of children in 1983, but no longer features in 1993. This can be attributed to the success of the immunization programme. Malnutrition has continued to feature prominently among the causes of death in children. The situation has been made worse in the 1990s by the severe droughts which are being experienced in this decade.

2.2.2.4 Top causes of mortality, all ages

| <u>1983</u> | <u>1993 (Above 5 years only)</u> |
|---|-----------------------------------|
| Diseases of respiratory system | Tuberculosis |
| Conditions originating in perinatal period | Intestinal infections |
| Measles | Malaria |
| Intestinal infections | Acute respiratory infections |
| Nutritional deficiencies | Viral diseases |
| Transport accidents | Diseases of pulmonary circulation |
| Homicide and injury purposely inflicted | Diseases of digestive system |
| Diseases of pulm. circulation and other heart disease | Ill-defined conditions |
| Cerebrovascular accidents | Hypertensive diseases |
| Pulmonary TB | Diseases of endocrine system |
| | Diseases of nervous system |

2.2.2.5 Maternal Mortality Rates (per 100,000 live births)

| Year | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 |
|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| Rate | 264 | 278 | 204 | 280 | -- | -- | -- | -- | 81 | 67 | 80 | 99 | 109 | 134 | 162 |

There is considerable discussion in the country about the true maternal mortality rate. The two surveys done at community level (the national census in 1992 and the DHS in 1994) have both shown a rate above 250. However the difference between the two is quite significant (395 and 280 for the census and DHS respectively). A community case-referent study done in Masvingo province in 1989 showed a maternal mortality rate of 168 for the rural women in the province. These figures all point to a relatively high level of maternal mortality in the country.

While maternal mortality seems to have declined in the 1980s, it has been steadily increasing since 1990, based on routine data collected by MOHCW. The reasons for this are not clear, though the increasing AIDS epidemic might be responsible for some of the deaths.

2.5 Maternal Health Care

Antenatal coverage rates, 1988 to 1994

| Year | 1988 | 1990 | 1991 | 1992 | 1993 | 1994 |
|------------|------|------|------|------|------|------|
| Routine | -- | 75% | 72% | 80% | 75% | 77% |
| MCH Survey | -- | -- | 95% | -- | -- | -- |
| DHS Survey | 91% | -- | -- | -- | -- | 93% |

Contact between health services and pregnant women, to provide antenatal care is very high, as evidenced by the results from surveys.

Proportion of births in health facilities, 1988 to 1994

| Year | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 |
|------------|------|------|------|------|------|------|------|
| Routine | 62% | 66% | 61% | -- | 58% | 67% | 49% |
| MCH Survey | | -- | -- | 79% | -- | -- | -- |
| DHS Survey | 70% | -- | -- | -- | -- | -- | 70% |

Delivery in health facilities is relatively high, as shown by the results from community surveys such as the DHS.

2.6 FAMILY PLANNING

Zimbabwe has one of the highest contraceptive prevalence rates in Sub-Saharan Africa. The 1994 Demographic and Health Survey (DHS) found out that 42% of currently married women use modern methods of family planning, an increase of 17% from the 36% found in 1988.

There has also been a substantial decline in the total fertility rate, as measured by the two DHS surveys in 1988 and 1994, and shown in the table below. This has most probably been due to the rising use of modern methods of Family planning.

| | 1988 | 1994 |
|------------------------------------|------|------|
| Total fertility rate | 5.5 | 4.4 |
| Currently using modern F.P methods | 36% | 42% |
| Using the pill | 31% | 33% |
| Using other modern methods | 5% | 9% |

However, the pill continues to dominate among modern methods of family planning, with little improvement in the more long-term methods.

Knowledge of at least one method of family planning is nearly universal, and nearly all those knowing a method also know a modern method. The most commonly recognised methods are the contraceptive pill (98%), the condom (95%), and contraceptive injection (87%); while only 47% know about male sterilization.

Eighty percent of currently married women, and 62% of all women aged 15-49 have used a method of family planning at some time in their lives, as shown in the table below. Most of the ever-users have used the pill (66%).

Population Policies

Though there is no explicit population policy in Zimbabwe, there is a strong commitment to family planning as evidenced by the creation of the Zimbabwe National Family Planning Council (ZNFPC) through an Act of Parliament in 1985, as a parastatal in the Ministry of Health and Child Welfare.

Steps have been taken towards the design and adoption of a national population policy, with broad participation from parliamentarians, local leaders and the Cabinet. Proposals have been submitted for the establishment of a Secretariat for Population Policy and Development that would oversee the formulation of a policy and implementation of a program. However, this is still under consideration.

Family Planning Programmes and Services

The ZNFPC is governed by an 18-member board chaired by the Permanent Secretary of the MOHCW, with deputy being the Permanent Secretary of the Ministry of Community Development. Its mandate is to bring family planning services and information to persons in need of them, with special responsibility for all FP training and contraceptive commodity distribution in the country (except for some items sold commercially by retail pharmacies).

The ZNFPC has its Head Office in Harare and administrative offices in all the eight provinces in the country. It has three service support and management units i.e : the Medical/Clinical Unit; the Community-based Distribution (CBD) Unit; and the Youth Advisory Services Unit. Every ZNFPC provincial office has counterparts of these three service units. It also has three technical support units, namely: Training; Information, Education and Communication (IEC); and Evaluation and Research Unit (ERU). A seventh unit, the Management and Administration Unit is run by the Deputy Director for Administration and Finance.

Total ZNFPC staff strength is over 1,000, of whom about three quarters are involved in the CBD system.

2.8 NUTRITION

Trend in Child Nutrition

The three standard indices of physical growth of children are presented below. Height-for-age measures linear growth. Child who is more than two standard deviations (SDs) below the mean in terms of height-for-age is stunted, whereas a child below three standard deviations is severely stunted.

Weight-for-height describes current nutritional status. A child below two standard deviations below the mean is wasted, whereas a child below three standard deviations is severely wasted.

Weight-for-age (underweight) is a composite index of weight-for-height and height-for-age and does not distinguish between acute malnutrition (wasting) and chronic malnutrition (stunting). A child can be underweight for his/her age because (s)he is stunted, because (s)he is wasted or because (s)he is both stunted and wasted.

| | <u>Below -2 SD</u> | | <u>Below -3 SD</u> | |
|-------------------|--------------------|-------------|--------------------|-------------|
| | <u>1988</u> | <u>1994</u> | <u>1988</u> | <u>1994</u> |
| Height-for-age | 20.3 | 21.4 | 8.7 | 6.1 |
| Weight-for-height | 1.1 | 5.5 | 0.2 | 0.7 |
| Weight-for-age | 9.9 | 15.5 | 1.6 | 3.0 |

N.B: The 1994 DHS looked at children under 3 years, whereas the 1988 survey looked at children under five years. Therefore the figures are not strictly comparable.

With the above caution in mind, it is apparent that acute malnutrition has increased in 1994 compared to 1988. The main reason for this rise in acute malnutrition could be the prevailing drought conditions in 1992-95. In 1992 the worst drought this century occurred and by the time the DHS was conducted the country had not fully recovered.

The low birthweight rate has been rising since about 1992, which coincides with the drought mentioned above. The low birthweight figures are shown below.

| Year | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 |
|------|------|------|------|------|------|------|------|-------|
| Rate | 4.9% | 6.9% | 5.6% | 6.0% | 6.3% | 8.4% | 8.6% | 10.8% |

The above figures, taken from the routine statistics of the MOHCW are probably under-estimates since they refer only to births that occur in health facilities.

Micronutrient Deficiencies

Iodine Deficiency Disorders (IDD)

A national survey of schoolchildren in 1988 showed that every province in country had at least a mild level of endemic goitre. Total goitre rates (TGR) for the provinces varied from 52% in Mashonaland Central to 17% in Matabeleland South, while the more severe visible goitre rates (VGR) varied from 7% in Mashonaland East to 0.7% in Matabeleland South province. The overall national rates were 44% TGR and 4% VGR.

A national IDD Control Programme has been started. Iodine capsules were distributed in Murehwa, the district which had the highest prevalence levels. Legislation to have all salt for human consumption iodated has been passed.

The Food and Food Standards Regulations were amended in February 1995 to allow iodation of all salt for human consumption at 30-90mg of iodine per kilogram of salt. Since virtually all salt in Zimbabwe is imported, the importers have been approached and they have agreed to import only iodated salt. A monitoring mechanism has been put in place to oversee compliance with these regulations.

Vitamin A Deficiency

A study of 6,000 children aged between 6 months and 6 years in Matabeleland North province in 1991 showed that Vitamin A deficiency is not a public health problem, though clinicians continue to observe clinical eye signs of vitamin A deficiency.

Institutional Framework

Soon after independence, a Department of National Nutrition (DNN), was established in the Ministry of Health, with a mandate to: determine the magnitude and extent of malnutrition in Zimbabwe; implement a nutrition surveillance system to monitor nutrition; develop nutrition programmes in line with the Primary Health Care strategy; use intersectoral cooperation to develop a National Food and Nutrition Policy; establish norms and guidelines for government institutional feeding; train institutional food service managers for government; and provide technical expertise to other government agencies.

However, in 1988 the DNN was made a Unit with the MCH Department as part of the internal restructuring of the Ministry of Health. This somewhat made it more difficult for the Unit to coordinate with other departments in other Ministries since it now has to go through the Head of Department who is the MCH Director.

The staff complement consists of: four nutritionists at Head Office; two nutritionists in each province. The major cities also have their own nutritionists.

However, the dietetics component of the department is very weak, with only four central hospitals and four of the provincial hospitals having posts for dieticians.

An unskilled post of nutrition coordinator was created soon after independence to work mainly within wards in districts for the Child Supplementary Feeding Programme, with donor funding. Though they have been accepted by government, they still do not have established civil service status with clear tasks and qualifications and a career ladder. In 1992 there were 120 nutrition coordinators who were all on temporary contracts.

Nutrition Programmes

The National Nutrition Unit in the Ministry of Health and Child Welfare is the overall coordinator of all nutrition-related activities in the country.

The following are some of the programmes done by the National Nutrition Unit.

i) Nutrition surveys and surveillance

Growth monitoring is part of the National Health Information System and data on children weighed is collected from all health facilities monthly.

Nutrition studies have been undertaken or commissioned in 1980, 1982, 1984, 1985, 1988 and 1994.

ii) Community-based growth monitoring

After a study tour to the Iringa Joint Nutrition Support Programme in Tanzania, community-based growth monitoring was started with pilot programmes in two wards each in Tsholotsho and Makoni districts in 1992. Evaluation of the two pilot districts showed that though community mobilization is time-consuming and gradual, the payoff in terms of community involvement is high. The programme has therefore been extended nationally.

iii) Child Supplementary Feeding Programme (CSFP)

The national CSFP was started soon after independence, initially run by NGOs and then by the Department of National Nutrition with assistance from SIDA. The programme attempted to avoid dependency by using locally grown foods and by including nutrition education. The programme has also been supplemented by the Supplementary Food Production Programme.

Because of the recurrent drought, the CSFP programme has been on and off. During the 1991/92 drought and again in 1995, massive numbers of children were fed through the CSFP programme.

iv) Community Food and Nutrition Programme (CNFP)

The Supplementary Food Production Programme was renamed the CNFP in 1989. Until then it had been funded mainly by SIDA. Government funding began in 1989 and two years later, government was responsible for all central funding though NGOs contribute funds for projects in specific areas.

The CNFP encourages villagers to grow nutritious foods such as groundnuts and beans in communal plots, as well as vegetables in community gardens.

v) Breastfeeding Activities

Zimbabwe began to participate in the World Health Assembly just as the International Code of Marketing of Breastmilk substitutes was being developed and passed, and was thus aware of the issue from the outset. It has been active in developing its own laws on the issue. In 1985, the Public Health Act was amended to limit the marketing of breastmilk substitutes. The regulations limiting the marketing of breastmilk substitutes are now being finalized by a multisectoral committee.

The National Nutrition Unit is active in promoting breastfeeding initiation in all hospitals through the Baby Friendly Hospital Initiative (BFHI). Up to the middle of 1995 18 hospitals had been designated baby friendly.

vi) **Micronutrient programmes**

The Iodine Deficiency Programme has been started to combat iodine deficiencies.

2.8 ENVIRONMENTAL HEALTH

Water Sources

According to the 1992 census, 77 percent of the total population had safe water supplies. Safe water sources included piped water, boreholes and protected wells. It was also recorded that 38 percent of the households had their main sources of water on their premises, 27 percent had water supplies less than 500 metres from the dwelling and 22 percent were more than one kilometer away from their water sources.

There is also a huge difference between urban and rural areas. Ninety nine percent of urban household had access to safe water, whereas the comparable figure for rural areas is 64 percent.

Toilet facilities

The 1992 census recorded that 66 percent of households had toilet facilities. The type of toilet is mostly flush toilet in urban areas and pit toilets in rural areas. In urban areas, 99 percent of households had toilet facilities, whereas in rural areas it was only 48 percent.

3. HEALTH DEVELOPMENT POLICY

POLICY

At independence, there was no coherent health policy. Generally, the system favoured a minority in terms of access and delivery of health services.

The new government recognised that health is a human right. Following a situational analysis, the Government laid a framework for the future with the publication in 1984 of the national health policy document, "Planning for Equity in Health". The key word "equity" was to apply to all, whether rich or poor, urban or rural.

The health policy aimed at equitable distribution of health care, with emphasis on community participation, decentralization of management and integration of curative and preventive services. Primary Health Care (PHC) was adopted as the approach to meet the urgent health needs of the majority of the population.

Health was thus identified as a development issue, whose promotion required a multi-sectoral approach.

The following documents are available, which expound on general health policy:

- a) Planning for Equity in Health
- b) Ministry of Health and Child Welfare Corporate Plan

Priorities

In pursuing its long-term strategy and policy for the development of health in Zimbabwe, the MOHCW identified the following priorities:

1. Maternal and Child Health
2. Nutrition
3. Family Planning
4. HIV Infection and AIDS control, including IEC for HIV/AIDS
5. Environmental health, including water and sanitation
6. Development of an Epidemiology and Disease Control System, particularly for the following conditions:
 - a) malaria
 - b) tuberculosis
 - c) Cancer
 - d) Rheumatic heart disease
 - e) accidents
 - f) blindness prevention
 - g) care of the elderly

Strategies

The following strategies have been identified to carry the health system forwards into the future:

a. Health Care Financing and Financial Management

Recognising that finances available to the health sector are getting scarcer and difficult to get, the Ministry is looking at various options to ensure continued finances, including:

- a) Better financial management of available funds.
- b) Community financing

- c) cost recovery
- d) health insurance

b. Improvement of the planning and management system

It has been recognised that one of the major weaknesses of the health system has been poor planning and management skills. Improvement in this area will be one of the major activities of the Ministry of Health.

c. Improvement of the quality of services offered and offering core services

One of the weaknesses identified in the system to date has been that public health services have tried to be all things to all people. In doing this they have then failed to satisfy anybody, i.e meet demand. One of the key activities identified has therefore been to define core services that will be offered by the various levels of the health system. This has already been done (1994) for the primary and secondary levels of the system (the clinics and district level). It is hoped that once these core services have been identified, then the system will concentrate on improving the quality of service offered.

d. Human Resources development and enhanced use of staffing resources

Staffing costs have traditionally consumed nearly three quarters of the health budget. It therefore follows that human resources should be used efficiently.

Areas which will be improved include optimising the ratios of trained to untrained staff and provision of administrative support staff.

e. Enhancing Inter-Sectoral Collaboration

Various opportunities for closer collaboration with relevant authorities being utilized.

For example, closer involvement of the private sector is being explored.

3.1 NATIONAL HEALTH PLAN

Planning Mechanism

The following planning documents are available:

- Planning for equity in health
- Health for all Action Plan
- The Corporate Plan

Planning has generally tended to be done at the top and then handed down to the lower levels. For example, all the above planning documents have all been produced at the centre, with minimal involvement of the periphery. However, an attempt is now being made to change the situation.

Decentralization

Government has committed itself to greater decentralization of the health service, to make services more accessible and accountable to the local people. It has been recognised that local authorities will have to play a greater role in the running of health services in their areas. The district level will form the focus of this decentralization strategy.

3.2 ORGANIZATION OF THE HEALTH SYSTEM

Institutions and Organizations offering health services

Five Subsectors are responsible for the provision of "modern" health care i.e:

- a) The Ministry of Health and Child Welfare (MOHCW)
- b) Local Authorities,
- c) Missions, Industrial sector
- d) Private Subsectors.

In addition to these, there is a traditional health care system which is largely officially ignored even though the vast majority of the population still use traditional medicine. The only official recognition that has been given to the traditional health system is the formation of the Zimbabwe National Traditional Health Association and a Council to govern its operation. It largely works on its own initiatives.

However, within the "modern" health system, all providers are supposed to follow the same Government of Zimbabwe policy. MOHCW is the largest provider employing 90% of the total workforce.

The following is a brief description of each of the main sectors which are active in the health field:

Local Authorities

Local authorities can be divided into two main groups i.e rural and urban.

Rural:

With the recent enactment of the Rural District Councils Act in 1994, all rural-based local authorities were amalgamated into one entity, now called the "Rural District Council" (RDC). Before this there were two main version of local authorities in rural areas i.e. the former Rural Councils which was responsible for commercial farming areas (mainly white areas) and District Councils which were responsible for communal areas (black or African areas). This was a hangover from the colonial period. Prior to the formation of RDCs, each type of rural local authority planned seperately for its own constituents, even though they fell within the same district. This therefore encouraged fragmentation of services. Now, each district is supposed to have one RDC which plans for services within that district.

Government has now made a decision that health services will be decentralized to these RDCs, though it is not clear at this stage what form this decentralization will take. However, neither the RDCs do not have a secure financial base and it is fairly certain that they will continue to depend on central government to finance their services.

Urban:

Depending on their size, urban areas have various forms of local government. The bigger urban areas have municipalities, while the smaller ones have town boards. These administer urban based services. The bigger municipalities have greater financial means than the smaller urban areas. They have a bigger population from which to raise revenue. They are therefore less dependent on central government for their activities. The smaller urban areas, like their rural counterparts, are more or less wholly dependent on central government to finance their health services.

Missions:

Before independence, rural health services were mainly catered for by churches and missions. Even now, mission health services form a significant proportion of rural health services. However, after independence most of their parent churches abroad seem to have taken the view that they should be able to function on their own. Most of them are now finding it difficult to keep going. Government made a decision, soon after independence, that it would give grants to mission health institutions to cover approved staff and running costs (but not capital costs). However, these grants are never enough to sustain their operations.

Mission health facilities formed an association called the Zimbabwe Association of Church Hospitals (ZACH) to share their ideas and present their views to government.

Private Sector Medical Services:

Private medical practice is allowed in Zimbabwe. Two main forms of private medical services can be discerned.

The first are health institutions run by private organizations such as mines and industrial concerns. Most big mines have their own health facilities such as hospitals and clinics, which cater for their staff and dependents. A few big industrial concerns own hospitals (such as Zisco Steel), but mostly industrial concerns have clinics to cater for their staff.

The second type of private medical services are services offered mostly by individual health practitioners. Private doctors surgeries can be found in most urban areas, but hardly any in rural areas.

Health Care financing system

In the period after independence, Zimbabwe increased resources allocated to the health sector substantially.

Government spending on health increased steadily during the 1980s, mainly to correct the imbalances that had been inherited at independence. However with the introduction of the Economic Structural Adjustment Programme (ESAP) in 1990, it has shown a decline, as shown below:

| Real per capita expenditure on health (Z\$) | |
|---|-------------------------------|
| 1979/80 | 8.19 |
| 1990/91 | 18.17 |
| 1991/92 | 16.02 (11.8% drop on 1990/91) |
| 1992/93 | 13.70 (14.5% drop on 1991/92) |

As can be seen above there has been a substantial decline in funding to the health sector since the start of ESAP. This decline in financing of the health sector is the single largest crisis facing the health sector in Zimbabwe today. Unfortunately it has come when the sector is also facing threats from the rising AIDS epidemic and a potential increase in malnutrition from recurring droughts since 1992.

There are various sources of financing of the health services in Zimbabwe, ranging from government (mainly central government), private sources (individual and medical aid societies) to donor agencies.

Sixty percent of the financing of health services is by the central and local government (this includes the Ministry of Health and Child Welfare, local authorities, various other ministries and mission health services).

Medical Insurance Societies (medical aid societies) constitute the single largest source of private sector funding of the health services, and account for 25% of national health expenditure. Industry, mines and the commercial mining sector contribute less than 10% of total national health expenditure.

3.3 EMERGENCY PREPAREDNESS AND RESPONSE

Zimbabwe has a National Plan for Civil Protection, which is coordinated by the Department of Civil Protection in the Ministry of Local Government, Rural and Urban Development (MLGRUD). The MOHCW collaborates through the departments of Epidemiology and Disease Control and Environmental Health.

In terms of Zimbabwe's disaster profile, drought is one of the most serious. Four (4) out of Zimbabwe's 8 provinces are permanently at risk for drought, even in times of overall "normal" rainfall. The worst drought in this century that Zimbabwe experienced was in 1991-92 followed by another severe drought in 1994-95.

Epidemics are also a priority. Outbreaks of cholera have occurred, the most recent being in 1992. The worst malaria outbreak in many years was experienced in 1992/93. Foci of anthrax and plague exist in the western part of the country.

3.4 PUBLIC HEALTH INFORMATION

The Ministry of Health and Child Welfare has a Health Education Unit within the Department of Maternal and Child Health whose task is to coordinate health education activities within the Ministry. Traditionally, the Unit has responded to requests from departments within the Ministry for assistance with health education campaigns for their programmes. This has resulted in its work being mainly ad hoc and uncoordinated with no clear long-term strategy.

However, recently, the Unit commissioned a consultancy which came up with a five-year IEC/Health Education Strategy. The basic feature of the proposed strategy is a 5-tiered program which includes:

- i) A focus on priority programmes, defined as programs for those health problems which are major contributors to morbidity and mortality. These were identified as: HIV/AIDS; CDD/ARI; Tuberculosis; and Infant malnutrition;
- ii) To mount health education campaigns for seasonal problems, such as malaria, diarrhoea and dysentery just before and during the appropriate season.
- ii) To be prepared to provide some health education information during epidemics.

- iv) To improve the quality and quantity of information provided to patients during their contacts with the health system.
- v) To provide assistance to other programmes which are not of priority attention, such as eye and skin care, household accidents etc.

It was suggested that for the execution of this strategy, the following principles apply:

- a) A respect for behavioural objectives. As far as possible, the ad hoc approach to health education will be desisted from, in favour of a planned approach with clear behavioural objectives.
- b) Use of research, monitoring and evaluation. Behavioural research will be the foundation for health educational programmes.
- c) Use of mixed media. It has been recognised that successful health educational programmes present their information on a particular issue in many different ways through many different media.

4. RESOURCES FOR HEALTH

4.1 Budget and Expenditure

Real health per capita recurrent expenditure by government rose fairly steadily during most of the 1980s, from Z\$10.25 in 1980/81 to \$14.78 in 1990/91. However, from the peak in 1990/91, these levels of real financing have not been maintained, as shown in Figure 1. Real recurrent expenditure per capita by the Ministry of Health and Child Welfare (MOHCW) fell by 18% in 1991/92 and by 12% in 1992/93. It rose again by 6% in 1993/94, but mainly because the Ministry overspent on its budgetary allocation by 13%.

The 1994/95 budgetary allocation of 1.067 billion Zimbabwe dollars was smaller by 2% in nominal terms than the 1993/94 budget. Although the final budget was not known at the time of writing (there are sometimes supplementary allocations within the year), if there was no extra allocations this would mean a 39% fall of recurrent expenditure in real terms.

Disaggregation of the data shows that there was more fall in expenditure for preventive services budget than for curative services. For example, most of the 6% rise in MOHCW expenditure in 1993/94 was in the Medical Care Services (curative) budget, while there was an uninterrupted fall in spending under the Preventive Services budget.

However, there has been an increase in spending for preventive services and in fact the gap between curative and preventive services has been narrowed, as shown below:

Per capita expenditure, 1980/81 and 1990/91 in nominal terms (real in brackets) (Z\$)

| | 1980/81 | 1990/91 |
|----------------------------------|-----------|----------|
| Medical care services (curative) | 12 (10) | 55 (11) |
| Preventive care services | 1.1 (1.0) | 11 (2.1) |

There has also been a steady decline in the real value of the revolving drug fund allocated to the Government Medical Stores (GMS). Since 1988/89, the drug fund has been frozen at Z\$17 million, meaning that there has been a 67% decline in the real value of the drug fund since that year.

The fall in the budget has also had adverse effects on the staffing situation in the public sector. For example, the number of nurses employed by MOHCW per thousand population dropped by 10% between 1991 and 1992 and again by 3% in 1993. The Ministry of Health and Child Welfare budget is divided into four main expenditure categories, namely: Administration, research, medical care services and preventive services.

The table below shows the trend in allocations to these categories from 1982 to 1994 (Z\$ in nominal terms):

| Fiscal Year | Administration | Research | Medical Care Services | Preventive Care Services |
|-------------|----------------|-----------|-----------------------|--------------------------|
| 1982/83 | 6,049,800 | 960,000 | 107,389,965 | 17,187,546 |
| 1983/84 | 5,163,000 | 1,169,000 | 113,605,000 | 19,062,787 |
| 1984/85 | 7,288,200 | 1,055,000 | 130,899,000 | 22,247,000 |
| 1985/86 | 17,537,000 | 1,201,000 | 153,577,000 | 27,298,000 |
| 1986/87 | 19,010,000 | 1,435,000 | 195,588,000 | 31,861,000 |
| 1987/88 | 19,523,000 | 1,927,500 | 230,596,800 | 46,530,700 |
| 1988/89 | 40,952,000 | 2,275,000 | 260,792,000 | 53,950,000 |
| 1989/90 | 67,047,000 | 2,415,000 | 317,274,000 | 50,753,000 |
| 1990/91 | 76,773,000 | 2,609,000 | 412,192,000 | 59,132,000 |
| 1991/92 | 98,460,467 | 3,010,000 | 499,474,372 | 69,050,161 |
| 1992/93 | 75,959,000 | 3,135,000 | 589,300,000 | 110,290,000 |
| 1993/94 | 21,170,000 | 4,905,000 | 783,020,000 | 114,113,000 |
| 1994/95 | 25,720,000 | 5,995,000 | 905,559,000 | 129,565,000 |

4.2 HEALTH INFRASTRUCTURE

As at the end of 1993, there was a total of 1378 health facilities in Zimbabwe, of which 224 were hospitals and 1154 were clinics and Rural Health Centers. The total of all facilities includes both public (mission, central government-owned and local government-owned) and private (mines, industrial etc) facilities.

Rural District Councils own 47 percent of all facilities, followed by central government with 32 percent. Therefore, more than three quarters of all health facilities in Zimbabwe are owned by government. The rest are either owned by church missions or by the private sector.

The following table shows the distribution of the health facilities by province.

Distribution and Ownership of Hospitals and Health Centres by Province

| Manica | Mash Cent | Mash East | Mash West | Masvingo | Mat North | Mat South | Midlands | Hara- | Bula- | Total wayo |
|-----------------------|-----------|-----------|-----------|----------|-----------|-----------|----------|-------|-------|------------|
| Hospitals | | | | | | | | | | |
| Central | - | - | - | - | - | - | - | 3 | 3 | 6 |
| Provincial | 1 | 1 | 1 | 1 | 1 | - | 1 | - | - | 7 |
| Maternity District | - | - | - | - | - | - | 1 | 1 | 1 | 3 |
| Rural | 5 | 4 | 5 | 5 | 2 | 5 | 5 | 6 | - | 37 |
| Mission | 10 | 3 | 10 | 8 | 11 | 5 | 5 | 6 | - | 58 |
| Special | 21 | 5 | 9 | 5 | 15 | 5 | 7 | 12 | 1 | 80 |
| Other * | 2 | - | 1 | - | 1 | - | - | - | 3 | 4 |
| | 1 | 1 | 1 | 4 | 5 | 2 | - | 7 | - | 1 |
| | | | | | | | | | | 22 |
| Health Centres | | | | | | | | | | |
| Govt | 62 | 40 | 51 | 34 | 65 | 29 | 32 | 57 | - | - |
| Council | 99 | 42 | 76 | 57 | 52 | 26 | 31 | 68 | - | - |
| Mission | 11 | - | 10 | 1 | 7 | 2 | 5 | 10 | - | - |
| Municip | 6 | 3 | 3 | 11 | - | 2 | 2 | 15 | 45 | 18 |
| Other + | 41 | 13 | 11 | 24 | - | 16 | 22 | 41 | - | - |
| | | | | | | | | | | 370 |
| | | | | | | | | | | 370 |
| | | | | | | | | | | 46 |
| | | | | | | | | | | 105 |
| | | | | | | | | | | 182 |

* includes: (i) industrial
(ii) private hospitals
(iii) mine hospitals

* includes: (i) industrial clinics
(ii) private clinics
(iii) mine clinics

Special hospitals include: psychiatric, ophthalmic and infectious diseases hospitals. The following table shows the population per health facility by province, for 1993.

Population per facility, by province

| Province | Number of Health Facilities | 1993 Population | Number of People per Facility |
|--------------|-----------------------------|-----------------|-------------------------------|
| Manicaland | 259 | 1,608,689 | 6211 |
| Mash Central | 112 | 910,730 | 8132 |
| Mash East | 178 | 1,069,481 | 6008 |
| Mash West | 150 | 1,174,977 | 7833 |
| Masvingo | 166 | 1,248,639 | 7522 |
| Mat North | 92 | 672,069 | 7305 |
| Mat South | 111 | 624,644 | 6527 |
| Midlands | 223 | 1,385,135 | 6211 |
| Bulawayo | 27 | 644,393 | 23866 |
| Harare | 60 | 1,617,871 | 26965 |
| Total | 1378 | 10,956,628 | 7943 |

4.3 HUMAN RESOURCES

The following is the breakdown of the major manpower categories in the country, as at the end of 1993.

| Health Personnel | Number | Population per health personnel |
|----------------------------|--------|---------------------------------|
| Doctors | 1 551 | 6933 |
| General nurses | 9 215 | 1167 |
| State Certified nurses | 12190 | 882 |
| Dental staff | 176 | 61101 |
| Rehab staff | 185 | 58129 |
| Environmental health staff | 1 162 | 9255 |
| Laboratory staff | 549 | 19588 |
| Pharmacy staff | 596 | 18043 |
| X-ray staff | 153 | 70286 |

The following table shows the numbers of selected health worker categories for 1990 and 1994.

Selected categories of registered health personnel

| | 1990 | 1994 |
|----------------------------------|------|------|
| Medical practitioners | 1320 | 1473 |
| Dental practitioners | 131 | 127 |
| Pharmaceutical chemists | 347 | 443 |
| Pharmacy technicians | 159 | 186 |
| Radiographers | 166 | 158 |
| X-ray operators | 48 | 34 |
| Environmental health technicians | 796 | 1041 |
| Environmental health officers | 145 | 177 |
| General nurses | 5739 | 6799 |
| Midwives | 2661 | 2915 |
| State certified nurses | 6779 | 8331 |
| State certified maternity nurses | 3337 | 4434 |

One major problem that Zimbabwe is experiencing is the inability to retain staff, mostly because of poor conditions of service. The country is losing the majority of the newly qualified doctors to neighbouring countries. Despite increased intake at the local medical school, there is still a major shortage of doctors.

Another problem is the unwillingness of local doctors to work in the rural areas. The majority of hospitals in rural areas is staffed by expatriate doctors.

4.4 DRUG POLICY

Zimbabwe has an Essential Drugs Policy, which is enshrined in the EDLIZ (Essential Drug List for Zimbabwe) document. EDLIZ was last revised in 1994 and is now in its 4th edition.

The policy is to make drug use more rational, cost-effective and standardised. Faced with dwindling real budgets it has become even more imperative that resources be used more wisely. The policy in the public sector is that prescription should be by generic name only, and only generic drugs should be used.

EDLIZ classifies drugs into SABC levels, in line with the referral levels of the health system. The meaning of the classification is as follows:

- S Specialist only (only specialists can prescribe these drugs)
- A Central and Provincial hospitals
- B District Hospitals with a Medical/Clinical Officer
- C Rural Health Centres/Clinics without a medical officer

Some drugs cannot be prescribed at the lower levels and should not be stocked at those levels.

The list of drugs in EDLIZ is divided into two, as follows:

- I Essential drugs for common conditions
- II Supplementary list for rare conditions (low incidence but nevertheless serious or life-threatening conditions)

EDLIZ also has guidelines on the treatment of common conditions and practitioners are expected to follow these guidelines.

The table below gives a summary of the trends in the list of essential drugs:

| Category | 1985 | 1989 | 1990 |
|---------------|------|------|------|
| ABC drugs | 224 | 94 | 83 |
| AB drugs | 226 | 256 | 254 |
| A drugs | 42 | 20 | 77 |
| S drugs | 89 | 198 | 154 |
| Supplementary | 0 | 0 | 24 |
| Total | 581 | 621 | 592 |

Escalating drug costs have also forced a re-think in the private sector. Recently the National Association of Medical Aid Societies (NAMAS), put out guidelines telling beneficiaries that they should urge their doctors to prescribe generic drugs. If a beneficiary is prescribed a non-generic drug then the medical aid society will only reimburse for the equivalent of a generic drug and the patient is expected to make up the difference. This is forcing more and more private patients to put pressure on private doctors to prescribe generically.

4.5 LOGISTICS AND EQUIPMENT

The procurement of supplies and equipment is vested in a number of Divisions and Departments, including:

The Government Tender Board:

a multi-ministerial group. It tenders for all government supplies.

Central Purchasing Authority and Central Stores:

which procures general items such as uniforms, electrical items, crockery, bedding and linen, furniture etc for all government departments

Department of Printing and Stationary:

responsible for all government printing and stationary supplies. All government Ministries order from them.

Government Medical Stores:

Supplies drugs, surgical sundries minor hospital equipment and some stationary to all "public" health facilities which include government, municipal and missions health facilities.

The above departments are the sources of all equipment and other logistical requirements for government. Their permission is required before purchases direct to the Private Sector can be made.

The Tender Board is a multi-ministerial group which evaluates Tenders on behalf of Ministries and Parastats for individual and collective commodity purchases in excess of Z\$45,000 (1995). Its administration functions include monitoring supplies, examining training needs, preparing policy circulars and maintaining and updating a master asset register. However, due to diverse work pressures, these activities have been restricted.

The Tender Board includes a Purchasing Unit, responsible for procurement of goods on behalf of Ministries. The items are purchased following the submission of lists, assessment of funding, discussion with the applicants and finalization of requirements and associated allocation votes. The applicants will provide details of their requirements, including estimated costs and catalogue references where possible.

First preference for purchase are the Government organizations, such as the Central Purchasing Authority and the Department of Printing and Stationary. If it has been established that the Government sources cannot supply, and these sources have given their authority, the procurement will be pursued with the private sector using the standard Tender process. For higher value items, a summary of the quotations and recommendations are submitted to an adjudication committee for a final decision.

The Purchasing Unit will place the order and is empowered to prepare import licences and duty free documentation if required for imports.

A network of 11 Maintenance Workshops exist within the MOHCW. However, qualified staff are leaving after being offered work in the private sector at significantly higher salaries. This drain on resources has undermined attempts to build experience and expertise. As a result, equipment repair has not been as good as it should be. Numerous pieces of non-operational and unreliable medical equipment awaits attention in the wards, departments and workshops of hospitals.

COOPERATION WITH THE UN SYSTEM

Most UN Organizations work with the government in their respective areas.

Those directly working with the Ministry of Health and Child Welfare include:

- i. The World Health Organization (WHO)
- ii. The United Nations Children's Fund (UNICEF)
- iii. The United Nations Population Fund (UNFPA)
- iv. The World Bank

5. MONITORING AND EVALUATION

Monitoring of the health system is done mostly through the National Health Information System (NHIS) which is described below.

A vital registration system is also in place but its coverage is very low, being estimated at less than 25%. The vital registration system only works well in the urban areas.

Various mechanisms are available to the MOHCW to evaluate the health services. Several PHC evaluations have been carried out (the last one in 1987). Community-based surveys have also been done mostly to evaluate coverage of Maternal and Child Health (MCH) services. These were done in 1984, 1988, 1991 and another one is planned for 1996.

The Central Statistics Office (CSO) does regular population censuses, which also produce valuable health-related data. The latest census was done in 1992. Progress in mortality reduction can be gauged from the census. The last census also include water and sanitation as well as maternal mortality.

The CSO, in conjunction with Macro International, also does regular Demographic and Health Surveys (DHS). The last DHS was done in 1994.

Regularly the CSO also does Indicator Monitoring Surveys, which also include health indicators. The last indicator monitoring survey was done in 1991.

The MOHCW, in conjunction with WHO, does annual rapid surveys to measure progress towards Health for All. These are done at community level. The reports should be available from both WHO and MOHCW.

Specialised surveys to measure specific aspects of the system are also done from time to time. For example, a series of surveys to monitor the effects of the Economic Structural Adjustment Programme (ESAP) on vulnerable groups have been done since 1992 by the Ministry of Labour, Manpower Planning and Social Welfare in conjunction with UNICEF.

One of the areas monitored is health. Reports for these should readily be available from both organizations.

6. HEALTH INFORMATION SYSTEM

The National Health Information System (NHIS) was started in 1985, as a way to make data collection within the MOHCW more systematic. It is administered by the Department of Epidemiology and Disease Control (EDC). There are several components to the system which includes:

- i. Outpatient data collection system on the major causes of morbidity (T5 system). This includes not only the major causes of outpatient attendances, but also growth monitoring data, immunization coverage data and figures of the occurrence of the EPI target diseases and maternity data. This data is collected on a monthly basis by all health facilities and summary data sent up the health system to the EDC department.
- ii. Inpatient data collection system (T9 system). The inpatient data collection system codes diseases according to the International Classification of Diseases (ICD-10) system. The data is summarised quarterly and sent up the system to the EDC department.
- iii. Notifiable diseases reporting system (T12 system). This system collects data on legally notifiable diseases which are of public health importance.
- iv. Weekly sentinel sites reporting system. This system can be said to complement the notifiable reporting system. Reporting centres which have quick communication facilities (either a telephone or radio-communication) have been selected to report every week on selected diseases which are of public health importance. These include dysentery, malaria, measles and poliomyelitis.
- v. Collection of data on workload in health facilities (HS3 system). This system collects data on bed capacities and bed utilization rates, among other things, in all institutions with in-patient facilities.
- vi. Tuberculosis (TB) reporting system. This is a specialized system which collects only data on TB.
- vii. AIDS reporting system. Because the AIDS problem was noticed after the NHIS had already been developed, it was difficult to add it to the existing forms. Therefore a separate system was put in place to report on HIV/AIDS.

LOCAL NEWS

Health budget to be cut by \$23m

THE Ministry of Health and Child Welfare has been directed by Treasury to cut its monthly expenditure by \$23 million.

The move, the ministry announced yesterday, could seriously affect delivery of essential health services.

The directive from Treasury is likely to worsen the already serious cash problems being experienced by the ministry, which has over the past months been hit by a spate of shortages of essential vaccines, drugs and food in its hospitals.

In an interview, the Minister of Health and Child Welfare, Dr Timothy Stamps, who has on several occasions

complained of inadequate Government funding, said the directive had forced his ministry to cut expenditure across the board, meaning all health projects would be affected.

His ministry would have to source for external funds to ensure that the quality of services does not decline. Dr Stamps was quoted recently saying: "In the absence of commitment of adequate budgeted funds by Treasury, or the proverbial good fairy, the deficiency of services of the hospitals is doomed to continue."

His ministry had requested an annual allocation of \$2,008 billion but was

only given \$1,37 billion.

The ministry required an additional \$638 million in order to provide an effective and efficient health service.

He said as of February, there had been a 10 percent rise in the prices of essential health products.

"I have now become a professional beggar... I hope there is now a degree of understanding in the Ministry of Finance that the Ministry of Health is not like that of Housing because my ministry cannot stop providing health services."

"I know that by May the allocated funds to my ministry would have run

out. I suppose we cannot expect healthy services to be immune to economic problems prevailing in the country," Dr Stamps said.

Mission hospitals and those in small towns were the most affected by the ministry's financial situation.

Some institutions had threatened to charge fees for health services, where they were supposed to be free.

"Some institutions are now even threatening to charge fees regardless of the Government policy. If they do this, health institutions will become less accessible, contrary to our policy of health," he said. — Zianna.