JAPAN INTERNATIONAL
CO-OPERATION AGENCY

HEALTH SITUATION ANALYSIS IN ZIMBABWE

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VOLUME II

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FOREWORD

The Japan International Co-operation Agency (JICA) would like to extend its support programme in the health sector. This report compiles an analysis of the health situation in Zimbabwe and will be utilised to determine priority areas for future assistance to raise the health status in the country.

The collection of information on health sectors had the full support of the Ministry of Health and Child Welfare (MOHCW).

Volume I analyses the Health Situation in Zimbabwe while Volume II describes the health development, the health resources, the health monitoring and evaluation, the health information system and the bilateral and multilateral co-operation with countries and international organisations or institutions.

It is the hope that this report contributes to the development of a health programme between the MOHCW and JICA.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BDDCA	British Development Division in Central Africa
BFHI	Baby Friendly Hospital Initiative
CAD	Canadian Dollar
CBD	Community Based Distributor
CBHC	Community Based Health Centre
CBD	Community Based Distributors
CBR	Community Based Rehabilitation
CEC	Commission of European Communities
CDD	Control of Diarrhoea Diseases
CHIZ	Current Health Information Zimbabwe
CIDA	Canadian International Development Agency
CPA	Country Programme Advisor
CSO	Central Statistical Office
CWS	Community Water and Sanitation
DANIDA	Danish International Development Agency
DASCA	Drugs and Allied Substances Control Act
DCC	Drugs Control Council
DEHO	District Environmental Health Officer
DHC	District Health Centre
DHE	District Health Executive
DHMB	District Health Management Board
DHSAdm	District Health Services Administrator
DHSB	District Health Services Board
DHE	District Health Executive
DHIP	District Health Improvement Programme
DHO	District Health Officer
DHSPS	Danish Health Sector Programme Support
DKK	Danish Krone
DM	Deutsche Mark
DMO	District Medical Officer
DNO	District Nursing Officer
DP	District Pharmacist
DTC	District Tuberculosis Co-ordinator
ECE	Early Child Education
EDC	Epidemiology Disease Control
EDLIZ	Essential drugs List for Zimbabwe
EPI	Expanded Programme for Immunisation
EPR	Emergency Preparedness and Response
ESAP	Economic Structural Adjustment Programme
FHP	Family Health Project
FP	Family Planning
FY	Financial Year

GDP	Gross Domestic Product
GMS	Government Medical Stores
GNP	Gross National Product
GOZ	Government of Zimbabwe
GPA	Global Programme on AIDS
GPD	General Programme for Development
GR	General Resources
GTZ	Deutsche Gesellschaft fur Technische Zusammenarbeit
HFA	Health For All
HHC	Health Centre Committee
HIP	Health Investment Project
HIV	Human Immunodeficiency Virus
HoDD	Head of Development Division
HPN	Health, Population, Nutrition
HQ	Head Quarters
HRH	Human Resources for Health
HRS	Health Research Systems
HSR	Health System Research
HST	Health Situation Trends
IBRD	International Bank for Reconstruction and Development
ICDS	International Classification of Diseases Standard
IDD	Iodine Deficiency Disorder
IEC	Information Education and Communication
IEH	Information, Education for Health
JICA	Japan International Co-operation Agency
IMR	Infant Mortality Rate
MA	Malawi
MCA	Medicines Control Authority
MCH	Maternal & Child Health
MO	Mozambique
MOF	Ministry of Finance
MOHCW	Ministry of Health and Child Welfare
MPCNH	Ministry of Public Construction and National Housing
MPSLSW	Ministry of Public Service, Labour and Social Welfare
MMR	Maternal Mortality Rate
NACP	National Aids Co-ordination Programme
NDF	National Development Fund
NDP	National Drug Policy
NDTPAC	National Drug and Therapeutic Advisory Committee
NEPC	National Economic Planning Commission
Nfl	Netherlands Guldens
NGO	Non-Governmental Organisation
NHIS	National Health Information System
NICARE	Northern Ireland Health Care System
NIP	National Indicative Programme
NLTPS	National Long Term Perspective Studies
NOK	Norwegian Krone
NORAD	Norwegian Agency For Development Co-operation

NPAC	National Programme of Action for Children
MOF	Ministry of Finance
MTR	Mid Term Review
ODA	Overseas Development Administration
OPD	Out Patient Department
ORT	Oral Rehydratation Treatment
PAAP	Poverty Alleviation Action Programme
PDC	Provincial Development Committee
PEHO	Provincial Environmental Health Officer
PHC	Primary Health Care
PHE	Provincial Health Executive
PHEO	Provincial Health Educational Officer
PHSA	Provincial Health Service Authority
PHSAdm	Provincial Health Services Administrator
PHT	Provincial Health Team
PMD	Provincial Medical Director
PNC	Post Natal Care
PNO	Provincial Nursing Officer
PSIP	Public Sector Investment Programme
PTB	Pulmonary Tuberculosis
RDC	Rural District Council
RH	Reproductive Health
RHC	Rural Health Centre
SADC	Southern African Development Community
SCF	Save the Children Fund
SDA	Social Dimensions of Adjustments
SDU	Strategic Development Unit
SF	Supplementary Funding
SIDA	Swedish International Development Authority
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
Swk	Swedish Krone
TA	Technical Assistance
TB	Tuberculosis
TFR	Total Fertility Rate
TM	Traditional Midwives
TT	Tetanus Toxoid
UCI	Universal Child Immunisation
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Education Scientific Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNV	United Nations Volunteers
USA	United States of America
VCW	Village Community Worker
VIDCO	Village Development Committee

VHW	Village Health Workers
WADCO	Ward Development Committee
WB	World Bank
WCT	WHO Country Team
WHO	World Health Organisation
WID	Women In Development
WS	Weekly Surveillance
ZACH	Zimbabwe Association of Church Hospitals
ZAM	Zambia
ZDHS	Zimbabwe Demographic Health Survey
ZEDAP	Zimbabwe Essential Drug Action Programme
ZESA	Zimbabwe Electricity Supply Authority
ZIM	Zimbabwe
ZNDP	Zimbabwe National Drug Policy
ZNFPC	Zimbabwe National Family Planning Council
ZRDCL	Zimbabwe Regional Drug Control Laboratory

EXECUTIVE SUMMARY

HEALTH DEVELOPMENT POLICY AND PRIORITIES

There was no clear health policy for the total population of Zimbabwe at independence. Recognising that Health was a human right, the Government developed a framework document "Planning for Equity in Health" with equity reflected as the key in all programmes. Primary Health Care was adopted as the strategy for health care delivery with emphasis on community participation and decentralisation. In order to translate the national policies into realities, Health for All Action Plans provided guidance for the long term evolution of the health sector. The introduction of ESAP (1990-1995) adversely affected the "Equity" through the increased cost-recovery and the decreased Government spending on health. The Corporate Plan and the corresponding Action Plan of 1991-1995 were running into budgetary constraints which led to reduction in quality of health care services.

In response to the economic recession, Zimbabwe embarked on a wide range reform process, emphasising rationalisation and efficiency. Health for All continues to be the Government's Policy focused on "Equity" with "Quality" to improve Health. The decentralisation of the health management structure to Local Authorities, the promotion of health sector investment, the regulation of the private medical sector, contracting out and the provision of core health services, are the central features of the Health Sector Reform. This process will lead to better response and accountability of the health care delivery system to local needs.

Priority Health Issues

Most of the health indicators show that the health sector in Zimbabwe has improved since independence. To sustain the initial health gains and improve the health of the nation, the new National Health Strategic Plan intends to bridge the gaps in key performance areas and contribute to the further improvements of the quality of life.

The MOHCW is currently developing the National Health Strategic Plan including the health development priorities. The areas where programmes need to be developed to reduce the morbidity and mortality are provisionally documented. The key performance areas essential to improve the health of the nation are discussed within the MOHCW. It is a fact that not all health priorities are the sole responsibility of the Health Sector.

Specific Health Policies

The Zimbabwe National Drug Policy (ZNDP) and the linked Essential Drugs List for Zimbabwe (EDLIZ) have been documented. The policy consists of components concerned with the drugs availability, rational prescribing and drug use, cost-effectiveness, quality assurance and standardisation. The dwindling budgets made

it essential to use resources efficiently and the Zimbabwe Essential Drug Action Programme (ZEDAP) is targeting the weaknesses in all sections of the Drug Policy. The ZNDP is an overall policy document guiding the policies on malaria and schistosomiasis in the above mentioned components. The policy guidelines for malaria and schistosomiasis are elaborated to components such as : essential drugs, treatment protocols, vector control, personal protection, health education and training, environmental health issues and research.

Development of the Health System Structure

The MOHCW structure is a dynamic organisational structure and is currently adapting modifications demanded by the changing priorities and circumstances. Primary Health Care is an integrated part of the entire health system. The district level is the key level of operation for the Primary Health Care (PHC). A functional referral system is in place from the primary level where the basic health care is provided to the quaternary level where specialised health services and overall policy guidance on strategic development in the health sector are organised. The present Health Sector Reform is reorganising the health services on the basis of decentralisation and is defining the new roles of each referral level.

Health Development Strategies

The strategies to carry the health care delivery system forward in the future are :

- The Health Care Financing and Financial Management
- The Improvement of the Planning and Management System
- The Improvement of the Quality of Services and Core Services Provision
- Human Resources Development
- Inter-Sectoral Collaboration

Development plan for Health Facilities

The Government is committed to improve access to essential health services for "All". A network of health facilities is required in each district. Water, Electricity and a Communication System are essential commodities to provide quality core health services and to respond rapidly and efficiently to health needs. The overall coverage of piped water in the health institutions in all the provinces excluding the cities is 70%, while the coverage for electricity is 53%. The overall coverage of communication system by radio or telephone is 65% . The coverage for the Rural Health Centres and Clinics in the provinces is found to be lower. In order to provide the essential quality core health services and to improve the health management information system, the health infrastructure in rural areas needs to be strengthened.

RESOURCES FOR HEALTH

Budget and Expenditure

Although the MOHCW "estimate-budget" has grown in nominal terms from 1986 onwards. The percentage that the Government has spent on health, decreased under ESAP from 1991 onwards caused by the high rates of inflation (25%) and the Government budget allocated to debt relief (30% in 1994). The MOHCW's budget is divided into four main expenditure categories : Administration, Research, Medical Care Services and Preventive Services. The decline in expenditure for preventive services was larger than for the medical care services over the years, jeopardising the field operations of the preventive services in the rural areas (1990-1996). The introduction of the users fee system during ESAP appears to have encouraged the use of curative services and decreased the demand for preventive services. The decline in the budget created a brain drain in the public health sector and consequently affects adversely the quality health services delivery. The number of nurses employed by the MOHCW dropped drastically during the past 15 months, 1890 nurses resigned.

Health Infrastructure

The Government's Policy to have at least one health institution per 6 000 to 10 000 people in the rural areas, has been achieved for all provinces. The physical infrastructure for delivery of PHC is becoming more equitable distributed. However the problems of access to quality health services still persists. Although the number of health institutions increased between 1993 and 1996 with 61, the number of people served per health institution increased equally, consequently, an increase in workload for health personnel.

All district public health institutions will be owned by the Rural District Councils within the context on the Health Sector Reform. The Mission Health Facilities will remain under their present ownership. There is no equivalent Local Authority to own the Provincial and Central Hospitals.

Human resources for health

A major problem is the inability to retain staff, mostly because of the poor conditions of service and the excessive workload. The MOHCW Human Resources Master Plan emphasises the urgent need for additional doctors, nurses, pharmacists, laboratory and rehabilitation staff.

MONITORING AND EVALUATION

The monitoring of the health care delivery system is the overall responsibility of the Epidemiological and Disease Control Services including the National Health Information Systems Unit in the MOHCW. Apart from the vital registration system, several other health related mechanisms for monitoring health programmes are used :

- Health Indicator Monitoring
- Health For All Exercise
- Household Surveys using the WHO/AFRO 27 Indicators
- Weekly Surveillance (WS)
- Sentinel Surveillance

National Health Evaluation Mechanism

Several mechanisms are available to the MOHCW to evaluate the health services and programmes such as : PHC evaluations, Community Based Surveys related to MCH/FP, Population Censuses and Demographic Health Surveys. These are carried out at regular intervals to measure progress, achievements and trends in Health and health related systems. The information generated from the evaluations serves as a base line for planning and programme management.

HEALTH INFORMATION SYSTEM

The Department of Epidemiology and Disease Control (EDC) is co-ordinating the National Health Information System (NHIS). The NHIS is committed to provide a relevant, reliable, complete and timely patient, disease, health status and health information base to clinicians, health policy makers, health planners, programme managers and supervisors at all levels of the health care delivery system. The NHIS is more systematically collecting data within the health care delivery system more systematic. The system consists of various components such as :

- Out-patient data collection system on the major causes of morbidity (T5 Form)
- In-patient data collection system coding diseases according to the ICD-10 Standard (T9 Form)
- Notification of Infectious Diseases System (T1 Form)
- Monthly Return Report on the Notifiable Diseases (T2 Form)
- Generation of information of Hospital Based Health Indicators e.g. performance of staff, cost of health service etc. (HS3/5 Form)
- TB Reporting System
- AIDS Reporting System
- Weekly Sentinel Site Reporting System (WS)

V

BILATERAL AND MULTILATERAL CO-OPERATION BETWEEN THE HEALTH SECTOR IN ZIMBABWE AND INTERNATIONAL ORGANISATIONS, INSTITUTIONS AND DONORS

The report provides a list of the major international organisations, institutions and donors supporting the health sector. It describes the history of co-operation, the organisational structure, the policy and strategies, the priorities and objectives, the future plans of co-operation and the available resources (budget).

1. HEALTH DEVELOPMENT IN ZIMBABWE

1.1. HEALTH DEVELOPMENT POLICY AND PRIORITIES

1.1.1. Introduction

A major change in the formal health system started more then ten years ago, after independence, in response to the new political order of "Growth with Equity" and "Equity in Health". The imperative need to re-establish justice and equity in the ownership of land, legislation/policy especially fiscal and monetary measures, in socio-economic order, education and health, made the new Government embark on the formation of a new developmental framework.

Recognising that 'Health' was a human right, the Government sought to achieve equality in "health status" and "health care" in Zimbabwe and that the rural population was cared for through advocacy of the Primary Health Care approach. The major restructuring at the MOHCW central level was the creation of Departments charged with health programme development and dealing with priority public health problems. Provincial and District Health Offices with the appropriate management structures such as the District Health Authorities and the District Health Executives were created accordingly, to guide and control the implementation of health policies in the assigned areas of operation. The health policy aimed at the equitable distribution of health care emphasising community participation, decentralisation of management with the development of an integrated comprehensive health care delivery system (promotive, preventive, curative, rehabilitative health services). The period, after independence was characterised by the availability of the necessary resources compared to the current situation of economic recession.

Zimbabwe currently goes through a period of economic problems. In response, a wide ranging reform process within the Government sectors is being implemented. This process emphasises on the rationalisation and efficiency as key factors in the health reform process.

The health care sector has five sub-sectors dealing with related health issues : the Ministry of Health, Local Government Authorities, Missions, Industrial Medical Services and Private Medical Sub-sectors, with the Traditional Health Care System in a parallel functioning position. All health care providers are supposed to be in line with the Ministry of Health Policy. In late 1995 the Ministry prepared a concept paper to introduce the Health Reform Agenda. The decentralisation of district health facilities to the Local Government is the key issue to ensure that the health services and its personnel are responding to the needs of the communities with special attention to the vulnerable groups.

1.1.2. Health Development Policy and Priority

Figure 1 presents the summary of the National Policies, Health Development Policies and Action Plans.

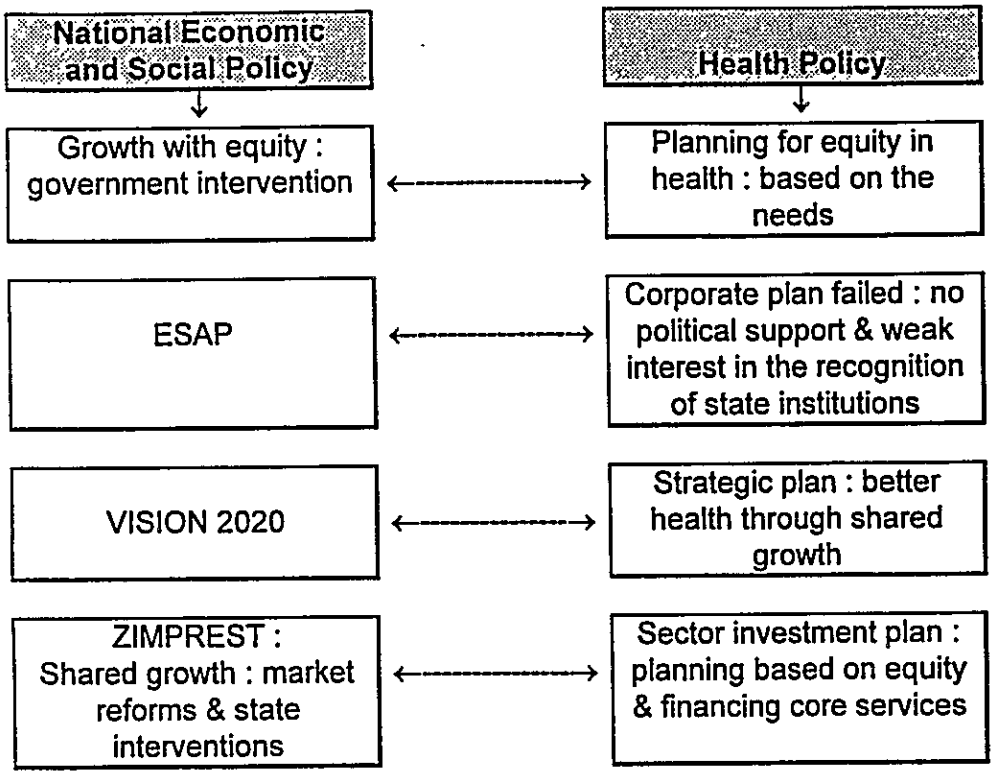

FIGURE 1 : RELATIONSHIPS BETWEEN NATIONAL ECONOMIC, SOCIAL POLICY AND THE HEALTH POLICY

Source : MOHCW, Management and Planning Division (Mr.Chihanga, 1997)

1.1.2.1. Growth with Equity : An Economic Policy Statement (1981)

During the decade since Independence and as outlined in the economic policy statement, the GOZ was committed to the attaining of a socialist and egalitarian democratic society. The statement provided a framework for overall sectoral policies and constituted the basis for the first National Development Plan. The policy embarked on a wide-ranging strategy to re-dress existing imbalances : growth of production and employment, increase in incomes and standards of living, promotion of rural development, creation of basic infrastructure, provision of social and health services in urban and rural areas etc. Both the three year Transitional National Development Plan (1982/83-1984/85) and the subsequent Five Year National Development Plan 1986-1990 aimed at expanding the economy while promoting growth with equity.

While formulation of development plans was carried out smoothly, the implementation faced difficulties and set targets were not met. During the last ten years the economy experienced set backs especially the decline of investment in the productive sectors with the rural development and land reforms, economic expansion and employment creation, not been achieved. Budget deficits and balance of payments dis-equilibria were persistent and economic growth fell short of the planned targets.

1.1.2.2. Planning for Equity in Health (White Paper - Health Policy) (1981)

In 1981, the national health policy was presented in a document entitled "Planning for Equity in Health". The establishment of a Primary Health Care (PHC) System, was adopted as the strategy for health care delivery and plans for its implementation were formulated in collaboration with the health partners.

The policy sought to achieve equality in health status and care in Zimbabwe and that the rural population was cared for. It advocated the adoption of the PHC approach whose key components of the health care delivery system were : appropriateness, accessibility, affordability, acceptability.

The major objectives or trusts of the plans and strategy were :

- to decentralise the health services management and administration
- the integration of fragmented curative and preventive services into a comprehensive health care delivery system with a special focus on Maternal and Child Health (MCH)
- upgrading the existing health facilities especially the clinics (490) and the construction of new Rural Health Centres (316)
- the re-orientation of health personnel towards the PHC concept and principles, the development of additional human resources for health care delivery
- the construction of training centres for Village Health Workers (VHW) in the then 55 districts and the training of 1000 VHW/year which was revised in 1984 to 1600 VHW
- the promotion of inter-sectoral collaboration and community participation in health care services delivery

The policy demanded a clear political commitment, adequate resource allocation and a defined strategy with set goals and targets. 'Equity in Health' remains the primary tool for the health policy in Zimbabwe.

1.1.2.3. Zimbabwe Health for All Action Plan (1985-1990)

In order to translate the national health policies, formulated in the White Paper 'Planning for Equity in Health', into realities within the framework of economic and other limitations there was a need for direction. The Health for All Action Plan based

on the Primary Health Care Approach provided guidance for the long term evolution of the health sector. The objectives, targets, and plan of action of each programme, along with the infrastructure development were guidelines in health development and addressed the health problems of the population. The Zimbabwe Health for All Action Plan outlined the way the health system was being organised based on PHC together with the managerial processes required for health system development including the required legislative modifications.

The main objective of the Health for All Action Plan was to ensure that all the people of Zimbabwe had access to comprehensive and effective health care which ensured the highest possible level of health and which allowed for full participation in the socio-economic development of the country.

Specifically the Health for All Action Plan embarked on the redressing of the past and current imbalances, inequities in the health sector through the development of comprehensive and integrated health care with special focus on the rural areas. The plan embarked on the establishment of a National Health Delivery System at four main levels :

- the primary level (grass-root level) with the Rural Health Centre as first contact between the community and the health sector
- the secondary (district) level offering support and supervision to the primary level
- the tertiary (provincial) level co-ordinating the health sector activities at district level
- the quaternary (central) level with its referral centres and the MOHCW, as head Office for policy development and strategic planning for peripheral implementation

The Health Plan embarked in 1982 on the increase of health facilities in rural areas including the launching of the VHW and RHC Programme related to :

- training (1 VHW/ 500-1000 population with a 1992 target of 12 000 VHW)
- infrastructure development (1 RHC/10 000 population with a 1986/87 target of 766 RHC)
- six new district hospitals for the 1985-90 period

The plan included as well the further upgrading of provincial hospitals and the strengthening of the central based capacity. The Health Plan of 1985-90 had set specific goals and targets for the MCH-(including EPI), Nutrition-, Water and Sanitation-, Health Education-, Disease Control-,(Malaria, Schistosomiasis, Diarrhoeal Diseases-, Cardiovascular-, Respiratory-, Cancer-) Essential Drugs Programmes, etc. The Health Plan included the targets of the Health Support Services, Health Financing, Human Resources Development Master Plan in support of PHC implementation. The plan was quite ambitious but with the economic set backs difficult to realise.

1.1.2.4. Economic Structural Adjustment Programme (ESAP) (1990-1995)

The past plans (the Transitional- and the First Five Year- National Development Plans) were formulated in an economic and social environment in which Governments controls, overprotection of the economy and monopolistic practices prevailed. The Second Five Year National Development Plan (1991-1995) launched in a rapidly changing political, social and economic environment in the Sub-Region and in the International Community, provided a platform for socio-economic reforms in order to create a better climate to achieve modernisation and efficiency in tune with the World's economic order.

The introduction of an Economic Policy Reform Programme encompassing a fiscal and monetary plan as well as legal and institutional reforms was essential for productive investment and employment creation. With support of the World Bank and the International Monetary Fund, the Five Year Economic Structural Adjustment Programme (ESAP) was announced in October 1990. It was intended to spur the economic growth by stimulating exports and investment through a liberalised economy. The aim was to achieve economic growth of 5 % by 1995 with a rise in investment of 25 % of GDP.

Major policy reforms were introduced in the areas of foreign exchange control, removal of subsidies, inflation control, etc. and in the area of fiscality. The target was to reduce the fiscal deficit to 5 % of GDP by 1994-95 against the 13 % in 1986-87 and 10 % in 1990-91. The aim of the programme was to re-gear the economy from public control to free market economy. The Government consistently cited the 1991-92 drought as the cause of the fall in national income in 1992 and the slow recovery in 1993.

The economic and social difficulties in Zimbabwe had been severe since the introduction of ESAP with the adverse effects on equity through the increased cost recovery and the decreased Government spending on health.

The MOHCW was aware of the cost recovery problems and was redesigning the systems. The Social Dimensions of Adjustments Programme (SDA) designed with a Social Development Fund (SDF) to run the programme was mandated to assist in the protection of the poorest from the adverse effects of cost recovery and the removal of subsidies as well as to administer the Employment and Training Programme for the retrenched people.

1.1.2.5. Health for all Action Plan (1991-1995)

The changes which occurred since the beginning of the decade and the imperatives resulting from ESAP made it essential to base the 1991-95 Health for All Action Plan on updated policies. The changes were caused by the progressive actions taken in the previous five years such as the construction and expanded availability of health facilities in rural areas, ESAP, drought of 1992, the impact of the HIV/AIDS pandemic, human resources shortage in key health care fields.

The levels of financing were declining due to the impact of ESAP and therefore the MOHCW was urged to institute measures for increasing efficiency and improving value for money in the provision of health care services. Political commitment to carry out a range of social policies to create equitable distribution of resources and opportunities was also required.

The overall purpose of the MOHCW was to promote the health and quality of life of the people of Zimbabwe. Therefore the Ministry was committed to its National Health Policy :

- Equity in Health in targeting the resources and programmes to the most vulnerable with PHC as main strategy for health development
- In prioritising the essential Health Issues in assessing the priority health problems and targeting the resources accordingly (MCH, AIDS/HIV/STD, Environmental Health, Epidemiology and Disease Control, Infrastructure development)
- In promoting accessible, appropriate Quality Health Care
- In strategically planning of the 'social base broadening' of health activities through community participation
- In restructuring the health services delivery system from the base upwards with re-orientating the health care workers

To achieve this goal the following broad objectives were set :

- to keep as many people in good health in the community
- to provide appropriate quality services for those needing care in strengthening links between health services levels and corresponding structures in the socio-political system and to ensure political and community participation as well as inter-sectoral collaboration
- to provide quality hospital care at the appropriate level
- to strengthen effective co-ordination mechanisms between sub-sectors of the health care system for standardisation and cost-effectiveness

The Service Delivery Targets were :

- to ensure value for money by efficient and effective service delivery
- to plan and manage resources effectively
- to establish strong links with the community at all levels in acceptable health service delivery
- to mobilise health sector resources and ensure their optimal use

1.1.2.6. The Corporate Plan (1992)

The Government announced that health would be spared from the burden of the reforms but reality turned out differently. The budget for public health had been reduced as a result of the overall down-sizing of the GOZ budget and the MOHCW

had been unable to maintain its part. Public expenditure on 'health share' declined from over 6% (1990) to 4.3% in 1995.

The ambitious objectives stipulated in the Health for All Action Plan of 1991-1995 and taken up in the mission statement on the development of health in Zimbabwe in the Corporate Plan were running into budgetary constraints as the GOZ cut back the supply to the health system and introduced "user charges" in the health sector. The MOHCW could not recover more than 2.5% of the expenditure. This led to reduction in preventive and promotive activities at clinics and hospitals and created an uncertainty regarding the availability of medicine and equipment and the trust of the community in the health care delivery system.

The objectives of the health care policy were based on the five elements :

- Equal access for all to health system facilities (equity)
- PHC development
- Quality of services delivery
- High priority on areas geared to the most commonly occurring diseases.
- High priority on preventive services and promotion of national health

The Corporate Plan could not be implemented as the political commitment was lacking and the climate was not conducive to implement the objectives. The priorities in the Government Sector Reform were set differently.

The corporate approach however did not influence much in view of change. The impact on the health indicators together with the budgetary constraints made the Government rethink the process of cost-recovery and how people could co-operate in Health. The Government formulated a National Economic and Social Policy through ZIMPREST with shared growth in view of market reforms and state interventions as targets. The MOHCW responded to it in the reformulation of its intention to pursue the Health Reform agenda.

1.1.2.7. Vision 2020 (1996-97)

Vision 2020 is a philosophy that grew out of the expressed views of Zimbabweans. The National Long Term Perspective Studies (NLTPS) Project funded by UNDP and executed by the National Economic Planning Commission (NEPC) held consultations to formulate a plan and a guiding document. The issues identified during the consultations in relation to health was that Zimbabweans should have affordable, equitable and accessible and adequate health schemes.

Vision 2020 elaborates on some broad strategies in relation to health such as the improvement of better co-ordination between the government, missions and municipality health services in partnership programmes. NGOs and missions provide 94 % of the services for the elderly, missions provide 35 % of all institutional beds and 70 % of the beds in rural areas (Turshen, 1994) and are valuable partners in health development.

In the document Vision 2020, the commitment to the Primary Health Care strategy is addressed in the renewal of the priority issues such as :

- the strengthening of programmes in water, sanitation, environmental health
- the improvement of community based health care with increased resource management capacity given to RHC and increased management capacity for integrated multi-sectoral programmes in nutrition and community growth monitoring
- The preventive health services including the home and community based care for AIDS patients that need to move beyond the technical approach with health information and sex education

The basic health services at the primary level need public sector support so that gains achieved in immunisation, child nutrition, family planning control of infectious diseases can be sustained. The stabilisation and improvement of salaries and conditions of service for health care workers is a prerequisite in the health care delivery system.

It is clear, as expressed in Vision 2020, that the Government has to make policy shifts in order to provide services to the most vulnerable groups with even smaller budgets. There may also be a need to move away from provision to the masses towards a more targeted approach. This however requires a political shift in thinking and skilled civil service in order to design innovative approaches and policies.

1.1.2.8. National Health Strategic Plan - Decentralisation and Health Sector Reform (1997-2007)

The current health policy and strategies which were outlined in the White Paper, Planning for Equity in Health were based on a rapid assessment of the health sector after Independence. Inequalities were revealed in :

- Health and social status
- The allocation of the health care resources reflected in the quality of life and the health patterns of the people
- The conditions related to poverty and poor socio-economic situation, nutritional deficiencies, communicable diseases, conditions related to pregnancy, child birth and the new born

These inequalities were presenting a higher prevalence in the majority of rural population.

Based on the findings a health policy and strategy were developed with a restructuring of the health care delivery system, reorientation of the manpower towards PHC and allocation of the resources to the priority areas identified. The Health for All Action Plans were drawn up and implemented according to the strategies in order to address the inequalities.

The improvements in health can be cited as a decline in mortality and morbidity with a rising life expectancy, higher literacy levels, and more self sufficiency in food stuffs.

Because of dynamics in the development of a nation, the health patterns and strategies to manage these, are changing accordingly. In the context of the health transition a new Strategic Plan is currently in its developmental stage. It will address the health related problems as poverty, urbanisation, industrialisation, education, decreasing health services resources, the higher demand for quality of services and the need to sustain the health gains. The Strategic Health Plan (1997-2007) will respond to the reforms set and the policy decision of the Government to decentralise the health management structures to Local Authorities and is formulating the policy of 'Equity with Quality' to improve 'Health' through shared growth and team approach. The task is to identify the priority health issues or key performance areas to sustain the overall health of the nation based on consensus through wide consultations and opinions of the people. The Strategic Plan is defining key health areas in which the Government, donor community and other stake holders can invest and support. 'Health' can only be seen as a component of 'quality of life' and in the mobilisation of resources of the other partners. In developing National Strategies, the identified health needs are to be taken into account and the programmes implemented within the context of the political mandate and commitment.

With Vision 2020 as described above, it is indicated that all Zimbabweans should have affordable access to health and social security schemes, education, housing and be free of controllable diseases.

The MOHCW is given the mandate to ensure that access to health for all does not become an empty slogan. The MOHCW has performed well in ensuring access to health, proved by the improvement of the key health indicators over the past 16 years. On the basis of the above and in an effort to provide better service to the consumers the MOHCW embarked on new health reform initiatives with key strategies proposed as follows :

- The renewal of the Primary Health Care Approach :
  * Socio-economic improvement of the population
  * Individual responsibility
  * Support and strengthening of the Primary Levels of Health Care (decentralisation)
- Partnership development :
  * Regulation of the Private Medical Sector
  * Public/Private Mix (contracting out of some parts of the health services)
  * Community Participation
  * Provider/Purchaser Split
- Shared Growth :
  * Cost sharing
  * Equitable distribution of resources

- Systems and organisational development :
  * Decentralisation
  * Re-engineering
  * Performance management (addressing brain drain, diminishing resources)
  * General management development
  * Human resources planning
  * Health Legislation
- Quality and management of health services
  * Customers satisfaction
  * Core Health Services in meeting the needs of communities.
  * Communication improvement (improving the MOHCW image)
- Health Systems Research and Development
- National Health Service Financing
  * Social Health Insurance
  * Fee/Revenue Retention
  * Better flow of funds to providers

In the development of the National Health Strategic Plan consideration is given to the International Agreements made by the Government of Zimbabwe such as the World Summit for Children which include the major Health and Health-related Goals, the renewal of the Health for All strategy and the Resolution on Action Plans to Improve Reproductive Health in East, Central and Southern Africa. Information from health managers in the field, communities, the health information system, reviews of departmental plans and MOHCW documents, is being gathered to include important qualitative aspects of the health situation in areas in which the MOHCW has performed well, badly or missed opportunities. The experiences and socio-economic trends from neighbouring countries are being used in the formulation of the health situation in the broader Regional Health Context. A further indication is being given on the priority health issues to be addressed over the next 5 to 10 years as presented in Table 1 which only gives a first impression of the difficulty to define the future role of the MOHCW in the management of these.

TABLE 1 : MOHCW KEY HEALTH ISSUES PERFORMANCE AND PRIORITY LIST OVER NEXT 5-10 YEARS

Basic Health Issues the MOHCW has performed well	Missed Opportunities in Key Health Issues	Priority Issues to be addressed by the Country over the next 5-10 years
MCH/FP incl. EPI	Staff retention	Strengthening MCH/FP incl. EPI
Implementation of PHC	Staff working conditions	Control of endemic diseases
Construction of Health facilities	Patient care (quality care)	Provision of safe water & sanitation
Expansion of training HW	RHC Drug availability	Increase accessibility to health services by providing health facilities
Provision of essential drugs	Cost recovery measures	Nutrition
Involvement of community in health care implementation	Ambulance services	Training of Health Personnel
Establishment of some specialist services at provincial/district hospitals	Resources availability (basic hospital equipment, project transport)	Health Services Decentralisation to ward level.
	Community B. Health Care Programmes (mental health)	Allocation of adequately trained personnel to all health facilities incl. RHC
	RHB and care for the mentally ill	Transport provision and improvement of ambulance services for community Case programmes : EPI. CBR, CBHC
		Communication (roads, telephones, radio) between clinics/RHC/district hospitals
		Health Education to communities related to health problems, promotion of community participation and compliance
		Adequate essential drug provision incl. Chronic disease drugs at clinic/RHC level

Source : MOHCW, Draft Document : Priority issues for strategic plan development (proposal for discussion - not a final document), 1997

Based on the epidemiological profile of diseases, the areas of public health concern which need to be addressed were listed according an agreed scoring system as +++ serious problem, ++ moderate problem, + mild problem as presented in Table 2.

TABLE 2 : AREAS OF PUBLIC HEALTH CONCERN BASED ON THE EPIDEMIOLOGY PROFILE OF THE DISEASES

Under five years	Above five years	Diseases of epidemic potential
Perinatal problems +	Maternal and Reproductive Health ++	Malaria +++
Respiratory disease +++	Respiratory disease, TB +++	Injury +++
Nutritional Deficiencies ++	STD/HIV ++++	Plague +
Diarrhoeal disease and dysentery ++	Mental health problems ++++	Dysentery & cholera ++
Skin disease +	Skin diseases +	Rabies and Anthrax +
Eye Disease +	Eye diseases +	
Injury ++	Injury ++	
Malaria and fevers ++	Cardio-vascular diseases +++	
Dental problems +	Cancer ++	
Bilharzia +	Hepatitis, liver diseases ++	
	Diabetes & renal diseases +	
	Dental problems +	
	Bilharzia +	

Source : MOHCW, draft document for discussion on the strategic planning formulation,1997

As Zimbabwe is a member of the Commonwealth Regional Health Community for East, Central and Southern Africa, the identification of health problems and priority issues needs to be viewed in the socio-economic and health context of the other surrounding countries. In this perspective the countries are faced with the dilemma of dealing with two kinds of health problems which are the problems related to poverty (infections and parasitic diseases) and the problems related to rapid urbanisation and industrialisation.

The formulation of the Health Strategic Plan is a dynamic process which takes time to reach consensus with all stakeholders. At this point in time it is not appropriate to document the real health priorities to be dealt with by the MOHCW and the other health partners as the MOHCW role and mission need further clarification within the context of the Health Sector Reforms and Decentralisation Process.

Decentralisation Policy and Strategy for Health Sector Reform

As previously mentioned the Government had committed itself to fully decentralise the management of the health services to the Rural District Councils in view of making services more accessible and accountable to the local people. The Local Authorities will play an important role in the implementation of a decentralised health care services delivery system with the district level being the focus of the whole strategic decentralisation process and the key to health status improvement. In line with the above it is suggested that :

- Rural District Councils be given ownership and responsibility for financing the District Health Services
- Hospital Boards be given ownership and responsibility for running Provincial and Central Hospitals
- District Health Services Boards and Hospital Boards be given responsibility for managing District Health Services and Provincial/Central Hospitals respectively
- The MOHCW Headquarters with the support of the Provincial Medical Directorates be given the responsible for setting policy, provide guidelines for health programme management, health financing and monitoring implementation of the health programme nationally
- Capacity building to equip 'management teams' with the skills required to run the District Health Services and the Hospitals, will be supported by the Central Government
- The implementation of these proposals should be two phased starting with the hospitals followed by the district satellite facilities

The administration and management of Health Services is quite complicated and therefore adequate preparation is needed towards implementation of the policy decision in order to sustain the gains achieved in the improvement of the health status. The principle of the decentralisation policy is to manage quality health services closer to the point of delivery in order to make them more responsive to the consumer needs and preferences as well as to delegate decision making to the appropriate level of operation so that the providers of services become the decision makers.

Through the process of Health Sector Reforms, described above, the Government reaffirms its commitment to the principles of :

- Improving Health Status and consumer satisfaction by increasing the effectiveness and quality of services
- Obtaining equity by improving the access of disadvantaged groups to quality care
- Obtaining value for money (cost effectiveness) from health spending considering improvements in both the distribution of resources to priority activities (allocative efficiency) and the management and the use of the resources that have been allocated (technical efficiency)

The MOHCW proposed reforms in the major areas of :

- Decentralisation
- Health Financing
- Regulating the Private Medical Sector
- Management Strengthening
- Contracting out

A comprehensive programme of reforms will ensure the sustainability of the health services delivery system and meet the objectives set by the currently developing Public Sector Reform Programme. The reforms will be consistent with equity in service provision, efficiency and effectiveness, financial sustainability, improved health status and active participation in service planning and delivery by both the communities and private sector.

1.1.2.9. ZIMPREST

Although its present status is questioned, ZIMPREST has as ESAP taken up a position in the Governments' policy developmental process. As stated before Zimbabwe made consistent progress in health, population and nutrition driven by decisions to increase public health expenditures and shift of emphasis towards rural areas, primary and preventive health care, nutrition and family planning. Gains in health indicators were achieved by focusing public investment on interventions with high economic returns as maternal and child health services, health education, nutrition education, food production, immunisation programmes, control of communicable diseases, the essential drugs programme and provision of basic and essential preventive and curative care. By reallocating investment from tertiary based care towards cost effective delivery of care at clinic and community level access to health services increased.

Up until 1990/91 the Governments' Health spending grew as a share of budgetary expenditures and as a share of GDP, peaking at 6.4 % of the budget and 3.1 % of the GDP. Since 1990/91 health spending however had been squeezed by the growing burden of debt service with the share of GDP devoted to Health spending falling drastically to 2.1 % of GDP and 4.3 % of the total budget.

ZIMPREST reforms will continue to support the public investment in health as priority element of the Government, aiming at the increase of aggregated health spending to 2.5 % of GDP strategy. The government will continue to take responsibility for financing and managing the health care delivery throughout the country in order to consolidate the gains achieved since independence.

The emphasis of ZIMPREST lays on the need to promote equity of access in the most cost effective way through emphasising strategies bringing highest social returns. The costly burden of AIDS however will be reviewed and key policy issues

reformulated. The focus on Primary Health Care will be restored through the implementation of the decentralisation strategies to local authorities. The MOHCW is responding to this in formulating its Health Strategic Plan.

As suggested ZIMPREST proposes the efficiency and effectiveness of the health care delivery system to be improved through improving the capacity utilisation, dealing with pandemics as AIDS, TB and Malaria cost effectively, reducing the donor dependency, increasing the effectiveness of social safety nets, improving the quality of the management information systems, building capacity for decentralisation.

ZIMPREST is clear in the formulation of the idea of "shared growth" and the following issues are being proposed in the implementation of the reforms :

- Maintaining efficient capacity and restore utilisation within the context of the stagnant expenditure levels in order to maintain quality and equity of access. This means to re-establish the priority given to PHC. It involves re-examining equity of access to physical facilities in the context of recurrent expenditure levels, service quality and capacity utilisation
- Restoring funding of health facilities run by missions and utilisation of the private sector to provide services and financing. The in-adequate assistance to mission health facilities to enable their full capacity utilisation of the preventive and curative services has lead to poorer output. The capacity of the private sector to provide health facilities has not been exploited enough
- The promotion of home based and community care for AIDS victims as it did not receive adequate technical, educational, financial support to give the required level of care. It has been noticed that the problems of AIDS, TB, Malaria and other pandemics are accounting for some reversal in the improvements in infant mortality performance and that Malaria and TB were possibly increasing as a result of neglected preventive strategies and the impact of AIDS/HIV on the resistance to the diseases
- The contributions of donors to capital development projects and special health education programmes need to be assessed. The inability of the public sector to take over the financial responsibility when donors were pulling out of the projects dislocated and disrupted the health services
- An in depth assessment of the system of subsidies for the disadvantaged groups to enable accessibility of health services and the effectiveness of the safety nets, has to be performed
- The funding modalities and performance monitoring systems need to be developed in support of the decentralisation of the management of health services provision

1.1.2.10. Sector Investment Plan

Once the Strategic Plan will be operational, the Sector Investment Plan will organise the resource mobilisation. The core health services will be prerequisite and decentralisation will be the strategic focus. Opportunities will be created to improve

access of health services and equity in delivery of the health services. One of the guiding principle is the customers' satisfaction. Reforms are not only seen as technical but also political and seen as 'means' in health services improvement. The economical changes are implicating changes in health care delivery. The decentralisation process however is depending on the reform implementation in the other sectors, such as financing, contracting out, general management, training of resources, regulation of the private sector. To make the whole decentralisation process successful the financial participation and the investment of the communities, local and donors, is also a prerequisite. The decentralisation process is a means to achieve public health but its credibility will depend on evidence.

The basic principle of equitable health care financing is that the healthy subsidise the sick. The Government will provide a basic package of preventive and curative services. This will be financed by the combination of local taxes, user charges and a national health insurance scheme. As part of the health sector reform agenda, work will be carried out on the costing of the basic health package and an agreement will be required on the contribution of central government, local government and the individuals to finance it.

A first decentralisation document has been prepared and reviewed by teams in the provinces and at central level explaining the proposed MOHCW position in better fund flow control, in retaining services fees so that quality of services can be improved. The point is that the implementation of the decentralisation process must be accompanied by appropriate financing mechanisms for service delivery. A National Health Fund has been established to make Government and donor funds flow possible to the requested areas, based on the agreed plans and services' contracts made. Figure 2 indicates the current flow of funds. Whatever mechanisms for financing are put in place, it will be essential that the MOHCW retains control of authority so that policies can be implemented.

The main aim for improving the efficiency and effectiveness of any health investment plan is to develop a national master plan for all primary and secondary level facilities. This could be achieved through :

- Approved norms and standards for the distribution; spatial and constructional quality of all type of facilities under private and public administrations including equipment, furniture and environmental safety issues
- Approved norms for staffing, capacity and utilisation of health facilities
- Overviews of the condition and utilisation of existing health facilities in all districts and provinces
- Designing development plans for the institutions
- Approved investment programme for short and long term development of the health services infrastructure, including master plans for the facilities
- Improved technical capacity in estates management in the MOHCW, MOF, MPCNH including data collection, decision making, administration
- Improved information and tools for estates management

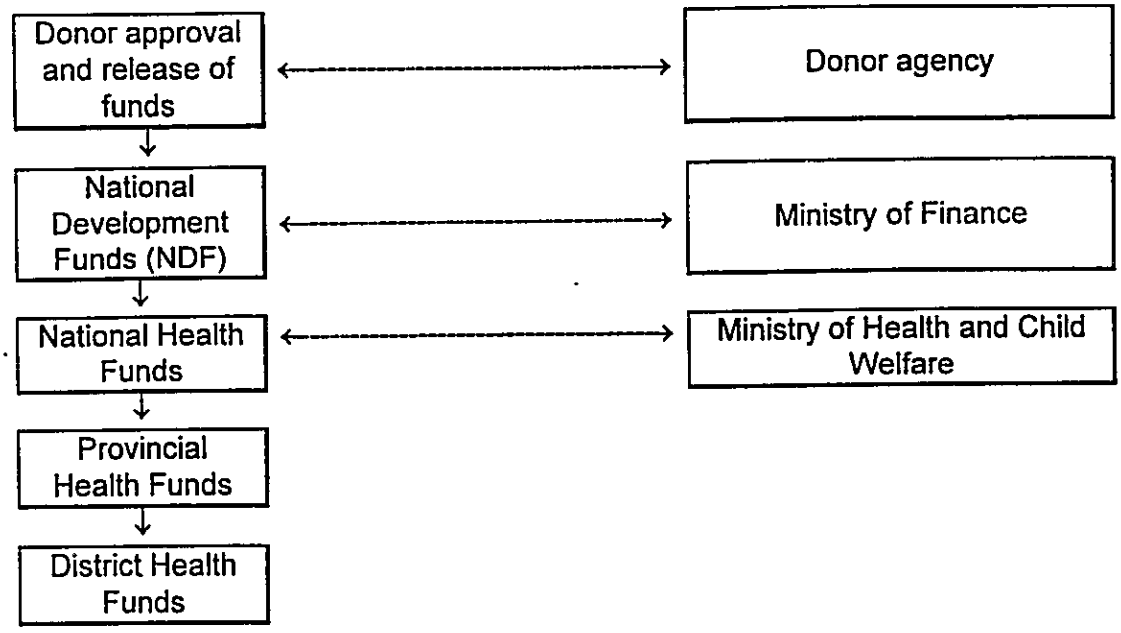

FIGURE 2 : FLOW OF FUNDS

The MOHCW, the Ministry of Public Construction and National Housing, Ministry of Finance will be involved in the health investment plan. Their participation in training to develop the master plans, estates management, designing development plans for facilities etc. will be required. The recent developed proposals for the tertiary level facilities investment plans are being discussed in the MOHCW.

1.1.3. Priority Health Issues

The health sector in Zimbabwe has achieved a lot in the last sixteen years as evidenced by the improved health indicators.

It proves that priority health problems identified and the strategies put in place have been effective. The new National Health Strategic Plan will bridge the existing gaps and contribute to the further improvement of the quality of life. To improve the overall health of the nation the following key performance areas are essential factors :

- Effective and full decentralisation of the health services (reorganisation of the current health care delivery system)
- Community mobilisation (people assume full responsibility of own health care through preventive and promotive activities)
- Reduce the morbidity and mortality through special programmes
- Health infrastructure development in areas with socio-economic depression
- Protection of special groups

- Restructuring of the health system
- innovative ways of health care provision and services
- Monitoring and evaluation

A final list will only be available after wide consultation through the MOHCW and the stakeholders.

A summary of the areas where programmes need to be developed to further reduce the morbidity and mortality are listed in Table 3.

TABLE 3 : PRIORITY HEALTH PROBLEMS

Communicable Diseases	Non-communicable diseases
• AIDS/HIV/STD * TB * Malaria * Diarrhoea * Skin Diseases	* Cardiovascular * Injury * Cancer * Diabetes * Eyes * Dental Conditions
• Nutritional Deficiencies * Kwashiorkor * Micro-nutrients * Obesity	• Life style * Substance abuse : alcohol, drugs, smoking * Sexual behaviour * Stressful environment
• Pregnancy and New Born Related Conditions * Perinatal * Maternal deaths * Abortions * BP/Eclampsia * Adolescence	• Environmental Issues * Housing * Air/water pollution * Food safety * Physical environment
	• Miscellaneous * Rabies * Plague * Anthrax * Bilharzia

Source : National Strategic Plan, MOHCW, 1997, Draft document

The current health gains are not only the result of the effective health care delivery of the MOHCW alone but they are a result of the combined efforts of several sectors and partners in health.

The MOHCW at this stage is taking wide consultation at all levels regarding the health development priorities. The health development priorities are viewed within

the new National Health Strategic Plan as earlier mentioned and briefly described as proposed and therefore it is impossible to elaborate on them at this moment widely. The Ministry is presently holding consultative meetings with key health programme managers to finalise the document and the health priority list including the objectives. As indicated before the MOHCW is defining its new role in health care delivery. It is a fact that not all health priorities will be the sole responsibility of the MOHCW. Within the context of the National Health Vision the MOHCW is defining its mission for the next ten years.

1.2. THE EXISTING STRUCTURE OF THE MOHCW

1.2.1. The Organisation

The Ministry of Health and Child Welfare structure is a dynamic organisation of necessity to be flexible because of the undergoing changes and modifications demanded by the changing priorities and circumstances. The MOHCW structure is being discussed and its implementing levels are presented.

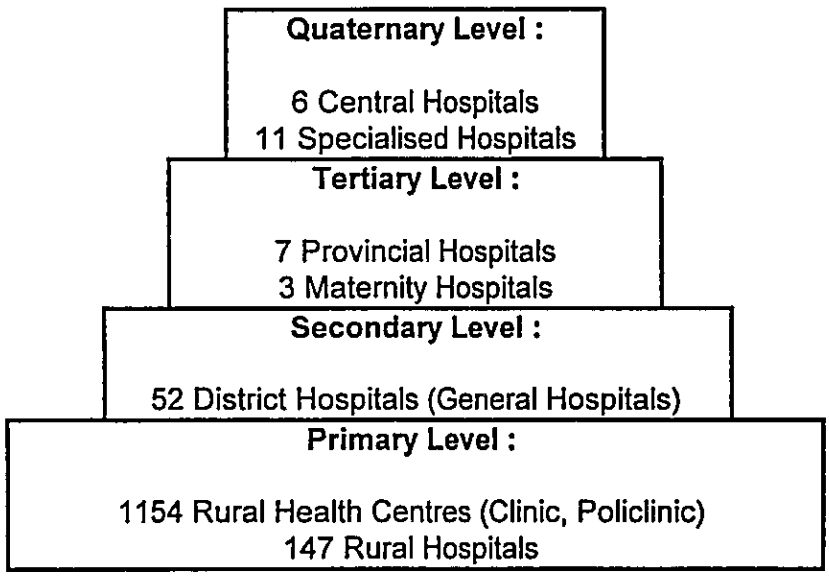

FIGURE 3 : STRUCTURE OF THE HEALTH SYSTEM

Source : MOHCW, Organisational Structure, 1993

The health structure in Zimbabwe has four operational levels as provided in Figure 3 :

- *Primary Level* : The basic health care unit is the Rural Health Centre/Rural (Council) 'Clinic' or Mission facility. If in-patient services are offered they are referred to as Rural Hospitals. It should be staffed with at least one nurse offering basic health care within a radius of 10 km.
  The Primary Level provides basic services with the purpose to raise the health status of the community and to be the first contact between the community and the referral system :

  * Preventive services (ante-natal and post-natal care, FP advice and provision of contraceptives, child growth monitoring and nutrition surveillance, immunisation, surveillance of notifiable disease outbreaks, sanitation and food safety)
  * Simple curative services (normal deliveries, treatment on presumptive diagnosis, minor surgical procedures)
  * Community based health care and outreach activities in co-operation with the village community workers, extension workers, environmental health technicians, farm health workers, traditional midwives, traditional healers, CBD, and others such as health centre committees

- *The Secondary Level (District Level)* : This level is responsible for the co-ordination and integration of Health Services in the whole district. The district is the basic planning and implementation unit of all activities in the Ministry. At this level there is a District Hospital/Mission Hospitals, in urban areas this is called General Hospital, which is the referral for the Rural Health Units. It is staffed with an X-ray operator, laboratory technologist, pharmacist, government medical officer (GP) and a District Medical Officer representing the public health system at district level. The district health services are :

  * The provision of secondary level curative care at the district hospital which is usually equipped with an outpatient department, emergency department, standard acute care, operating theatre, laboratory, X-ray department dental unit and pharmacy
  * The management of all public and private sector health facilities and activities are executed by a district health team consisting of members from all sectors of the district. It forms the link between the local community, government and other agencies. It makes joint decisions in the running of health services in the district
  * The co-ordination and monitoring of the implementation of community based health care programmes such as immunisation, sanitation programmes, MCH and FP programmes etc.
  * Support and supervision of the primary level activities

- *Tertiary Level (Provincial Level)* : The provincial level is an intermediary level between district level where implementation is taking place and the central level where policy formulation and strategic planning happens. It functions as the

second referral level in terms of curative services at the Provincial Hospitals. They deal with more specialised and complicated health problems and are the first specialist referral medical support to the district hospitals. The provincial Health Executive has co-ordinating and supervising responsibilities of all health activities in the province as well as effective communication with both levels.

- *Quaternary Level (Central Level) :* This level provides a wide range of specialist services including the training of health personnel. The Central Hospitals are the national referral centres for the whole country and perform also the function as teaching hospitals. (Two in Harare and three in Bulawayo). In addition there are specialised hospitals that exclusively deal with ophthalmic diseases, infectious diseases, psychiatric and nervous disorders. The health care system at the central level is responsible for the overall policy guidance on strategic development in the health sector. It provides technical support and guidance on the implementation of health policy, its monitoring and evaluation.

1.2.2. The Structure

The existing structure of the MOHCW is presented in Figure 4.

1.2.2.1. Central Level

The MOHCW is headed by the Permanent Secretary who reports to the Minister and the Deputy Minister of Health and Child Welfare. The Permanent Secretary under the current law is a Medical Doctor. The different divisions comprise of a number of Departments, briefly described here after. Three (3) Divisions each headed by a Deputy Secretary are responsible for the Health Support Services, Health Care Services and Finance, Administration/ Personnel, Planning and Management.

1.2.2.1.a. *Health Care Services Division*

The Health Care Services Division is in charge of the following six Departments each headed by a Director :

- *Epidemiology, Disease Control and Health Information Department :* monitors effectiveness of health programmes, plans the disease preventive and control programmes to reduce morbidity and mortality and disseminate health information through the Sub-Department : "National Health Information System" that currently compiles data from vertical programmes in a national framework.

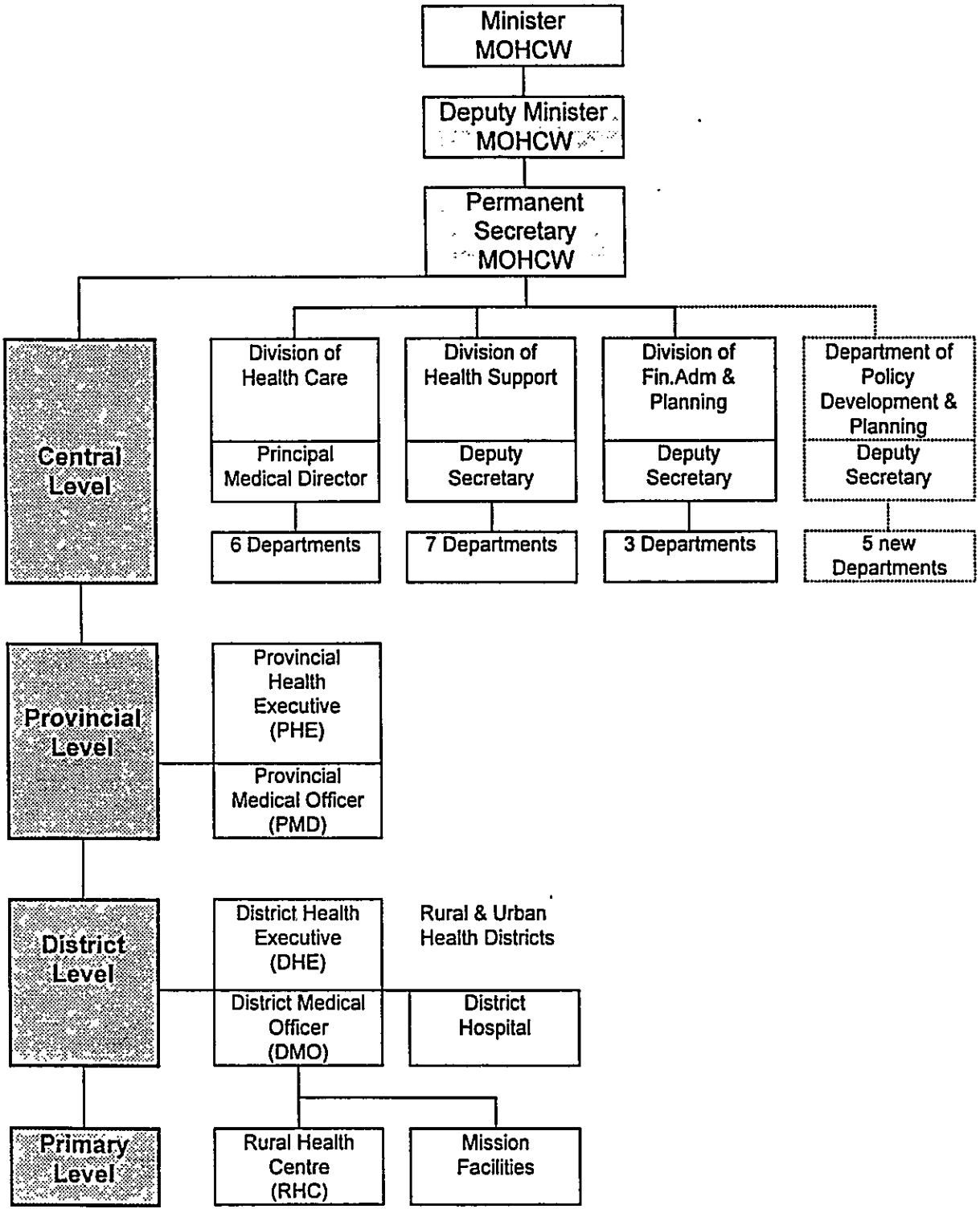

FIGURE 4 : MOHCW ORGANISATIONAL CHART : EXISTING SITUATION, 1995

- *Maternal and Child Health (MCH) :* promotes, co-ordinates, monitors and evaluates MCH countrywide. To improve and protect the health and nutrition of families and communities through specific programmes that reduce maternal, infant and child mortality, morbidity and malnutrition. Activities include the training of trainers and health care providers in various programmes.

- *Nursing Services :* establishes, implements and sustains an effective nursing service delivery network in preventive, promotive, curative and rehabilitative health care at community, district, provincial, central levels. The department trains nurses, nurse tutors and midwives.

- *Pharmacy Services :* is responsible for development and promotion of the profession, for countrywide provision of Medical and Surgical supplies in the public sector. The department plans, organises and controls pharmaceutical services countrywide.

- *Dental Services :* in charge of the oral health and dental care including school dental services. The department provides education and training of dental therapists, technologists.

- *Family Health Project :* is involved in capital projects supported by the donor community. The activities cover the planning and execution of infrastructure (health facilities and accommodation) in provinces and districts.

- *National AIDS Programme* (not considered as a Department of the Health Care Services Division) : is in charge of prevention of transmission of HIV/STD and the reduction of the medical and psycho-social effects of the epidemic. The department develops and establishes multi-sectoral involvement in the implementation of the programme.

- *Provincial Directorates including the Hospitals* (see provincial level) : The Provincial Directorates report directly to the central level.

1.2.2.1.b. *Finance, Administration/Personnel, Planning and Management Division*

The Finance, Administration/Personnel, Planning and Management Division is responsible for the following three (3) Departments each headed by a Under secretary :

- *Personnel and Administration Department :* adheres to the procedures with regard to the MOHCW operations or management of assets and resources. Procurement, supplies and regular sundries for the functioning of the Ministry. The department is also in charge of the MOHCW staff in liaison with the Public Service Commission and in compliance with the

Government regulations. The department is involved in the recruitment, informing on service conditions, monitoring of performance and remuneration.

- *Finance Department :* develops appropriate financing schemes for health and health financing policies. It ensures proper administration of MOHCW budgets at all levels and the donor support. The department is responsible for control of revenue collection and user fees and reports regularly on the financial status of the MOHCW.

- *Health Development, Planning and Management Department :* develops guidelines and manuals for health managers at all levels in annual and long term work plans, provides the budget planning and human resources development. The department is in charge of the management of the required training and development of curricula. This department was recently reformed.

1.2.2.1.c. *Health Support Services Division*

The Health Support Services Division is in charge of the following Departments each headed by a Director :

- *Blair Research Institute :* executes and/or monitors health related research. It provides assistance and consultancy services on health related research.

- *Public Health Laboratories :* are responsible for the laboratory staff education and the functioning of the laboratories and their staff. In using the laboratory network the MOHCW is in a position to determine disease causes, trends and treatment procedures.

- *Government Analysts :* are in charge of the analysis of the clinical specimens and samples, environmental samples and industrial materials in order to maintain the required standards.

- *Environmental Health Department :* preserves health and related environmental standards in Zimbabwe. The department monitors, supervises and evaluates the general performance of all ranks of society. It is responsible for the promotion of appropriate and adequate technology in environmental health.

- *Radiological Services Department :* controls, supervises and maintains quality of the radiological services in the country.

- *Clinical Psychological Services Department :* develops and expands the clinical psychology and promotes the introduction of clinical psychology in the medical curricula.

- *Equipment and Maintenance Department :* develops inventories of all hospital equipment as basis for maintenance schedules. The department is in charge of the training of hospital equipment technicians.

1.2.2.1.d. *Policy Development and Planning Department*

Currently a department but under the new proposed structure it will become a division. This new division is discussed under the proposed structure in Figure 5 chapter 1.3.1.

1.2.2.2. Provincial Level

The central level regards the Provincial Health Service Authority (PHSA) (Provincial Office headed by the Provincial Medical Director (PMD)) as its extended arm. The PHSA facilitates the provision of health services within the province. Being in charge of planning, monitoring and evaluation of the health services delivery system, the Provincial Office has sufficient insight in the functioning of its districts to compile the provincial health budget, advise on budget allocations in collaboration with the District Health Teams. The PHSA provides logistical and technical support to the District Health Teams and co-ordinates health related activities of the Non-Governmental Institutions.

The Provincial Health Service Authority works under the direct authority of the Ministry of Health. The Provincial Health Executive (PHE) and the Provincial Health Advisory Board maintain the health standards in the area to which assigned and contribute to the development of national policies. The province will play a key role in the Health Sector Reform with extended tasks and a strong facilitator's role. The PHE is composed of : Provincial Medical Director (PMD), Provincial Health Services Administrator (PHSAdm), Provincial Health Educational Officer (PHEO), Provincial Nutritionist , Provincial Environmental Health Officer (PEHO), Provincial Nursing Officer (PNO). The composition of the PHE can vary from province to province. The composition given above is the minimal one. Each member has its own responsibility with specific links to the district and central levels.

The Provincial Health Team (PHT) works with the PHE and facilitates the co-ordination within the province. The PHT functions under the Provincial Development Committee (PDC), headed by the Provincial Governor and made up of provincial heads of the ministries and NGOs. The Provincial Health Committee (PHC) is a subcommittee of the PDC and provides political support and inter-sectoral co-ordination of health related activities in the province.

The Provincial Hospitals are managed by a Hospital Executive, consisting of the PMD, PHSAdm, the Provincial Hospital Matron, Provincial Pharmacist etc. and assisted by the Provincial Hospital Advisory Board with the inclusion of two (2)

members appointed by the Minister of Health. The hospital services provision has been described previously. They report on health issues to the Provincial Health Services Authority.

1.2.2.3. District Level

The district is the basic unit for planning, implementing, monitoring and evaluating the rural health services and it has close links with its political, administrative authorities and other sectors.

At the district level the "District Health Executive (DHE)" and a District Advisory Board maintain health standards in the district. The DHE sets the priorities in dealing with health problems and plans the health services provision accordingly. It allocates and monitors the resources used for the health services. The planning, supervision, support of PHC activities as well as the provision of district hospital care are organised at this level.

The structure of the DHSA is comparable with the PHSA. The DHT with as members the DHE is comparable with the PHT. The DHE is headed by the District Medical Officer (DMO), assisted by the District Nursing Officer (DNO), the District Pharmacist (DP), the District Health Services Administrator (DHSAdm), the District Hospital Matron and the District Environmental Health Officer (DEHO). This composition however can vary from district to district according to the available capacity and the specific health related priorities. The DHT consist also of the members of the mission and mine hospitals, heads of RHC, District and Rural Council including the district administrator. The DHE plans, monitors, supervises the district health activities. The DHE members have their specific responsibility and provide technical support. The DMO is overall responsible for the health services in the district and the district hospital.

District Hospitals are managed by a Hospital Executive, consisting of the DMO, DHSAdm, District Matron, DP and is assisted by a District Hospital Advisory Board with two members appointed by the Minister of Health. They report to the DMO regarding health related issues, planning and management.

The district political structure is important to be mentioned in view of the decentralisation process and the health sector reforms. The District Council is headed by the District Administrator (MOLGRUD) with planning authority for the district operating on a annual budget within the respective legislation. The District Development Committee forms the political link between the DHSA and the multi-sectoral DHC (chaired by the DMO). The DHC is the key body for local political control and stimulating community involvement.

1.2.2.4. Primary Level - Rural Health Services

It is the policy of the Government to have at least one health centre for every 6 000-10 000 people in rural areas. All provinces achieved the target of one health centre per 10 000 people (inclusive the industrial, mines and private clinics). The data shows wide variations between districts within provinces. It is the MOHCW's most peripheral unit of the health care delivery system with Rural Health Centres (RHC) in rural areas and Clinics in urban areas. As previously described they are staffed with at least one nurse, and one health assistant, sometimes an environmental officer and supported by the VCW, CBD, etc. They are responsible for the health activities of a Ward and the supervision of the health workers. The RHC provides basic but comprehensive promotive, preventive, curative and rehabilitative care with MC/FP activities, normal deliveries, nutrition, immunisation, environmental sanitation, safe water supply, control of communicable diseases etc. Health Centre Committees (HCC) are established and provide links between the health staff and the community for the co-ordination and the implementation of the health services in the area. The Ward Health Committee with members of the community provide community input into the functioning of the RHC and they contribute to local health activities.

The Village political structure such as the Village Development Committee (VIDCO) facilitates the integration of health related activities with other village concerns. The VIDCO and the HW determine the community priorities.

1.2.3. The Organisation of the Hospitals at all levels

District hospitals are managed by a Hospital Executive (DHE) consisting of DMO. District Health Services Administrator (DHSAdm), the district hospital matron and the District Pharmacist (DP). This body is assisted by the district hospital advisory board with two members appointed by the Minister of Health, a councillor of the local authority, local practitioners and members of the general public. The district hospitals report to the DMO.

Provincial and Central Hospitals are in principle managed by similar structures. They report to the PMD and the central level respectively. The central hospitals and national special hospitals provide quaternary level health care for patients referred from the provinces and city level units. At the same time the central level hospitals provide teaching capacity for university and MOHCW. The provincial hospitals are the referral hospitals for the district level. Most of the hospitals are upgraded general hospitals. The responsibility is carried by the provincial health service authority. The provincial hospitals provide also post basic training opportunities for doctors and nurses.

1.2.4. Other Health Care Providers

1.2.4.1. Local Authorities

- *Rural District Councils :* A Government policy decision (Rural District Councils Act - 1994) made District Councils, responsible for communal lands and the Rural Councils, responsible for the commercial farming and small town areas, merge into one entity. The separation in planning and implementation of activities fragmented the health services. The RDC plans for the services in the whole district with the provision of primary health care services in line with the Rural Health Centres and accounts for 2.5% of the total expenditure on Health Care (source : Framework for Economic Reform 1991-1995). A total of 1154 Health Centres are operational countrywide and their activities are supervised and co-ordinated by the DMO's and the PMD's.

- *Municipalities :* Municipal Health Services administered by the Local Governments of the 12 large towns consist of a range of services varying from small clinics to the complex network of polyclinics, maternity homes preventive and inspection services and varying degrees of environmental sanitation. The bigger municipalities have more financial means than the smaller urban clinics. Revenues are raised, making municipalities less dependent on the Central Government for their health related activities.

1.2.4.2. Missions

Missions were the first to provide medical care to the rural population and their services vary from hospitals to clinics. They played an important role in the training of nurses. The services are supervised by the DMO's and PMD's. Some mission hospitals are assigned responsibilities comparable with those from District Hospitals. Mission health facilities are forming the Zimbabwe Association of Church Hospitals (ZACH). The association shares its ideas and present its views to the Government. The Government provides grants to the mission health facilities to cover the running costs. In view of the health sector reform the financial aspect of the mission hospitals will be reviewed and the District Health Services Board will assess the viability and cost effectiveness of each mission facility. They then decide on the designating of some of the facilities as District Hospitals. The other mission health facilities are graded comparable with the other health facilities in the district. Accordingly the assessment, the funding levels will be determined.

1.2.4.3. Private Medical Sub-Sector

This sub-sector of independent practitioners receive payments directly from clients or medical-aid societies. The services are mainly offered in private hospitals in large urban centres.

1.2.4.4. Industrial Medical Services

This sub-sector offers health services regarding mining and industrial concerns but limited to the employees of the company or industry, varying from small dispensaries and clinics at the workplace to hospitals of up to 140 beds.

1.2.5. Deficiencies of the Old Structure

It became evident for the MOHCw that :

- the target of equity in health care, as formulated after independence did not achieve its goal
- the district health system was not functioning properly
- the health gains achieved were gradually decreasing

which related to the areas of concern such as :

- low motivation of staff and dissatisfaction in the quality of care
- low user-confidence in the system
- lack of operational resources and facilities
- poor health financing structure
- lack of insight in health care costs

This resulted in the MOHCW conducting a review of its functions, taking into account the Government policies and learned lessons from world wide trends in the provision and management of health services. It became clear that major shifts in the provision of health care were needed in the areas of :

- financing the health services
- decentralisation
- health management strengthening
- commercialisation
- regulating the private sector

Through the process of the health sector reform the commitment to the following principles were reaffirmed :

- improving health status and consumer satisfaction by increasing effectiveness and quality of services
- obtaining greater equity by improving the access of disadvantaged groups to quality care
- obtaining greater value for money (cost-effectiveness) from health spending, in the improvement of allocative and technical efficiency and managing the services near the point of delivery in order to make services responsive to needs and preferences of the client

1.3. THE NEW PROPOSED STRUCTURE

1.3.1. Introduction

The Government of Zimbabwe (GOZ) proclaimed a nation-wide move to decentralisation of services and activities. The "Public Service Review Commission" (1987) produced a list of reforms resulting in decentralisation of functions in the GOZ structure. The MOHCW took up the challenge of the Health Reform Programme and produced guidelines "Health Sector Reform in Zimbabwe, Decentralisation Policy Setting (April 1995) and "Health Sector Reforms" (August '95) to rectify the deficiencies and develop a new structure. A major priority, the new structure has to address, is the ability of the health care system to deliver decentralised comprehensive integrated health services based on primary health care, aiming at improved and equitable service provision. Consultative meetings were held on constraints to decentralised health care delivery and the development of appropriate facilitating structures.

The consultative meetings were attended by key representatives of the MOHCW drawn from the central, provincial and district levels. At the end of the consultative meetings a hierarchical structure that recognised the Rural District Councils as key-partners in health development was proposed.

In response to the problems, the MOHCW has embarked on the Health Sector Reform with the general trend to manage services closer to the point at which they are delivered in order to make services more responsive to consumer needs and preferences. Furthermore, the decentralisation of the resource management authority to the health service provider unit will ensure the cost effectiveness of the resources and will empower the local communities in improving efficiency and management. The proposed Health Reform Programme is based on the shift from curative to preventive activities. It is committed to the principles of health status improvement, improving equity through better access to quality health services for disadvantaged groups and more cost effectiveness from health spending in the distribution, management and use of the allocated resources. This proposal has been discussed more in depth under the section decentralisation and strategic plan.

1.3.2. Proposed Organisation of Health Services at all Levels

The new proposed hierarchical structure of the MOHCW is presented in Figure 5.

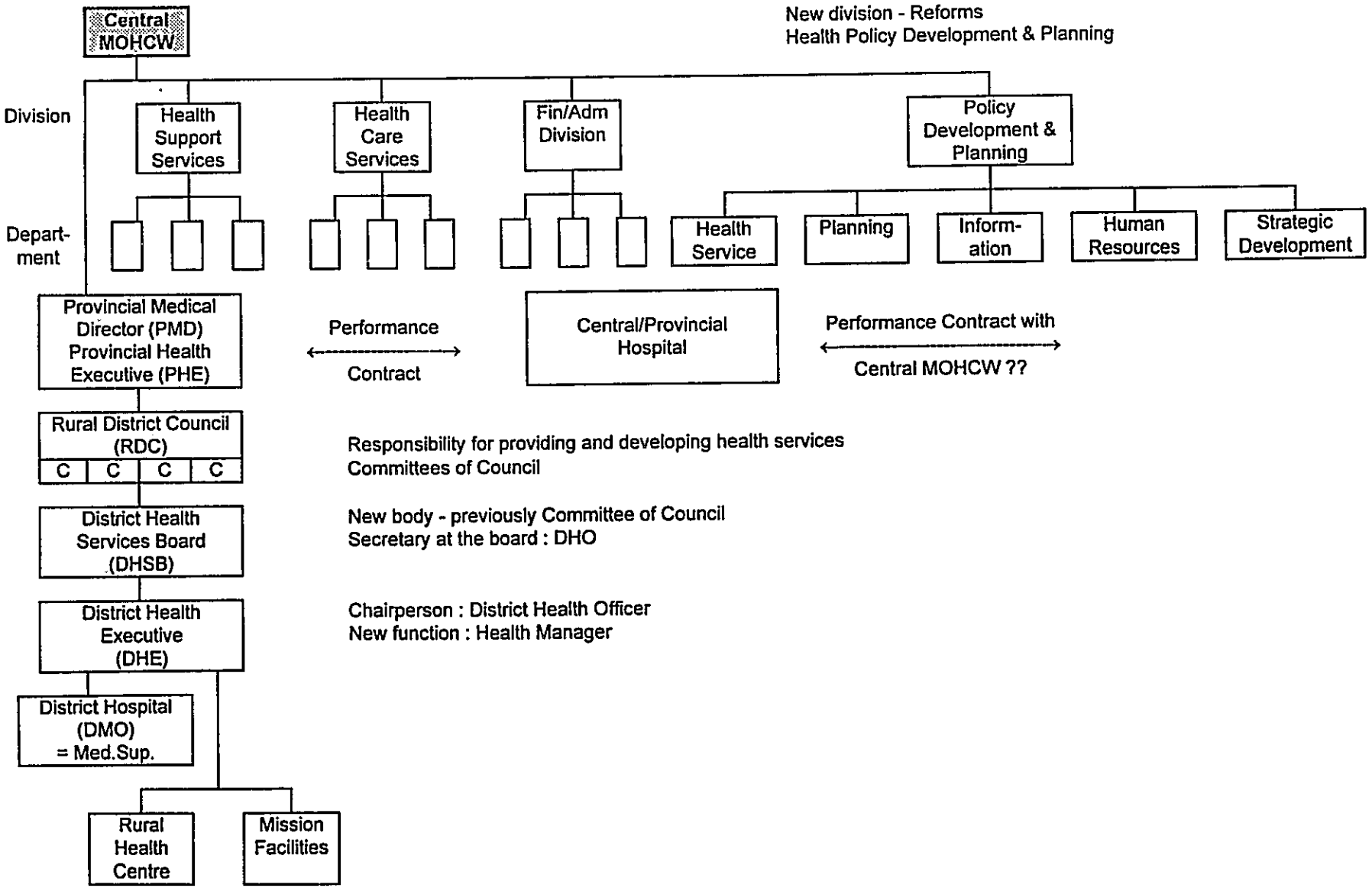

FIGURE 5 : OVERALL RELATIONSHIPS : HEALTH SECTOR DECENTRALISATION

1.3.3. The Ministry Headquarters and the Provincial Medical Directorates

The proposed changes mean that the way the MOHCW operates will change completely. Ownership of all health institutions will be given to RDC and Hospital Boards. The staff working in these institutions will become employees of the RDC or Hospital Boards. The MOHCW will not be directly responsible for the health services provision.

The main role of the MOHCW will be to set policy and to provide a legal enabling environment for the operations of various health service providers and purchasers, providing finance, allocating resources and monitoring implementation of the Nation's health programme. Specifically the role of the MOHCW will be :

- Setting national health policy, health services priorities, developing the necessary legal instruments and other guidelines for implementation of health policy
- Providing arrangements for funding of health services and regulating the operations of third party payment schemes
- Monitoring the implementation of health programmes by each provider
- Providing support for capacity building of health service providers in management of health services and service provision
- Supporting the training and development of the human resource base
- Co-ordinating the technology assessment
- Supporting research

The divisions of Health Care Services, Support Health Services and Finance and Administration are staying the same in organisation and structure with the same number of departments as discussed in chapter 1.2.2. A new division of Policy Development and Planning will be created. This division will have five new departments : Health Services, Planning, Information, Human Resources and Strategic Development. The new division will be responsible for the policy developments in the MOHCW.

The Provincial Medical Directors' Offices, previously the provincial office will become Departments of the Ministry within the provinces and function on behalf of the Ministry. Ministry staff and PMDs will be the only civil servants. This effectively will reduce the Ministry Civil Servant Staff from almost 23 000 to 2 518.

The Provincial Medical Director's responsibilities will be :

- To advise the District Health Management Board (DHMB) on annual plans including activity targets and allocation of budget
- To support DHMB in the implementation of the plans
- To prepare a staff development plan
- To monitor and review the progress of the DHMB in implementation of the plans
- present reports to the Ministry which will provide the basis for further evaluation

- To prepare financial audit
- To review the quality of services and set standards in consultation with the DHMB and the Hospital Management Boards
- To facilitate the provision of training

Provincial and Central Hospitals

Provincial and Central Hospitals are mostly run as District Hospitals, except for the Parirenyatwa Hospital. It is proposed that the provincial and central hospitals are operating under the direction of Management Boards. It is intended that the staff are not civil servants but be employed by the Hospital Board. Within each hospital, management functions will be allocated to each Clinical or support service department. The delivery of services should be in support of the District Health Services avoiding duplication. Special Hospitals will become independent and run by Boards. The funding will come from the Government because the revenue capacity generated from clients will be limited. The funding of the Provincial/Central Hospital will come as grants and move towards a contract system. The institutions responsible for training will get support of the Ministry for the human resources development. A co-ordination mechanism ensuring optimal utilisation of the resources and avoiding duplication of services should be set up for the Provincial/Central Hospitals.

1.3.4. District Level

The reorganisation of health services after independence, decentralised the operational responsibilities but not the control of resources and authority which remained central. Implementation of the health sector reforms will give districts authority over financial resources as well as the management of the health services. This will give the Central and Provincial Level the opportunity to re-orient their scope of work and emphasise on policy development, monitoring, strategy development and technical and managerial backstopping.

The District Health Services which will be functioning independently with overall authority, will be owned by the Rural District Councils and managed by the District Health Boards ensuring the efficiency and responsiveness to local needs. The proposal is that the Board will be accountable to the MOHCW through the Provincial Medical Director's Office. The Executive powers will be executed by the DHE. The district Health Officer will be the chief Executive of the District Health Service. The other officers will be responsible for the health services as described before including corporate management capacity. The DHE team will be employed by the Rural District Council and will be responsible for :

- Implementation of community and institution based health services on the basis of core services produced by the Ministry
- Management of public sector health facilities

- Managing the district health resources
- Promotion of links with the RDC
- Promotion of community involvement in health services

At first the Board will be financially supported by the Ministry through health grants to be used for promotive, preventive health services. A National Health Insurance Scheme will be put in place with the appropriate funding arrangements in the near future. Health facilities will be paid for the services they provide instead of getting budgetary allocations. The District will mobilise additional revenue for the District Health Service. The purchase of equipment, vehicles, drugs and other supplies to run the health services will be done in using the available resources.

The mission hospitals will be assessed by the District Health Services Board and designated district hospital or otherwise according to its viability and services provision. Resource support will than be allocated according the designation.

The role of the District Office will be to provide and manage the strategic framework in which service provision in the district will be accommodated. The District Office will perform the following tasks :

- Planning to meet the District health needs with the available resources
- Supporting providers in achieving targets as agreed in service contracts
- Supporting providers in setting targets and agreeing on core contracts
- Promotion of community involvement and inter-sectoral partnership in health
- Evaluation and monitoring of the performance of units (providers) to ensure quality of service
- Negotiation and conclusion of service contracts with the provincial office and other providers
- Allocating and monitoring the use and management of health resources in the district to ensure value for money
- Preparing and submitting performance reports to the provincial office
- Mobilise resources for the development of health services

The role of the District Health Services Providers (district hospital, rural hospital, RHC, mission clinics/hospitals, private hospital and practitioners, traditional healers, community health services) units) will be :

- Monitor and give price-service provision in their units
- Manage quality and performance
- Manage and develop the human resources
- Report on performance

1.4. SPECIFIC HEALTH POLICIES

1.4.1. Drug Policy

Shortly after independence Zimbabwe embarked on the formulation of a National Drug Policy. This policy was based on the WHO concept of essential drugs in conformity with the Alma Ata Primary Health Care paradigm. The policy was further developed with technical support from WHO and endorsed by Cabinet in 1987. The NDP of 1987 included all major elements of a drug policy :

- Selection of essential drugs
- Quantification of needs
- Financing
- Procurement
- Storage
- Distribution
- Rational use
- Quality assurance of drugs.

A strong national drug policy has been in place for many years. It was only consolidated in one document after an extensive revision in a period of rapid change and development both in the private pharmaceutical industry and the public procurement system, when funds to purchase drugs and medical supplies became extremely difficult. The Zimbabwe National Drug Policy, ZNDP was endorsed by Cabinet in 1995.

The Essential Drugs List for Zimbabwe, EDLIZ, has been in use since 1985 and been revised in 1989 and 1994. It is covering a comprehensive list of appropriate drugs as well as blood product protocols and information on relative costs and stock requirements. Drugs play an important role in the health care delivery system in Zimbabwe. With the new policy the MOHCW hopes to strengthen and improve the pharmaceutical services throughout the nation in an efficient and cost effective way.

The overall goal of this national policy is to improve and sustain 'Health' with the available resources through appropriate treatment and preventive measures, using safe, good quality, effective, affordable drugs. The ZNDP is linked with the National Development Plan and the National Health Policy aiming at "Health for All". In promoting its aims the policy places emphasis on the selection and use of essential, generic-named drugs. It also underscores the need for adequate, relevant training of all health professionals for sufficient drug information to be made available. It promotes rational prescribing and optimal dispensing at all levels of the health care delivery system in both public and private sectors.

The Pharmacy Directorate will function as a policy making instrument in the context of the health sector reforms and the decentralisation process of the MOHCW.

The operational and management activities will be executed by the entire Pharmacy Structure with the Medicines Control Authority as a newly self financing independent advisory body. The General Medical Stores are becoming a newly self financing independent procurement, storage and supply organisation on a non-profit basis that support the Pharmacy structure. The Zimbabwe Essential Drug Action Programme (ZEDAP) will be targeting the weaknesses in all sections of the Drug Policy especially on rational prescribing and drug use and has had already an increasing impact on the entire health sector with its training and IEC component.

The policy will ensure the availability of essential pharmaceutical supplies. It emphasises optimal selection, drug financing, procurement, production, distribution, store management and quality assurance. The Government aims at having a drug availability of 90% for all the essential drugs at PHC level at all times. Despite the policy, the availability of essential drugs continues to be a problem. At the public sector health facilities the available levels are below acceptable targets. Although the ZEDAP Essential Drugs Surveys, 1989 to 1995 show significant gains made, these were not improved and sustained. The problems of irrational prescribing and drug use continues and a deterioration in drug supply management was noted according to the annual report of 1995.

The aim of the policy is also to ensure that the selection of essential drugs is included in the 'EDLIZ' based on the concept of essential drugs (essential drugs are the drugs of utmost importance, basic, indispensable to satisfy the health needs of the majority of people). EDLIZ drugs are, in agreement with the national four-tier referral system :

S : for specialist prescription
A : for Central and Provincial Hospitals
B : for District Hospitals
C : for Rural Health Centres

The Policy aims at making affordable drugs adequately available in securing funds for quantified drug needs of the public sector. The promotion of the procurement of good quality drugs, raw materials, at the lowest price possible, in adequate quantities within the available resources, is also a policy target. The drug procurement is centralised through the Government Medical Stores (GMS) with two regional and four provincial medical stores. The GMS functions as a semi-commercial agency. The commercialisation plans of GMS has been agreed by the Government in view of the health sector reforms and are at an advanced stage although this can take still two years before completion. GMS will operate as a self financing independent procurement, storage and supply organisation on a non-profit basis. It will provide essential drugs to the public sector at competitive prices with the optimum guarantee on efficiency, quality and availability. It will provide drugs to the private sector after having met the needs of the public sector. GMS has long enjoyed DANIDA support and therefore withdrawal of funds from the essential services before GMS activities have been sustained through privatisation, needs to be reviewed.

The Policy aims at promoting the cost effective local production of safe, effective, good quality drugs in order to achieve self-reliance. However, reports on wide-spread sub-standard, spurious or counterfeit drugs in commerce are a treat to Zimbabwe that imports 30 % of finished product consumption and 98 % of raw materials for local manufacturing. Surveillance need to be strengthened in view of these developments.

The Policy aims at ensuring safe, cost-effective and efficient distribution of drugs and medical supplies to the entire country to ensure the availability and accessibility to all. The policy aims also at maintaining the quality and safety of drugs during storage and at minimising wastage. The assurance of safekeeping drugs and medical supplies at all levels and at all intervals of the supply chain, is another policy target. A number of district and mission hospitals have inadequate or lack totally, storage space and pharmacy premises. The MOHCW has embarked on health reforms which means that hospital pharmacy and clinic dispensary will become the direct responsibility of Hospital Boards and District Rural Councils. The new role of the hospitals in the decentralised set up will require far going redesign and upgrading to act as backup for the hospital and its clinics. Furthermore if clients at all health facilities from primary to quaternary level are to have sustainable access to essential drugs, an effective procurement and distribution system must be in place. Drug supply management will be a key area of development.

The policy aims at ensuring that drugs and medical supplies of good quality, safety, and efficacy are used by the population. The quality assurance set-up is in accordance with internationally accepted standards as specified under the Drugs and Allied Substances Control Act (DASCA -1969) and Regulations. The Drug Control Council (DCC) (1971) is a body corporate screening all manufactured and imported drugs for registration under the DASCA. Recently a Bill passed and granted more autonomy to the DCC now called the Medicines Control Authority in view of the reforms in the health sector. The DASCA provides for the regulation of persons and outlets in the supply of drugs. The Zimbabwe Regional Drug Control Laboratory, ZRDCL (1989) was established to test drugs for registration and surveillance purposes. Zimbabwe has become self sufficient in ensuring the quality of drugs. Essential drugs even after selection as appropriate for medical conditions will be only supplied if they are conform to set standards of quality.

The policy considers drug research and development activities essential in order to strengthen its implementation. Regular reviews and amendments in the existing legislation are a necessity in order to implement the ZNDP. The Zimbabwe Essential Drug Action Programme (ZEDAP) executes on a regular basis (2 yearly) surveys in order to provide baseline information regarding the drug availability, drug use etc. in public and private sector. They give recommendations for future activities and provide basis for policy decisions and legislation.

The policy aims at ensuring that drugs are prescribed; dispensed and used rationally in the public and private sectors in order to maximise the therapeutic benefits obtained and minimise the costs involved. Wastage of resources, prolonged

morbidity and even death of clients may result from inappropriate drug use. Therefore the Policy underscores the rational prescribing and drug use as key areas to focus the interventions on. All health workers at each level of the health care delivery system who diagnose, prescribe and dispense drugs, need training in the essential drug concepts; stock management and rational drug use including dissemination of information on drugs and vaccines to health workers and consumers. Through the collaboration between the Drug and Toxicology Unit of the University, National Drug and Therapeutic Advisory Committee (NDTPAC) and the Medicines Control Authority (MCA) it is possible to monitor the appropriate drug use in the country.

The monitoring and evaluation of the various components of the policy are essential for future planning and implementation. The successful implementation of the policy can only be made possible through the collaboration and co-operation of all sectors. The drugs availability, the promotion of efficient drugs management and rational drug use can be achieved through improved regional and international co-operation.

The provision of efficient pharmacy services in both private and public sectors can be achieved through training and retention of an adequate number of staff at each level of the health care provision. It is hoped that the restructuring of the civil service will improve the conditions for the remaining staff. The Directorate of Pharmacy Services within the MOHCW requires strengthening to control the decentralised system and the management capacity of the future managers in the decentralised functions.

ZEDAP has according to the terms of reference taken up many issues which form a good basis for the further implementation of the NDP. But a concern is that the implementation structure within the MOHCW which could put the NDP in full practice is not strong enough. The Directorate of Pharmacy Services drew up a comprehensive plan for its own decentralisation. This experience could be used as an example for other departments in the MOHCW.

1.4.2. Policy in relation to Malaria

As malaria continues to be one of the major disease problems of public health concern, it is considered essential to look critical at the malaria policy. The National Malaria Control Co-ordination Unit of MOHCW is responsible for the co-ordination of policies, guidelines and activities related to malaria control in collaboration with other sectors and the provinces for their technical support.

The first line drug recommended in the Malaria Policy is chloroquine : in the adult the dose of 25mg/Kg over three days or as recommended by the EDLIZ is prescribed as soon as malaria is suspected. The treatment protocols are also clearly defined in the policy guidelines. The initial doses should be taken in the presence of a health worker or other responsible person. The rest of the drug is given with clear verbal and if possible written instructions. In case of vomiting within 30 minutes of oral administration of the drug, injectable chloroquine may be given to adults by a

certified clinician but is contradicted with children under the age of ten years. In case of therapeutic failure a combination of Sulpha/pyrimethamine (Fansidar) is to be given by a certified nurse in a single dose (three tablets per adult). The injectable form is only given in case of vomiting within 30 minutes of administration.

The policy of malaria illustrates the levels of prescribing treatment of Malaria in Malaria Areas depending on the nature and severity of cases. It is a policy issue that at household level the health education of the community is important for rapid intervention in suspecting malaria in all fever cases in malaria areas and to administer early treatment. At village level the first line drug treatment can be administered by the trained health worker with referral afterwards if necessary. When a certified nurse is available the second line drug can be administered in agreement with the drug policy and the regulations in case of treatment failure. In hospitals the medical doctor will treat accordingly with referral of complicated cases such as renal failure to higher specialised institutions.

Almost all the malaria in Zimbabwe is caused by *P. falciparum*. Only a few cases of malaria are due to *P. vivax* or *ovale* or *malariae*. Complications occur only with *P. falciparum* and in non-immune people : young children, pregnant women, debilitated persons, malaria non-affected dwellers, relocated persons such as refugees, security forces, travellers.

The incubation period for the symptoms and signs of malaria to spread is about 9-15 days but if drug prophylactic was taken may be prolonged.

The malaria policy document describes further the regimes and protocols in the case of Chloroquine sensitivity or resistance. These should be followed (in case of treatment or prophylactic) carefully according to different malaria types and degrees of severity for various groups of clients such as children, adults and pregnant women. Special attention is given in the policy to the imported malaria for timely diagnosis of malaria cases outside malaria areas. Chemo-prophylactic for pregnant women is only recommended in highly endemic areas (stratum A). In view of the fact that half of the population inhabits non-malaria areas and therefore has no immunity to malaria, chemo-prophylactic for travellers from non-endemic stratum C to highly endemic stratum A is recommended in the policy guidelines.

One of the policy issues is the vector control through spraying of human dwellings in stratum B areas which are vector prone. In stratum A spraying should be phased out as soon as correct management and protection of pregnant women can be assured. In stratum C spraying should be carried out in case of outbreaks. The policy recommends that Deltamethrin should be sprayed at the onset of the rainy season for its efficacy and short residual action. Larviciding for small scale reduction of breeding places and near wells in Stratum A is mentioned in the policy document, but is subject to research to measure the cost effectiveness.

The policy mentions the personal protection against mosquito bites through impregnated mosquito nets. Applied operational research and piloting of bed-net projects should be executed before recommending large scale operation. In the

control of epidemics, the policy promotes retrospective research in order to find the factors responsible for the differences in conditions which lead to epidemics. The policy aims further at health education to create awareness of the malaria problem in order to reduce the morbidity and mortality due to malaria.

The function of the National Malaria Control Unit in epidemiological surveillance will be to prepare policies, guidelines and protocols for monitoring progress in surveillance. For malaria epidemiological surveillance it is important to collect next to data on morbidity and mortality also data on other indicators (early warning indicators, subsequent warning indicators etc.). The policy aims at improving the knowledge and the management capacity of health workers in various aspects of malaria control. In order to strengthen the programme the policy aims at improving the capacity for applied research in order to use this as backup for the control of malaria.

1.4.3. Policy in relation to Schistosomiasis

At present the global strategy of control of schistosomiasis is to reduce schistosome related morbidity rather than primarily eradicate the disease. No clear cut National Policy is developed on the strategy of larviciding, although laviciding is operational in Zimbabwe. The most effective schistosomiasis control methods appearing in the policy is the morbidity control of the disease. The implementation strategy will be consisting of combined efforts of :

- selective treatment of individuals and control over new transmission by killing the intermediate host snails at the site of infection
- health education
- improved water and sanitation supplies

The selective snail control is the way forward in the control of schistosomiasis and could be taken up in the policy. The policy could be targeting the children aged 5-14 years as the prevalence is high in this age group.

1.5. HEALTH DEVELOPMENT STRATEGIES

The strategies to carry the health care delivery system forward into the future are mentioned below :

1.5.1. Health Care Financing and Financial Management

The Ministry currently develops its structure for consistent and regular Health Care Financing. Government's financing is reliable in the sense that it can be expected every year, but unreliable in its amounts.

In the period after independence the resource allocation to the health sector increased as the funding was mostly used for the upgrading and the building of RHC in the districts. ESAP made the Governments' spending on health, declining. The impact of the AIDS epidemic and the drought came at the same time of this decline and has put a greater burden on the health care service delivery system. In 1993/94 the government budget earmarked for health was 5.1%, in 1994/95 it was 4.46% and in 1995/96 it was only 4.68%.

At present time the Government is responsible for at least 60% of all health related expenditures. In the health sector however there is an increasing gap between the needs and the capacity of the Government to provide the finance to meet these needs. The Government maintains its commitment to equity in health care and therefore explores on a partnership between the public and private sectors, central and local government in developing a system to provide the finances. Other financial resources have also to be investigated. Each year finances become more scares and difficult to obtain. The MOHCW is investigating different options to ensure the availability of adequate financial resources :

- Better financial management of available resources
- Community financing (community based health insurance) : organised locally by the community through voluntary participation and flexible payment methods entitling users to free or reduced cost treatment at local institutions
- Cost Recovery (fees/revenue)
- Health Insurance (risk sharing)

The basic principles of any equitable system of health care financing are aimed at achieving equity and sharing risk, with the healthy subsidising the sick and the rich the poor. Not one revenue raising system is likely to be sufficient. It is however important to decide which roles the individuals and the state at central or at local level are taking. It is proposed that the Government will ensure a basic package of preventive and curative services available at time of need regardless the income. This is to be financed by a combination of local taxes, user charges and a national health insurance scheme. Individuals can supplement the scheme by taking out private insurance or purchasing health care directly.

As part of the health sector reform agenda, the costing of a basic health care package was carried out, as well as an agreement developed on the contributions of central and local government and individuals to finance it. In depth work will be carried out on the National Health Insurance Scheme and the capacity of individual municipalities, rural councils to raise revenue for the primary health care component of the package. The MOHCW will retain sufficient lines of authority so that health policies can be implemented within the scope of the financial system. It is necessary to develop the same regulatory capacity over the private insurance industry as it is the case with the private provider sector.

The flow of the finances as presented in Figure 6 is a key element in monitoring performance and compliance with agreed levels of service provision. Funds provided centrally will be disbursed to the Provincial Office through the MOHCW on the basis of an agreed resource allocation formula. Provincial Offices will disburse funds on a quarterly basis to the Rural District Councils and their providers. The Provincial Office will monitor performance on basis of the service contract and disburse finances accordingly. The providers execute then the services which are funded as defined in the service contract. In return the consolidated district accounts and performance reports produced on monthly basis at the district level are sent to the central level via the provincial directorates.

The sources of revenue for financing the Health Services are :

- General Taxes : in the form of subsidies (Grants) provided centrally
- Fees : retained fees (cost-recovery) will be used to improve local health activities and is a net addition to the resources. In the interests of equity, part of this revenue is retained by the providers. Part of this is invested in a fund managed and disbursed by the Boards
- Proposed Social Health Insurance Scheme : Payments from the proposed National Health Insurance Fund are made directly to providers for services rendered to members of the fund
- Donors : These funds will flow through the same channel as described above

Revenues from fees and the local resources can not cover the health costs. The subsidies or grants provided centrally will cover the gap and the size depends on the cost of defined priorities. The subsidy will finance salaries for staff, drugs and surgical items.

The financial management system of the MOHCW as presented in Figure 6 is well under way to cover the whole health sector. It can fully absorb the flow of funds to the provincial level. The administrative capacity at district level has been developed and the system has been introduced. It is foreseen that the MOHCW channels the funds to the districts through the provincial office. The Provincial Office has an advisory role in proportioning the amounts according to contracts. The district's capacity in planning and accounting is in place as 50 key persons were posted at district level as financial managers. The MOHCW is developing the plans for the involvement of district providers in planning, budgeting and resource management.

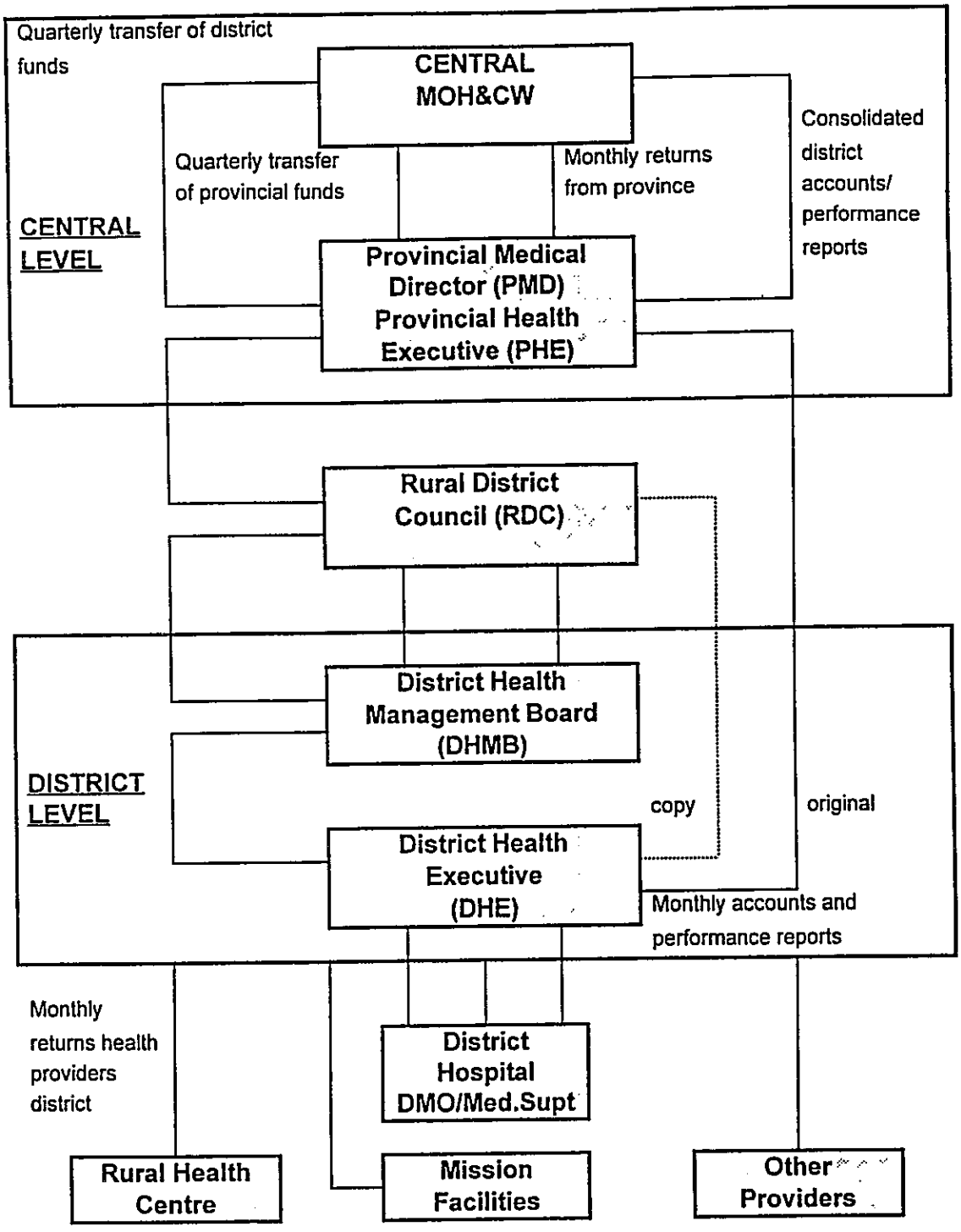

FIGURE 6 : DECENTRALISATION OF HEALTH SECTOR
FLOW OF FUNDS/INFORMATION REGARDING PROVINCIAL/ DISTRICT FUNDS

Because of the business-like approach of health care where services are sold within the framework of well defined and well managed performance contracts, different financial management and planning skills are required.

1.5.2. Improvement of the Planning and Management System

A reorganisation in the MOHCW took place in reshaping the Department of Health Services Management into a Department of Planning and Management. The transition to a decentralised service delivery system is representing a major challenges to the management system. It is essential that a programme is developed ensuring that all dimensions of the reforms are understood. While the decentralisation section is dealing with structural matters, the health management strengthening is referring to the systems and processes supporting these structures (financial systems; human resources development, equipment and supplies, planning, building management capacity, information).

In the process of the health sector reform the Department of Planning and Management has changed again in a Health Policy Development and Planning Division (presented in Figure 5 chapter 1.3.1.) in order to release the pressure on the Top Management Team. This division is drafting all the policies needed and undertakes the planning and preparation of the reforms (particularly in the areas of decentralisation and health financing). This division also assists the Ministry in the development and implementation of the systems and procedures necessary to support the reform process.

To improve the health management system a lot has been done and is continuing under the Management Strengthening Project which is supported by ODA and Northern Ireland Health Care System (NICARE). Other donors, including DANIDA, WHO, and the World Bank are supporting the new division by providing advisors in the areas of Health Sector Support, Planning and Health Financing.

Two key elements are addressed with the reforms namely the earlier Corporate Plan of the MOHCW as previously discussed, and the legislative framework. The Corporate Plan that provided the focus for development in the health services delivery system, is being reviewed in terms of the decentralisation and the new requirements of the reforms. The review is seen in the light of the current development of the strategic plan for the period 1997-2007. The analysis of the legislative framework is necessary as a cadre for the operationalisation of the health services in terms of the facilitating capacity towards the reforms. The responsibilities of the different stakeholders in and outside the health sector are currently being formulated.

1.5.2.1. Building the Capacity of Local Management

The changes in the structures at the District and Provincial levels due to the decentralisation process will affect the management capabilities of the stakeholders. The Provincial Offices will play a regulatory role on behalf of the Government. The challenge in implementing the change is at the District level.

Technical support and the development of new skills for health managers are essential requirements to execute the new management role at district level. A lot of diagnostic work has been done and formed the basis of the Ministry's management strengthening programme. Important management issues to be dealt with in the future are :

- Mobilising and allocating resources to increase benefits
- Devising appropriate and cost-effective mechanisms and health care strategies to achieve the objectives
- Investigating financial resources, redirecting existing and creating new money sources
- Delegating the decision making to the appropriate level
- Developing a management culture focused on objectives and accountability
- Developing performance indicators and criteria for performance evaluation and audit

1.5.2.2. Management Development and Training

The MOHCW in collaboration with the donors are developing strategies to strengthen the capacity in finance management, supplies management, information management, general management and human resources management. These strategies are complemented by training and development programmes for middle, senior and top managers. The transfer of management of local health services to local authorities through the decentralisation process is new for the staff at the districts and need new management skills.

To build the capacity of districts in the management of the process and services, two elements will be required :

- allowing the operational levels to develop and maintain systems, methods and procedures so that health services respond to local needs
- integration of training and development activities into wider human resources development

In view of the reform programme, the district and provincial managers require skills in :

- the use and interpretation of financial and service information for planning
- reviewing future resources and resource allocation

- the new process of contract management
- performance monitoring

The focus of the current management development programmes is developing a core team of managers already in the health sector and those joining in from the local authorities. Available resources from the national and provincial level will assist with the training and support.

The hospital and district level finance and information management systems are being developed. The information managers can use the information to plan, monitor and implement health programmes with the available resources. The new management system will facilitate the accountability between the different levels to achieve the targets set for the national health priorities.

1.5.3. Improvement of the Quality of Services and Core Services Provision

The overall purpose of the MOHCW is to promote "Health and Quality of Life" of the people. In pursuing this the MOHCW reaffirms its commitment to :

- Equity : obtaining greater equity by improving access of disadvantaged groups to quality care
- Renewal of the PHC strategy
- Obtaining greater value for money from health spending (cost effectiveness)
- Improving Health Status and consumer satisfaction by increasing the effectiveness and quality of services

Historically seen, the public health sector was responsible for the major part of health services delivery. There are reasons for maintaining and strengthening the public sector but experiences in other countries showed that market forces alone do not work in decreasing health care cost and improving the quality. It is more the opposite that is happening. To increase efficiency and effectiveness in the health care delivery system, new management initiatives such as the decentralisation and civil services reforms are now promoted. Since independence the health sector has grown and clarifying the roles of the major actors is fundamental. Previously the MOHCW performed both the functions of service purchasing and service provision. The scarce resources of the Government for the health sector presently makes this mandate unachievable.

The responsibilities of those providing and those acquiring services are different. Their split will influence the cost and quality performance of the provider units. The assurance that the providers are paid for work they do on the basis of an agreed contract will improve the quality of the services. Market forces are giving the opportunity to the purchaser to acquire the services from the providers which they find the most appropriate.

The general trend of the decentralisation is that the health services should be managed closer to the point at which they are delivered in order to make the services more responsive to the clients' needs or preferences and cost effective.

The quality of services will improve when they are focused at the customers needs and are offered as a package. This means that core identified health services will be offered by various levels of the health care delivery system.

A document was prepared in 1994 to define the core health services at the Rural Health Centre (RHC), community and district level. The core health services' package is defined as the minimum combination of health services to be provided at a specific health care level at a specific cost. The rendering of the package will help to protect the current level of health services delivery and will hold the provider accountable. The re-introduction of user-fees and the introduction of a Social Health Insurance Scheme need to go together with these improvements to the quality of care.

The MOHCW developed the Patient's Charter, a document which illustrates the Governments' commitment to the provision of quality services which are affordable and meeting the patients' needs.

A quality of care study being executed by the MOHCW/MCH/FP, will be completed by the end of June 1997 and will be a guideline to the MOHCW on the improvements in the quality of care.

1.6. DEVELOPMENT PLAN FOR HEALTH FACILITIES

1.6.1. Introduction

The Government is committed to improve access to essential health services for "all", based on needs. Therefore each district is requiring a network of health facilities. Clinics and rural health centres are providing basic curative care and are the base from where the preventive and promotive programmes are being organised. The basic programme of the Ministry was first made public in 1981 in the 'Equity in Health' policy framework. The first Five Year National Development Plan placed emphasis on the provision of Rural Health Centres. The public sector investment programme (PSIP) was meant to address maximum care delivery with minimum costs in constructing 316 new RHC and upgrading the 450 existing clinics to RHC.

The Government RHC which were provided for, under the PSIP suffered from inadequate resources resulting in the stagnation of the programme to the extent that the latest RHC were constructed in 1987. Table 4 reflects the RHC's constructed since independence according to the source of funds. The majority of health facilities currently being constructed are either sponsored by local government,

NGO's, Donors or Resettlement Programmes. A total of 231 were built and 15 new RHC are under construction within the Family Health Project, phase II. Once they are completed, a total of 246 RHC will be established leaving a balance of 70 to reach the target of 316.

TABLE 4 : RHC's CONSTRUCTED SINCE INDEPENDENCE ACCORDING TO THE SOURCE OF FUNDS.

Source of Funds	Number of RHC	Target
Government	67	
EEC	47	
ADB	83	
SIDA	10	
Total before 1987	207	
Adding RHC built after 1987	24	
Total after 1987	231	
RHC under FHP phase II construction	15	
Total	246	316

Source : FHP, Phase II, 1997

During the period of 1980's, a standard stock type of RHC design was developed with a bed capacity of six to nine. Most of the clinics have been upgraded to that standard. About 57 clinics were upgraded under the FHP, phase I, and a 65 clinics are currently being upgraded under the FHP, phase II. The complete upgrading of the 450 targeted clinics has not yet been achieved due to the limited resources.

1.6.2. Water, Electricity and Communication

Table 5 reveals the health institutions with water, electricity or solar, piped water and communication system in all provinces and cities as at 1995. The lowest coverage of electricity is found in Masvingo (38.4%) and Matabeleland North (34.8%). The total coverage of the provinces excluding the cities of Harare, Bulawayo and Chitungwiza, is only 52%. The overall coverage of piped water which is meant to be "safe water supply", excluding the cities, is above 70%. The lowest coverage is in the Midlands 54.3% and Mashonaland Central 62.9% which is quite below the average coverage. The coverage of the communication system by radio or telephone excluding the cities, is 65.3% as of 1995. The coverage of only 35.9% for Matabeleland North is very low. Masvingo coverage is only reaching the 50% while the other provinces have coverage above the 60%.

TABLE 5 : HEALTH INSTITUTIONS WITH WATER, ELECTRICITY, COMMUNICATION SYSTEMS PER PROVINCE FOR 1995

Province	No. facilities built before 1980	No. of Waiting Mother Shelters	No. with Solar or Electricity	Coverage	No. with Piped Water	Coverage	No. with Radio or Telephone	Coverage	No. facilities fenced	Total
Manicaland	104	59	144	63.2%	199	87.3%	152	66.7%	149	228
Mashonaland C	59	13	59	56.2%	66	62.9%	68	64.8%	69	105
Mashonaland E	115	15	80	50.0%	112	70.0%	119	74.4%	119	160
Mashonaland W	93	27	118	69.0%	125	73.1%	124	72.5%	113	171
Masvingo	115	59	63	38.4%	125	76.2%	83	50.6%	101	164
Matabeleland N	68	26	32	34.8%	80	87.0%	33	35.9%	83	92
Matabeleland S	43	29	44	42.3%	101	97.1%	68	65.4%	101	104
Midlands	167	27	101	48.6%	113	54.3%	158	76.0%	177	208
Sub Total	764	255	641	52.0%	921	74.8%	805	65.3%	912	1232
Chitungwiza C	2	NS	5	13.9%	5	13.9%	5	13.9%	5	36
Harare C	NS	NS	48	100.0%	48	100.0%	48	100.0%	48	48
Bulawayo C	27	NS	NS	NS	NS	NS	NS	NS	NS	27
TOTAL	793	255	694	51.7%	974	72.5%	858	63.9%	965	1 343

Source : Provincial Health Profiles and City health Information Departments - NHIS Unit

Note : NS : Not Stated
Chitungwiza City data is only for local and central government institutions.
The data from the cities are not clear

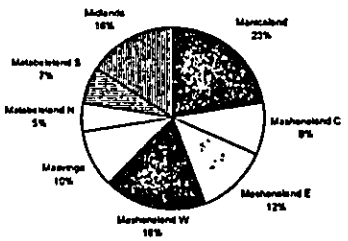

FIGURE 7 : SOLAR/ELECTRICITY

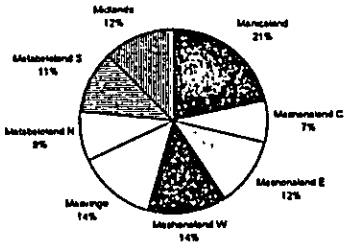

FIGURE 8 : PIPED WATER

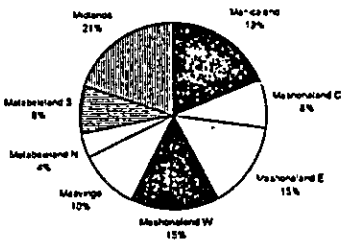

FIGURE 9 : RADIO/TELEPHONE

DISTRIBUTION OF HEALTH INSTITUTIONS WITH ELECTRICITY, WATER OR COMMUNICATION SYSTEM PER PROVINCE

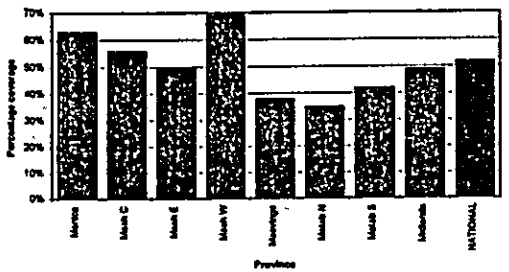

FIGURE 10 : SOLAR/ELECTRICITY

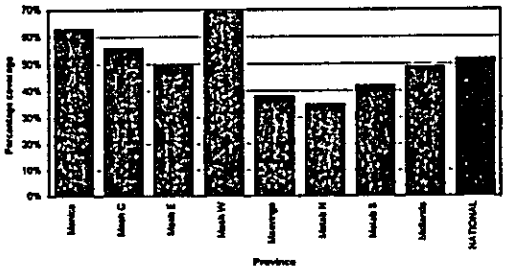

FIGURE 11 : PIPED WATER

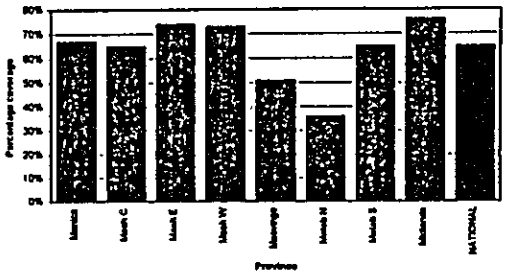

FIGURE 12 : RADIO/TELEPHONE

PERCENTAGE COVERAGE FOR ELECTRICITY, WATER AND COMMUNICATION PER PROVINCE/NATIONAL FOR HEALTH INSTITUTIONS

Figures 7,8 and 9 provide information on the distribution of health institutions with electricity, piped water and communication systems in place. Most health institutions are situated in Manicaland and Midlands provinces while the Matabeleland provinces have a lower number of developed health institutions.

Figures 10, 11 and 12 indicate the coverage per province for electricity, piped water and communication systems.

To find out the coverage of electricity, water and communication system for the Rural Health Centres, it is assumed that the provincial, district, rural and specialised hospitals including the health units in the cities have those facilities. Table 7 presents the calculation made according to the available information from Table 6 based on the 1995 figures. Only a rough percentage was possible.

Providing a trend over the period 1985 until 2005 is impossible as the only relevant available data is from 1995. The data from previous years is incomplete and not representative for comparison.

Table 7 and Figures 13,14 and 15 present the RHC/Clinics provided with water, electricity or solar and communication system as well as the electricity, water and communication system coverage. The overall percentage for electricity coverage at the RHC in the provinces is 43.8% which is quite low. The percentage of safe water is 70% which means that still 30% of the RHC depends on volunteers to fetch water for the continuation of the health services delivery. The overall coverage of the communication system by radio or telephone is about 60% which means that the communication with the first referral level is lacking behind especially in case of emergencies. The provinces with the lowest coverage for electricity are Matabeleland North and South and Masvingo with a coverage below the 30%. The lowest coverage for water is noted in the Mashonaland central and Midlands provinces with a percentage below 55% while the overall provincial percentage is 70%. The communication system by radio or telephone is very poor developed in Matabeleland North with only 22% covered as well as the Masvingo province with a 41% coverage while the overall provincial coverage, although low, is 59%. In comparing the coverage in Table 5 and the coverage in Table 7 for electricity, piped water, and communication system, the same trends were observed in the provinces. Table 5 is illustrating higher coverage because the hospitals at provincial and district level are included and mostly they are supplied with electricity, piped water and communication system. Table 7 presents lower coverage as only the clinics and RHC are being taken in consideration although it is assumed that rural hospitals are provided with electricity, water and communication system. The data of 1995 needs to be read with caution as a shift of health institutions is taking place in which rural hospitals are being considered as primary health care facilities. This could influence the coverage data slightly. A more in depth research related to the electrification, safe water supply and communication system of RHC/Clinics is needed in order to improve the quality of health services provision.

TABLE 6 : HEALTH INSTITUTIONS BY PROVINCE AND TYPE 1995

Province	Central	Provincial	Maternity	District	Rural	Special	Other*	Total Hospitals	Total Clinics	Total
Manicaland		1		6	24	2	3	36	192	228
Mashonaland C		1		8	4		1	14	91	105
Mashonaland E		1		6	9	2	4	22	138	160
Mashonaland W		1		5	8		6	20	151	171
Masvingo		1		6	14	1	5	27	137	164
Matabeleland N				6	5		5	16	76	92
Matabeleland S		1		5	9		4	19	85	104
Midlands		1	1	6	9	2	8	27	181	208
SUB-TOTAL	0	7	1	48	82	7	36	181	1 051	1 232
Chitungwiza C	1							1	35	36
Harare C	2		1			3	1	7	41	48
Bulawayo C	2		1			5	2	10	17	27
TOTAL	5	7	3	48	82	15	39	199	1 144	1 343

Source : Provincial Health Profiles 1995 and City Health Information Departments

Notes : * include industrial and private hospitals
Data of Harare, Bulawayo and Chitungwiza are not clear
Total Hospitals include the rural hospitals, District hospitals including the Government and mission hospitals

TABLE 7 : RHC/CLINICS WITH ELECTRICITY, WATER, COMMUNICATION SYSTEM PER PROVINCE FOR 1995.

Province	Total No. RHC/Clinics	No. RHC/Clinics with Solar or Electricity	Percentage RHC/Clinics with Solar or Electricity	No. RHC/Clinics with piped water	Percentage RHC/Clinics with piped water	No. RHC/Clinics with Radio/ Telephone	Percentage RHC/Clinics with Radio/ Telephone
Manicaland	192	108	56.3%	163	85%	116	60.4%
Mashonaland C	91	45	49.5%	46	50.5%	54	59.4%
Mashonaland E	138	58	42%	90	65%	97	70%
Mashonaland W	151	98	65%	105	69.5%	104	69%
Masvingo	137	36	26.3%	98	71.5%	56	41%
Matabeleland N	76	16	21%	64	84%	17	22.4%
Matabeleland S	85	25	29.4%	82	96.5%	49	57.6%
Midlands	181	74	41%	96	53%	131	72.4%
TOTAL	1051	460	43.8%	740	70.4%	624	59.4%

Source : Provincial Health Profiles and City health Information Departments - NHIS Unit, 1995 data

Note : It is assumed in the calculations above that the hospitals (central, provincial, district, rural and others) as indicated in table 6 have all electricity, water, and communication system.

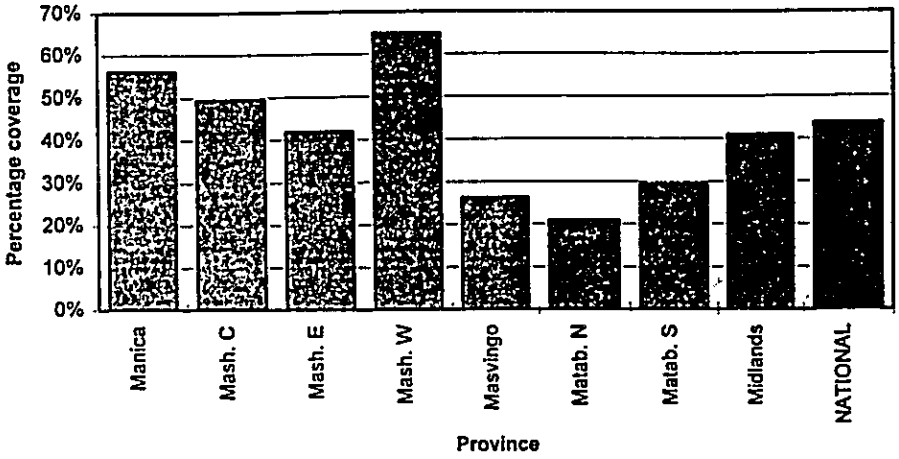

FIGURE 13 : SOLAR/ELECTRICITY

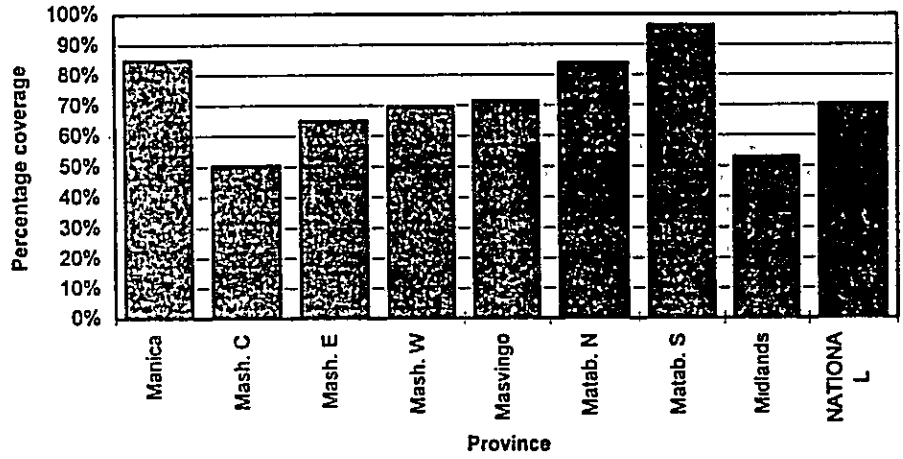

FIGURE 14 : PIPED WATER

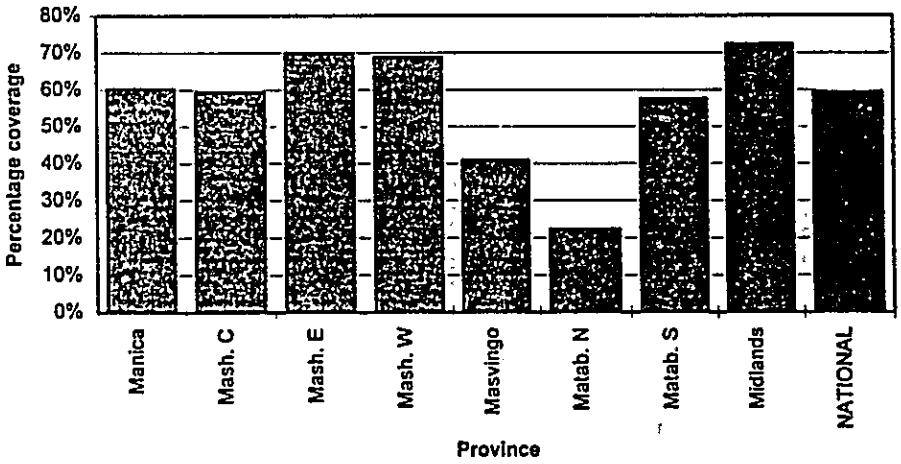

FIGURE 15 : RADIO/TELEPHONE

PERCENTAGE COVERAGE FOR ELECTRICITY, PIPED WATER AND COMMUNICATION PER PROVINCE FOR RHC/CLINICS

1.6.2.1. Rural electrification and alternative sources of energy

A proposed Rural Electrification Master Plan and Policy was prepared in 1991 clarifying the mode of financing projects that are financially non-viable for the Zimbabwe Electricity Supply Authority (ZESA).

The developmental constraints to the implementation of the policy and planning for electrification in rural areas were :

- the degree to which Zimbabwe can depend on imported electricity which is a critical factor influencing the system costs and security
- the capital requirements of system expansion

The largest component of rural electrification costs are the distribution and connection costs including the costs of transmission systems for strengthening and extension. One of the factors influencing the rural electrification programme is the low sales revenues relative to the capital costs of services. In the absence of subsidies from Government most rural electrification projects are financially non-viable without grants or soft loans.

At independence the government initiated a programme of rural electrification to increase the number of electrified centres in communal and resettlement areas. The target of electrifying 70 centres by the end of the first five year national development plan was not achieved.

For centres close to a ZESA grid a commitment was made to have these connected. Centres far from a ZESA grid needed an alternative source of energy supply. The provision of community power supply through diesel generators and solar energy has been on an ad hoc basis. Under the FHP phase I, four districts covering all RHC had their communication systems improved with the installation of a radio network system. Under the FHP II, all the 16 target districts are going to be installed with solar lighting and radio network. The European Union Funds were made available for Matabeleland North and South and the Midlands province while the Norwegians were funding the other districts.

The electrification of the rural institutions using solar energy is identified as one of the strategic renewable energy projects for Zimbabwe under the World Solar Programme 1996-2005. The funds to implement the strategic plan for the electrification of 250 RHC need to be mobilised. A cost recovery mechanism need to be put in place to ensure sustainability of the project.

1.6.2.2. Water supplies

The failure of the 1991/92 rains affected over 30 % of the national primary water supplies. In the communal areas up to 60 % of the water supplies were completely dry. Water in most district and provincial hospitals were rationalised while rural

hospitals, RHC/Clinics had to rely on volunteers to collect water, to continue the health services delivery. Since 1993/94 a water project funded by the European Union covered a total of 149 centres in all provinces by the end of 1995 as shown in Table 8. The Table indicates that the balance of 43 % still need to be covered by the water project. The Midlands has achieved a coverage of 70 % but still eight targeted centres need the safe water supply being installed. Mashonaland East, West and Central have only completed 28 % of the target set. 34 centres need still to be covered by the project.

Figure 16 makes a comparison between the centres planned to be provided with safe water and the target set by the water project. Of the planned 62 centres only 24 were provided with a safe water supply system in Masvingo which means that still 38 centres are relying on volunteers to fetch water for the continuation of the health services delivery. 43 centres do not yet have the safe water supply in Manicaland.

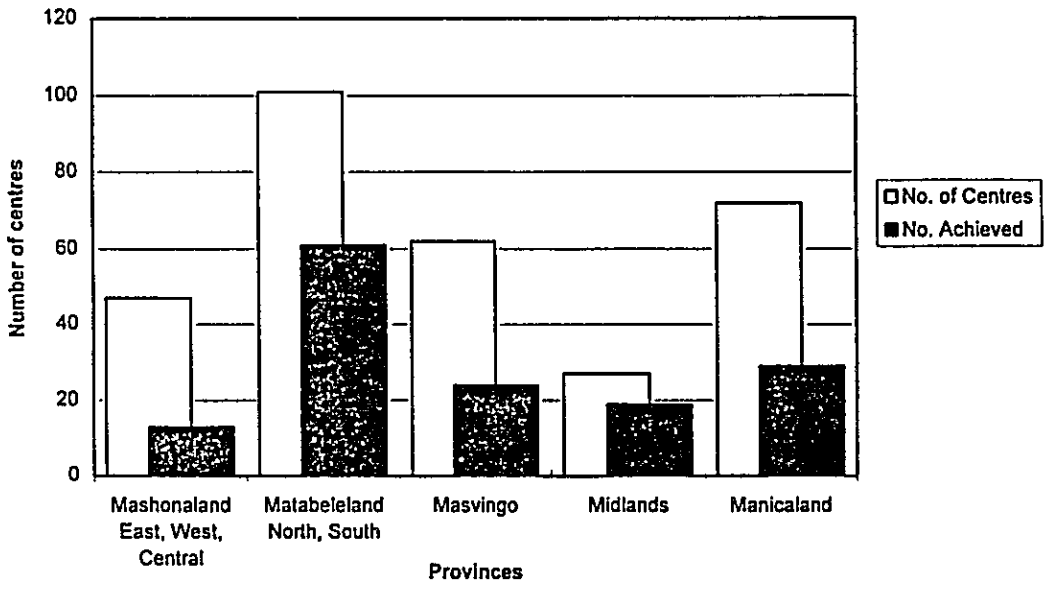

FIGURE 16 : COMPARISON BETWEEN THE NUMBER OF CENTRES PLANNED AND ACHIEVED - 1995

TABLE 8 : IMPLEMENTATION OF THE WATER PROJECT - 1995

Province	No. of Centres	No. Achieved	Percentage of Completion
Mashonaland East, West, Central	47	13	28%
Matabeleland North, South	101	61	60%
Masvingo	62	24	39%
Midlands	27	19	70%
Manicaland	72	29	40%
TOTAL	309	149	47%

Source : FHP, phase II, MOHCW, 1997

Table 9 reflects on the laboratory facilities at central, provincial and district level. It also represents the laboratory facilities in Mission Hospitals, Rural hospitals and RHC. An in depth research on laboratory facilities and the provision of laboratory services is needed. As can be noticed from Table 9 all provincial and central hospital Institutions have laboratory services. But not all of these laboratories are adequately staffed and equipped and can perform all the laboratory activities. Most of the district hospitals from which data was collected in 1995 have some laboratory activities although space, personnel and equipment are mostly inadequately provided. One of the exemples is the population per laboratory health staff in the provinces as discussed in chapter 2.3. According to the data it can be noticed that there is overall only one laboratory staff (laboratory technologist or technician) per 98 000 population.

Table 9 presents also information on the laboratory tests done by major categories per province. The major categories illustrated in Table 9 are Haematology, Serology, Parasitology and Bacteriology. The data on virology was not available and therefore not reflected in the table. The laboratory tests data per major categories is only available by provinces and not for the cities of Harare, Bulawayo and Chitungwiza. Analysis of the data related to the laboratory tests is difficult as it is not clear at which level and type of health institution the tests are performed. A general observation is that in the Midlands province the Haematology tests are more frequent (128 000) than in Matabeleland North. All provinces perform the major laboratory tests.

TABLE 9 : PUBLIC LABORATORY FACILITIES AT CENTRAL, PROVINCIAL , DISTRICT LEVEL, MISSION AND RURAL HOSPITALS AND RHC AS WELL AS THE THE PUBIC HEALTH LABORATORY TESTS BY MAJOR CATEGORIES BY PROVINCES FOR 1995

Province	Central Laboratory	Provincial Laboratory	District Laboratory	Mission/ Rural Hospitals Lab. facility	RHC lab facility	Total Report-ing Centres	Haema-tology	Serology	Parasito-logy	Bacterio-logy
Manicaland	-	1	9	40	110	160	8 1311	31 859	55 713	38 956
Mashonaland C	-	1	9	11	52	73	54 619	15 775	21 800	17 502
Mashonaland E	-	1	37	34	178	250	14 594	18 608	14 519	35 263
Mashonaland W	-	1	6	21	76	104	34 294	21 490	40 217	13 356
Masvingo	-	1	4	38	48	91	65 003	27 137	58 302	36 769
Matabeleland N	-	1	2	3	38	44	2 681	5492	10 869	2 879
Matabeleland S	-	1	8	6	58	73	19 410	16 707	22 413	10 411
Midland	-	1	21	36	128	186	128 000	28 972	79 320	69 765
SUB-TOTAL	-	8	96	189	688	981	-	-	-	-
Chitungwiza C	1	-	-	-	-	1	-	-	-	-
Harare C	2	-	1	-	-	3	-	-	-	-
Bulawayo C	2	-	-	-	-	2	-	-	-	-
TOTAL	5	8	37	189	688	389	399 912	166 040	303 153	224 901

Source : Mr. Ruwende, MOHCW/EDC NHIS Unit, data collection on Laboratory facilities with regard to microbiology, 1995