Health in Zimbabwe since Independence:
the Potential & Limits of Health Sector Reform

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Ill Health and Health Care in 1980

Extreme income inequality, inherited from a century of British colonialism, was evident in the wide disparities in the health of Zimbabwe's people. The maldistribution of facilities was matched by a concentration in urban areas of health personnel, especially professionals. Even the distribution of lower-level auxiliaries, medical assistants, was disproportionately urban.

Economic and Social Reforms since Independence

Zimbabwe's independence saw the ushering in of a primary health care (PHC) approach designed to reduce these many disparities. After a brief post independence economic boom, much of the population experienced a decline in economic well-being. Post-independence Zimbabwe saw several economic and social reforms relevant to health instituted, although some have subsequently been eroded since the implementation of an economic structural adjustment programme.

Health Reforms
Facilities

Despite an improvement in rural access to services, the distribution of clinics is still very uneven. In the mid 1980s, the Ministry of Health (MOH) concluded an agreement with the World Bank to establish a family health project. During the first phase a number of district hospitals were selected for expansion and upgrading. While the selection of disadvantaged or populous districts was appropriate, the inclusion in the project of districts already well endowed aggravated existing inequities.

Services

Health care has been provided free since 1980 to those earning less than Z$150 per month. At that time, this covered the majority of the population, but from 1986, the minimum industrial wage has exceeded Z$150. Many workers are now excluded from the free service, despite a decrease in the value of wages since 1980. Despite the government's enthusiasm for PHC, the referral system still functions poorly. Central hospitals are still not used primarily as referral hospitals to deal with more complex or uncommon cases.

Special Programmes

Special programmes set up since 1981 are some of the achievements that we in South Africa can look to as a model. In 1981, an expanded immunization programme against infectious diseases among children and tetanus among pregnant women was initiated. This substantially increased the number of children immunized in rural areas, although vaccination coverage in the urban areas was much higher. Diarrhoeal disease control was prioritized in 1982 and by 1988 over 90% of mothers were aware of oral rehydration therapy (although only 59% knew the correct recipe). The rural-urban differential in antenatal care was also significantly reduced. Zimbabwe has also attained the highest rate of contraceptive use in sub-Saharan Africa. A nutritional programme helped to feed over 250 000 children at the peak of the 1980s drought, although the recent drought has badly affected the programme and the nutritional status of all groups.

Health Personnel
Increase in Personnel

The rise in health personnel numbers since 1980 is significant. Training programmes have also reoriented curricula towards the new health policy. New cadres, such as rehabilitation assistants, have been trained and posted to extend the delivery of basic health care. By 1987, about 7000 community based village health workers (VHWs) had been trained by the MOH, enhancing promotive and preventive care in rural areas.

Within the context of this expansion, the major areas of inequity in health personnel distribution arise in private vs public practice, urban vs rural provision and in different levels of care. This is particularly true of the more "costly" personnel.

The war is won - 1980. *Photo: Joe Alfers*

Doctors

About 60% of doctors are not in government service. This maldistribution is even greater with respect to specialists. The proportion of doctors in public service has risen by only 10% between 1980 and 1989, despite an increase of about 40% in the number of doctors graduating from the university. This difference represents the high attrition rate of graduates from government service, with less than 15% in government service five years after graduating. This maldistribution of personnel has been dealt with partially by recruitment of expatriate doctors who continue to fill the majority of provincial and district government posts.

In 1983, 67% of doctors were at central level, with only 15% at provincial level and a further 15% at district/mission hospitals. By 1988, the proportion of doctors at central level had increased to 72%, with 12% in the provinces and 16% in district and mission hospitals. This indicates little redistribution of this category of personnel. Central hospitals, which do not function as referral facilities, absorb the bulk of the high cost personnel, while rural mission and district hospitals continue to be poorly staffed and reliant on expatriate doctors.

The maldistribution of doctors has raised the criticism that the use of

academic merit alone in selecting medical students, has resulted in an urbanized, higher income profession unwilling to work outside the main centers. The 1980 policy of holding new graduates for several years in the public sector has faced opposition from the profession. In 1988/89, junior doctors went on strike against serving in what they described as the poor conditions of many rural health services. The continued orientation of many senior medical practitioners towards urban, central and private practice has also reinforced the hostility amongst medical undergraduates towards rural, public sector service, despite the reorientation of the medical curriculum and the clear need for their redeployment.

This trend among doctors applies to other categories of personnel, with an inverse relationship between the cost of personnel (salary/wage) and the distribution to rural care, to lower levels of care and to the public sector. Hence the more academically qualified, higher paid state registered nurses are concentrated in private, urban and central facilities, while state certified nurses are found in the public sector, district hospital and rural health services. Pharmacists, dentists, laboratory technicians and radiographers are also centrally located and have a high attrition rate to the private sector, while environmental health personnel are more commonly located at public sector, rural facilities.

The salary vote in the MOH has increased greatly, the greater proportion of this vote being absorbed by high cost personnel, who are still concentrated in urban, central facilities despite rural health needs and the lack of an effective referral system. The attrition to the private sector exacerbated this distortion. Within the private sector, high cost personnel trained with public funds primarily service a very small proportion of the higher income population, whose health needs are less.

Popular Involvement in the Health Sector

A central feature of the PHC approach is "community participation". The unfolding relationship, before and after political independence, between the state and the developing institutions of popular organization is central to understanding the process of popular involvement or "community participation" in all areas of social development, including health.

It is in situations where the old order and power structures are overthrown that comprehensive PHC has the best chance of succeeding. It is in such conditions that popular participation in decision-making and self reliance can grow and flourish.

Political Change and Direct Democracy

This situation was most evident in "semi-liberated" communal areas, particularly where ZANU (PF) guerrillas had been active for a long period. In these areas the party had created popular organisations, initially responsible for supporting the liberation effort, but later structured to perform essential social and economic tasks as an alternative to the Rhodesian government's rudimentary district administration. In those areas, organisations were made up of various tiers of people's councils, which were set up on village, ward, district and provincial bases. Functions of these committees at various levels differed considerably. Grassroots village committees, for instance, dealt with the day-to-day problem of helping guerrillas and providing basic services to the community. Services involving the outlay of large sums of money would be passed to higher committees.

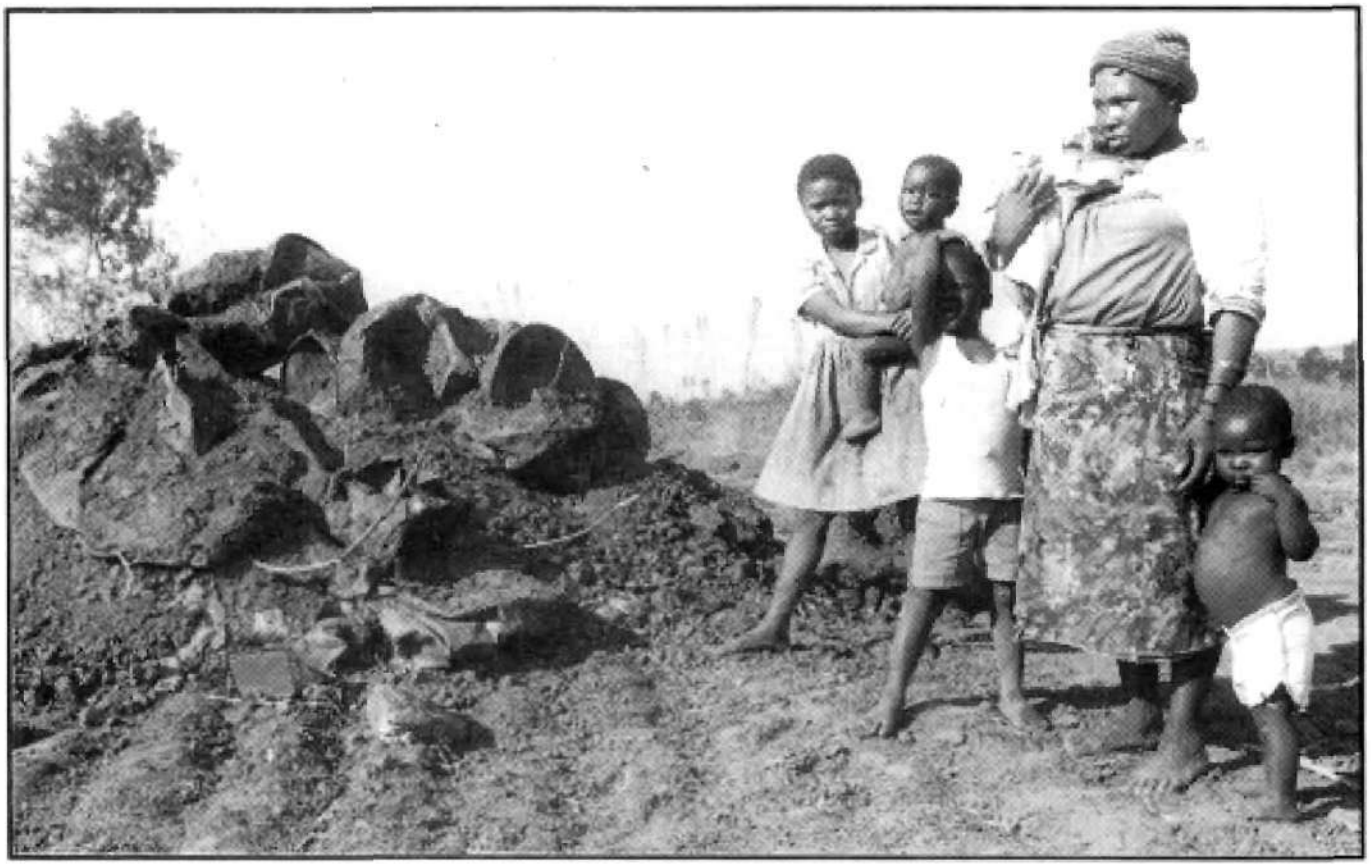
A major gain of the revolution was the practice of direct democracy, where peasants and workers for the first time participated in the formulation, implementation and evaluation of policy. The right of the peasants and workers to control, reject and reelect representatives became a reality - a far cry not only from their previous experience where they had no vote, but also from the experience of western 'democracies' where representatives are elected infrequently to parliament or local government bodies without effective control being exercised by the electorate. This gain has persisted in certain parts of the country but has been progressively eroded with the passage of time.

The Post-Colonial State

What is the basic structure of the post-colonial state, and what is its relationship to popular organization? Far from being dismantled and supplanted by a decentralized workers' and peasants' state, a centralized hierarchical structure with permanent institutions, the security forces, civil service, judiciary, etc, has expanded since independence. Not only is the standing army much greater in size, but the civil service has also expanded. The racial character of the state has changed, rather than the essential class character of the state.

Bureaucracy and Representation

Between 1980 and 1982, district councils vested with local administrative development powers were established replacing the colonial district commissioners and chiefs. Although this system of local government is an advance over the previous structure, with ward representatives elected by popular vote and with greater



Special programmes prioritised immunisation, diarrhoeal disease control, antenantal care, nutrition and expanding the rate of contraceptive use. *Photo: Cedric Nunn*

resources than in the past, it remains an extension of the central state. Full-time local government officials are salaried by and responsible to the Ministry of Local Government and Town Planning. Councillors, although elected every few years, are neither answerable to their electorate on a day-to-day basis nor subject to recall for unsatisfactory performance. Most popular committees, particularly those more recently established, had, already by 1983, become marginal. A fragile and evolving system of direct democracy was thus supplanted by representative democracy.

In 1984, decentralized structures were set up "to facilitate popular participation" in local government. These village development committees (VIDCOs) at village level and ward development committees (WADCOs) at ward level were formed. However, these structures are less numerous and more geographically removed from the majority of villagers than were the popular committees which were in attendance at the frequent mass meetings held during 1980 and 1981 at village level.

Popular mobilization, initiated primarily in support of the national liberation struggle, was adopted in the early post independence period to confront the challenges of reconstruction and development. It has been eroded by the growth of a centralized system of local government.

The Village Health Worker Programme (VHW)

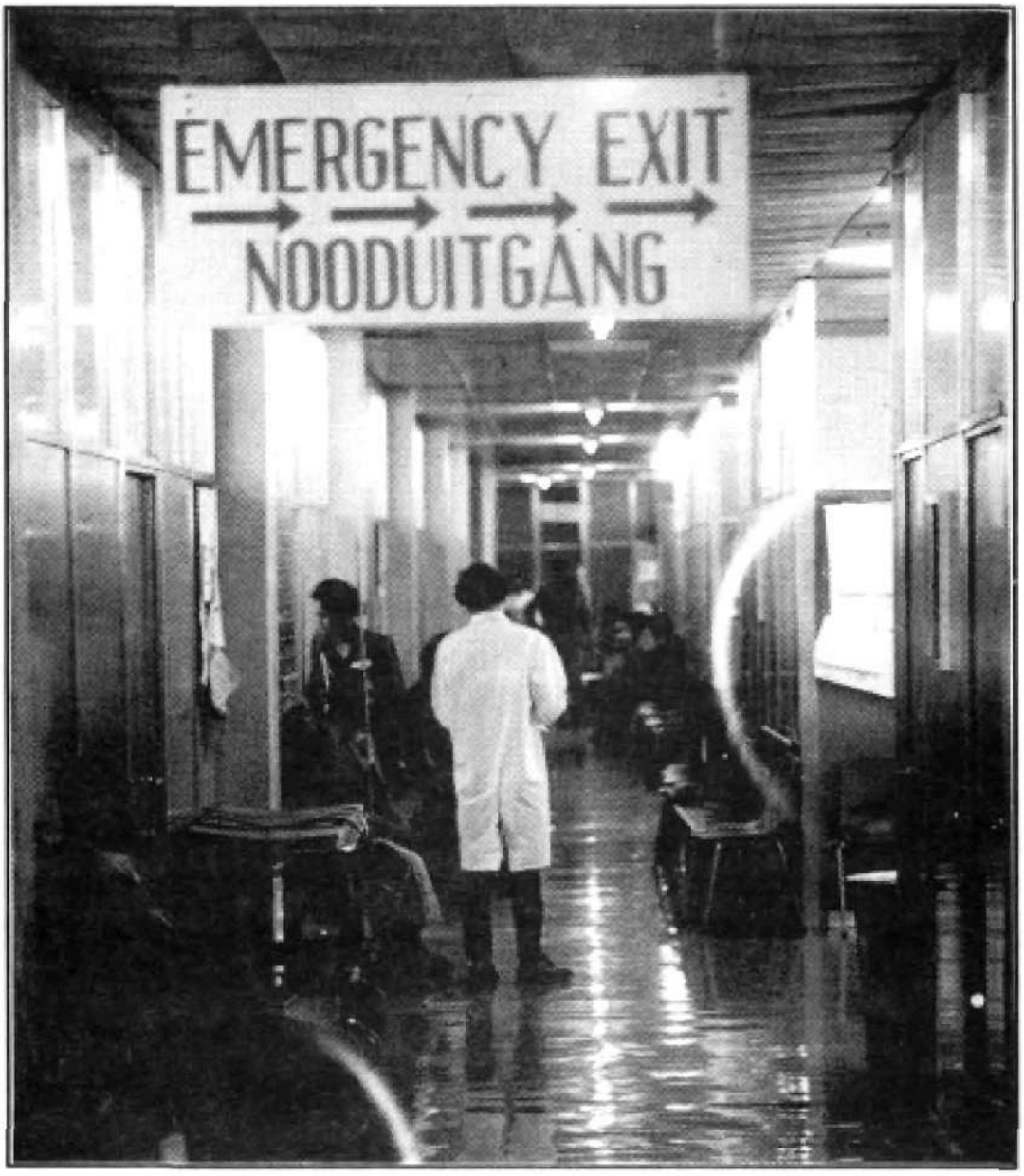
Village health worker (VHW) programmes which are democratically controlled by the poor majority can serve the function not only of extending health care to isolated communities, but also of mobilizing people to transform their conditions. In most poor communities the tendency is for the better-off and better-educated to dominate. This has implications for both the selection and control of the community based health worker. It questions the notion of "community" as an homogeneous, conflict-free group of people. Villagers are also divided among themselves, particularly where economic stratification exists, as it does in rural Zimbabwe.

Bondolfi VHWs

The beginnings of bureaucratization and the undermining of popular initiative is well illustrated by an example involving the village health worker programme. During the 1980 ceasefire, a health worker at Bondolfi Mission (Masvingo), was approached by the ZANU (PF) District Committee and asked to take on the training of popularly-elected health workers in "nutrition, child care, hygiene, sanitation and a little home treatment". The area was well organized into one political district with 28 branches. Each branch had a committee of 16, who were popularly elected. Of these, two were responsible for community health matters. Training commenced for 56 branch health leaders in May 1980. Their six months' training included theory and practice, the latter being done after planning with their communities. Due to the project's popularity and increasing community demand, the people decided to have an unpaid VHW for every one to three villages, resulting in the selection and training of 293 VHWs, 35 being from other districts.

Government VHWs

In late 1981, the government began training VHWs. These are supposed to be selected by their communities in consultation with the district council. In some areas there is real popular involvement in the selection of these workers. This is being done at ward level. However, in many areas it is done by the district council. In others, it is acknowledged that "there is some nepotism, councillors choose their wives and friends". The payment of these VHWs is made by district councils from a grant received from central government. This means that VHWs are responsible to the district councils rather than the villagers they serve, although



Most doctors are still concentrated in central hospitals. *Photo: Critical Health*

with widespread rural poverty it would be impossible for many communities to fund their own VHWs.

When the government scheme was set up, ten of the Bondolfi VHWs were taken on and trained. The government VHWs receive a more formal training, spending more time in the clinic or hospital, than the Bondolfi VHWs. Because of their lower concentration in the population, they have to cover a considerably larger area than the Bondolfi women. This means that most of them are full-time workers. The Bondolfi scheme, although still functioning, by mid-1984 involved only about 100 VHWs. There are a number of reasons for this, but as one local VHW organizer said, "When the government scheme started, and some were paid Z$33 a month, others stopped working because they were not paid".

Here again a general political problem is illustrated. In contrast to the original VHWs, who were directly selected by meetings in the villages and answerable to the local people, the government VHWs are chosen and paid by the

Direct involvement in the development of programmes has been slowly eroded. *Photo: Guy Tillim*

District Councils. These bodies are democratic, but only in a distant and representative way.

If responsibility for the VHW is delegated to a remote state structure, then the crucial element of popular mobilization is missing. The VHW is no longer directly answerable to the poor of the community and cannot be recalled by them. He or she becomes just another health service employee - more appropriate perhaps, but still answerable to an outside body.

Further developments recently have virtually eliminated the possibility of popular democratic control over the health sector through the VHW. In early 1988 the VHW scheme was "handed over" to the Ministry of Community and Cooperative Development and Women's Affairs. VHWs and Home Economics demonstrators have been combined into a single group of "village community workers" who, although notionally part time, have written conditions of service and are

regarded as civil service employees. The nature of the VHW has been qualitatively transformed. This community-selected and accountable cadre has now become a civil servant responsible to her employer. The possibility of true grassroots involvement in both defining health problems and tackling them collectively has now receded. Further, any possibility for popular democratic control of VHWs becoming a focus for democratization at all levels of the health sector now seems remote.

Democratic Control of Health Services

Health policy makers in 1980 called for greater control by, and communication between all levels of health workers within the health sector, together with community decision-making in health interventions. In practice, the democratic control of health services has been enhanced by the formation of district health teams and health executives, creating a mechanism for collective planning by health workers at the same level, as well as the exchange of ideas between health cadres and other representatives in local authorities. Social control over health care is, however, limited by a number of factors:

- representatives on decision making bodies are often the more powerful and higher income sections of the communities covered;
- no structures exist for patients to influence policy, such as ward committees;
- mass organisations (such as the co-operative and trade union movements) have played little role in the organization of health care; and
- the district health team reflects intersectoral interests, but is not necessarily democratic.

The democratization of health care also implies changing the ideology of health care, demystifying the causes of ill health, and giving people a vital role in resolving health problems. The extent to which the health sector has moved from biomedical to socioeconomic explanations for ill health, and from curative to preventive care is variable. It appears to have depended greatly on the orientation of the district and provincial health personnel. Despite programmes such as the VHW programme, consumers still appear to be poorly organized and relatively weak in expressing collective health care demands.

Health workers have a strong hierarchical organization. There are many professional associations. Some are being split into different interest groups (such as the SRN/SCN division in the nursing profession, and the many associations representing doctors). As government workers health cadres have no industrial relations body recognised in terms of the Labour Relations Act (1985) to negotiate for improved working conditions and wages. In addition, the many professional divisions in the sector weaken any coherent approach to personnel issues. Hence,

for example, while doctors use their associations to advance their own interests, as in the case of the recent doctors strike, their demands do not consider overall changes in conditions for health personnel.

Conclusion: changes in health status

Available data show that progress has been made in addressing Zimbabwe's legacy of ill-health. There has been a sharp decline in both IMR (Infant Mortality Rate) and under 5 (U5MR) since the late 1970s. Changes in morbidity are difficult to determine because of problems of comparability of available data for the period under consideration. However, there are indications of a reduction in the incidence of immunisable diseases, although there appears to have been a recent resurgence of TB in association with the rapid increase in HIV prevalence.

Levels of undernutrition appear to have declined significantly between 1980 and 1983/84, although there is less firm evidence of a decline thereafter. While the situation appears to have improved with respect to wasting, levels of stunting remain discrepantly high. The improvement in mortality and morbidity has probably resulted from an energetic expansion and reorganization of health care provision. The adverse effects of drought, recession and stabilization policies have been partially offset by aid supported relief feeding programmes. However, economic recession and structural adjustment have reduced incomes for large numbers of rural and urban households since the immediate post-independence boom. This reflects itself in continuing high levels of childhood undernutrition which seems to have remained static or improved marginally despite the health care drive.

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