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HEALTH SERVICE DEVELOPMENTS IN ZIMBABWE

Are there Lessons for South Africa?

INTRODUCTION

The views put forward in this paper are based on my personal experiences as a medical officer of health (the Assistant Provincial Medical Director) for Matebeleland from January 1983 to January 1984. Hence I cannot claim to give a total overview of the health services in Zimbabwe, but rather one of an outsider who held a middle-management position in a volatile area of the country.

When Zimbabwe achieved majority rule in April 1980, it inherited a well-developed health service structure in terms of physical amenities. However, this service was racially segregated, administered centrally along vertical professional structures, with little community consultation and a large curative bias.

This paper will describe some of the major beneficial and detrimental developments in the government health sector since independence, as well as developments in the private and traditional sectors.

1. BENEFICIAL DEVELOPMENTS

This term is used in relation to its observed effects on the majority of people. The major beneficial developments have been in the evolution of sound and progressive health service policies. They are as follows:

1.1 **Unification** of Government health services under one body. Racial segregation was removed. This contrasts with the eight different medical authorities operating in South Africa, based on race and geographical area, which have created a duplication of services at great expense. The removal of racial segregation in Zimbabwe was not problematic but has resulted in most Whites and more of the well-off Blacks using private hospital services.

1.2 **Equity in Health:** It is estimated that 80% of the population live in rural areas in Zimbabwe and that over 70% of the total population are children and women in the child-bearing age. Hence priority has been given to the development of the health service in rural areas and particularly to maternal and child health services. The number of rural health centres has more than doubled since independence and health services have been made free to the majority of people. (Those families whose income is less than 2$150 per month).

1.3 **Integration of Medical Professionals:** In the past each professional group, whether they were doctors, nurses, nutritionists, environmentalists, etc, had their own vertical structure and chain of command in the Ministry of Health. There was little interprofessional liaison and great hostility was evoked when encroachment of "territory" occurred. The policy of the Ministry of Health has been to create multi-disciplinary teams at each level. The members of these teams should have equal status and be primarily responsible to the team and the community they serve, and secondarily to their seniors within the Ministry of Health.

1.4 **Inter-sectorial Co-operation:** The influence on health of factors such as the availability of food, adequate water supplies and sanitation, education, women's status and the general infrastructure is given full cognisance. Hence regular meeting of representatives from each ministry are held at every level to ensure the co-operation and understanding of the objectives of each sector.

1.5 **On-going Evaluation:** A unified national health information system has been introduced in which all health workers are involved in the collection, collation and discussion of results at local health authority meetings. Each authority is then expected to make decisions based on the information and to implement them to improve the service. This has created a dynamic environment in which health workers are more aware and critical of their activities, as well as of the health status of their communities.

1.6 **Decentralisation and Democratisation:** The Ministry of Health has been inspired by the success of health programmes in China and Cuba. The essence of these programmes appears to have been the active involvement of communities in their own health services. The ministry has attempted to create a similar service in the following way:

The Ministry of Health provides the overall health service policies, training, supervision and monitoring of activities. At each administrative level joint medical team and community representative health authorities have been created. These authorities will be allocated budgets and it is their responsibility to implement the policies of the Ministry in a way that is appropriate to the needs of their communities.

The structure of the decentralised health service is as follows:

STRUCTURE OF THE DECENTRALISED HEALTH SERVICE IN ZIMBABWE

ADMINISTRATIVE LEVEL (AND POPULATION SERVED)	HEALTH SERVICE TEAM	COMMUNITY REPRESENTATIVE BODY	HEALTH SERVICE AUTHORITY
Central (7.5 million people)	Ministry of Health	Parliament and Cabinet	No joint authority at present. The Ministry of Health is the authority.
Provincial (approx. 1 million people)	Prov. Medical Officer Prov. Nursing Officer Prov. Health Inspector Prov. Nutritionist Prov. Health Educator Prov. Hospital Superintendents City Medical Officers	Provincial Council	Provincial Health Services Authority
District (100 000/200 000 people)	District Medical Officer District Nursing Officer Environmental Health Officer Health Information Officer Village Health Worker Trainer	District Council	District Health Services Authority
Ward (10 000/20 000 people)	Rural Health Centre Med. Asst. Health Assistant Child spacing Educator-Distributor	Ward Council	Ward Health Committee
Village (0000/2000 people)	Village Health Workers Traditional Birth Attendants	Village Dev. Committee	Village Health Committee

Conflicts inevitably arise between the medical, professional and community representative groups in interpreting the implementation of policies. No formal channel has yet been established to resolve their differences and at present it is usually the medical team, and particularly doctors, who have the deciding vote.

The above policies have been implemented to varying degrees in different geographical areas. Their success appears to be related to the level of community organisation and motivation and experience of the authority members. However, the policies have created a system which has a broad approach to health problems, which should be responsive to local health needs, and in which communities can actively participate.

2. DETRIMENTAL DEVELOPMENTS

2.1 **Political Partisanship:** The overriding detrimental development in the health and other sectors has been the intrusion of party politics, particularly in pursuance of a one-party state, in the following areas:

(a) Staff Appointments: This has mainly occurred at a central level but is increasingly seen at other levels. Appointments have been made on the basis of political affiliation rather than on ability, training or experience. This has lead to demoralisation of other staff members.

(b) Suppression of Opposition: Recent elections of local representative bodies in Matebeleland have been conducted under much harassment and intimidation of electorate. ZANU has achieved land-slide victories in Tsholotsho and Gwanda, districts, were there is overwhelming support for ZAPU. Under these circumstances the ability of communities to actively participate in their health services is greatly jeopardised.

(c) Obeisance to the Military: There has been no support for, or any attempt to intervene on the behalf of, Health workers caught in the conflicts in Matebeleland. Several have been killed and dozens have been assaulted. When the Ministry of Health has been approached for assistance the persons concerned have replied that military activities take priority and that they are not prepared to become involved. Clearly the principles of the Geneva Convention are over-ruled by political objectives.

While a political perspective is desirable on health service management, particularly in perceiving health as a manifestation of the socio-economic environment, the pursuance of political party dominance through the health

service has been found to be destructive to the latter's development.

2.2 Co-option And Discrediting Of Traditional Practitioners.

At independence the Minister of Health strongly supported the formal recognition of the valuable role played by traditional practitioners. This was welcomed by many health workers who felt that greater co-operation between the western and traditional sectors would benefit their patients. However, it appears that the platform of support for traditional practitioners was merely an attempt to obtain political support. The body which was set up to register and monitor acceptably qualified traditional practitioners, ZINATHA, registered any person who was prepared to pay the registration fee, in an attempt to increase its membership and lobbying strength. Many charlatans were given recognition. Unfortunately this had the effect of discrediting the abilities of competent traditional practitioners.

The establishment of a successful mode of co-operation between the traditional and western medical sectors would require great sensitivity and awareness, as the premises for practice are profoundly different, being the ancestral, cosmic perspective for the former and the scientific model for the latter.

The gross attempt to co-opt the traditional sector has sadly done great damage to the development of a co-operative system.

2.3 Restriction of Fertility Control

Depo-Provera, a long acting injectable contraceptive, was banned shortly after independence. This action was taken supposedly because of suspicions about carcinogenicity and effects on fertility. However, reports subsequently produced by the World Health Organisation which gave clearance to Depo-Provera on these aspects were ignored. When questioned about this, members of the Ministry of Health have admitted that the real reason Depo-Provera was banned was due to the pressure applied by men to have it removed. They were against their wives being able to control their own fertility without their husband's consent. The Child Spacing and Fertility Association have unofficially reported that their contraceptive usage has halved since the banning of Depo-Provera.

This antagonism towards women being able to unilaterally control their fertility appears to have been caused by the one-sided educational programmes of the Family Planning Association. In the past these programmes were directed only towards women, which their men found alienating and threatening. It was only after independence that these strong feelings could be manifested.

2.4 Support For Private Practice.

The official policy of the Ministry of Health is that no doctor employed in a full time capacity by the Government should see private patients. However, it is believed that many doctors in the Ministry do have private practices themselves, as do senior consultants in the teaching hospitals. This has a demoralising effect on junior doctors who are often left without supervision to carry the government-hospital patient load, at low salaries compared to the private sector.

It is hence not surprising that the vast majority of young doctors go into private practice as soon as they can, and that nearly all of the doctors taking up posts in rural hospitals are missionaries.

The involvement of government doctors in illicit private practice was apparently not a large feature before independence. The present situation is not unusual in the developing world, but is certainly out of line with the purported socialist policies of the new government. If socialism and equity in health had been a real intention it is surprising that the government did not nationalise all health resources and ban private practice outright, as was done in Zambia at independence. Officials in the Ministry of Health state it is their intention to gradually move towards nationalisation, but so far the trend has been in the opposite direction.

CONCLUSION

While the health service policy developments in post-independent Zimbabwe have been progressive, the interference of party political considerations, particularly in pursuance of a one-party state have been destructive.

I feel that the developments in the health service in Zimbabwe, particularly concerning co-operation with the traditional sector, fertility control and private practice, bring to light issues which we in South Africa have still to confront. We could do well to learn from Zimbabwe's experience.

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