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# Equity in Health: Zimbabwe Nine Years On\*

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## ABSTRACT

This paper summarises Zimbabwe's legacy in both health (or disease) and health services. It then examines the changes in the economic environment which have taken place in Zimbabwe since independence in April 1980, concentrating on those which are relevant to health. It also describes the post independence restructuring of the health sector itself. Access to health care and some aspects of the functioning of the referral system are also briefly dealt with. The questions of community participation in health and accountability of health workers, both central to the Primary Health Care (PHC) approach, are addressed by a brief discussion of the Village Health Worker (VHW) programme. The relevance of this example for the health sector as a whole is briefly examined. Finally, the paper considers some changes which have taken place in health status since independence and attempts to analyse the sources of these.

## Introduction

This paper will look at the broad context of health and health services in Zimbabwe. It was originally conceived as a background paper for a *Journal of Social Development in Africa* workshop, and was intended to inform discussion on the role of health manpower in relation to equity in and access to health services in Zimbabwe.

It is generally accepted that the health of a nation is a sensitive expression of the prevailing socioeconomic conditions, and that disparities in disease experience reflect differences in both living conditions and access to health care. This paper will, therefore, address both the social and economic context of disease in Zimbabwe, as well as the measures taken by the health sector to deal with it.

## Background

Much of this and the next section is drawn from Sanders and Davies (1988).

In colonial Zimbabwe, as in other under-developed countries, the greatest burden of death and disease fell on infants (under one), young children, and women in the child-bearing

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period. In addition, mortality varied substantially by geographical area, race and class. In 1980 there was a 1:3:5:10 ratio in infant mortality rate (IMR) between whites, urban blacks, and rural blacks, corresponding to a 39:5:1 ratio in incomes (Ministry of Health, 1984a). While the IMR of 17 per 1 000 for the white population approximated that of industrialised countries, for the majority black population it was estimated to be 120 per 1 000.

While the better off showed the disease pattern seen in industrialised countries, the majority of the population suffered nutritional deficiencies, communicable diseases and problems associated with pregnancy. Maternal under-nutrition contributes to low birth weight in 10-20% of all births. This, and protein-energy malnutrition, were the commonest forms of childhood malnutrition, predisposing the victims to more severe and often fatal infections. The most important of these were measles, pneumonia, tuberculosis and diarrhoeal diseases, which, together with meningitis, neonatal tetanus and other infections of the newborn, accounted for most infant and young child mortality. Of the occupational diseases, industrial lung diseases such as asbestosis, silicosis (and tuberculosis) and coalminer's lung; stress-related disorders such as high blood pressure; and plantation-related problems such as schistosomiasis, malaria and the toxic effects of pesticides and herbicides, were all (and are increasingly) visible but undoubtedly under-reported. Mental ill health and alcohol-related problems were also common, the latter being reflected in liver disease and indirectly in sexually transmitted diseases, and increasingly now AIDS.

This disease pattern was rooted in the system of production which prevailed in Rhodesia, its distribution being reinforced by the structures of racial domination. Undernutrition was particularly prevalent in the Tribal Trust Lands (TTLs) and amongst children of workers on commercial farms. Although the TTLs were termed the 'subsistence sector', with increasing land alienation and degradation due to a lack of inputs, peasants were unable to subsist from agriculture alone. Increasingly, families were forced to supplement their unreliable agricultural production with cash remitted from the urban industrial or plantation sectors, while providing a growing supply of landless wage labour. Airborne infections spread easily in the cramped, often smoky housing conditions existing in both urban and rural areas. Poor sanitation and inadequate water supplies predisposed people to common and debilitating intestinal, skin and eye infections. In the white farming areas, where nearly 20% of the black population lived, conditions were often worse (Gilmurray et al, 1979).

These environmental factors undermined much of the impact of the health care system. This system had all the features typical of an inappropriate, inequitably distributed developing country service, compounded by inequalities based on racial discrimination. For example, in 1980/81 the average annual expenditure per head for private sector medical aid society members was Z\$144 compared with Z\$31 for the urban population using public services and Z\$4 for the rural population. The latter concealed further disparities, for only districts surrounding urban areas were relatively well served. In 1980/81, 44% of publicly funded services went to the urban-based sophisticated central hospitals serving about 15% of the population, while only 24% went to primary and secondary level rural health services for the majority of the population (Ministry of Health, 1984a).

In line with the distribution of facilities, all categories of health personnel, especially professional grades, were concentrated in the urban areas. In 1980 there were over 1 138 doctors, 4 652 nurses, 2 897 medical assistants and 393 health assistants. Of the doctors, in 1981, 42 per cent (900) were wholly engaged in private practice, with between 80 and 90 per cent of these being in Harare or Bulawayo. In 1982/3 there were 370 doctors in central and general hospitals, 28 in district and 42 in mission hospitals, that is only about 5 per cent of those registered to practise were working in the rural areas (Ministry of Health, 1984b). Even the distribution of lower-level auxiliaries, medical assistants, was disproportionately urban, although this group and health assistants formed the core of the team at district level and below.

Zimbabwe's independence saw the ushering in of a new vigorous thrust in health care based on the primary health care approach. Simultaneously, however, after a brief post independence economic boom, there has been a decline in the economic well-being of much of the population caused by a combination of international recession, prolonged drought, South African destabilisation and domestic macroeconomic policies. The relatively short period in which both these processes have been operating provides an illuminating case study of both the potential of effective health sector interventions and their limitations in the context of a deteriorating economic environment.

### Changes in the economy and social services

In Zimbabwe, as a result of the successful independence struggle, certain economic measures and social reforms have been instituted which have almost certainly positively influenced health. The most important of these include the setting of minimum wages for all categories of labour, food subsidies, the land resettlement programme, expanded education, water development and drought relief programmes.

National minimum wages were introduced by the government in July 1980. As Table 1 shows, wages (constant 1980 prices) for domestic and industrial (and other) workers rose significantly between July 1980 and January 1982, and were in most cases substantially greater than pre-independence wages. However, although nominal minima have been raised regularly since then, there has been an erosion of their purchasing power since 1982. In other words, fairly substantial gains were made between independence and January 1982, but the real value of these was undermined by a wage freeze between January 1982 and September 1983 and by the 1982 devaluation and subsequent depreciation of the Zimbabwean dollar. The wage freeze and devaluation were part of a fairly standard stabilisation (economic adjustment) package imposed by the government in late 1982 under the stimulus of an International Monetary Fund standby credit scheme. (The IMF agreement was suspended after approximately one year but most of its elements have been retained by the government).

Another element of the stabilisation package which has undoubtedly had an important effect on nutrition has been the removal in 1982 and 1983 of subsidies on basic foods. This has resulted in substantial food price increases which have particularly affected low income

households. In 1982 and 1983, prices rose by some 100% for maize meal, 69-95% for beef, 50% for milk, 25-30% for bread and 25% for edible oils. Further price rises have since occurred. Apart from these direct effects of the removal of food subsidies, the raising of controlled prices of electricity, railway tariffs and fertilizers also influenced the general price level, albeit with some lag.

The combined effect of these price increases can be gauged from the movement of the consumer price index (CPI) during the period. Between August and September 1983, which was when the most significant removal of subsidies took place, the CPI for low income urban families rose by 15.6% (equivalent to an annual inflation rate of 18.7%), while the index of food prices for this group rose by 27% in that month. Clearly the attempts to reduce and remove subsidies contributed significantly to the rise in the cost of living. This was aggravated by the 1982 devaluation and subsequent depreciation of the Zimbabwean dollar.

Declines in real wages and food price increases have adversely affected many urban and rural dwellers, particularly those rural households which are net consumers of food. Aggregate marketed output of crops, particularly maize and cotton, has increased markedly in Zimbabwe's communal (rural) areas since independence. However, economic differentiation amongst peasant farmers means that this surplus is being produced by a relatively small segment, while at the other end of the scale a significant group is unable to subsist on the land and is depending increasingly on wages and food remitted by urban migrant workers. This differentiation or stratification, present before independence, was created by settler colonial policies, especially with regard to land. Some indication of the extent of this is given by the results of the National Household Capability Survey 1983/84, which showed, *inter alia*, that about 60% of households have no access to land; that 50% of the land is controlled by about 20% of households; that approximately 50% of households have no cattle; and that about 10% of households own half the cattle. Similarly figures concerning communal area sales of all agricultural producers to marketing boards show great differences between the various provinces. Thus in 1985/86 earnings per head from such sales ranged from \$7,30 for Matabeleland North to \$104,05 in Mashonaland West (World Bank, undated). Such large differences between provinces will almost certainly also be reflected amongst households within provinces. The process of rural differentiation is likely also to have been accelerated by the drought.

Since independence the government has resettled, mostly on an individual basis, a large number of effectively landless people. Many have benefited in agricultural and thus nutritional terms. However, the acquisition of mostly marginal agricultural land and poor technical and infrastructural support for many settlers have resulted in no improvement in health and nutrition status for many. Stabilisation measures (economic adjustment) resulted in 1983 in a severe cutback in the *resettlement programme* (Ministry of Finance, 1986).

Insofar as *education* contributes to better health behaviour, Zimbabwe's phenomenal post-independence expansion in school enrolment is highly significant. Total numbers at school grew from about 900 000 in 1979 to 2,7 million in 1985, an average annual increase of over 20%. The bulk of this expansion has been at primary level (CSO, 1986). The impact that this will have on health is likely to show up only in the long run. On the negative side, increased schooling has imposed a financial burden on many parents, leading to reduced expenditure on other items, including food. Primary education is now free, but resources are required from parents for uniforms, transport, building funds and labour inputs.

Although improved *water supplies* by themselves probably have little direct impact on health in the short term, they may augment the impact of improved sanitation and also contribute through freeing women's time for other health-promoting activities. Since independence there has been a steady improvement with over one-third of the communal area population now having access to improved water sources.

Finally, *drought relief*. This programme, which was introduced in 1982 after the commencement of the drought, peaked in 1983/4 when it consumed slightly over 2,3% of the government budget. In drought-stricken areas it provided a basic food ration to many people and was critical in mitigating widespread nutritional deterioration.

## Changes in the health sector

Much of this section is drawn from Loewenson and Sanders (1988).

### (i) Health Policy

Post-independence health policy, as expressed in **Planning for Equity in Health** (Ministry of Health, 1984a) reflected the broader national objectives outlined in the Transitional National Development Plan, to establish a society "founded on socialist, democratic and egalitarian principles" and to end "imperialist exploitation through more equitable Zimbabwean ownership of the means of production". The priority task in 1980 was stated to be the restoration and rehabilitation of the war torn infrastructure.

With the expressed recognition that the causes of ill-health lay in the conditions of people's lives and in the context of an urban, racially and curatively biased health care system, the government in 1980 guaranteed to transform health care so that all citizens would have access to a comprehensive integrated National Health Service.

This health system was envisaged as integrally linked to other development programmes, such as the organisation of rural infrastructure, education, housing and food production. The adoption of the Primary Health Care approach demanded the direction of new resources towards previously deprived areas in the improvement of nutrition and the control of preventable diseases. This policy stressed the conscious and active participation of communities in transforming their own health.

The state recognised the presence of multiple and uncoordinated providers of health care, and a maldistribution of personnel between urban and rural areas and between social classes. This threatened the establishment of a national unified health service, so various measures were proposed (Transitional National Development Plan, TNDP, 1983):

- the abolition of racially discriminatory laws
- a restriction on the expansion of private facilities
- post-training bonding of health workers to the public services
- barring of immigrants from private practice
- incorporation of the traditional health sector
- rationalisation of therapeutic procedures through the establishment of an essential-drugs list
- establishment of a universally applied national health insurance scheme.

*(ii) Advances in the health sector*

In line with the new Primary Health Care (PHC) approach, the management and delivery of care has been slowly transformed. The curative and preventive structures have been integrated in provincial and district health team structures, themselves accountable not only to higher levels of the health structure but to the local government structures at the level of service. The doctor in the rural district hospital is no longer a curative professional only, but is responsible for mobilising, through the health team, the range of health promotive, curative and rehabilitative services being developed, as well as the training of new cadres and the integration with other sectors. Active steps have been taken to reform medical education to train doctors more relevantly towards the country's needs. Some of the changes introduced since independence are:

- a) **Free Health Care:** Health care has been provided free of charge, since September 1980, to those earning less than Z\$150 per month. The minimum industrial wage of Z\$182 per month now exceeds this limit, which has remained static since 1980.
- b) **Hospital and Rural Health-Care Building Programme:** A vigorous construction and upgrading programme for health-care facilities has been undertaken. By January 1987, 224 rural health centres had been completed (Ministry of Health, personal communication). In addition a number of provincial and district hospitals as well as many rural clinics have been upgraded.
- c) **Zimbabwe Expanded Programme on Immunisation:** An expanded programme of immunisation against the six major childhood infectious diseases, and tetanus immunisation of pregnant women, was initiated in 1981. Studies show that the percentage of children between 12 and 23 months who are fully immunised in rural Zimbabwe rose from 25 to 42 per cent between 1982 and 1984 (Ministry of Health 1984c), whilst the proportion in Harare City rose from about 56 to 80 per cent between 1983 and 1986 (Ministry of Health, 1984c; Harare City Medical Officer of health, personal communication). Recent data (1986) for Manicaland and Mashonaland East provinces, where coverage is probably better than the country average, show that 63 per cent and 69 per cent respectively of this age group are now fully immunised (Ramji, Provincial Epidemiologist, personal communication).
- d) **Diarrhoeal Disease-Control Programme:** In February 1982 diarrhoeal disease control was declared a priority by government. Emphasis has been placed on improved case management, mainly by oral rehydration therapy (ORT), epidemic control, improved nutrition, prolonged breast feeding, and improved environmental hygiene through water supply and sanitation. Although hard data are not available, questionnaire responses and interviews conducted in October/November 1984 suggest that the number of attendances for diarrhoea at health-care facilities has decreased (Cutts, 1984). There has been a significant increase in the percentage of rural mothers who can prepare a correct solution for ORT, so that home-based management of the problem is increasingly practised (De Zoysa, 1984; Mtero et al, 1985; Ministry of Health, 1984a).

- e) **National Nutrition Programme:** A Department of National Nutrition was established. Its responsibilities included nutrition and health education, with particular regard to breast feeding and weaning practices, growth monitoring and nutrition surveillance using child health cards, and supervision of the Children's Supplementary Feeding Programme (CSFP) and food production plots. By June 1984, 80 per cent of children aged one possessed a growth card (as against 71 per cent in 1982) and 83 per cent had been weighed at least twice in the first year of life (58 per cent in 1982) (Ministry of Health, 1984c), although only 35 per cent of Harare mothers could consistently and correctly interpret the growth curves (Ministry of Health, 1985). The CSFP was initiated in November 1980 in response to immediate post-war food needs. A daily energy-rich supplementary meal was supplied to predominantly undernourished young children in communal areas. The programme operated between 1981 and 1985 during the height of the drought. At its peak, over a quarter of a million children in over 8 000 communal area feeding points were receiving food (Working Group, 1982; Ministry of Health, 1984a).
- f) **National Village Health Worker Programme:** The National Village Health Worker Programme (VHW) was launched in November 1981 to train multipurpose basic health workers who were selected and based in the village. Out of a target of 15 000 VHWs, about 7 000 had been trained by early 1987. Related to this programme was the Traditional Midwives Programme (TMP) designed to upgrade the skills of household level women operatives in identifying at-risk pregnancies, basic midwifery, elementary hygiene, and basic child care.
- g) **Child Spacing:** The Child Spacing and Family Planning Council (CSFPC), a parastatal institution established in 1981, superseded the voluntary, government-assisted family planning association. Its early emphasis on child spacing has since shifted back towards a concern with population growth, reflected in its new name, the Zimbabwe National Family Planning Council (ZNFPC). Largely as a result of its activities, Zimbabwe has the highest rate of contraceptive use in Sub-Saharan Africa.

### (iii) *The budgetary implications*

All these and other programmes required expansion in government expenditure. Table 2 shows how the vote allocations and the actual expenditure of the Ministry of Health (MOH) changed over the period. In current price terms there was an immediate expansion of 44,7%, in real terms 27,5%. The Ministry's share of the budget rose to 5,1%, showing that there was a relative shift in emphasis. This growth continued into the next budget year so that by fiscal year 1981/82, the MOH's actual expenditure had almost doubled in real terms. However, following the downturn in the economy in 1982 and the introduction of stabilisation measures in 1983, the real growth of 47 per cent in the 1981/82 budget was turned into a real decrease in expenditure of 9,1 per cent in the 1982/83 fiscal year.

The share of preventive services in the MOH budget has risen from 7,9 per cent in 1979/80 to 14 per cent in 1985/86, while that of medical care has fallen from 87,1 per cent to 77,9 per cent. These figures actually understate the shift towards preventive care since some of the

costs of such care, especially with respect to immunisation, have probably been reduced by the integration of curative and preventive services. This change reflects the impact of the changed philosophy of the MOH after independence.

There has also been a steady rise in the share of the Ministry's budget allocated to salaries and allowances, from 26.8 per cent in 1980/81 to 44.7 per cent in 1985/86 (Government of Zimbabwe, various). This reflects increasing personnel, rising wages and the unwillingness of the government to dismiss salaried employees during a period of budget restraint.

The MOH makes major grants to the central hospitals in Harare, to local authorities, missions and voluntary organisations. The central hospitals' share of the MOH budget has been reduced since independence. The local authorities, missions and voluntary organisations provide health care services at the local level particularly in outreach programmes such as immunisation, diarrhoeal disease control and supplementary feeding. In real terms their grant increased from Z\$22,2m in 1980/81 to Z\$35,9m in 1981/82 and back to Z\$24,4m in 1984/85. This recent fall in real resources has constrained their work, especially their ability to perform outreach work during 1984 and 1985.

We thus see that government funding of health sector services grew substantially after independence, but has remained virtually static since 1981/82. Within this trend in overall levels, there has been a shift towards preventive services, reflecting the changing philosophy of government.

Resources are also provided to the health sector by foreign aid donors, who play an important part in easing some of the constraints faced by government. Although the total amount of aid going to the sector has not been large in comparison with the overall MOH budget, it has been significant in relation to the funding allocated to specific projects. In 1983 18 per cent of the ZEPI budget came from bilateral and multilateral aid donors. Similarly, the funding for the CSFP has come primarily from aid agencies.

## **Problems in the health sector**

### *(i) Access and utilisation*

It has been noted that in the past hospital services reflected the divided nature of the society in which they developed, that 'a parallel hospital system was developed for the black population', and that "occupancy rates were far greater in the 'closed' (black public) than in the 'open' (mainly white, private) wards at Parirenyatwa Hospital'. With the repeal of the Medical Services Act in 1981, the distinction between 'open' and 'closed' facilities was abolished. However, it remains the case that Harare Hospital is busier and relatively less well staffed, particularly in terms of qualified nursing staff, than Parirenyatwa Hospital. For example, in 1988 the Pediatric Medical Wards at Harare Hospital had a mean bed occupancy of 111.7 per cent with 4 538 discharges and deaths, compared with Parirenyatwa's 93 per cent occupancy and total discharges and deaths of 2 837; mean length of stay in hospital for children in Harare Hospital was 9 days compared with just under 11 for Parirenyatwa Hospital. The total number of patients discharged or dying in 1988 was 58 766 for Harare with a mean duration of stay of 6.4 days, compared with 39 663 and 8 days for Parirenyatwa

(Medical Records Department, Parirenyatwa Hospital). Although differentials between these two hospitals have been reduced since independence, Harare remains the 'poor sister' with a much heavier workload and poorer facilities than Parirenyatwa which, by its location, is much less accessible to high density suburb residents most of who rely on public transport. The continuing disparities in terms of utilisation and resources are summed up in the unit costs of patient care in 1986: Z\$38,67 for Harare hospital and \$92,76 for Parirenyatwa (Sanders et al, 1989).

**In Planning for Equity in Health** (Ministry of Health, 1984a:13) it was noted that "the [hospital] system is supposed to provide a chain of increasingly sophisticated facilities so that patients with more complex conditions can be referred up the line. In practice the referral process functions poorly. For the mass of the people in the rural areas, the provision of facilities is so poor that it does not allow for an efficient referral chain. In addition, it is only in the central and the better general hospitals that anything but the most basic medical and surgical care is available. The result is that people by-pass their local health facilities and put services pressure on the larger institutions, especially the central hospitals".

Despite the government's enthusiastic PHC drive and its stated commitment to equity in health, the referral system appears still to function poorly. In a study performed in early 1980 at one district (Karoi), one provincial (Chinhoyi) and two central (Harare and Parirenyatwa) hospitals data collected illustrated this quite starkly. While 32,6% of Karoi hospital in-patients came from within 10 km of the hospital, for Chinhoyi the figure was 37,6%, and for Harare and Parirenyatwa 59,3% and 56,2% respectively! Further, 50,9% of in-patients at Parirenyatwa Hospital had used this facility as their first point of contact with the health service and 42,4% as their second point of contact. The corresponding figures for Harare were 11,0% and a staggering 67,8% who used this 'quaternary' facility as their second place of contact with the health service. The pattern of illness in in-patients at these different levels of hospital was remarkably similar with a small number of conditions accounting for a significant proportion of hospitalised patients.

#### (ii) *Community participation and democratic control*

A central feature of the PHC approach is democratisation - the process essential to genuine 'community participation'. In **Planning for Equity in Health** (Ministry of Health, 1984a:38) the importance of this is spelled out. "This principle of mutual respect and dialogue is at the heart of the new relationship to be created between the health service and the community. Both sides will benefit. The people will feel the health units and activities are 'theirs', and will utilise and participate in them as such. The health workers will receive a boost to their morale and motivation; their activities, being responsive to the local situation, will be more effective and efficient in the use of resources."

Popular democratic control is a crucial ingredient for the success of primary health care initiatives and is one - some would say the most important - feature distinguishing PHC from previous approaches. Community health worker or VHW programmes which are democratically controlled by the poor majority can serve the function not only of extending health care to even isolated communities, but also of mobilising people to transform their

living conditions and thus their health. In communities where most people are poor and often illiterate 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. Indeed, it calls into question the very notion 'community', as a term that suggests a homogeneous, conflict-free group of people. This is almost never the case. It is not simply that villagers as a homogeneous whole are divided from professionals. Villagers are also divided among themselves, particularly where economic stratification exists, as it does in rural Zimbabwe.

The beginnings of a process of bureaucratisation and the accompanying undermining of popular initiative is well illustrated by an example from the health sector involving the village health worker programme. During the ceasefire in 1980, 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 organised into one political district with 28 branches. Each branch had a committee of 16, who were popularly elected. Of these 16 two were responsible for community health matters. Training commenced for these 56 branch health leaders in May 1980. Their six months' training included both theory and practical work, the latter being done after planning with their communities. Due to this project's popularity and increasing community demands, the people decided to have an unpaid village health worker (VHW) for every one to three villages, resulting in the selection and training of 293 VHWs, 35 being from other districts. (It is important to note that selection and control of these workers was at village and branch level with on-going popular participation). From this project sprang up a Development Committee, organised by the people themselves. In the words of Sr Nhariwa, the original trainer, "its aims is to coordinate the work done by VHWs in different areas, and organise other development projects that are directly involved with health ... The formation of the Development Committee has strengthened the health projects and intensified these projects making the people more determined than ever".

In late 1981, the government began training VHWs. The aim was to have about 12 000 VHWs countrywide. By early 1984 about 3 000 had been trained. These VHWs are supposed to be selected by their own communities in consultation with the District Council. In some areas there is real popular involvement in the selection of these workers, this being done at ward level (although many wards would be far too large to allow effective popular participation). However, in many areas it is done by the District Council, and in some it is acknowledged that "there is some nepotism, councillors choose their wives and friends". Further, the payment of these VHWs (Z\$33 per month) is made by District Councils from a grant received from central government. This means, inevitably, that VHWs are subjectively responsible to their District Councils rather than the villagers they serve, although with widespread rural poverty it would be impossible for many communities to fund their own VHWs. (This possibility depends on the success of the government's rural development strategy for the majority - the poor peasants and workers).

When the government scheme was set up, ten of the Bondolfi VHWs who were working at the time 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 much

lower concentration in the population they have to cover a considerably larger area than the Bondolfi women. This means that, in effect, 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 drop-out, but as one local VHW organiser said (Sanders and Carver, 1985):

“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 village health workers, who were directly selected by meetings in the villages and answerable to the local people, the government VHWs are chosen and paid by the 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 mobilisation is missing. The VHW is no longer directly answerable to the poor people 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. Once again ‘communities’ are not homogeneous units but are divided into conflicting classes and interest groups. It will always tend to be the richer and more powerful section of the community who dominate local government bodies which are only infrequently reelected. Direct control over VHWs at the grassroots level is the best way of ensuring that they are answerable to the poor.

More recently there have been further developments which 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 still parttime, 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 of popular democratic control of VHWs becoming a focus for democratisation at all levels of the health sector now seems remote.

**Planning for Equity in Health** goes on to say (Ministry of Health, 1984a:38): “This new relationship should not be limited to the periphery of the health system, but should permeate all levels of the service, up to the central hospitals ... An active popular involvement in health affairs should help these (professional) workers overcome their superiority complexes, be they in relation to the public in general, to black Zimbabweans in particular, or to more junior members of the health service”.

Just as the public should have representation on health service structures, and channels through which to lodge complaints in the event of bad treatment, so junior health staff should have the opportunity to participate in discussions and decision-making. These are two facets of the same process, that of debureaucratisation and democratisation of the health service, in which hierarchical relationships will be two-way, and there will be much stronger feedback communications from the base upwards. This is a political question which must have repercussions in the whole health sector.

What progress has there been in rendering professional health workers accountable in some way to the communities they serve? What steps have been taken to ensure that junior health staff have their voices heard by their senior, professional colleagues? Very little and very few are the unfortunate answers. While there are some structures at district and provincial levels that allow for dialogue between professional and non-professional staff, between health workers and lay members of the community, these are often top-heavy and meet infrequently. At central level such bodies do not even exist. The experience of Mozambique, where all staff and also patients were represented in hospital ward committees, has never been attempted in Zimbabwe.

In addition to the creation of democratic structures, responsiveness and accountability of health workers could be positively influenced by more community involvement in the selection of trainees (including medical students) and better orientation and training. The steps taken by the medical and nursing schools to make their curricula and sites of training more relevant and more community-oriented are welcome. They are, however, insufficient and fragile where they are not backed up by the creation of permanent structures in which true community involvement can occur, and through which accountability of health workers can be enforced.

### *(iii) The private sector*

This section, and the following two major sections, draw heavily on Loewenson and Sanders (1988).

What role has the private medical sector had in the quest for equity in health? It has been documented for many countries that private sector delivery of health care results in severe distortions (see, for example, Sanders and Carver, 1985). Zimbabwe is no exception. The MOH provides 44 per cent of service by value and bears 51 per cent of national health costs. The private sector, providing 33 per cent of services by value, bears only 17 per cent of costs, these being raised through medical aid societies. In 1982 government was reported to be subsidising this sector by Z\$4,5m (Ministry of Health, 1984a). The private sector generally serves a small urban elite, inflating their annual health expenditure per capita to Z\$145 compared to the national average of Z\$3. This is also the group with the lowest estimated infant mortality. In 1980, the 300 doctors in private practice earned an average of 1,5 times the income of government doctors (Loewenson and Sanders, 1988).

There have been initiatives to control the activities of government doctors in respect of private practice, to limit the expansion of private medical facilities at the institutional level and to remove the use by private practitioners of state facilities without charge. A 1987 Bill requiring doctors to practice at a designated government institution for five years before being permitted to enter private practice is one such initiative. The private sector, however, continues to provide care largely to the higher-income groups, sustained mainly through the expansion of private and public medical aid societies. Contributions to these societies are abateable under the Income Tax Act, hence, apart from the direct subsidy, the private sector is also indirectly subsidised by tax abatements on medical aid contributions and on payments for private care. Removing all these subsidies, and taxing the private care as a luxury

commodity, would potentially raise an estimated Z\$17m per year for public expenditure (Ushewokunze, 1984). With the current wage for industrial workers being Z\$182 per month, above the Z\$150 limit set in 1980 to qualify for free health care, medical aid societies are now offering schemes to attract the working class, and involve them further in supporting the private delivery of health care. Policies executed within the state sector still do not apply within the private sector. For example the Essential Drugs List was formulated in 1985 in order to derive the most effective and economically rational supply of drugs. However, at present it only applies to the state sector, whilst the private sector is still permitted to utilise the imported drugs outside this list.

### Changes in health status

The pre-1980 health-monitoring system had large gaps in recording death and disease in black workers and peasants. The legacy of that socioeconomic bias persists to some extent, but has been mitigated somewhat by rationalisation of the health information system and by the completion of the 1982 census and the wider coverage of socioeconomic and health surveys. Hence data on post-independence changes in health status are pieced together from a wide range of sources with a probably continuing selective bias against inclusion of the most impoverished groups.

#### (i) Mortality

The most marked change in health is reflected in the reduction in infant mortality from an estimated 120 per thousand in 1980 (120-200 rural, 50-90 urban) to 83 in 1982 (CSO, 1986). The maternal mortality rate has similarly fallen by 28 per cent between 1980 and 1983. Disaggregations of IMR by social class have not been carried out since 1980, and although it is probable that the rural-urban difference in mortality has narrowed due to improvements in rural health care, class inequalities in mortality have been maintained.

#### (ii) Morbidity

There is little evidence of a significant reduction in disease incidence since 1980. Diarrhoea, pneumonia, measles and tetanus, linked with undernutrition, remain the major causes of child mortality, the first two accounting for 54 per cent of 0-4 year deaths in 1980 (UNICEF, 1985). Some statistics, such as those on diarrhoeal disease collected from hospital in five different provinces, indicate a rise in admissions since independence, but this may merely reflect increasing utilisation of health care (Cutts, 1984).

Reductions in immunisable communicable disease admissions have been noted. For example, declines in measles have been reported from health facilities taking into account the biennial incidence of measles (Todd, 1985). This has been consequent on the 150 per cent increase in immunisations between 1981 and 1983. Diseases not as closely targeted for selective PHC strategies, or less susceptible to vertical programmes of technological manipulation, such as pneumonia, bilharzia, malaria and other parasitic infections, remain at high seasonal endemic levels. Pneumonia remains the principal cause of registered infant

mortality; malaria has a registered incidence of 227/100 000 (Ministry of Health, 1981), and endemic levels of parasitic infections of up to 90 per cent have been reported (Ministry of Health, 1984e).

### (iii) *Nutrition*

Two Ministry of Health surveys carried out in 1982 and 1984 provide the only nationwide time-series data on children's nutrition. The later survey did not disaggregate rural and urban clusters and used a different sampling base which hinders comparison. However, the data indicate no significant change in the prevalence of under-nutrition of under-five year olds, with severe and moderate undernutrition affecting approximately 16 per cent of children (UNICEF, 1985).

Data drawn from surveys carried out in large-scale farms, and urban areas between 1981 and 1983 indicate a reduction in child nutrition in that period (see Table 3). These reductions in undernutrition coincide with an improvement in real incomes in the 1980-1982 period following rises in real wages and productivity. In the 1983-86 period there is no evidence of further improvements. This is also a period of static average real incomes in worker and peasant households.

Thus, while declines in child undernutrition have occurred from 1980-83, in the last four years nutritional improvements have levelled off. Nutritional data are not disaggregated by land or employment security in rural and urban areas, so that the relative effects of retrenchment and rural stratification are not evident. It is probable that undernourished children come predominantly from un- and under-employed working-class households and peasants with least land and financial resources.

Mortality declines therefore appear to arise primarily from more accessible curative care, the greatly expanded use of oral rehydration therapy for diarrhoea, and the decline of certain communicable diseases such as those targeted by the Expanded Programme on Immunisation. These interventions appear to have reduced the fatal outcomes in certain illnesses without any clear evidence of a reduction in the prevalence of non-immunisable diseases.

Little work has been done to disaggregate these patterns of ill-health by class, or to look at the impact of current economic changes on selected groups. Recent surveys in agricultural labour communities indicate that the growing pool of un- and underemployed labour in the sector experience higher levels of undernutrition and reported ill-health than fully employed labour (Loewenson, 1986). Such patterns of ill-health are likely to arise from trends in social differentiation, whether in respect of land concentration in the peasant sector, or concentration of capital generating increasing poverty and unemployment in the formal sector.

The increasing intensity of production and technological innovation has resulted in a rise in reported occupational accidents from 5 071 in 1975 to 13 727 in 1984 (CSO, 1986). The most notable areas of concern at present are acute mechanical and chemical accidents. Scientific assessment of the chronic risks of mineral dusts and carcinogens has not been carried out. Increasing state and worker concern over environmental and occupational health has yet to be translated into legal, institutional and scientific forms.

## Conclusion

In national terms, independence has clearly removed the worst nutritional and communicable disease effects of the settler colonial state, particularly those arising from racist and military policies. However, the persistence of an economy owned and controlled by a few and so capital intensive as to supply little employment has meant that major health improvements have been effected by health care interventions rather than by substantial changes in socioeconomic conditions. Further, such improvements have been constrained by reductions in expenditure on social service as part of the financial structures imposed by the economic recession.

In 1980, the Ministry of Health adopted the Primary Health Care approach as its major policy guideline, with its implications for democratising the health care system, and identifying health intervention at the broadest level with the active participation of local communities. The implementation of that policy since 1980 has witnessed the expansion of a national village health worker programme, widespread expansion of primary curative and maternal and child health care, and significant improvements in village level water supplies and sanitation in certain areas. The provision of free health care for all those earning less than Z\$150 in 1980 greatly increased the use of facilities, although major problems of access and utilisation still remain. These are the visible signs of the national commitment towards destroying the old order of racist and undemocratic health care institutions, which also entrenched a class bias in the distribution of health care.

However, the class bias still persists, and many struggles remain to be waged. Public sector facilities remain more accessible to the urban and better off population and the referral system functions poorly. The private sector continues to threaten the delivery of a nationally integrated health system, propped up as it is by widespread medical aid funding which is increasingly being targeted at capturing the higher income sections of the working class, to the cost of the under-, un- and informally employed. Private monopoly interests, such as those of the drug companies remain powerful and relatively unchallenged. The democratisation of the health care system has the potential to be strengthened by decentralisation of the planning and administration of health services so that an increasing contribution from working-class and peasant perspectives is encouraged. Thus there is a continuing struggle to demystify health planning and confront those interventions in which medical professional decisions dominate, in favour of programmes which may transform the social and economic relations which underlie ill-health.

Thus within the health sector the struggle to implement a policy directed at the health needs of the whole population with a rational distribution of health resources is one antagonistic to the private interests and control at the economic base. The emerging divergence between declining death rates and static quality of life as reflected in nutritional status is indicative of the rapid expansion of health care provision on the one hand, and of the relatively static economic conditions for the majority on the other. It would be presumptuous to render judgment on the 'outcome' of these forces a mere eight years after independence, particularly in the context of the huge threat to national and regional health by imperialism's closest

regional ally - the South African State. As in other aspects of transformation within Zimbabwe, one can say with conviction ... the struggle continues.

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**Table 1**  
**Chronicle of Minimum Wage Changes Legislated Monthly Minima in Z\$**

Date	Domestic workers	Agricultural workers	Industrial workers	Mining workers	Low-income Urban CPI	Constant domestic	1980 Prices industrial
	(a) (b)	(a) (b)		(a) (b)		(a) (b) (c)	
	(1) (2)	(3) (4)	(5)	(6) (7)	(8)	(9) (10)	
1 Jul 80	30 (c)	30 (c)	70	43 70	99.2	30 (c)	71
30Dec80	30 (c)	30 (c)	85	58 85	102.4	29 (c)	83
1 May81	- -	- -	-	(d) 85			
1 Jan 82	50 62(e)		105	105	117.1	43 53	90
1 Sep 82	55 67	55 65	115	110	169.5	32 40	68
1 Jul 84	65 77		125	120	184.2	35 42	68
1 Jul 85	75 93	75 93	143	143	196.9	38 47	73
1 Jul 86	85		158			37	68

- Notes:
- For those workers who also receive payments in kind
  - For those who do not receive payments in kind
  - Benefits to be added to cash wage but value of benefits not specified
  - From this date mineworkers not paid in kind
  - From this date 3 grades of domestic workers were recognised with the minima rising by Z\$ 200 for each grade. Z\$50 was the lowest grade.

Table 2

## Central Government Budget Allocation to the Ministry of Health 1978/79 to 1985/86

Fiscal Year	Vote Allocation		Actual Expenditure		Actual Growth Rates			
	Current prices Z\$m	1980 prices Z\$m	Budget share %	Current prices Z\$m	1980 prices Z\$m	Budget share %	Current prices %	1980 prices %
1978/79	46.2	58.2	4.6	45.6	57.4	4.8	-	-
1979/80	54.2	61.5	4.4	53.5	60.7	4.6	17.3	5.7
1980/81	83.7	83.7	5.1	77.4	77.4	5.3	44.7	27.5
1981/82	108.9	116.8	5.1	106.1	113.8	5.6	37.1	47.0
1982/83	131.6	110.5	4.5	123.1	103.4	4.8	16.0	-9.1
1983/84	139.0	117.3	4.6	139.0	117.3	4.8	10.5	13.4
1984/85	159.4	118.2	4.5	156.6	116.2	4.9	12.7	-0.9
1985/86	196.2		5.1					
1986/87	229.4		5.0					

Note: Z\$1,6 = US\$1 (1985)

Sources: 1978/79 - 1983/84: Zimbabwe, *Annual Report of the Controller and Auditor General*, Harare  
 1984/85 - 1986/87: Zimbabwe, *Estimates of Expenditure*, Harare  
 1980 price figures are calculated using an index of health sector wages.

Table 3  
 Malnutrition Data from Selected Studies

Year	Area	Type	Number in Study	% Severe Wasting	and Moderate Stunting
1981	Bindura	Farm	223	21	30
1983	Bindura	Farm	524	8	15
1985	Mashonaland West	Farm	1 449	5	28
1981	Bindura	Mine	623	6	15
1983	Bindura	Mine	1 171	4	13
1982	Bindura	Urban	543	6	9
1983	Bindura	Urban	329	2	9

Note: Farm = large scale commercial farm

Sources: Chikanza I et al, *Central African Journal of Medicine*, Vol 27 No 5, pp 88-93.  
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