Family Health in Zimbabwe

The first Bank-funded family health project in Zimbabwe strengthened public management of and provision of health services in rural areas, according to an audit by OED. The project upgraded hospitals and health facilities, trained health workers, and established an information and education center. The project was a good example of a cost-effective move toward a primary health care system. Hospital construction, however, cost much more than expected, and efforts to decentralize services were hindered by a misunderstanding of the roles and powers of government agencies, some of which were not involved in project preparation.

The audit suggests that plans for civil works must take into account factors such as population density, demand for services, and regional differences. When planning changes in the responsibilities or budgets of government agencies, details must be worked out in advance and planners must understand the relationships between different government bodies. The borrower must be active in administrative oversight. A second health project has taken these lessons into account.

When a Bank-supported family health project was approved in 1986, Zimbabwe had an annual population growth rate that would have doubled its population every 20 years. Maternal and children's health made heavy demands on the health care system, and many of the problems affecting mothers and young children were caused by diseases that were either preventable or relatively easy to treat.

The project aimed to increase the availability and use of family planning services; improve health services for mothers and children; and strengthen the government's institutional capacity to plan, manage, and evaluate its services in these areas.

The project was designed to:

- provide management training at the Ministry of Health;
- train health workers in family planning and midwifery, and build training facilities at eight district hospitals;
- upgrade eight district hospitals with equipment, training, and staff accommodations;
- upgrade and equip 82 public health centers and 20 privately run facilities;
- provide family planning services at 22 urban centers; and
- establish information, education, and communication services in family planning and health.

Results

Institutional development. The project contributed substantially to the institutional development of the health sector. It established a course that trained managers to become district-level administrators. This supported the decentralization of the system at the local level and improved the delivery of health services by freeing medical staff from administrative duties. In-service training of managers was also carried out at all levels.

Training. The project trained district-level trainers and nurse tutors in family planning and in maternal and children's health. As a result, all nurses graduating from basic and post-basic training since 1987 can provide these services, and almost all state-certified nurses are trained in midwifery and family planning (previously, 90 percent of them had no midwifery training). The basic training curriculum was redesigned. Construction of the training schools reduced costs, as it was no longer necessary to rent hotel accommodations for students.

Decentralization. The project was less successful in decentralizing services from the health ministry to the districts. What decentralization meant and the precise relationships between various ministries were not clearly identified or understood. This led to conflicts between ministries. For example, about 9,000 village health workers—the country's principal health outreach workers—were transferred from the Ministry of Health to a new ministry and assigned new tasks. As a result, there was a shortage of health outreach personnel in the field.

Infrastructure. A total of 58 health centers and 18 facilities were upgraded or built. Construction at the district hospitals, however, ran into time and cost overruns (initial cost estimates were about half actual costs). The project used a standardized, 140-bed design, without taking into account differences in population size and utilization patterns between districts. Thus, hospitals in several districts were too large, relative to local population and need, while others were too small to meet demand. The Ministry of Public Construction and National Housing was not involved in the project’s preparation, and the differences in procedures used by that ministry and the Ministry of Health created bureaucratic delays.

Family planning. Startup of the urban family planning component was delayed, partly because it was unclear which government department was responsible for implementation. Eight of the 22 centers were established, but municipalities responsible for city clinics were not involved in project preparation, and there were no organizational links between the ministry and city clinics. Hospitals received training and equipment, but less than originally planned.

Dissemination. An audiovisual center was established for information, education, and communication services. It was intended to be used by the Ministry of Health but was located in and used mostly by the National Family Planning Council. There was initial confusion about responsibility for the center, and procedural differences within the two agencies strained relations. As a result, the facility has not been used efficiently.

Sustainability. The project’s benefits are likely to be sustained, in large part thanks to the completed health facilities and the large number of trained health practitioners and teachers. Two factors beyond the project’s control may affect the health sector in the future: a deep economic depression, which has put severe financial constraints on the budget, and the HIV epidemic, which is straining the capacity of the entire health system.

Lessons learned

The lessons learned from this project concern primarily coordination among government agencies and cost effectiveness.

Ministry coordination. Understanding and clearly identifying relations between different ministries is important to the outcome of projects involving decentralization. Knowledge of the different procedures adopted by government bodies would have prevented problems in reorganization efforts and in the running of the audiovisual center. The Bank’s misunderstanding of relations between the central ministry and the municipalities—and of the differences in their procedures—was a factor in the disappointing performance of the urban family planning component.

Effective cooperation between separate line agencies involves more than agreement on broad policy statements. Shared objectives are valuable, but cannot replace the detailed work, ideally completed during project preparation, of documenting and specifying the procedural and administrative changes that are necessary for effective cross-agency cooperation.

Bank staff must understand the degree to which an individual ministry has budgetary authority and autonomy in pursuing organizational changes.

Costs. Designs for civil works must accurately assess local demand for services and must address the question of how best to ensure the appropriate supply and distribution of skills. Plans must be flexible enough to change if and when necessary, and should avoid applying the same “blueprint” designs to different conditions.

Close attention must also be paid to the details of design, tendering, procurement, maintenance, and recurrent costs. The borrower must take a proactive stance in administrative oversight, and its public agencies must be committed to cost efficiency. The Bank must be consistent in its careful supervision of a project through implementation.

Applying the lessons. Zimbabwe and the Bank disseminated these lessons through workshops in the Bank’s Southern Africa region to discuss facility planning and management issues. The lessons from the first project are being used in a second family health project, approved by the Bank in 1991. An architect provided liaison between the project unit and the public works ministry during hospital design, and more accurate cost appraisals were made.

Zimbabwe’s commitment to accountability and cost effectiveness is ensuring stronger performance in the second project, which is expected to build twice the number of hospitals at the same cost as the first project. The Ministry of Health and the National Family Planning Council are coordinating the use of production facilities at the information, education, and communication center, and relations between the two bodies continue to improve.

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