The Impact of World Bank Support to the HNP Sector in Zimbabwe

June 30, 1998

Sector and Thematic Evaluations Group
Operations Evaluation Department
Currency Equivalents

Currency unit = Zimbabwean Dollar
US$1.00 = Z$16.3 (1998)
= Z$1.8 (1988)

Abbreviations and Acronyms

AIDS Acquired Immune deficiency syndrome
CAS Country Assistance Strategy
CBD Community-based distributor (of contraceptives)
DANIDA Danish International Development Agency
DFID Department for International Development (formerly British ODA)
DHS Demographic Health Survey
FHP1 First Family Health Project
FHP2 Second Family Health Project
FY Fiscal year
HIV Human immunodeficiency virus
HNP Health nutrition and population
IBRD International Bank for Reconstruction and Development
IMF International Monetary Fund
MCH Maternal and child health
MOF Ministry of Finance
MOH Ministry of Health (officially: Ministry of Health and Child Welfare)
NACP National AIDS Control Program
NGO Nongovernmental organization
OED Operations Evaluation Department
RHC Rural health center
SIDA Swedish International Development Agency
STI Sexually transmitted infections
USAID United States Agency for International Development
VHW Village health worker
ZEDAP Zimbabwe Essential Drugs Action Program
ZEPI Zimbabwe Expanded Program on Immunization
ZNFPC Zimbabwe National Family Planning Council

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MEMORANDUM TO THE EXECUTIVE DIRECTORS AND THE PRESIDENT

SUBJECT: The Impact of the World Bank Support to the HNP Sector in Zimbabwe

Attached is the Operations Evaluation Department (OED) report entitled *The Impact of World Bank Support to the HNP Sector in Zimbabwe*.

The report evaluates the performance of the Bank in supporting projects to expand health services and fund drug purchases, and the influence Bank policy dialogue and sector work, both at the macroeconomic and sectoral level, on sector performance. The report demonstrates the importance of improving the coherence between Bank macroeconomic dialogue and sector lending, and that the Bank must give greater attention to the implementation of health financing policy advice to avoid adverse impacts on the poor. The report also shows that Bank efforts to improve access to rural health services must be accompanied by attention to health workforce issues, and appropriate siting of health facilities. Based on lessons learned the report indicates a number of areas in which emphasis should be placed in forthcoming activities.

Attachment
Preface

1. Over the past two decades, the World Bank has emerged as the world's largest lender in the health, nutrition, and population (HNP) sector. In addition, the Bank plays a major role in providing advice on national health policies. This Country Sector Impact Study is one of four studies being undertaken by the World Bank's Operations Evaluation Department (OED) as part of a comprehensive assessment of the Bank's development effectiveness in the HNP sector. The other study countries are Brazil, Mali, and India. Zimbabwe was chosen because of its past successes in improving the health of its population, its long-term relationship with the World Bank, and because of the relative availability of household and health service data.

2. This study is based upon review of World Bank project documents, interviews with World Bank staff, government officials, and health workers, focus group discussions with health workers and health system clients, and analysis of facility and household data. Data sources include the Ministry of Health's National Health Information System, Demographic and Health Surveys, the 1995 Zimbabwe Poverty Assessment Survey, and the Situation Analysis survey conducted by the Zimbabwe National Family Planning Council. The study commissioned several background papers, and the author visited Zimbabwe four times over the course of a year, once to discuss study design, twice to conduct interviews and supervise research, and a final visit to discuss preliminary findings with government and civil society. Drafts of the study were reviewed by both World Bank staff and officials at the Ministry of Health, and their comments were incorporated into the final text.

3. Timothy Johnston was task-manager and author of this study. Ms. Susan Stout directed the overall OED assessment, Mr. Benjamin Crow and Ms. Marcia Bailey provided assistance with administration and document formatting, and Mr. William Hurlbut provided editorial support. OED was greatly assisted by the World Bank resident mission in Zimbabwe: Mr. Ebrahim Jassat, Ms. Debra Cubbitt, and Ms. Gillian Williams-Lovell provided valuable assistance in facilitating research and coordinating visits. In the Ministry of Health, Dr. Bruno Pioiti in the Department of Epidemiology provided support and guidance in the collection and analysis of health facility data. Mr. Osten Rutsate and Ms. Epi Ushewokonz in the Family Health Project unit facilitated site visits and provided useful background on the projects. Dr. Paulinus Sikosana, Permanent Secretary of the MOH, was supportive throughout the study and provided comments on the study draft, and senior managers and staff in the ministry were generous with their time and insights. The Famine Early Warning System office in Harare shared time-series data on health statistics, nutrition, and other indicators. OED is also grateful for the support and cooperation of current and former members of the Bank's Zimbabwe health team. Their willingness to share insights and reflect on past experience contributed significantly to this study, and embodies the Bank's goal of becoming a learning organization.
Summary and Principal Findings

1. This Sector Impact Study assesses the relevance and impact of World Bank policy advice and project support to health, nutrition, and population in Zimbabwe over the past 15 years, including the influence of macroeconomic dialogue and policies on the health sector. The Bank's first loan sought to improve the quality and availability of health services in eight target districts, including expansion of infrastructure and provide training, and a follow-on loan in 1991 expanded the program to an additional 16 districts. A 1993 loan funded the acquisition of drugs for treating sexually transmitted infections (STIs), as well as medical supplies and laboratory equipment. The Bank has also sponsored policy dialogue and sector work on health financing and cost recovery, population, and nutrition. In addition, the Bank provided key advice and financial support for the Economic Structural Adjustment Program (ESAP).

2. The government's strong emphasis on prevention and integrating primary health care, family planning, and nutrition contributed to rapid improvements in health, fertility, and nutrition outcomes during the 1980s, but the changes predate Bank investments. In the 1990s, health and health service indicators stagnated or declined under the combined burdens of AIDS, economic crisis, and drought, although fertility continued to decline. Zimbabwe now has one of the highest HIV prevalence rates in the world, which threatens to reverse the health progress made in the 1980s. Bank-sponsored projects provided valuable support to the health sector, but impact was overwhelmed by these larger trends. Even though HIV/AIDS is best addressed through prevention and behavior change, declining per capita health spending and growing demands for curative care have weakened the preventive focus of the MOH.

Principal Evaluative Findings

3. The Bank has usually “done the right things” in the Zimbabwe health sector, but has not always “done things right.” Bank policy advice and project support have generally been relevant to Zimbabwe's epidemiological profile and health sector needs, but they have often experienced difficulties in implementation. The Second Family Health Project (1991-98) was an exception; it was effectively implemented (“did things right”), but the design was not sufficiently flexible to adapt to rapid changes in the health sector, particularly critical shortages of health staff.

4. Zimbabwe’s 1991 economic structural adjustment program liberalized the economy but failed to control the budget deficit, which together contributed to strains on the health sector and on the poor. High budget deficits fueled inflation and led to growing interest payments, which in turn contributed to declines in real health spending and real wages for health workers. Although health workers were protected from retrenchments, reductions in MOH administrative and maintenance staff reduced efficiency and added to morale problems. The Bank encouraged adoption of an exemption system to protect the poor from increased cost-recovery in the social sectors, but shortcomings in design and implementation meant that the program reached only a small percentage of intended beneficiaries. Economic liberalization without deficit reduction contributed to economic stagnation and limited job creation. Higher costs for food and social services, combined with declining formal sector wages and lingering effects of severe drought, have left many of the poor worse off than before adjustment began.
5. Bank health financing sector work led to increased cost-recovery efforts, but it had limited success in mobilizing additional resources for health, improving quality and efficiency, or protecting the poor. The Bank persuaded the Ministry of Health to increase user fees in the early 1990s, but the Ministry of Finance did not permit fee retention until late 1997. Because fees were not retained, facility quality did not improve and bypassing of clinics continued. Total cost recovery declined as a percentage of the MOH budget, primarily because government made little progress in improving hospital billing. Attendance for some preventive services shifted from hospitals to clinics, suggesting improved efficiency, but outpatient attendance by the poor declined following fee increases, as a consequence both of increased prices and declining quality. The Bank must complement its broad policy recommendations with detailed dialogue on implementation, give greater attention to the institutional context, and coordinate sector and macroeconomic dialogue.

6. The Bank has been well-positioned and effective in promoting the integration of key HNP interventions. Bank sector work and project support contributed to the integration of nutrition and family planning into health services. The percentage of women obtaining contraceptives in health facilities increased since the late 1980s, which is partly attributable to Bank-sponsored family planning training.

7. Bank support for expanding district infrastructure and staff training has improved service quality and contributed to increased facility deliveries, inpatient attendance, and contraceptive prevalence, but has had no measurable impact on outpatient attendance or disease patterns. Outpatient attendance actually declined following facility completion in 1991, coinciding with drought, increased fee enforcement, and drug shortages, suggesting that improved infrastructure and training alone are inadequate to improve outpatient utilization.

8. The impact of upgraded facilities on maternal attendance varied considerably depending on the appropriateness of site selection. In genuinely underserved districts, maternal deliveries increased several times over following facility completion, while in others, deliveries stagnated and inpatient attendance fell. Domestic political influences and Bank insistence on upgrading existing facilities contributed to inappropriate site selection.

9. The Second Family Health Project (FHP2) improved on facility design and site selection and built 16 district hospitals for the cost of the original 8. For FHP2, the Bank placed an architect within the MOH, who worked to ensure maximum efficiency in facility design. International competitive bidding resulted in construction costs 40 percent lower than government estimates, and facilities were completed on time and nearly on budget by the end of 1997. Unfortunately, the government health system faces a severe shortage of health personnel, which is making it difficult to staff the new facilities, and threatens to undermine their impact. No strategic evaluation was undertaken during FHP2 design to assess whether building an additional 16 district hospitals was still appropriate, and the “blueprint” investment nature of the project limited the Bank’s flexibility to respond to rapid changes in the sector.

10. The staff shortages are the result of recent political decisions by government (abolishing training for State Certified Nurses and firing striking health workers), high turnover of health staff, and the absence of effective health manpower planning. Erosion of real wages in the public sector and increasing workloads have contributed to turnover and low morale. Although Bank staff periodically raised concerns regarding health staffing, they were not effective in addressing the institutional constraints to action. The Bank has supported technical assistance for work force
planning, and raised concerns regarding health staffing during supervision missions, but did not undertake formal sector work until 1998. Once construction began, it was not possible contractually or politically to delay construction or reduce the number of hospitals pending resolution of staff shortages. Responsibility for health personnel is divided among various ministries (MOH, Ministry of Finance, and the Public Service Commission), and the Bank did not use its leverage at the macroeconomic level to elevate and add urgency to the dialogue. The MOH, Bank, and donors have made health staffing a priority for future support, but all parties should ensure that the various responses are coordinated.

11. Bank support for the purchase of STI drugs closed a major financing gap, contributed to significant cost savings in drug procurement, and initially increased drug availability. Other bottlenecks later emerged that reduced drug availability, undermining program effectiveness. STI drug availability increased to 89 percent in the first two years of the project, but then fell to 73 percent in 1996, primarily because of reversals of government contract awards by Bank procurement specialists, and delays in registering drugs procured through international competitive bidding (ICB). Government staff did not initially receive adequate training in Bank procurement procedures, and Bank supervision of procurement was initially inadequate to resolve bottlenecks. Increased supervision and management attention by both government and Bank staff contributed a recovery in STI drug availability in 1998.

12. Bank-funded research has helped raise awareness in Zimbabwe regarding the seriousness of the AIDS epidemic, and the Bank has cosponsored innovative community AIDS prevention initiatives. The government's response, however, still is not commensurate with the scale of the epidemic, which may claim 1 million lives in the next decade.

**Lessons and Recommendations**

- Macroeconomic policies and performance have had a greater influence on the health sector than Bank project lending, but the Bank has not effectively linked health sector investments and strategies to macroeconomic dialogue, particularly regarding health staffing and civil service reform. Political leaders, however, have not demonstrated commitment to deficit reduction. To prevent further deterioration in the public health sector, government must give priority to reducing the budget deficit and restructuring debt service. In the medium-term, the budget for health will remain constrained, so government and partners will need to focus on increasing efficiency and redistributing existing expenditure.

- The AIDS epidemic is the most serious problem facing the health system and, along with the deficit, the economy as a whole. Government and political leaders must give greater priority and visibility to AIDS prevention, and establish an effective intersectoral response to the epidemic. Experience elsewhere has shown that strong leadership and political commitment can halt the growth of the epidemic and save hundreds of thousands of lives.

- Bank advice has usually been technically sound, but implementation of recommendations has sometimes faltered because of inadequate attention to institutional or political constraints. The Bank often has not adequately assessed the ability of borrower institutions to cope with the size of Bank projects, or the demands of policy changes. In particular, the Bank initially recommended establishing an exemption system to protect
the poor from health fee increases without considering the administrative viability of such a system. The Bank and government therefore should give greater attention to adapting programs to existing capacities. By establishing clear technical criteria for equity and efficiency during project design and implementation, the Bank can reduce, but not eliminate, distorting political influences.

- The Bank has been particularly effective when it has promoted integration of programs or cooperation among various government ministries, but it needs to use its potential influence as facilitator more widely and strategically, particularly now that the challenges facing the sector are more complex and require cooperation from a wide range of stakeholders.

- To address staff shortages, government will need to establish economic stability (to reduce inflation and prevent further budgetary declines) and develop a comprehensive health staffing strategy. The challenge is that budget constraints will not permit significant increases in personnel expenditures. Designing and implementing the strategy will require negotiations among a variety of stakeholders, including the MOH, Ministry of Finance, Public Service Commission, and health professionals. The Bank could assist by providing analysis and facilitating consensus, including between government and the IMF.

- The Bank could better balance efforts to promote efficiency and cost savings (for example, through large projects and international competitive bidding for procurement) with the need to maintain flexibility and achieve impact. Flexibility of lending instruments in a changing environment is a major determinant of project effectiveness, but flexible design should not substitute for clear strategy.

- Project with a major pharmaceutical component require up-front training for both government and Bank staff—with periodic follow-up training—to avoid bottlenecks that could interrupt drug availability. Bank procurement procedures could be streamlined to reduce the burden on borrowers, but the cost savings achieved through international competitive bidding are also essential to ensure drug availability in the face of tight budgets and growing demand for drugs.

- The Bank needs to better balance its efforts to improve the physical access of the rural poor to health services, with greater attention to ensuring financial access for the poor.

- Preventive and community-based approaches were fundamental to the rapid health improvements of the 1980s, and could be applied more vigorously to the challenges of the 1990s, particularly HIV/AIDS and malaria.

- Although umbrella projects and sector-wide approaches can help improve coherence of donor activities, they require a strong strategic vision from government and negotiated agreements among all parties to be effective.
1. Introduction and Evaluative Framework

1.1 Over the past two decades, the World Bank has emerged as the world's largest lender in the health, nutrition, and population (HNP) sector. In addition, the Bank plays a major role in providing advice on national health policies.

World Bank HNP Activities in Zimbabwe

1.2 The World Bank began sector work in Zimbabwe in 1983, and its first loan—the Family Health Project (FHP1)—was approved in 1986. The Second Family Health Project (FHP2) was approved in 1991, and a separate project focused on Sexually Transmitted Infections (STI) began in 1993. The Bank played a key role in project design and mobilizing additional donor support for FHP1 and FHP2, but government provided the majority of financing for both projects. Zimbabwe was classified as a middle-income country until the early 1990s, which meant that government could only borrow from the Bank at slightly below commercial interest rates. Zimbabwe subsequently qualified for subsidized IDA lending, so the STI project is financed by a no-interest loan with a 40 year repayment period. The STI project finances half of the government's drug budget, giving the Bank a greater financial role in the sector.

<table>
<thead>
<tr>
<th>Table 1.1: Bank Lending to HNP in Zimbabwe</th>
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<tr>
<td><strong>Project Appraisal</strong></td>
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<tr>
<td>Family Health Project</td>
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<td>Second Family Health Project</td>
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<td>Sexually Transmitted Infections Prevention and Care</td>
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Evaluative Framework

1.4 Figure 1.1 shows the two major pathways through which the World Bank can influence the health sector and health outcomes in a given country. The first is lending and policy advice directed at the health system. In Zimbabwe this includes the Family Health projects, the Sexually Transmitted Infections project, and the various sector studies focused on health, nutrition, population, and health financing. Through these activities, the Bank has attempted to improve access, quality, and efficiency of health services.
Alternatively, the Bank can influence the health sector and health outcomes indirectly, through its macroeconomic policy advice and support for economic reform. Economic policies can affect the health system directly, particularly the resources available for health; they can also influence household incomes, which are a major determinant of health status. This paper considers the impact of both Bank health sector support and of the economic structural adjustment program on the Zimbabwe health sector. A major theme of this study is that economic policies, including shortcomings in the implementation of the structural adjustment program, have had a larger impact on the Zimbabwe health system than Bank project lending, and that sector priorities have not been adequately integrated into the macroeconomic dialogue.

1.5 This Sector Impact Study seeks to answer three fundamental questions. First, were the Bank's projects and policy advice relevant to the needs of the Zimbabwe health sector (did the Bank "do the right things")? In particular, did they address major disease burdens and key constraints on health sector performance? Second, were Bank-supported interventions clinically effective and economically efficient in achieving their stated objectives (did the Bank "do things right")? Third, what has been the impact of Bank programs on HNP outcomes, services, and institutional development, and are these impacts sustainable, including financial sustainability and the availability of health staff.
Methodology and Data

1.6 Assessing the World Bank's impact on health system performance and outcomes is challenging for several reasons. First, as Figure 1.1 illustrates, health systems and health outcomes are influenced by a variety of factors. Bank-supported projects are not controlled experiments, and factors inside and outside the project can contribute to changes in health status and system performance. Second, the World Bank is one of many actors in the health sector. All Bank-supported projects are implemented by government, many with cofinancing from other donors. The Bank can influence government policies, but policy decisions and implementation ultimately rest with government. Borrower performance is typically the most important influence on both project outcomes and sector performance (OED 1997). The study therefore tries to assess where the Bank contributed to changes in the sector, without attributing all of the changes to the Bank's inputs.

1.7 Because of these evaluative challenges, the study drew on a variety of data and analyses, both qualitative and quantitative, to reach conclusions regarding the Bank's development effectiveness. OED commissioned several background papers, including focus group discussions with health system clients and providers in two locations: a high-density suburb of Harare, and a rural FHP1 district (Reed and Associates 1997). The study author and local consultants also conducted extensive interviews with nurses, doctors, and MOH officials at the district, provincial, and national levels (Ellis 1997; Bassett 1998). These sources provided insights into how client and providers perceived that Bank-supported investments and policy advice had affected the quality, accessibility, and efficiency of health services. A local health specialist provided a paper on the evolution of the Zimbabwe health system and health services since 1980 (Loewenson 1998).

1.8 To assess quantitatively the impact of the Family Health Projects on access to health services and health status, the study compared changes over time in project and non-project districts using health service data. Since only FHP1 was completed at the time of the study, the analyses sought to assess whether indicators had improved in FHP1 districts relative to other districts. Using the Ministry of Health's National Health Information System, consultants working in collaboration with the Department of Epidemiology compiled district-level time-series data from 1988 to 1996 for a number of key health service and outcome indicators. They then aggregated the districts in three groups: FHP1, FHP2, and non-FHP districts to assess whether the Family Health Project districts showed a relative improvement over time (Bassett 1998). A consultant working in conjunction with the Zimbabwe National Family Planning Council used data from the 1991 and 1996 Zimbabwe Situation Analysis of Family Planning Programs to compare changes over time in the quality and availability of family planning services in FHP and non-FHP districts, and to assess changes in the number of providers trained in family planning nationwide (Chibatomoto 1997; ZNFPC 1992 and 1997).

1. A local firm specializing in qualitative research conducted the focus groups, and participants were not told that the World Bank was sponsoring the discussions. In each location, separate focus groups were conducted for nurses and doctors, and clients were divided into four different groups, with separate groups for low and middle-income women and men.
1.9 These analyses provide insights into project impact, but must be treated with caution. Some project components, such as training and management training, were implemented nationwide, while others, such as infrastructure development, targeted project districts. Other factors, such as local disease patterns and cost-recovery policies, also influence utilization. In analyzing trends, the study has assessed what changes can be plausibly attributed to Bank-supported projects or policy dialogue, and which appear to be the result of other factors. Finally, the study also drew on a variety of secondary research conducted by government, the World Bank, academics, NGOs, and donors to supplement the research commissioned for the study (see References).

Structure

1.10 The paper is divided into seven chapters. Chapter 2 discusses the relevance of World Bank policy dialogue and project lending in the context of the Zimbabwe health sector during the 1980s and 1990s. Chapters 3 to 5 focus on the impact and influence of Bank policy dialogue on the Zimbabwe health sector, with separate discussions of health and structural adjustment, health financing policy advice, and the dialogue on health staffing. Chapter 6 discusses the effectiveness, efficiency, and impact of Bank project support, including the FHP1, FHP2, and STI projects. The final section draws lessons from Bank experience in Zimbabwe and suggests directions for the future.
2. The Relevance and Influence of Bank HNP Strategy

2.1 To what extent were World Bank policy advice and project lending relevant to Zimbabwe’s epidemiological profile, and did the Bank focus on key constraints facing the health system? This study begins by considering this question over two distinct periods in the evolution of the Zimbabwe health sector, roughly corresponding to the 1980s and 1990s. The discussion includes the evolution of government and Bank sector strategy, as well as the causal factors underlying trends in health sector performance and key health indicators. Two major themes emerge: first, the government’s integrated approach to maternal and child health (MCH), nutrition, and family planning contributed to rapid health improvements in the 1980s. Second, the Bank and government have had difficulty adapting their strategies and programs to the rapid sectoral changes of the 1990s.

Zimbabwe Health Sector

2.2 The Zimbabwe health system is diverse; health care is delivered by central government, municipalities, rural district councils, church mission facilities, private providers, and traditional healers. The government operates a four-tier health system. The first level consists of nearly 1,000 rural health centers, half of which are operated by Rural District Councils, with others run by the Ministry of Health (MOH), missions, municipalities, and industry. At the next level, 37 district hospitals and 80 mission hospitals provide curative care and basic surgery, and serve as referral centers for the clinics. The third level consists of seven provincial and five general hospitals that provide some specialist services, although in some provinces they are not much better equipped than the district hospitals. Finally, six central hospitals form the top of the referral system. In each district, a District Health Executive, headed by the District Medical Officer and a District Nursing Officer, is responsible for planning and delivery of both curative and preventive services. A Provincial Health Executive led by the Provincial Medical Director plans and supervises health services in each province. The Zimbabwe National Family Planning Council (ZNFPC), a parastatal under the MOH, operates a network of urban clinics, supervises more than 500 community-based distributors, undertakes educational campaigns, and trains nurses in family planning. Traditional healers are widely consulted, particularly in rural areas.

2.3 At independence, the government inherited an economy and health system characterized by gross racial inequalities and disparities between urban and rural areas. For the black population, the greatest burden of disease fell on infants, young children, and women in their child-bearing years, while whites mostly experienced problems associated with lifestyle and aging. Infant mortality among whites was only 14 per thousand births, but was nearly 90 per thousand for blacks, and was even higher in some rural districts (Hill and Marindo, 1997). The average cost of health care received by whites was 36 times that of rural blacks (MOH 1984). The health services in rural areas were provided either by rural mission hospitals or private clinics associated with mines or commercial agriculture; coverage was limited, and there were few outreach or preventive services.

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1. Many of the Provincial Medical Directors are highly experienced, but the District Medical Officers tend to be recent medical school graduates fulfilling requirements for government service.
Government HNP Strategy

2.4 The government strategy was to increase public health expenditures, shift spending toward rural areas, and focus on primary and preventive health, nutrition, and family planning services. The government strategy endorsed the integrated Primary Health Care (PHC) approach and emphasized improving the health of women and children, particularly in rural areas (MOH 1984). The government also planned to achieve universal access to primary education in rural areas. The strategy called for a two-stage approach to improving health and strengthening health services for the underserved majority. First, government rapidly expanded community-level interventions, including MCH services, health education, family planning, nutrition education, and food production, the Zimbabwe Expanded Program on Immunization (ZEPI), communicable disease control, water and sanitation, an essential drugs program, and basic preventive and curative care. Village health workers (VHWs) were the backbone of the PHC system. They were to be backed up by an expanded Rural Health Centers (RHC) network, putting everyone within 8 kilometers of a health center. In addition, community-based distributors (CBDs) of contraceptives were to provide increased access to family planning services in rural areas. The next stage was to provide support for clinic services and strengthen the referral system by establishing a hospital in every district and training providers in the PHC approach. Only half of the 57 districts in Zimbabwe had designated district hospitals, and many of these were small, poorly staffed and equipped, or damaged from the war (MOH 1984).

Health Financing and Expenditure Trends

2.5 Real government spending for health increased rapidly in the economic boom years following independence, then grew only 4 percent annually from 1982 to 1988, slightly ahead of the population growth rate (World Bank 1992). In 1990/91, health spending peaked at 6.8 percent of the national budget and 2.9 percent of GDP. On a per capita basis, real health spending reached Z$49 (about US$20) in 1991, among the highest in Africa (see Figure 2.1). Government revenues and economic growth did not keep up with the expanded government spending of the 1980s, and the government budget deficit averaged 10 percent of GDP annually. In 1991, government launched its economic structural adjustment program just before the worst drought of the century struck. The combination of drought and inadequate implementation of the adjustment program contributed to a 30 percent decline in per capita health spending from 1990/91 to 1992/93.
Figure 2.1: Trends in Government Health Expenditure

<table>
<thead>
<tr>
<th>Year</th>
<th>Health expend. per cap.</th>
<th>Health as % expenditure</th>
</tr>
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<tbody>
<tr>
<td>1990</td>
<td>$50</td>
<td>8.0%</td>
</tr>
<tr>
<td>1991</td>
<td>$48</td>
<td>7.0%</td>
</tr>
<tr>
<td>1992</td>
<td>$45</td>
<td>6.0%</td>
</tr>
<tr>
<td>1993</td>
<td>$42</td>
<td>5.0%</td>
</tr>
<tr>
<td>1994</td>
<td>$40</td>
<td>4.0%</td>
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<tr>
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<td>$38</td>
<td>3.0%</td>
</tr>
<tr>
<td>1996</td>
<td>$36</td>
<td>2.0%</td>
</tr>
<tr>
<td>1997</td>
<td>$34</td>
<td>1.0%</td>
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Note: The figure uses actual expenditure data from MOF. Source: GOZ, Ministry of Finance, 1997.

Real per capita health spending recovered somewhat subsequently, and health expenditure as a percentage of total government spending reached an all-time high of nearly 8 percent in 1996/97. The budget remains under pressure, however, from growing interest payments on government debt (see Chapter 3).

2.6 The composition of health spending in Zimbabwe is diverse, although central government continues to dominate. Estimates of total private spending for health range from 20 to 30 percent. The vast majority of these funds are spent by the urban affluent population, mostly through private insurance (KPMG 1996).

World Bank HNP Strategy

2.7 Health officials and planners in the new government—many of whom had recently returned from exile—were exceptionally able and committed, and the government developed its initial health strategy independently of the Bank. The Bank and government shared, however, the international consensus regarding the PHC approach developed at the Alma Ata conference in 1978. The Bank therefore focused on supporting government priorities, while attempting to influence some aspects of policy through sector work and project lending. The Bank’s initial sector study in 1983—Zimbabwe: Population, Health and Nutrition Sector Review—influenced government nutrition policy, highlighted the importance of integrating family planning with health services, and raised awareness within the MOH regarding health financing concerns. Since other donors were providing grant support for expansion of basic health services, FHP1 supported the “second stage” of the government’s strategy—strengthening infrastructure and district-level service provision, particularly for family planning and MCH. The goals of the project both were relevant to the disease burden of the mid-1980s (MCH and family planning) and addressed important priorities for the health system (see Chapter 6).

2.8 Bank advice contributed to the development of the government's nutrition strategy. At independence, Zimbabwe had a small but active nutrition community encompassing MOH staff, NGOs, and academics, and the new government made improved nutritional status in rural communities a priority. The initial community nutrition programs were innovative, but were not

2. The figure uses actual expenditure estimates from the Ministry of Finance for both health and total spending. Actual expenditures have in some years differed substantially from budgeted allocations. The recent increases in health spending as a percentage of total expenditure is a result of increased allocations to health, overspending of the health budget, and real declines in the total budget.

3. The 1978 Alma Ata conference, sponsored by the World Health Organization, was a major international meeting involving donors and health officials from many developing countries that is commonly credited with establishing a consensus on the importance of primary health care.
well integrated with other health services. The Bank's initial sector work was useful in synthesizing the various nutrition activities and research already underway, and emphasizing the importance of integrating nutrition interventions with health and family planning. Nutrition interventions subsequently became a critical entry point for community health education and mobilization, thereby boosting the credibility of related PHC programs. Although the nutrition unit remained within the MOH, by the early 1990s it had successfully catalyzed the development of an intersectoral nutrition strategy. Most of the direct funding for nutrition and nutritional training came from the Swedish government (SIDA). The Bank's main contribution has been as advice and credibility rather than money. The Bank's endorsement of nutrition as a high-return investment increased the credibility of the nutrition unit within the MOH and with the Ministry of Finance (MOF), and facilitated the development of the intersectoral strategy. Bank staff emphasize, however, that the Bank has learned as much from Zimbabwe regarding nutrition as Zimbabwe learned from the Bank.

2.9 The 1983 PHN sector study and Family Health Projects contributed to the integration of family planning into health services. Zimbabwe already had a long tradition of family planning at independence, but it was associated with the racist policies of the colonial regime. In a remarkable turnaround, political leaders became convinced by the early 1980s that increased family planning was essential if Zimbabwe was to improve the health and well-being of the population. With U.S. Agency for International Development (USAID) support, the government established the Zimbabwe National Family Planning Council (ZNFPC) as a parastatal under the MOH. Government and USAID reasoned that an autonomous organization could make more rapid progress in promoting family planning, but the Bank argued that integration of family planning into health services was necessary to maximize coverage. This advice was incorporated into the design of FHP1, and contributed to increased contraceptive prevalence (Chapter 6).

Health Trends in the 1980s

2.10 In the decade following independence, Zimbabwe achieved impressive gains in basic health indicators, nutrition, and contraceptive prevalence. Infant mortality declined from about 90 per thousand in 1980 to 53 per thousand in 1988, while child mortality fell to roughly 80 per thousand. Child immunization increased from 25 to 80 percent, much of which came in the few years after independence, with a corresponding drop in immunizable diseases. The prevalence of chronic child malnutrition declined from 22 to 12 percent, despite recurrent droughts. The use of modern contraceptives increased from 14 to 36 percent in 1988, the highest level in sub-Saharan Africa. Life expectancy increased from 56 to 64 years (CSO 1988). During this time, the government built and staffed more than 500 rural health clinics, providing nearly 80 percent of the rural population with access to health services, and deployed more than 4,000 village health workers in rural communities. Most of these changes predate Bank project investments.

2.11 The rapid health improvements of the 1980s are in large part attributable to improved nutrition, reduced fertility, and primary health care interventions. Although household economic status is the primary determinant of health, these health improvements were achieved without a

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4. The Bank had strong partners in these efforts. The government's nutrition team has been both technically skilled and politically savvy. The intersectoral strategy required strong political skills of the nutrition unit, because they had little formal leverage and relied primarily on persuasion. The Bank's 1992 Zimbabwe Nutrition Review was written primarily by the Zimbabwean director of the nutrition unit as part of FHP2 project preparation, and subsequently published by the Bank (Tagwireyi and Greiner 1994).
significant increase in household incomes (Sanders and Davies 1988). The percentage of girls attending primary school also increased dramatically in the 1980s. Statistical analysis of household survey data has consistently shown that the mother’s educational level is the strongest determinant of child survival, nutritional status, and contraception use, but it takes several years for increased primary school attendance to translate into improved child health (Guilkey 1997). The Zimbabwe experience therefore demonstrates that an effective government health system can help poor households improve their health and increase the use of modern family planning methods (Hill and Marindo 1997; Jhamba 1997; Thomas and Maluccio 1996, Hill).

2.12 Government PHC and family planning investments promoted equity and benefited the poor. Various econometric analyses have shown that government health and family planning investments had a significant impact on child health and nutrition, and fertility, with the strongest impact on women with low income and less education (Thomas and Maluccio 1996). Figure 2.2 shows that in the 1980s, child mortality among women with no education declined twice as rapidly as those whose mothers had primary or secondary education.

Figure 2.2: Child Mortality by Education of Mother

2.13 This also suggests that PHC interventions and community outreach were effective in reaching poor and less educated households (Hill and Marindo 1997). The rapid improvements in MCH indicators were concurrent with the expansion of PHC interventions but predate the Bank-supported construction and upgrading of district health facilities (see Chapter 6).

2.14 In the late 1980s, the sector began to change. First, by the early 1990s, the adult HIV prevalence rate had already reached 10 percent in Zimbabwe, but political leaders resisted acknowledging the extent of the AIDS epidemic. Second, Government began preparations with the World Bank and IMF for the structural adjustment program that was launched in 1991. Government and the Bank initially thought that the adjustment program would bring increased growth and that the social sectors and the poor would be protected. As Chapter 3 shows, these proved false hopes. Third, private provision of health services increased steadily through the 1980s, then expanded rapidly in the 1990s, contributing to staff shortages in the government health sector.

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5. Agricultural production in communal areas improved from 1980 to 1986, which probably contributed to improved nutrition and health. Communal agricultural production stagnated thereafter and household incomes on average did not increase significantly during the 1980s (World Bank 1995).

6. Since the Demographic and Health Surveys do not collect data on household income, education may also serve to some degree as a proxy for family income.
Weakening Strategic Focus

2.15 The MOH’s own strategic focus began to weaken because of staff turnover and competing political pressures on the ministry, even as the challenges facing the sector became more complex. The ministry updated its sector strategy in the late 1980s and early 1990s, and reaffirmed its commitment to primary health care and prevention. From the late 1980s, however, a series of political decisions weakened the preventive and primary health care focus of the government health system. In 1988, over strong MOH objections, government transferred the village health workers out of the ministry and converted them into all-purpose community development workers (see Box 2.2). In the early 1990s, the government yielded to nurse demands and abolished training for the state certified nurses, who were trained for rural service and still staff most rural hospitals and health centers. The idealism of the early 1980s gave way to increased assertion of professional interests by various health cadres in the 1990s, which center primarily on preferences for urban service and increased opportunities for private practice.

2.16 The Bank had only partial success in adapting its strategy to this new context. In the late 1980s, halfway through FHP1, the Bank and government began preparing a follow-on project. Although the design of FHP2 incorporated implementation lessons from FHP1, neither the Bank nor government undertook a strategic evaluation to determine whether the design was the most effective means to address the disease burden and sector constraints. The Bank considered integrating AIDS prevention into FHP2, but at MOH request, they instead developed a separate project for Sexually Transmitted Infections (STIs). The STI Project responded to the AIDS epidemic and to a critical shortage of government funds for drug procurement, which was due in part to rising drug prices during the adjustment period. Bank staff worked with government to prepare the project quickly, and deliberately chose to restrict funding to commodity provision. Keeping the project simple was an appropriate strategic decision on the part of Bank staff, but as the discussion in Chapter 6 illustrates, sustaining drug availability was not simple.

2.17 Private health care and insurance expanded rapidly in the 1990s, but cover mostly urban and affluent populations. Although the government initially saw private medicine as a threat to the public health system, insurance schemes proved popular with government officials and the middle class. Total health insurance enrollment grew to 5 percent of the population in the late 1980s and currently stands at about 7 percent. Health insurance beneficiaries are mostly urban and middle class, or employed in the formal sector (KPMG 1996). In the early 1990s, the government further eased restrictions on private practice. Most doctors in district hospitals now operate private practices, as do nearly all government doctors in urban areas. Reports of doctors absent during government working hours, or persuading public patients to see them in private, are increasingly common (see Box 2.1). The government has proposed legislation to regulate the private sector, but it is still grappling with how to respond. Except for a brief discussion in the 1990 health financing sector work, the Bank has not reviewed private sector regulation or insurance issues. The Bank is developing considerable experience with these issues in other countries, however, which could usefully be shared with Zimbabwe.
Box 2.1: Client and Provider Attitudes Toward Private Versus Public Health Care

Most clients express preference for private care, but low-income clients say it is rarely affordable; they therefore rely on government facilities or traditional healers. Clients prefer private care because of the increased likelihood of seeing a doctor, greater privacy, shorter waiting times, more considerate and responsive treatment, and greater availability of drugs. Government facilities—particularly in urban areas—were perceived as crowded, not private, and requiring long waits. Some government nurses are rude and drugs often out of stock. Women agreed, however, that government clinics still provide high-quality antenatal care and well-baby services. Some low-income urban men reported visiting private doctors occasionally, but both urban and rural low-income women relied primarily on the government system. Many rural low-income clients expressed preference for mission hospitals over government hospitals because of the greater concern and religious orientation of the providers. Rural low-income clients reported little access to private modern care, but commonly consulted traditional providers, depending on the nature and perceived cause of the illness (Reed and Associates 1997). Bank support for government provision of basic curative and preventive services is therefore justifiable on equity grounds, and the Bank's efforts to include mission hospitals in FHP2 upgrading were also appropriate.

Health providers generally express strong preferences to work in the private sector, compared to government or mission hospitals. In focus group discussions, both nurses and doctors said that pay, conditions of service, and workloads are better in the private sector. Nurses said that mission hospitals tended to have the least resources, although some appreciated the continued strong commitment of workers in the missions. Government service was seen as least desirable, although it sometimes provided opportunities for free training. Doctors were particularly concerned about low pay, inadequate travel allowances, and limited opportunities for private practice in rural areas. Nurses also complained of low pay, but were equally concerned about conditions of service and the declining respect accorded their profession (Reed and Associates 1997).

Health Trends in the 1990s

2.18 Fertility and chronic malnutrition continued to decline in the 1990s, but child and adult mortality increased and MCH indicators stagnated. According to the Demographic Health Survey (DHS), from 1988 to 1994, infant mortality stagnated at 53 per thousand births, while child mortality increased from 75 to 77 per thousand. Since 1988, the percentage of women giving birth in a medical facility and percentage of children fully immunized remained unchanged at 75 percent and 80 percent, respectively. Fertility continued to decline, however, along with increased use of modern contraceptives (from 36 percent in 1988 to 42 percent in 1994). Chronic malnutrition (stunting) fell from 30 percent in 1988 to 21 percent, despite a severe drought in 1991, but acute malnutrition (wasting) increased fourfold to 5.5 percent. Antenatal care coverage remained constant at slightly above 90 percent (CSO 1995).

2.19 AIDS already is having a devastating impact on Zimbabweans and on the Zimbabwe health system, and the situation will get worse over the next decade. Zimbabwe is experiencing one of the worst AIDS epidemics in the world. The Zimbabwe National AIDS Control Program (NACP) estimates that 20 percent of the adult population—and a total of 1.4 million people—is infected with HIV, and a total of 1.8 million are likely to be infected by 2005. Almost all of those infected will develop AIDS and die on average within 10 years. Already by 1994, men's death rates in Zimbabwe were about three and a half times higher than they were in the late 1980s, and women's death rates were about two and one half times higher (Timaeus 1998). In sentinel surveys, approximately 20-40 percent of urban women attending antenatal care

7. Several factors appear to contribute to the rapid spread of HIV in Zimbabwe: high prevalence of other sexually transmitted diseases; multiple sexual relationships occurring concurrently for a significant percentage of the population; high mobility of the population, facilitated by a good transportation network; and cultural factors (including high alcohol consumption among men, and a reluctance to discuss sexuality openly).
tested HIV positive, and the prevalence appears to be rising. Although highest in urban areas, adult prevalence is 10 to 20 percent in rural areas. The number of tuberculosis cases has risen five times since 1995, of which two-thirds are currently HIV positive (NACP 1997). AIDS increases demand for health care and may reduce resources available for those without AIDS. Hospitals are increasingly discharging AIDS patients for “home-based care,” but few facilities or communities have the resources to support home care. Economically, AIDS is likely to affect growth through the loss of young adults in their most productive years and through reduced public and private savings (Loewenson and Kerkhoven 1996). AIDS is expected to result in more than 1 million orphans by 2005, which will create strains on extended families and contribute to poverty (NACP 1997).

2.20 **AIDS is the primary cause of mortality increases, but the health system also is under growing stress.** The NACP estimates that AIDS accounts for all the observed increases in infant and child mortality and that survival rates for children without AIDS may have improved (Figure 2.3). As shown in figure 2.3, mortality of children of educated mothers (who are more concentrated in urban areas where HIV prevalence was initially higher) increased in the 1990s, while that of children of uneducated women (mostly rural) continued to decline. Yet AIDS does not explain the stagnation in MCH service coverage indicators, including vaccination coverage and facility deliveries. Declines in the health budget led to reductions in real recurrent spending and real wages for public sector workers in the 1990s. Many skilled providers and managers are moving to the private sector or leaving the country. A bitter two-month strike by urban nurses and junior doctors in late 1996 further contributed to attrition and declining morale.

**Figure 2.3: Deaths to Children Under 5**

Although prevention and education are the most cost-effective means to fight AIDS, the government has failed to spearhead a behavior change movement, and has devoted limited resources to fighting AIDS. In Zimbabwe, knowledge of AIDS among adults is now nearly universal, but the accuracy of knowledge is often poor (CSO 1995). Researchers in Zimbabwe and elsewhere in Africa have concluded that interventions that change behavior are the most effective and efficient means of reducing HIV infection (World Bank 1997; Loewenson and Kerkhoven 1996). The effectiveness of clinical interventions, such as STI treatment, is substantially increased when they are combined with peer counseling. Although the NACP, donors, and local and international NGOs are sponsoring a variety of initiatives to change behavior, the various programs are under-financed and lack leadership and focus. NACP has not assigned leadership positions to behavior-change specialists. Furthermore, although the NACP is supposed to be responsible for mobilizing a broad-based intersectoral response to the AIDS epidemic, it is located within the MOH, and recommendations to create a higher level multisectoral organization have not been acted upon. Although government has increased its allocation to HIV/AIDS prevention in recent years, 90 percent of the NACP’s budget still is donor funded. The government’s 1997 NACP
The contribution of Z$39 million amounts to less than three Zimbabwe dollars per HIV-infected person.

**Box 2.2: Village Health Workers and Community-based Distributors**

Chapter 2 argues that effective community prevention and outreach programs were an important factor behind the rapid improvements in health, nutrition, and contraceptive prevalence during the 1980s. The government initially deployed two different cadre of community workers in the early 1980s: village health workers (VHWs) who served under the Ministry of Health, and community-based distributors (CBDs) of contraceptives, who worked for the Zimbabwe National Family Planning Council (ZNFPCC). The World Bank supported the establishment and training of various community health worker programs globally in the 1980s, but has become more skeptical regarding their effectiveness in the 1990s. The evolution and effectiveness of the VHW and CBD programs illustrate the potential and pitfalls of community workers.

The village health workers had roots in the independence struggle, where mobilization of support from rural communities included efforts on health education. Following independence, many of the former independence fighters were transformed into VHWs, carrying the spirit of the independence struggle into mobilizing communities for improved health. The MOH considered VHWs the first line of the health system, and were linked to the health system through regular supervisory visits from clinic staff. The rapid improvements in vaccination coverage, treatment of diarrhea, and child feeding practices are substantially attributable to VHW effectiveness. Although initially selected by communities, in the early 1980s the VHWs became paid employees of the MOH, which according to some observers, contributed to a decline in community responsiveness, and local political leaders often influenced CHW selection. But by most accounts, VHWs continued to fulfill their health education and outreach functions effectively. In the late 1980s, following a political struggle, the VHWs were transferred out of the Ministry of Health and converted to all-purpose community development workers (CDWs). The Bank planned to include VHWs in FHP1 training, and objected to the transfer, but without effect. The CDWs still carry out some ad hoc health activities, but spend much of their time on small-scale income generating projects.

The community-based distributors were established in the early 1980s as the outreach arm of the ZNFPCC in rural areas (ZNFPCC clinics are all urban-based). The ZNFPCC carefully selected CBDs from rural communities, provided them with training, regular contraceptive supplies, bicycles, and created a supervisory structure in each district. Their job description remains focused on advocating and supplying contraception, which has contributed to their effectiveness. A striking contrast between the CBDs and the current CDWs is pay: remuneration for CBDs starts at Z$1,600 per month (US$100), while the CDWs are paid only Z$75 (US$5). Most CBDs have been in post 10 years or more as a result. An econometric study using household and community data from the Demographic Health Survey found that the impact of a CBD on the contraceptive prevalence in a rural community is equal to the impact of a district hospital. In contrast, VHWs did not have a significant impact on use of contraception (Thomas and Malluccio 1996). The CBDs are therefore expensive, but effective. ZNFPCC acknowledges, however, that it needs to streamline the CBD program, particularly since some CBDs are located in communities where clinics have been recently constructed.

Neither the CBDs and CDWs are currently involved in AIDS and STI prevention. With HIV prevalence 10 to 20 percent in rural communities, these cadre should be mobilized in the new fight to change sexual behavior and prevent AIDS. Training will be required to help them overcome reluctant to discuss sexual issues. Government also could consider returning CDWs to the Ministry of Health.

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The Bank has supported AIDS research and peer education through regional grant programs, which has increased knowledge and awareness regarding AIDS. In the mid-1990s, the Bank used research funds from the STI project to sponsor a major study on urban STI and HIV prevalence and transmission (Latif 1995). The study was carried out by local researchers and was the first to confirm the alarming high (30 percent) HIV prevalence rate among pregnant women in Harare, which helped raise awareness among government officials and the public of the epidemic's suicides. Bank staff also used the Bank's Special Grants Fund to support the Network for Improved Adolescent Sexual Health Initiative, which sponsors research and internships at the University of Zimbabwe, as well as the University of Nairobi and a South African nongovernmental organization (NGO). Among other programs, the University of...
Zimbabwe sponsors research and workshops on sexual behavior change and provides technical advice to partners throughout the region. Total Bank contributions to this initiative will be about $1.3 million over three years (about 13 percent of the initiative's budget). This has helped leverage an additional $1 million in support from the Swedish government (SIDA). The University of Zimbabwe has been an effective partner, so a relatively small investment by the Bank has produced a substantial payoff.

2.23 While the Bank was instrumental in integrating family planning and health programs in the 1980s, family planning and STI programs remain poorly integrated. The Bank’s 1989 population sector work provided a comprehensive overview and recommendations for improved family planning—both service provision and enhancing demand—but did not sufficiently highlight AIDS or STIs. The Bank did not include any STI or AIDS prevention activities in FHP2, instead preparing a separate project explicitly to address STIs. MOH officials advised that pushing too hard on HIV/AIDS might provoke a political backlash, and family planning officials were concerned that their programs could suffer if associated with STIs. It is difficult to judge, in retrospect, whether the Bank might have been more assertive. A consequence, however, is that STI and AIDS programs are not well integrated into the health system and are only marginally integrated with family planning. This has two negative repercussions. First, family planning programs continue to advocate non-barrier family planning interventions, without sufficient regard for STI prevention. Second, the extensive network of family planning clinics, providers, trainers, and community-based distributors have not been effectively mobilized to combat the AIDS epidemic (ZNFPC 1998). One the other hand, Bank staff used the STI project as an opportunity to engage MOH and ZNFPC officials in discussions about the reproductive health approach. Government has expressed interest in moving toward an integrated reproductive health approach in future programming.

2.24 The Bank’s most recent Country Assistance Strategy (CAS) calls for the integration of AIDS into Bank activities in every sector—but it does not elaborate. Senior Bank management appear to have been reluctant in the early 1990s to give AIDS prominence in country dialogue. The 1997 CAS for Zimbabwe is the first to highlight AIDS. This is a welcome step. Translating its goal of a coordinated Bank approach to AIDS into concrete objectives and programs in each sector will require additional investments of staff time, however, and continued oversight from the country director.

2.25 Increased political commitment is essential. Political opposition has given way to acknowledgment of the AIDS problem, but strong support from the highest political levels will be necessary to confront the epidemic effectively. With such commitment, the government and its partners could have a significant impact on the epidemic, saving hundreds of thousands of lives. Without it, efforts of the Bank, other donors, and civil society will remain constrained, and thousands of lives will be needlessly lost.

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8. Although discussing human sexuality is often sensitive in a traditional society, the political challenge is no less than the government successfully confronted when mobilizing national support for family planning in the 1980s, which had previously been associated with colonial racism.
3. Structural Adjustment and the Zimbabwe Health Sector

3.1 This chapter begins with a discussion of the impact of economic policies and structural adjustment on the health sector. As pointed out in Chapter 1, the Bank’s indirect influence on the health sector through macroeconomic dialogue can equal or exceed the impact of direct health sector support. In fact, subsequent sections conclude that shortcomings in the implementation of economic reforms threaten the sustainability and impact of Bank health sector projects.

3.2 Among the Zimbabwe public, the World Bank is most widely known and associated in the public mind with the Economic Structural Adjustment Program, commonly known as ESAP. This association is perceived almost universally in a negative way. The Zimbabwe public blames ESAP for deterioration in the health system, as well as high unemployment, rising prices, and increasing poverty. Assessing the role of adjustment in health and socio-economic trends since ESAP began in 1991 is complicated by several factors. First, Zimbabwe was struck by the worst drought of the century just as the program was launched. Second, AIDS is placing a growing toll on health and the health care system. Third, the most critical element of ESAP—reducing the budget deficit—was not achieved. Assessing the effects of the program as implemented therefore is different than evaluating what might have occurred either if government had done nothing or if the budget deficit had been reduced. Sorting out the effects of the reform program from drought and AIDS is extremely difficult, and made more so by data limitations (Marquette 1997).

(Although increased cost recovery in the social sectors was one of the goals of ESAP, the Bank’s dialogue on health financing and cost recovery will be discussed in Chapter 4.)

Program Design and Implementation

3.3 The 1991 Zimbabwe Economic Structural Adjustment Program encompassed a package of reforms intended to dismantle the system of economic controls that were established by the white minority regime in the pre-independence period and maintained after independence. Unlike some African countries, Zimbabwe was not forced to adopt an adjustment program by an economic crisis. Rather, by the late 1980s government officials became concerned that the economy was over-regulated and not generating sufficient growth or jobs for the growing population. The reforms were thus relevant and necessary. ESAP sought to shift the economy toward greater reliance on market forces and indirect instruments of economic management to promote higher growth, increased employment, and poverty reduction. The IBRD and IMF provided extensive technical advice during program design and supported implementation through adjustment loans. The central components of the program included:

- reducing the fiscal deficit from over 10 percent of GDP to 5 percent by 1994/95;
- trade and exchange rate liberalization;

9. Although critics commonly assert that the IBRD and IMF forced ESAP on Zimbabwe, other domestic constituencies, most notably the industrial association and commercial farmers, also began to lobby government in the late 1980s to reduce economic controls. Once political leaders endorsed the program, the Ministry of Finance pushed strongly ahead to implement many of the measures (Skalnes 1995).

10. Most critics of adjustment in Zimbabwe also acknowledge that reforms were needed (Chivzo 1993).

11. The Bank provided a US$175 million Structural Adjustment Loan (SAL), which was complemented by other donor financing.
• domestic deregulation, including elimination of price controls; and
• social safety nets.

Reducing the budget deficit—which averaged 10 percent of GDP during the 1980s—was a critical component of the program. ESAP planned to reduce the budget deficit by cutting subsidies to parastatals; reducing the civil service wage bill;\(^1\) and increasing cost recovery for government services, including health and education. Government and the Bank agreed that budgets for health and education should be protected to the extent possible; health professionals and teachers were exempt from the civil service reduction target.

3.4 To protect the poor and those negatively affected by adjustment, government established the Social Dimensions of Adjustment (SDA) program. The SDA was responsible for administering a Social Development Fund (SDF), which was funded by both government and donors. The SDF supported a food subsidy for low-income urban consumers; compensation or exemptions for poor households from health and education fees; and training for those retrenched from government or parastatals.

3.5 The severe drought of 1991/92 devastated crops and livestock and contributed to a 6 percent decline in GDP, just as ESAP was being implemented. Falling revenues and increased government spending on food relief added to the fiscal deficit.

3.6 **ESAP successfully liberalized the economy but failed to control the budget deficit.** Despite the drought, government maintained its commitment to the reform program, implementing some reforms ahead of schedule. The foreign exchange control system was largely dismantled. Foreign investment regulations were liberalized, price controls on a variety of commodities (including food) were eliminated, and the public monopoly on agricultural marketing was removed. The other two major goals—reducing the fiscal deficit and protecting the poor through social safety nets—were not achieved. Despite budget cuts, the fiscal deficit grew because of drought, and declines in tax revenues.\(^1\) As a result, interest rates and inflation remained high, crowding out private investment and undermining economic growth and job creation (Addison 1996a; Morandé 1994). Continued high deficits and increased interest on domestic debt resulted in rapidly increasing interest payments, which further constrained the budget. Government also made little progress in reforming the parastatal sector. Losses from these publicly owned enterprises amounted to 3.5 percent of GDP in FY93/94, more than total expenditures on health.\(^1\)

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12. Government committed to reducing the civil service wage bill from 17 percent of GDP in FY90/91 to 13 percent by FY94/95, primarily by reducing the number of civil servants by 25 percent (22,000 staff).

13. Government reduced spending significantly, from 46 to 39 percent of GDP, between FY89/90 and FY93/94. Budget cuts were matched by declining revenue, however, so the deficit remained between 8 and 11 percent of GDP from 1991 to 1994. Consistent with Bank and IMF recommendations, government lowered personal and corporate income tax rates and reduced tariffs on imports in the first years of the program, reducing revenues by almost 6 percent of GDP. Reduced tax enforcement also contributed to revenue declines. Budget cutting focused excessively on meeting targets, not maximizing savings and efficiency. Although government eliminated 18,000 civil service posts (against a target of 22,000), all but 7,000 were vacant, and most of these at low levels, so the savings were minimal.

14 Data unless otherwise cited are drawn from internal World Bank documents, including a 1995 audit of the adjustment program by the World Bank’s Operations Evaluations Division.
3.7 The SDA program was over-stretched, under funded, and reached only a small percentage of the poor. The government, World Bank, and NGOs now widely agree that the Social Dimensions of Adjustment program failed to protect the poor (World Bank 1996a; MPSLSW 1996). The program suffered from multiple problems, including delays in getting started, inadequate funding, and reliance on an over-stretched Department of Social Welfare for implementation. Project design did not adequately assess the cost and feasibility of an income-based exemption system in a country with weak administrative capacity and only 20 percent of the population in formal employment. The program was poorly advertised; in the early 1990s a majority of the eligible poor were not aware that they were entitled to free services. Despite some subsequent improvements, only 20 percent of the urban poor and 10 percent of the rural poor received assistance with health fees (UNICEF 1994; MPSLSW 1996). (Cost recovery and the fee exemption system are discussed further in Chapter 4)

3.8 Liberalization of maize markets was successful. Government removed subsidies for processed maize meal but opened the market for small processors. Prices for processed meal increased by about 50 percent initially, but soon a large number of hammer mill operators entered the market. This drove down the price of the more nutritious hammer meal. Household surveys found that the poor switched to hammer meal, without increasing costs or decreasing consumption, and government saved substantially on subsidies (Addison 1997; UNICEF 1994).

3.9 Zimbabwe’s poor are mostly worse off than before adjustment began. Several factors have conspired against both the rural and urban poor, some related to the design and implementation of ESAP, others not. First, inflation has hit the poor particularly hard, because food inflation has outpaced overall price inflation.15 Second, slow employment growth together with inflation and retrenchments in both the public and private sector resulted in increased unemployment and declining formal sector income. Although affecting urban areas most directly, rural incomes were also affected because of decreased remittances (Addison 1997). Third, the highly unequal distribution of land and assets—although not caused by adjustment—has meant that the poor have been less able to take advantage of the benefits of economic liberalization (World Bank 1996a). Other factors were not directly related to adjustment. The 1991/92 drought devastated rural livestock and depleted household assets, from which many poor households still have not recovered. Also, AIDS is increasingly contributing to household poverty (Loewenson and Kerkhoven 1996). As a result of these and other factors, the percentage of households living in poverty has probably increased over the adjustment period, and the poor are on average worse off than in 1990 (World Bank 1996a; Addison 1997).16 Increased cost recovery was therefore implemented at a time of declining real household incomes, which further contributed to financial barriers to health care for the poor.

15. By one estimate, from 1990 to 1995 prices for low-income families increased by 433 percent, while the consumer price index rose 335 percent (Addison 1997). The majority of the poor are rural and live on marginally productive lands; they therefore are dependent on remittances from formal wage earners and are net food purchasers. While the poor benefited from increased availability of hammer meal, the elimination of food price subsidies, together with drought and continued problems in the marketing system, contributed to food inflation. Overall, high inflation is primarily the result of the failure to reduce government deficit spending (see above).

16. Preliminary data from the 1995/96 Income, Consumption and Expenditure Survey indicate that poverty has increased since 1991 (CSO 1998). The impact of adjustment and other factors on poverty is complex, however; for more thorough discussion, see Addison (1997) and World Bank (1996a).
Impact on the Health Sector

3.10 Government and the World Bank planned to protect the social sectors during adjustment, but the combination of high government budget deficits, growing debt service, and the implementation of economic liberalization placed significant strain on the health sector. Some of these problems—including stagnant growth and reduced discretionary government spending due to high deficits—would very likely have occurred in the absence of reforms. The discussion below describes some of the consequences of ESAP as it was implemented, without trying to determine what would have happened without the program, or with more effective implementation.

3.11 Real per capita spending on health declined in the 1990s, but the percentage of the discretionary budget devoted to health increased. Growing interest payments, combined with an overall reduction in total government spending, explains an apparent paradox. Although per capita government spending declined in the early 1990s, spending as a percentage of the discretionary government budget reached its highest levels ever in 1996 (World Bank 1996b). Relative to other programs, government protected social sector spending, but interest payments came to dominate the government budget (Figure 3.1). The growing interest payments are primarily the result of the government financing the deficit through local borrowing at high interest rates. In 1996/97, over three-quarters of interest payments were for domestic debt.

Figure 3.1: Government Expenditure Allocations, 1989/90 and 1996/97

<table>
<thead>
<tr>
<th>Expenditure 1989/90: Z$6,446 m</th>
<th>Expenditure 1996/97: Z$6,247 m (1990 Z$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health 7%</td>
<td>Health 8%</td>
</tr>
<tr>
<td>Education 16%</td>
<td>Education 19%</td>
</tr>
<tr>
<td>Interest on Debt 15%</td>
<td>Interest on Debt 25%</td>
</tr>
<tr>
<td>Other 49%</td>
<td>Other 40%</td>
</tr>
<tr>
<td>Defense 13%</td>
<td>Defense 8%</td>
</tr>
</tbody>
</table>


3.12 The real declines in health spending were about equally shared between real reductions in the wage bill and non-wage recurrent spending. Real wages for health workers declined by nearly 30 percent from 1991 to 1995, although they recovered much of that loss following substantial wage increases in 1997. The effects of real declines in recurrent spending were felt throughout the system, but preventive and outreach programs appear to have been among the hardest hit. Some of the measures introduced to maintain budget targets also reduced the efficiency of expenditures. 17

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17. In the mid-1990s, the MOF established a month-to-month stop-payment system to control overspending in sector ministries. The program effectively reduced spending, but at the expense of imposing extreme rigidity on budgets. Some drug and equipment suppliers stopped shipments to the MOH because of unpaid bills.
3.13 Health and education professionals were protected from civil service reductions, but clerical and maintenance posts were cut. To achieve the targeted 25 percent reduction in civil service posts, the Public Service Commission focused on reducing posts at the lowest tier of the civil service. An estimated 25 percent of administrative and maintenance posts within the MOH were either eliminated or frozen in the early to mid-1990s (EU 1998). This had two major consequences. First, health professionals, particularly nurses, were left with an increased burden for administration and maintenance, contributing to low morale. Maintenance and sanitation in some facilities also worsened. Second, the loss of key administrative staff undermined efforts to improve hospital billing, and administrative and budgeting systems. Most of the pressure to reach numerical and budgetary targets for civil service reduction has come from the IMF, while the Bank has placed relatively greater emphasis on improving civil service performance in its dialogue. Civil service reduction targets remain a key component of economic reform agreements between government and the IMF and World Bank, however, suggesting that the quality and efficiency criteria are still not adequately reflected in macroeconomic dialogue.

3.14 Declining wages and growing demand for health workers and administrators in the private sector led to increased attrition of senior civil servants and health workers. The liberalization of currency and import controls under adjustment facilitated expansion of private health facilities. Among health workers, public-private wage differentials are highest among doctors, but the growing number of private hospitals and nursing homes has increased demand for nurses as well. Real wage declines for senior civil servants coincided with growing demand for skilled administrators in the private sector. Increased difficulties in attracting and retaining experienced administrators, particularly those with budgeting, planning, and financial skills, has emerged as an obstacle to improving the efficiency and effectiveness of government.

3.15 Exchange rate liberalization increased the cost of imported drugs and equipment, which contributed to shortfalls in government drug budgets. The government's allocation for the General Medical Stores revolving drug fund remained nearly constant in nominal terms in the early 1990s, while exchange rate liberalization and inflation contributed to sharp increases in drug prices (Penrose and others 1997). The resulting shortfall between the government drug budgets and growing drug needs contributed to stock outs. The STI project helped bridge this gap (see Chapter 6).

3.16 Focus group discussions with consumers and providers reveal a broad consensus that the quality of government health services declined significantly in the 1990s. The most commonly cited reasons were declining morale, staff shortages, and shortages of essential drugs. Consumers in the catchment area of an FHP1 hospital acknowledged their appreciation of new infrastructure, but emphasized that these other factors overwhelmed the impact of the new investments (Reed and Associates 1997). Although the causes of low morale and drug shortages are not purely economic, the problems with ESAP design and implementation contribute to them.

3.17 Political leaders have demonstrated little commitment to deficit reduction. The future of the Zimbabwe economy and social sector spending depend on significant reductions in budget deficits and reducing the burden of domestic interest payments. Although the Ministry of Finance has demonstrated commitment to fiscal control, political leaders appear to consider 10 percent budget deficits acceptable. The 1997 announcement of huge payments to war veterans threatens to inflate the deficit further without significant cuts in other programs or increasing
already-high taxes. If the deficit is not reduced, interest payments will continue to grow, leading to further declines in social sector spending and eventual economic crisis.\(^{18}\)

**Lessons**

3.18 Several findings emerge from Zimbabwe's adjustment experience. First, although reforms were needed, shortcomings in the design and implementation meant that the program did not meet its ultimate goals—growth and poverty alleviation. Second, both government and the World Bank intended to protect the social sectors and the poor, but the measures put in place were insufficient. Third, although the design document for FHP2 suggested that it might help alleviate the social costs of adjustment, as long-term investment projects, the Family Health Projects were affected by adjustment but without significantly reducing its social costs. Fourth, social spending will come under growing pressure unless the budget deficit is reduced and the national debt restructured.

3.19 How does the Zimbabwe experience with social sector spending compare with that of other adjusting countries? An assessment by the Bank's Operations Evaluation Department (OED) of the social costs of adjustment found that on average, countries classified as strong adjusters experienced initial declines in health and education spending in the first years of adjustment, but subsequently, social sector spending increased above pre-adjustment levels. In contrast, countries that did not adjust, or failed to implement most of the agreed-upon measures, experienced steady declines in real social sector spending (Jayarajah and others 1996; van der Gaag 1997). Consistent with the Zimbabwe experience, countries that implemented most of the liberalization measures but failed to control the budget deficit had mixed results: on average, real spending on education increased but real health spending fell. As in Zimbabwe, the reason was that continued high inflation and growing debt service eroded real health spending (Jayarajah and others 1996).

3.20 This is not to suggest that everything would have been fine if government had implemented all of the required adjustment measures. As discussed above, the program had a number of design flaws. In addition, in a country such as Zimbabwe, with a large informal sector and highly unequal income distribution, economic stabilization and liberalization alone will not necessarily lead to poverty-reducing growth without additional measures to increase productive opportunities for the poor. Economic stability, including low inflation and small government deficits is therefore a necessary but not sufficient condition for sustaining the social sectors and reducing poverty.

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18. Government could reduce the burden of interest payments through various measures, including using a no-interest loan from the World Bank to substitute for domestic high-interest debt. If political leaders respond to a large Bank loan with additional consumption spending, however, the country would be worse off than before.
4. The Influence and Impact of World Bank Health Financing Policy Dialogue

4.1 A major strategic goal of the World Bank is to bring a financial perspective to the Zimbabwe health sector. The Bank was concerned that the rapid expansions in health service provision of the 1980s would not be financially sustainable without increased attention to improved efficiency and strengthening the resource base for health, including increased cost recovery. The Bank pursued this objective primarily through policy dialogue and sector work, although the Family Health Projects also sought to improve the efficiency of the health system at the district level (see Chapter 6).

4.2 This section will examine three aspects of the Bank’s role in health financing policy in Zimbabwe: the quality of the Bank’s analysis and appropriateness of recommendations; the influence of Bank analysis and recommendations on policy; and the impact of policy changes on health services and clients.

Quality of Analysis

4.3 The Bank’s analyses of health financing generally have been technically strong and have increased awareness of health financing issues and options within the Ministry of Health. The 1983 PHN sector study raised awareness of the importance of efficiency and sustainable financing within the MOH and established the Bank as a credible adviser on these issues (World Bank 1983). In 1987, the MOH requested that the Bank sponsor sector work on health financing, and helped develop the terms of reference. The 1990 study assembled a wide range of data on health funding sources and expenditure in Zimbabwe. The study was published in 1992, and was widely read and discussed at all levels of the health system (World Bank 1992) (see Box 4.1). The health chapter of the 1995 Public Expenditure Review effectively summarized health financing trends in the 1990s (World Bank 1996b). The sector study and the PER have become standard references for government, donors, and NGOs; even those who disagree with Bank recommendations still use and respect Bank financial analysis (Watkins 1997).

4.4 The 1990 sector study did not adequately assess institutional and political constraints to implementation, demand for health services, or the impact of cost recovery on the poor. The major weakness in the Bank’s initial health financing work was inadequate attention to institutional and political factors influencing recommendations. First, the recommendations for resource mobilization assumed that additional resources raised would be allocated to the MOH budget, but all revenue from fees was returned to the central treasury, and the Ministry of Finance determined central budget allocations independently of revenue increases. Second, the study asserted that clients would be willing to pay more for improved quality, without analysis of how quality improvements would be achieved, and with only anecdotal evidence regarding willingness to pay. Third, it tended to assume that changes in price signals would be adequate to improve the efficiency of the referral system, without giving adequate attention to other factors encouraging bypassing, including low quality at peripheral facilities, and inadequate transport. Finally, the study did not adequately consider the administrative costs and viability of recommendations, including the exemption system for the poor and fee collection at rural clinics. The Bank learned from subsequent experience (see
below), and the 1995 Public Expenditure Review placed stronger emphasis on balancing financial revenues from fees with administrative costs, particularly at lower-level facilities (World Bank 1995b).

### Box 4.1: Health Financing Sector Review Recommendations

The 1990 health financing study was the Bank’s most comprehensive and influential analysis of health funding and expenditure in Zimbabwe. The study was organized around three major topics: resource mobilization for health; increasing the allocative and technical efficiency of health care; and developing systems and skills to support stronger health financing.

To improve resource mobilization for health, the health financing study recommended increasing user fees in public facilities (to restore them to real 1985 levels); establishing a national health development fund (financed through alcohol or tobacco taxes); increased “cost-sharing” by local government and church mission health providers; and expansion of the private health insurance system. The Bank suggested that the recommended measures could generate up to Z$250 million additional resources annually for the health sector:

<table>
<thead>
<tr>
<th>Annual Revenue (Z$ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>User charges</td>
</tr>
<tr>
<td>Full-cost pricing for private patients</td>
</tr>
<tr>
<td>Out-patient fees</td>
</tr>
<tr>
<td>Drug charges</td>
</tr>
<tr>
<td>Adjusting fees for inflation</td>
</tr>
<tr>
<td>National Health Development Fund</td>
</tr>
<tr>
<td>Cost-sharing with local gov’t and mission facilities</td>
</tr>
<tr>
<td>Expanded private insurance</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

Of this total, the study estimated that Z$130 million could be available to the MOH (equal to more than half of the MOH’s 1987–88 budget). Based on these recommendations, the ESAP and the second Family Health Project set a goal of recovering 10 percent of the MOH budget by 1995.

To increase the efficiency of health expenditures, the Bank recommended increasing the share of the MOH budget devoted to primary-level services and preventive care; reducing hospital costs by strengthening the referral system and eliminating unnecessary expenditures; improving the efficiency of drug procurement; and improving the cost-effectiveness of capital investment.

To strengthen the management of resources for health, the sector study recommended revising the MOH budget and expenditures formats; continued decentralization of budgeting; building up MOH capacity to plan health staffing; improving accounting skills at all levels; decentralizing the procurement of certain goods and services; and experimenting with contracting out selected services to the private sector.

Most of the discussion centered on cost recovery. The study appropriately emphasized that improved billing at central hospitals and reducing public subsidies to private care were more important financially than cost recovery at primary and secondary health facilities. Fees should be set to encourage clients to seek care at the lowest level of the system. At lower levels, the main goal of cost recovery was to enhance the efficiency of the referral system and deter unnecessary use. The study called for charging separately for inpatient and outpatient drugs to recover costs and deter unnecessary use. The Bank also recommended shifting the burden for proof of income to the client and increasing the income threshold for free care.
Influence on Policy

4.5 Bank policy advice influenced the government’s decision to strengthen enforcement and increase levels of fees for government health facilities. MOH officials were persuaded by the arguments in favor of increased cost recovery, and the recommendations were given “teeth” through their links to the adjustment program. The sector work and the Bank’s increased attention to cost recovery globally also gave ministry officials a sense of being part of a larger movement toward greater efficiency and sustainability of health systems worldwide. Staff decided to publish the sector study hoping that it would facilitate debate and lead to a more detailed study on implementing a new fee schedule. The MOH strengthened fee enforcement in 1991, then raised the levels of fees in 1994 (see Box 4.2). Government increased the exemption level for free care in 1992, shifted the burden of proof of income to clients, and began charging separately for drugs, consistent with Bank recommendations.

Box 4.2: Changing Policies for Cost Recovery

At independence, government eliminated health service fees for all those earning less than ZS$150 per month, which effectively exempted 70 percent of the population. Elimination of fees led to a substantial increase in health service utilization, along with a 40 percent drop in revenue from cost recovery (from ZS$3.2 million in 1979/80 to ZS$1.9 in 1981/82), equal to about 3 percent of the MOH budget. Government established a new fee schedule in 1985, but inflation eroded the percentage officially qualifying for free care and the real value of fees collected, and weak enforcement meant that few paid. Patients increasingly bypassed clinics to seek care directly at hospitals, undermining the efficiency of the referral system and crowding central hospitals.

Partly in response to Bank recommendations, government changed user fee policies several times in the 1990s:

- 1991: Strengthened enforcement of existing user fees at all levels.
- 1992: Increased the exemption level to ZS$400/month.
- 1993: The MOH briefly abolished fees for rural facilities (January-June)
- 1994 (January): Increased user fees at all levels by an average of 2.5 times in nominal terms, with the largest increases at tertiary levels and urban areas, and strengthened referral enforcement.
- 1995 (March): Eliminated fees at rural hospitals and rural health centers.

4.6 The Bank was not involved in implementation of the 1994 fee schedule. After publication of the sector work in 1992, the Bank’s involvement in health financing issues was sporadic. The MOH did not request further technical assistance, and Bank staff spent most of their time on project implementation. Although consistent with major recommendations of the sector report, some aspects of the new structure were contrary to Bank recommendations. For example, the Bank had recommended providing important preventive services (including antenatal care) free or at highly subsidized rates, yet the fees for antenatal care “booking” were doubled.

4.7 The 1995 study of rural user charges may have influenced the government’s subsequent decision to eliminate fees in rural health clinics and rural hospitals. The MOH and World Bank came under heavy criticism domestically following the introduction of the new fee schedule (Chisvo 1993; Lennock 1994). In late 1994, the MOH asked the Bank to support a local
consultancy study on the impact of the new fee structure on rural health services and the referral system. Bank staff worked closely with the firm to ensure that the study would not simply serve as an ex-post justification of the increases. The study concluded that the levels of fees, and widespread confusion about user charges and referral policies, reduced attendance without improving referral efficiency (MOH 1995). Although this study was one of several that year, it lent credibility to the concerns raised by other donors and NGOs. The MOH announced the abolition of fees for rural health centers and rural hospitals soon after the report was released, although impending elections may also have influenced the decision.

4.8 Government did not implement other recommendations for increased revenue, for institutional and political reasons. Although user fees were not a major potential source of revenue, they were within the direct control of the MOH and could be increased by administrative decree. The other recommendations were longer-term endeavors, requiring new legislation, institutional change, and the cooperation of other ministries and stakeholders (see Box 4.1).

4.9 The MOF did not permit facilities to retain revenues from cost recovery until 1997. The sector study recommended fee retention but also suggested that fees would help reduce the central budget deficit. The Ministry of Finance until recently opposed fee retention out of concern for accountability and budget control. Bank health sector staff occasionally raise the fee retention issue with the MOF in individual meetings but did not elevate their concern by convening a joint meeting of senior finance and health officials or by including fee retention as an issue in macroeconomic dialogue.

4.10 The government made only modest progress in reducing public subsidies to private health care. The sector study pointed out a number of areas where the public sector was substantially subsidizing private health care, including a tax deduction for private insurance, inadequate costing of private use of public facilities, and delays or lack of billing for private patients and private insurance in public hospitals. In 1989, the government reduced the tax deduction for private health insurance, but continued problems with budget and information systems constrained progress in improving billing and charging full cost for private services.

4.11 The MOH reduced grants to local government, although not to mission hospitals. The sector study’s recommendation to reduce central funding for mission hospitals and rural district council clinics was shortsighted, and fortunately not implemented, since these facilities provide most of the services in rural areas. In the 1995 PER, the Bank modified its position and advocated increased funding for missions and rural district council clinics (World Bank 1996b). MOH did reduce funding to municipal health services sharply in the 1990s. Major cities do have independent tax bases, but reduced central funding has made municipalities increasingly reliant on user charges, and many have abandoned MOH guidelines for fee schedules and exemptions for the poor.

19. Various studies on aid conditionality and the politics of adjustment have found that policy measures that can be implemented with a “stroke of a pen” by a small group of senior policy makers are more likely to be adopted than those that require significant institutional change or agreement among various stakeholder groups (Nelson and Eglinton 1993).

20. The MOF finally approved retention in late 1997 after donors and the MOH had invested in training and accounting systems at the district and hospital level. The MOF has sent mixed signals about whether the revenue collected would be additional, or would be subtracted from subsequent vote allocations.
4.12 The percentage of budget allocations to tertiary facilities have declined slightly since 1991, but so have allocations to primary and preventive interventions. The PER found that allocations to central hospitals had declined from 49 to 45 percent, but it estimated that the allocation to primary and preventive care also declined, from about 39 percent to 36 percent\(^2\) (World Bank 1996b). Despite Bank calls for increased allocations to basic and preventative services, budget pressures in the 1990s have squeezed these services more than curative care, and political pressures have focused on sustaining curative care.

4.13 Recommendations for improved financial management formed the basis for the capacity-building component of the second Family Health Project, which British ODA/DFID supported. This component sponsored health financing workshops, and funded technical assistance to improve the MOH financial allocations system and hospital billing. Despite being formally part of FHP2, ODA/DFID did not coordinate closely with the Bank, so the component did not act as an effective follow-up to the sector study recommendations. Also, the component did not establish clear outcome objectives, which might have retained a focus on the goals established in the sector work.

4.14 The sector study’s projections of additional resources for health were optimistic. In addition to the recommendations for revenue mobilization, the sector study anticipated that accelerated economic growth during the 1990s would generate additional resources for health. Instead, growth stagnated and the anticipated additional resources did not materialize. Few in the late 1980s anticipated the economic downturn of the 1990s. But by painting an excessively optimistic picture of potential future resource availability, without risk analysis of alternative implementation scenarios, the study might have unintentionally contributed to inadequate prioritization of expenditure and public investments.\(^2\)

Impact of Policy Changes on Quality, Efficiency, and Revenue

4.15 Because health facilities were not permitted to retain fees, no service quality improvements resulted. Although a number of factors underlay service quality, fee retention is essential if cost recovery is to translate into improved availability of drugs and equipment (Nolan and Turbat 1995). Instead, fee increases coincided with declining drug availability and deteriorating service quality in government facilities. Clients complain that they are paying more for worse services, and are particularly bitter that after paying a consulting fee drugs are often not available (Reed & Associates 1997).

4.16 Total cost recovery declined from 3 to 2 percent of the MOH budget, primarily because little progress was made in improving the billing system at major hospitals. More strict enforcement and increased levels of fees resulted in increased cost recovery in nominal terms, but the gains were eroded by inflation and inconsistent enforcement. Even with strict enforcement, potential revenue from primary and secondary facilities was limited. Central

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21. Most of the reductions were in allocation to Parirenyatwa Hospital, but allocations to other hospitals increased. MOH budgets do not give breakdowns according to primary care versus other activities, so the figures quoted are estimates.

22. The sector study described “a number of...exciting options” for the anticipated additional revenues, including new infrastructure, training, and salaries for “thousands” of additional nurses and community workers.
hospitals did not achieve real revenue increases and continued to lose millions through inadequate billing and subsidization of private care.23

4.17 Central hospitals’ billing remained weak because of inadequate incentives, poor management, and limited resources. First, senior MOH officials were not willing to devote scarce staff time to capture revenue that would then be sent to the central treasury. Second, the ODA/DFID financial management project funded a single technical specialist who was tasked both with revising the entire MOH financial system as well as improving hospital billing.24 Third, financial management and administration at central hospitals remains inadequate. The situation has been exacerbated by reductions in administrative staff in conjunction with the structural adjustment program.25

4.18 Changing fee structures have resulted in only marginal improvements in the efficiency of the referral system. The new fee structure in 1994 resulted in some shift of outpatient and preventative services to lower levels, but bypassing of clinics actually increased in some districts (Bijlmakers and others 1996). The introduction of the new fee structure did not produce the expected efficiency gains for several reasons. Most bypassing was a result of inadequate quality at lower levels. Although the 1994 fee schedule charged higher rates for higher-level facilities, the differences with clinic fees were small enough that clients sometimes preferred to pay higher rates and transport costs to go to hospitals. Fee changes were not well advertised and generated considerable confusion among clients and providers. Clients also were confused by the new referral rules—in one survey, over a third reported no knowledge of the referral system (MOH 1995). In rural areas, going directly to a hospital is considered less risky for serious illness. In urban areas, the lack of secondary referral facilities undermines the referral system. Municipal clinics are only open during the day; at night, and for any referral cases, patients must go to one of the central hospitals. The elimination of fees at rural health centers has improved the referral system in districts, although drug shortages remain a problem (MOH 1996).

Impact on Service Utilization and the Poor

4.19 Cost has become a significant barrier to access of health services by the poor, particularly in urban areas. In focus group discussions, low-income clients in both urban and rural areas said that cost is often the primary consideration in the decision to seek care (Reed and Associates 1997; Mutizwa-Mangiza 1997). The tightening of fee enforcement coincided with the severe drought of 1991/92, and many poor households faced rising prices and stagnating incomes during the 1990s. The exemption system reaches a small percentage of the poor and has become distorted by patronage (Loewenson 1998). In 1995/96, 42 percent of the urban poor who reported an illness in the previous month gave “cannot afford” as the reason for not seeking treatment,

23. The Bank’s recommendations were not new. The government’s 1984 health strategy paper estimated that 24 percent of total health expenditure was from the private sector, but about half of the value of services received by medical aid society beneficiaries was financed by government (MOH 1984).

24. Despite these constraints, the project made some progress, particularly with United Bulawayo Hospital. The consultant has since left, however, and additional effort is needed to translate the improved systems into strengthened billing.

25. Parirenyatwa Hospital, for example, lost all of its accountant posts and currently has no qualified accountant. Some posts were restored, but salaries were set too low in relation to the private sector to attract qualified staff. Improving hospital management has proved challenging in other African countries, but the time and resources devoted in Zimbabwe were clearly inadequate.
compared to 14 percent for rural poor (CSO 1998). Removal of fees for Rural health centers has helped the rural poor, but the urban poor face significantly higher prices and more strict fee enforcement. In addition, district hospitals often act as a primary facility for the surrounding catchment area. The poor living near district hospitals face a difficult choice between traveling up to 30 km to visit a clinic or paying the district hospital fees (Criel 1996).

4.20 Vaccination coverage declined in the early 1990s but then recovered after a concerted effort by the MOH and partner donors. Although immunization remained free, cuts in budgets for transport and travel allowances contributed to declines in outreach. A survey by the Zimbabwe expanded program on immunization (ZEPI) found, however, that in districts where coverage had declined, management problems were also responsible (UNICEF 1994). Intensive efforts by the MOH and UNICEF subsequently helped solve some of the funding and management problems. Budgets remain constrained, but districts have learned to sustain coverage by combining trips for supervision, outreach, and immunization.

4.21 Although ANC fee increases were excessive, overall attendance has remained high. Attendance for antenatal care initially declined in some districts and urban hospitals serving poor populations following fee increases, but it subsequently recovered in most districts. Household data indicate that the percentage of women attending ANC remained high at around 94 percent during the 1990s, with rural attendance only slightly lower than urban (CSO 1995). The major long-term consequences of the fee increases appear to be: (i) low-income women are waiting to begin antenatal care, either to save money or to ensure the pregnancy will reach full term; (ii) financial burden on poor households; and (iii) a shift in ANC attendance from urban and district hospitals to clinics (Bassett 1998). The former two are cause for concern, while the latter may indicate greater efficiency.

4.22 Nationally, the percentage of births in health facilities has not changed since 1988, but there have been variations among districts and increases in home deliveries in the months following price increases. The 1994 DHS found that 91 percent of urban women and 61 percent of rural women delivered at a health facility, virtually the same as found in the 1988 DHS (CSO 1988, 1995). Increased financial costs may have undercut Family Health Project efforts to improve physical accessibility. Urban women strongly prefer to deliver at facilities, so even though prices increased substantially (from Z$60 to Z$120 in Harare, for example), they either managed to get exemptions or paid anyway. Yet monthly data from Harare Central Hospital—which mostly serves low-income clients—shows an increase in the number of “babies born before arrival” (BBAs) following the price increases of 1991 and 1994, accompanied by increased death rates of BBAs (Iliff 1995). This suggests that the initial shock associated with the price increase, accompanied by initial low knowledge about exemptions, caused some poor women to deliver at home or delay seeking assistance. In rural areas, despite the shift to clinics for ANC, the percentage of deliveries at hospitals did not change significantly (Bassett 1998). Low-income women in the catchment area of a district hospital, however, may be required to pay regardless of income. This may explain why one longitudinal survey (in Murehwa district) found that deliveries declined significantly among rural women following the 1994 increase (Bijlmakers and others 1996).

4.23 District outpatient attendance appears to have declined following increased fee enforcement, with the greatest declines among children. According to health service data compiled for this study, the outpatient attendance rate for children under 5 fell by 30 percent from 1990 to 1992, which coincided with increased fees in 1991 and decreased incomes from the
1992 drought. Attendance rose sharply following the removing of rural fees in 1995, but average under-5 outpatient attendance rates are still below 1990 levels. In contrast, adult attendance fell only 20 percent over those two years and by 1996 was 20 percent above 1990 levels (Bassett 1998). Quarterly and monthly data show the clinic attendance in some districts doubled following the brief abolition of rural fees in 1993, and again in 1995 (Biljmakers and others 1996). A study by the MOH, however, found that the sharp increases in clinic attendance in 1995 were followed by declines in some districts, apparently because of increased drug shortages (Zigora and others 1996). The pattern in urban areas was more complex. While at some urban hospitals attendance dropped, it increased at others, apparently because of differing levels of fees and enforcement. Reduced treatment for minor illnesses may have accounted for some of the attendance declines; fewer children were brought to clinics with minor diarrhea (MPSLSW 1996). But focus groups and interviews with providers and clients suggest that some low-income clients were delaying treatment on minor illnesses until they became more serious, requiring additional care (Reed and Associates 1997).

4.24 In hospitals serving low-income populations, inpatient attendance dropped following fee increases, then recovered, but the average length of stay declined permanently. National data show no clear trends, partly because fees alone do not determine bed days; the AIDS epidemic and policies for care of AIDS and tuberculosis patients are also important determinants. The decline in bed days may indicate improved efficiency, but it is difficult to tell without further knowledge of the nature of the illnesses treated.

Health Outcome Indicators

4.25 Chronic child malnutrition remained mostly constant through the 1990s, despite drought and increasing HIV incidence, because of widespread distribution of drought relief and child supplementary feeding programs. Drought relief reached almost half of the rural population at its peak in 1992/93, and an estimated 1 million children received supplementary feeding (UNICEF 1994). These programs targeted all children under 5, but did not target by family income or child nutritional status. The programs were therefore costly, but they prevented widespread malnutrition despite crop failure and increasing poverty for some households (Murenha 1997). From 1988 to 1994, the Demographic Health Survey found that child stunting (an indicator of chronic malnutrition) continued to decline, while wasting (acute malnutrition) had increased (CSO 1995). The Bank and others suggest that this indicates continued improvements in nutrition for most children, while increased wasting is a consequence of children born with AIDS. A 1994 study at Harare Central Hospital, however, found that half of the clinically malnourished children admitted were HIV-positive, indicating that while AIDS is an important contributor to malnutrition, it alone does not explain the increases. Since stunting is a long-term indicator, further household survey data will be needed to determine if stunting is also increasing, particularly now that drought relief and the child supplementary feeding program are being phased out.

26. In Harare, for example, attendance at Harare Central Hospital increased because of greater relative fee increases at Parirenyatwa Hospital. Attendance at Chitungwiza Hospital, serving a low-income, high-density suburb, however, fell by almost a third, without a corresponding increase in clinic attendance, suggesting that the poor were forgoing care (Biljmakers and others 1996).

27. The children with AIDS tended to have marasmus (calorie deficiency), while HIV-negative malnourished children tended to exhibit kwashiorkor (protein-energy malnutrition), which is related to poverty (Ticklay and others 1997).
4.26 Increases in infant and child mortality are primarily the result of AIDS. The NACP estimates that, based on the estimated 30 percent HIV prevalence among pregnant women in Zimbabwe,\textsuperscript{28} AIDS accounts for all the recently observed increases in infant and child mortality, while the mortality rate of children without AIDS may have actually declined. Continued improvements for non-HIV babies—despite stresses on households and the health system—could be plausible for two reasons. First, even though poverty has increased, nutrition interventions may have maintained child health. Second, despite overall declines in the health system, attendance and satisfaction with antenatal and well-baby services remains high.

4.27 Maternal mortality has increased since the late 1980s, not all of which can be attributed to AIDS. AIDS is clearly having an impact on maternal mortality which, while relatively rare, is a key indicator of the status of the health system overall. Facility data undercount maternal mortality but shows a more than doubling from 1988 to 1995 (MOH 1998). A detailed study of maternal mortality in both Harare and Masvingo province estimated that 90 percent of the deaths studied were preventable, and only 20 percent of the urban maternal deaths and less than 10 percent of rural could be associated with AIDS, although that percentage would undoubtedly be higher today. In Harare, the major preventable causes were delays in treatment, inappropriate diagnosis, and other factors related to clinical quality and care (many of the cases were attended by nurses or junior doctors). In rural areas, major factors were lack of transportation, and communication, and inadequate care at rural hospitals. The majority of women had attended antenatal care and booked for delivery at a facility. Fees per se do not appear to contribute to the overall MMR increase (Mbizvo and others 1994).

Lessons

4.28 A major lesson from the Bank’s experience with health financing in Zimbabwe is that providing sound financial analysis and advice is not sufficient to achieve objectives. Inadequate attention to incentives, the institutional environment, and the administrative viability of exemption mechanisms may result in negative consequences for efficiency, financial recovery, and the poor. Another lesson is the importance of clearly explaining policy changes to providers and the public. The confusion generated by poorly advertised or frequent changes in cost recovery policy can deter attendance and encourage bypassing of the referral system—further undermining the primary objectives of the policy. Both the government and Bank have learned from difficulties encountered by cost-recovery in recent years, but this learning came at a high price. Adopting a more flexible, experimental, and participatory approach to policy change would allow all stakeholders to learn from experience before implementing a new policy nationwide.

\textsuperscript{28} Sentinel surveys have found that prevalence rates among pregnant women range from 20 to 40 percent (NACP 1997; Gregson and others 1996).
5. Bank Policy Dialogue on Health Staffing

5.1 Low health worker morale and staff shortages have emerged as major constraints on sector performance, the quality of care, and the impact of Bank-supported project investments. The problems of insufficient staff and declining morale have a variety of causes, but have become more acute in the 1990s, concurrent with deteriorating conditions of service and conditions of work in the public sector, and growing demand for health professionals in the private sector and neighboring countries. Although currently the majority of vacancies are in central hospitals, the MOH continues to have difficulties attracting and retaining providers in rural facilities. This section seeks to answer three questions: What are the sources of the staff shortages and morale problems? How has the Bank sought to address these issues? Has the Bank been effective?

Staff Shortages and Declining Morale

5.2 Staff shortages are the result of changing health labor markets, the abolition of the State Certified Nursing cadre, the firing of striking nurses, and inadequate planning. The causes of staff shortages differ somewhat among health cadres. Shortages of doctors, pharmacists, and laboratory technicians result primarily from high demand and significantly higher pay in the private sector (EU 1998). Government doctors are spending an increasing amount of time in their private practices, often at the expense of patient care and supervision of nurses and junior doctors. Although government pay is lower than the private sector, many government doctors do not work the hours expected. An increasing number are leaving the public sector entirely. Public/private wage differentials for nurses are not as high as for other cadres, but nurses consider working conditions to be better in the private sector (see Box 2.1).

5.3 During the design of FHP2, the Bank made projections of expected staffing requirements for existing facilities and the new FHP2 facilities, taking into account the current levels of training and attrition rates. Based on this analysis, the Bank and government agreed to concentrate on in-service training rather than expanding training output. In 1991, MOH actually decreased nurse training intakes because restriction on new hiring under the adjustment program led to a growing number of unemployed nurse training graduates. Project planning also assumed that the FHP2 facilities would be the major health sector investments from 1991 to 1996. Based on these projections the PSC agreed that the MOH could hire as many nurses as it could train. Yet government proceeded with two other major hospital expansions that were not included in the original projections. The MOH subsequently had to return to the PSC to request additional staff to accommodate these inadequately planned expansions.

5.4 Two political decisions unforeseen during FHP2 project design have contributed to the current nursing shortage. First, the government’s abolition of the State Certified Nursing (SCN) cadre has led to a reduction in the number of nurses available to the public sector. Additionally, the MOH has requested an additional 350 nurses for Chinhoyi Provincial Hospital and the new pediatric wing at Harare Central Hospital.

29 In addition to the FHP2 facilities, MOH has requested an additional 350 nurses for Chinhoyi Provincial Hospital and the new pediatric wing at Harare Central Hospital.
cadre in 1991 cut the number of nurses being trained by two-thirds, to fewer than 200. Second, government fired participants on a strike by nurses and junior doctors in 1996, which led to the loss of nearly 300 nurses and the closing of several wards in central hospitals. The longer-term problem is high attrition rates—about 10 percent annually for nurses—and low recruitment. Government recruits only about 30 percent of nurse training graduates into the public health system. The MOH has increased nursing intakes to 1,000 per year, but the Bank estimates that even with increased training, at current retention and recruitment rates, the number of nurses in government service will decline over the next decade.

5.5 Government continues to have difficulty attracting and retaining professional staff in rural facilities, particularly doctors and nurse midwives, because of inadequate housing and amenities; inadequate allowances and incentives for rural service; limited opportunities for private practice (for doctors); and family concerns (Reed and Associates 1997; Woelk 1997). The Bank's FHP investments, along with those of other donors, have improved staff housing at some facilities, which has contributed to recruiting and retaining staff, but were insufficient to counteract these other trends.

5.6 Rudeness and insensitivity by providers is a significant factor cited by clients in the declining quality of care in government facilities. The most common complaints were of being ignored or treated rudely by nurses. Female clients report also instances of women in hospitals or municipal clinics being shouted at or sometimes even slapped while in labor (Mtemeli 1994). These problems were seldom reported in the private sector, or at mission hospitals and rural health centers, where the nurses are said to be more dedicated and connected with the community. Not all nurses interviewed acknowledged the problems with nurse behavior, but those who did attributed it to overwork and low morale (Reed and Associates 1997; Ellis 1997).

5.7 Declining real wages, nonpayment of overtime and travel allowances, increased work loads, shortages of drugs and equipment, and fear of HIV all affect morale. Doctors tended to express greatest concern about inadequate wages in the public sector, while nurses are equally concerned about conditions of work and conditions of service, as well as the perceived lack of respect accorded to their profession by government and the public. Fears regarding AIDS infections are compounded by shortages of gloves and other protective equipment. Some also suggested that baby clinics were happier places than the adult wards, where the high death rate of AIDS patients contributes to discouragement (Reed and Associates 1997). Some cultural factors are also at work: younger nurses were consistently said to be ruder and less responsive than the older nurses, who still retain some of the spirit of the post-independence period. Class issues—related to patients both poorer and wealthier than the nurses—also appear to play a role (Bassett 1997).

5.8 A fundamental problem is the lack of an effective labor relations system between government and health workers. The health system has experienced strikes or other industrial action every several years since independence, most commonly by nurses and junior doctors. Yet there remains no effective system whereby grievances can be effectively negotiated and resolved.

30. State Certified Nurses were trained to serve in rural posts, often without supervision of a doctor. Pay and benefits for SCNs, however, were lower than for the State Registered Nurses (SRNs), even though they often performed the same duties, creating resentment and tension among nurses. Abolition of the distinction between SCNs and SRNs was a key demand in a 1991 nursing strike, which led to government's decision. Training then focused on upgrading SCNs to SRNs. A further concern is that SRN training emphasis hospital service, and tends to draw students from urban areas who are reluctant to serve at rural clinics.
before escalating (Loewenson 1998). The 1996 firing of striking nurses and junior doctors has contributed to bitterness as well as staff shortages. Without softening requirements for budget control, the Bank could encourage government to improve negotiation and dispute resolution with civil servants, including health workers.

5.9 **Government has yet to develop a coherent system for health workforce planning.** The system has two major shortcomings. First, government planning has not incorporated health labor market concerns into projections for training needs and salary levels. Although health training is highly subsidized, government does not balance the cost of training, salary levels, and budget with the costs of attrition. A second major obstacle to planning health staffing in Zimbabwe is the lack of coordination among the Ministry of Finance, the Public Service Commission, and the Ministry of Health. The number and conditions of service for government health workers are determined by the Public Service Commission, which requires approval from the Ministry of Finance before establishing new posts or granting increases in salaries or allowances. The MOH has taken the role of supplicant to the MOF and PSC, often requesting more posts than it expects to receive, with the expectation that the numbers will be reduced. The ministry developed a health staffing strategy for the period 1991–96, which established normative (and unrealistic) goals for increased staffing based on the size and beds of facilities, rather than workload, health objectives, or budget constraints (MOH 1993). Conversely, the PSC and MOF do not adequately incorporate sector requirements or efficiency goals in granting staff requests. For example, the FBP in-service training program has had considerable difficulty retaining nurse tutors—they have no career structure and are graded on the same level as a junior nurse—but the PSC refused to repeated requests from MOH and Bank staff to have the posts upgraded. Similarly, a more rational planning system might have avoided the elimination of key accounting and finance posts.

5.10 **Political and administrative linkages between health professionals and the rest of the civil service constrain efforts to improve conditions of service for MOH staff.** Health professionals represent 6 percent of the civil service, so moderate improvements in pay, allowances, or incentives for rural service would not have a large impact on the national budget. The problem is that the PSC has tried to maintain consistency among various cadre of civil servants, and politically, granting pay increases or special incentives for health workers often leads to similar demands from teachers and other professionals. The PSC has found it easier to “just say no” than to navigate these competing constituencies.

**Bank Efforts to Improve Workforce Planning**

5.11 **The Bank has supported technical assistance for workforce planning and regularly raised health staffing concerns in its policy dialogue, but with limited impact on policy thus far.** The Second Family Health Project attempted to establish a workforce planning department within the Ministry of Health, and also a personnel information system. The department never found an institutional home within the ministry, however, and its work was hindered by competition among other departments. The ministry could not retain staff to operate the information system, and the software was not compatible with that used elsewhere in the ministry or in the Public Service Commission. Design of the staffing component therefore did not adequately assess the institutional context for information within the ministry, or consider the role

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31. The total authorized MOH staff establishment, including maintenance workers and general hands, was 24,600 in 1997, or 14 percent of the civil service (PSC 1997).
of other possible partners, including the PSC and the Health Professions Council, which is responsible for registering all health professionals annually.

5.12 Since the early stages of FHP1, the Bank has periodically included a consultant specializing in health staffing in supervision and project design missions. The consultant and Bank staff worked with the ministry and the Nursing Directorate in particular to project future health worker requirements, assess training needs, and develop a training information database. Despite considerable effort, particularly on the latter, MOH staff have either been too preoccupied with other concerns, or inadequately trained in workforce planning, to internalize the technical assistance. The Nursing Directorate now hopes that the Health Professions Council will be able to maintain training records for nurses. In addition, Bank staff regularly raised concerns about staffing for the future FHP2 hospitals during supervision missions. PSC and MOF had initially committed to providing staff for the facilities, and MOH included staff for FHP2 facilities in 1995/96 staff and budget estimates. MOH did not formally initiate the process for requesting staff, however, until the hospitals were nearly completed. In early 1998, the MOF granted funds for the posts, but approval from the PSC was still pending.

5.13 The Bank has not attempted to promote coordination among the MOH, PSC, and MOF. With an important role in the health sector and in the macroeconomic dialogue, the Bank is well placed to facilitate coordination among the Ministry of Health, Public Service Commission, and Ministry of Finance. As yet, however, the Bank has not done so. Health sector staff have raised various concerns in individual meetings with the PSC or MOF, but never convened a joint meeting of these ministries to promote problem solving on key health staffing issues. Neither did the Bank elevate health staffing concerns into the macroeconomic dialogue, beyond exempting social sector staff from civil service reductions.

5.14 The Bank does not have a coherent strategy regarding health staffing, and sectoral and macroeconomic advice have at times been inconsistent. In the health sector, the Bank supports a significant expansion in health infrastructure, with increased requirements for health staff, and argued for improved incentives for health workers. In the macroeconomic dialogue, the Bank has emphasized the importance of reducing the civil service wage bill. Although agreeing to protect the number of social sector professionals, the Bank has implicitly endorsed a strategy of reducing wage expenditures through real declines in civil service salaries. In recent years, the Bank has placed a stronger emphasis on improved civil service efficiency, while the IMF has maintained a focus on meeting civil service reduction targets. Yet in some macroeconomic analyses, the Bank has suggested that an excessive wage bias remains in the social sectors, even though salaries have never risen much above 60 percent of the MOH recurrent budget. The Bank suffers from an understandable ambivalence. On one hand, without deficit reduction and macroeconomic stability, progress in the social sectors and economy in general will continue to be undermined. On the other, improved quality will be difficult to achieve without improved

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32. The delayed request may partly be the result of inadequate planning by the MOH, but may also reflect the ministry's expectation that the PSC would be more responsive to the request in a "crisis" situation.

33. The macroeconomic section of the 1995 Public Expenditure Review (PER) provides a telling example. First, it suggested that since the wages but not number of health workers had declined, the real output from the health sector had remained constant. It then noted that government was only spending an estimated US$9 per capita on basic health services, while “Better Health in Africa” had recommended that a country of Zimbabwe’s income should spend about US$13 per capita (World Bank 1994b). Even though the “Better Heath in Africa” estimates included the cost of personnel, the PER assumed that the shortfall was for non-wage recurrent costs, and concluded that the health sector suffered from wage bias. The health sector did not support this conclusion (World Bank 1996b).
incentives for health workers. There are no easy solutions to this dilemma, but the Bank needs to consider trade-offs and develop a coherent position.

5.15 The Bank and government agree that staffing is a major priority for the sector, and are sponsoring the first sector work on health workforce issues. Bank staff identified health staffing as a priority for sector work in the early 1990s, but decided to devote time and resources to developing the STI project instead. In addition, the MOH showed limited interest in health workforce sector work at the time. As health staffing reached crisis levels, the Bank and MOH agreed that it should be first priority for sector work. In early 1998, the MOH and Bank developed terms of reference and used project preparation funds to hire an international consulting firm to conduct a thorough analysis of the health staffing situation in Zimbabwe, and make recommendations along with cost estimates. The recommendations are to form the basis for a new MOH staffing strategy, but the consultants are to consult closely with other relevant ministries, including the Ministry of Finance and Public Service Commission.

5.16 Based on previous experience, unless the analysis is followed by negotiations among key players regarding priority actions, the ability of the MOH to effect changes may remain constrained. The PSC is currently working to develop its own health staffing database, as is the Health Professions Council. Several other donors have also identified health staffing as a priority for technical assistance and project support, including the European Union (EU 1997). At present, these various donor efforts do not appear to be well coordinated.34 The Bank should work closely with the various interested donors and ministries to build consensus around key actions.

5.17 The government’s ability to attract and retain senior civil servants has emerged as a major constraint on the development of sector strategy as well as workforce planning. Despite donor rhetoric regarding capacity building, at times it seems that the MOH is a training ground for donors. In the past year, various donor agencies have hired away several department heads and the chief medical officer. MOH staff cannot be blamed; with donors and private sector agencies often offering several times government salaries, it is a tribute to their dedication that highly competent professionals choose to work and stay within the ministry. While short-term measures to “top-up” salaries or provide other extra-budgetary incentives to key staff can cause more problems than they solve, the Bank and other donors might explore ways of ensuring that senior policymakers can be attracted and retained within the ministry.

34. The World Health Organization project also aims to support the development of a staffing strategy starting from the provincial level.
6. **Bank Project Support**

**The First and Second Family Health Projects**

**Objectives**

6.1 The First Family Health Project (1986–93) had three objectives: (i) improve health status, particularly for mothers and children; (ii) increase the availability and use of family planning and MCH services; and (iii) strengthen the government’s capacity to plan, manage, and evaluate maternal and child health and family planning services. Project components included upgrading of district hospitals and more than 80 clinics in eight target districts; training for nurses in family planning, MCH, and midwifery; information, education, and communication (IEC) activities to increase demand for health and family planning services; management strengthening at national, provincial, and district levels; and urban family planning (World Bank 1986). A nutrition component was dropped from the final design to reduce the project’s complexity.

6.2 FHP2 (1991–98) had the same goals, and also included a nutrition component. Of the 57 districts in Zimbabwe, Family Health I focused on eight target districts (one in each of Zimbabwe’s eight provinces) while FHP2 focused on an additional 16 districts (two in each province). The training and capacity building components of both projects were nationwide (World Bank 1991).

**Design and Implementation**

6.3 **FHP1 targeted important and relevant concerns that were appropriate to Zimbabwe’s epidemiological profile and consistent with government priorities.** The project’s emphasis on family planning and maternal and child health was appropriate. Childhood and maternal illnesses represented more than half the burden of disease, and population growth rates were among the highest in the world. Government had already secured grant financing, primarily from Scandinavian donors, to expand basic health services, but bilateral donors were unwilling or unable to finance district hospitals. Despite Ministry of Finance reluctance to borrow for the social sectors, it agreed to borrow from the Bank for health infrastructure development, but insisted that technical assistance must be funded with government or grant funds. The search for cofinancing further delayed project planning, but the Bank eventually secured cofinancing agreements from four bilateral donors. Since the project funded a key component of the government’s health strategy, borrower commitment to the project remained high throughout design and implementation. The loan was approved in 1986, after three years of preparation.

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35. Until the early 1990s, Zimbabwe was classified as a middle-income country and therefore had to borrow from the Bank on commercial (IBRD) terms. Initially, the Bank planned to provide a $25 million loan, but the Ministry of Finance reduced the loan request to $10 million just before project negotiations, stating that the government would cover the balance. The government therefore became responsible for financing half the total project costs, but neither the government nor the Bank evaluated the fiscal implications of this decision.

36. Bilateral contributions included Norway ($10 million), Netherlands ($1.8 million), United Kingdom ($1.8 million), and the Federal Republic of Germany ($1.3 million).
6.4 **FHP1 successfully upgraded the district hospitals in the 8 target districts to 140-bed facilities, but construction costs were double appraisal estimates and facility designs were inefficient.** All 8 district hospitals were completed, as were 58 of the 82 planned clinics. Final construction costs were more than double the appraisal estimates, however. Completion took two years longer than planned, and the layout of the facilities was inefficient in a number of respects. Several factors led to these problems. First, FHP1 was the first major construction project managed by the Ministry of Health, which had no staff with architectural experience. Second, project appraisal did not adequately assess the capacity of the Ministry of Construction to implement the project (for example, half the Ministry of Public Construction and National Housing posts were vacant at appraisal). Third, the local building industry was overstretched by the project, and the performance of some local contractors was substandard. In response to the delays, the Bank, MOH, and Ministry of Construction increased attention to supervision, and project implementation improved considerably in the final years (GOZ 1995).

6.5 **The districts chosen were not all underserved, and the size and placement of facilities did not always correspond to the catchment population.** Districts varied considerably in total population, density, and availability of rural hospitals, but the project built a standard 140-bed hospital in each district. Bank insistence on only upgrading existing facilities, and political influences, distorted district and site selection. In the hope of minimizing recurrent costs, the Bank insisted that only existing hospitals be upgraded rather than constructing new facilities. Although the “upgrades” were essentially equivalent to building a new hospital, districts without any district hospital at all were bypassed in favor of those that could be upgraded (GOZ 1995). Even within districts, existing facilities were not necessarily near the most underserved populations. Two districts that were already well-served by mission hospitals were selected because of regional political influences.

6.6 **FHP2 incorporated many of the implementation lessons from FHP1, and district officials played a greater role in the planning process.** Planning for FHP2 began in 1989, before the completion of the FHP1 hospitals. The MOH and World Bank compiled a report detailing lessons from the implementation of FHP1, and established more stringent criteria for district selection. The Bank agreed that some new facilities could be built, and the government agreed that mission hospitals could be eligible for upgrades. For political reasons, however, the project focused on two districts in every province, which constrained flexibility.

6.7 Neither the Bank nor government conducted a strategic overview to determine whether construction of an additional 16 district hospitals was still appropriate in light of emerging economic and epidemiologic trends. Despite impressive work to incorporate implementation lessons from FHP1, project design never seriously considered whether building and upgrading 16 district hospitals represented the most efficient or effective means to address the future disease burden (GOZ 1995).

6.8 **The designs for the FHP2 hospitals were more efficient than for FHP1, such that the 16 FHP2 hospitals were built for the same cost as the original 8 FHP1 district hospitals.** The Bank successfully argued in favor of placing a consultant architect within the MOH to strengthen the ministry’s hand in dealing with the Ministry of Construction. The architect worked closely with MOH officials to ensure maximum efficiency of space, avoid unnecessary expenditures on

37. Of the districts chosen, four were clearly underserved, two were marginally so, and two already had adequate mission facilities and health indicators above the national average.
construction, minimize staffing requirements, and allow for future modifications (Hopkinson and Kostermans 1996). The ministry was sufficiently pleased with the arrangement that they retained the architect position even after it was no longer funded by the project. The Ministry of Construction originally resisted giving the MOH a role in construction design but has come to accept the arrangement. International competitive bidding (ICB) for FHP2 hospital construction resulted in costs 40 percent lower than originally estimated by the Ministry of Construction and forced local contractors to lower their prices. The hospitals were completed on time and nearly on budget in late 1997.

Despite efficient construction, shortages of health manpower affect all levels and cadres of the health system. The completion of the 16 FHP2 district hospitals created an embarrassing situation for the World Bank and government. The new hospitals and clinics required an estimated 900 new nurses, 30 additional doctors, plus pharmacists and laboratory technicians. Yet even without the new facilities, 1,000 nurse posts out of 8,600 are vacant, and 80 out of 780 doctors posts are vacant (EU 1997). Providers and the press complain that government and the Bank have been building new facilities “when we don’t have staff for the existing ones” (Reed and Associates 1997; Ellis 1997). The Ministry of Finance approved funds for the posts in early 1998, but it remains unclear where the new staff will come from, and whether facilities will simply divert staff from other mission hospitals and rural health centers, weakening services elsewhere (Chapter 5).

With the increased burden from AIDS and associated diseases escalating, and the growing burden on central hospitals, there is no doubt that the improved district facilities are "needed." The key question is whether the government can sustain social sector spending (see Chapter 3) and establish an effective health workforce planning system (Chapter 5). If government can successfully address manpower shortages and improve the efficiency of staff allocations, the new facilities have the potential to improve access and quality of care in underserved districts. If not, their impact will be significantly reduced.

FHP2 was not sufficiently flexible to respond to the rapidly changing economic, institutional, and epidemiological context in Zimbabwe. Bank staff made efforts to respond to the changes, but the fixed investment nature of the project constrained flexibility. Once construction was under way, it was not possible contractually or politically to reduce the number or staff requirements of the facilities. The construction program itself therefore was not an effective instrument through which to promote policy dialogue on health staffing, even though it was dependent on health staffing. Bank staff did, where possible, reallocate funds to new priorities as they emerged, but the scope for flexible programming was limited.

The projects improved transport and communications, but chronic maintenance problems kept up to half the vehicles off the road. All vehicles procured by the projects became the property of the Central Mechanical Engineering Department (CMED), which was also responsible for maintenance. Vehicles sent for repair by districts would often wait for months or even more than a year for repair. Over the 10 years of project implementation, Bank supervision missions routinely complained of poor vehicle repair and received promises that performance would improve, but improvements were rarely sustained. Anecdotal evidence suggests that clients are more likely to use RHCs if reliable communications are available. FHP1 provided communications equipment to the targeted hospitals and rural clinics, but with considerable delays (mostly due to resistance from the telecommunications parastatal).
6.13 The Family Health Projects substantially increased the number of providers with training in family planning, midwifery, and maternal and child health (MCH), and helped integrate family planning into health services. In-service training centers built in FHP1 districts served the entire province and were also used for training during FHP2. About 1,850 nurses, or 70 percent of the original target, completed the six-week family planning course. The completion of training centers and hospitals generated significant cost savings, since trainees no longer had to be housed in hotels (GOZ 1995). FHP2 reportedly met output targets, but did not maintain adequate training records, despite Bank efforts to strengthen the training database. An OED analysis of facility survey data found that from 1991 to 1996, the percentage of providers with training in family planning improved from 65 to 91 percent, much of which can be attributed to the project (Chibatamoto 1997).

6.14 The FHP1 capacity-building component supported training workshops and helped establish a new cadre—the District Health Services Administrator. The FHP capacity-building components were funded and managed by British ODA/DFID. In FHP1, this component sponsored management training workshops for district, provincial, and central MOH staff, and supported the establishment of the training program for a new cadre, the District Health Services Administrator (DHSA). The DHSA has helped to relieve the District Medical Officer of administrative duties and strengthened District Health Services Authorities. Because the skills developed in the program are in high demand, however, districts have trouble retaining administrative officers. Most of the management development effort has targeted individuals, rather than focusing on strengthening district management systems or disease targeting. The government's Project Completion Report suggested that workshops on health financing helped increase cost consciousness among district officials (GOZ 1995).

**Project Impact**

6.15 Since the FHP2 facilities were only recently completed, the discussion of FHP impact focuses primarily on FHP1 facilities, and on provider training, which was sponsored by both FHP1 and FHP2.

6.16 The maternity wards in the FHP1 hospitals were mostly open by 1990, although other hospital and clinic construction continued through 1992. From 1989 to 1995, the rate of maternity admissions in FHP1 districts increased by almost 50 percent. The admission rates in non-FHP districts were over 60 percent higher in 1989 than in both FHP1 and FHP2 districts, but did not change significantly subsequently (Bassett 1998). Admission rates in FHP2 districts did increase modestly over this time, which could be the result of improved transport, although the data do not allow firm conclusions (see Figure 6.1 below).

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38. The government's 1984 health strategy proposed creating District Health Services Authorities to: i) support, supervise, and upgrade PHC activities in the district, ii) supervise provision of district hospital care (MOH 1984).
6.17 Hospital deliveries increased several-fold in the most underserved FHP1 districts, but in others admissions increased only slightly or remained static despite the new facilities (see Figures 6.1 and 6.2). This demonstrates the importance of careful planning and citing of facilities in order to improve access. In Tsholotsho district, the original hospital had no electricity or doctor, and there were no other mission or private hospitals in the district (Figure 6.3).

Total maternity admissions in Tsholotsho increased four fold from 1989 to 1995, including a doubling when the maternity ward opened in 1991 (even though fee enforcement increased that year). In contrast, maternity admissions at Mount Darwin Hospital have remained nearly static since the new hospital opened. Women may be going instead to a nearby mission hospital, the provincial hospital, or traveling to Harare.  

6.18 Inpatient hospital admissions also increased significantly in FHP1 districts. As expected, the expansion of staff and hospital facilities led to an increase—usually doubling or more—of hospital admissions. The

39. For this graph, FHP1 districts were classified by “need” according to proximity of FHP1 hospital to other comparable mission or government hospitals. Tsholotsho and Gokwe were classified as “needy,” Hurungwe, Mt. Darwin, and Mutoko as “moderately needy,” and Zaka, Nyanga, and Bietbridge as “less needy.”

40. In addition to FHP1 infrastructure and training, Tsholotsho district benefited from a long-term capacity-building project sponsored by a Belgian NGO (Medicus Mundi), that intensively focused on building teamwork and planning capacity within the district health executive. The rapid increases in this district are therefore likely the result of location in an underserved area, significantly improved infrastructure, and intensive management strengthening.
changes also varied by facility location, with general admissions at Mount Darwin declining by almost half from 1991 to 1993, but increasing almost three times in Tsholotsho.

**Figure 6.3: Tsholotsho Hospital General and Maternity Admissions**

![Graph showing Tsholotsho Hospital General and Maternity Admissions from 1989 to 1996](image)

Source: National Health Information System, MOHCW, Bassett 1998

6.19 The FHP1 inputs had no discernible impact on outpatient utilization, which appear to be mostly influenced by changes in fee policies, disease patterns, and drought.

Figures 6.4 and 6.5 show the trends in under-5 and adult outpatient attendants rates from 1988 to 1996. Outpatient attendance rates for FHP1 districts (as well as the others) actually declined by 30 percent for children and 20 percent for adults from 1989 to 1992, corresponding to the opening of hospitals and clinics. The figures also show no significant changes among project and non-project districts. Several factors explain the declines. The major reasons appear to be increased enforcement of user fees in 1991, severe impact of the drought on household incomes in 1992, and declining service quality. Under-5 utilization reached its lowest point in 1994—when fees were increased by 2.5 times on average—then increased sharply following the abolition of fees at rural health facilities in 1995, and by 1996 had nearly recovered to 1990 levels. Over-5 utilization fell less and recovered more rapidly following the removal of rural fees, pushing 1996 utilization rates nearly 25 percent above 1990 levels. Drug shortages became more common in the early 1990s, particularly in rural health centers, which may have discouraged attendance (ZEPI 1996). Malaria is sensitive to drought and in FHP1 districts malaria incidence decreased by half from 1990 to 92, but this represents only about 20 percent of the under-5 outpatient decline.
6.20 **FHP1 had no apparent impact on major disease patterns.** This study aggregated facility-based incidence data for several major conditions—measles, malnutrition, malaria for children, and adult STIs—according to FHP1, FHP2, and non-FHP districts. The time trends show significant fluctuations between 1988 and 1996, corresponding to the changing population incidence of these conditions over time, but with no differences among project and non-project districts (Bassett 1998). The Family Health Projects were not intended to target specific diseases but rather, were to help build district capacity to plan and implement health programs. The lack of
impact on the major disease burdens indicates a need for greater focus on linking investments with monitoring and addressing major health problems.

6.21 The integration of family planning into health services contributed to increased contraceptive prevalence. Before the project, most family planning services were delivered through the Zimbabwe National Family Planning Council (ZNFPC) urban clinics and community based providers (CBDs) in rural areas. The training of health professionals in family planning sponsored by the project was successful, such that by 1994, 55 percent of contraceptives were obtained in government health facilities (CSO 1994). Increased contraceptive prevalence from 1988 to 1994, therefore, can at least in part be attributed to the project.

6.22 The provider training contributed to improved service quality, but the impact was reduced by high turnover and declining morale. In interviews, nurses and health officials strongly felt that the FHP training contributed substantially to improving the quality of services, particularly for family planning and MCH (Ellis 1997). Facility survey data also indicate that the training helped impart specific family planning and maternity skills. Providers with training did not, however, demonstrate improved counseling skills, apparently because the curriculum for improving counseling was developed after the FHP1 training was conducted (Chibatamoto 1997).

6.23 Staff turnover has reduced the effectiveness and impact of FHP training programs, particularly for skilled staff. The in-service training program experienced problems with retaining nurse tutors, with added expenditures for continually retraining tutors. The Public Service Commission (PSC) set the salary at a junior nurse level (despite protests from the MOH and the Bank) and the post was never integrated into the career structure for nurses. The midwifery training program did not meet its goal of increasing the number of nurse-midwives in rural facilities because of high trainee turnover. A certificate in midwifery is standard qualification for promotion, so those with training soon were promoted out of RHCs and district maternity wards, or left for the private sector, where maternity nurses are in high demand.

6.24 Poor morale among health workers, AIDS, and declining real health spending undermine service quality and reduced the impact of training on service quality. Focus group discussions with clients revealed that negative provider attitudes—together with drug shortages—were responsible for declines in the quality of government health services. A 1994 survey conducted by officials in one district found that nurse attitudes were an important reason some women chose not to deliver in a health facility (Mtemeli 1994).

6.25 Both the MOH and Bank staff have become acutely aware of the need to improve the quality of care and provider attitudes. In 1996, the Bank supported a major review of the quality of care, but poor performance by the local research firm undermined the usefulness of findings and recommendations (ARL- Techtop 1997).

41. In 1991, 86 percent of providers in FHP1 districts performed pelvic examinations, compared to 53 percent in other districts. In 1996, 89 percent of providers in FHP1 districts were offering maternity delivery services compared with 80 percent in FHP2 and 69 percent in non-FHP districts (Chibatamoto 1997).
**Project Management, Supervision, and Cooperation**

6.26 Within the MOH, the investment components of the project were managed by a project management unit (PMU), but each of the program subcomponents was managed by the relevant line department. Despite some problems of turnover within the PMU, this arrangement worked well. The Bank retained strong continuity of task managers and key consultants, with only four task managers over the first 10 years of the projects. This continuity helped foster the relationship and policy dialogue between the Bank and MOH.

6.27 Relatively frequent supervision by the Bank, including visits to districts and construction sites, helped resolve various implementation problems. As FHP2 progressed, Bank staff spent an increasing amount of time on broad sectoral issues, including budgets, national AIDS response, and staffing. The project did not always prove effective for promoting dialogue on these issues, however, limited discretionary funds were available for research and consultancy on issues of interest to the ministry, which contributed to a sense by government that the Bank's primary role in the sector was project implementation.

6.28 **Although the Bank initially led donor coordination during FHP1, the MOH increasingly took responsibility for project review and donor coordination.** During FHP1 design, the MOH asked the Bank to use the project as an “umbrella” to bring further coherence to donor activities. Donors and government were generally satisfied with the arrangement, but some problems arose. Funds from NORAD and the Netherlands were managed by the Bank, and supervision was undertaken jointly. Other donors participated in the project but maintained control of their own components. This separate management created some difficulties in maintaining program coherence, and several components were threatened when one of the donors pulled out of FHP2. By FHP2, the ministry chaired the review meetings, which included representatives from project districts and all cofinancers. These meetings became effective problem-solving sessions for the ministry, with benefits beyond the project.\(^{42}\)

6.29 As FHP2 draws to a close, however, most donors are negotiating programs with government on a bilateral basis. The ministry’s draft 10-year National Health Strategy establishes a strategic vision for the sector, but does not prioritize expenditures and investments within projected budget constraints. It therefore is not yet an effective instrument for coordinating donor programs. Translating these strategic goals into budgetary priorities will be important to maintain coherence among donor activities and sustain the MOH’s leadership in donor coordination.

**Monitoring and Evaluation**

6.30 Although FHP1 was supposed to be a pilot program, monitoring and evaluation were inadequate to assess the project’s impact on the health system or health outcomes. FHP1 established several indicators to monitor project progress, and the MOH conducted a baseline survey of the eight target districts in 1986. Rather than following up on progress in FHP1

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\(^{42}\) The MOH and Bank recently experimented with hosting the review meetings in one of the project districts; this format was enthusiastically received by donors and district officials, and has been maintained subsequently. Donors not supporting the project have expressed interest in attending these meetings but currently do not participate.
districts, the national MCH survey in 1991 provided baseline data on FHP2 districts. The government’s project completion report criticized the decision to proceed with a second Family Health Project before undertaking a thorough evaluation of the first (GOZ 1995).

Box 6.1: Linking Health Information to Decisionmaking:

A difficulty encountered in many World Bank projects and developing countries is that the information needed for effective program monitoring is either not collected, of low quality, or collected and not used. The Department of Epidemiology in the MOH has a strong disease surveillance program and collects a wide range of valuable health information. The MOH has used the information system to control disease outbreaks, and for monitoring specific program performance, such as child immunization. The ministry also has begun to use regional and district data as part of a resource allocation formula. A problem in the system is that although considerable data on health system performance are tabulated in annual reports at the national and regional level (and soon to be produced by each district), these data are presented with limited analysis. As such, their implications for policy often are not fully assessed.

Several performance indicators were routinely reported as part of FHP2 monitoring, but they were national aggregates and not always useful for guiding project decisions. The time-series utilization data collected by the Department was valuable for this study, but had not previously been assembled by the Bank or MOH as part of routine project monitoring. With the computerization of the system, such time-series analysis could be used more widely in the future.

The ministry is still in the process of clarifying responsibilities for data analysis. Districts collect routine information, but do not have incentives to analyze or use the data, largely because resource allocations are still not related to workload, disease burdens, or performance indicators. As one former district official stated, “It’s not that we can’t plan or analyze the data, it’s that even if we do, it doesn’t make a difference...” The recently-established Strategic Planning Unit could help to bridge the current gap between data and planning. Also, the MOH is in the process of selecting a limited number of indicators to monitor sector performance. More negotiation will be necessary, however, to build consensus among district, provincial, and national officials regarding priorities for the effective collection and use of health service data, and how to appropriately link performance measures to resource allocations.

6.3 Monitoring and evaluation was not always on an analysis of the linkages between indicators and project activities, however, or of how the indicators would influence project implementation. FHP2 chose national MCH outcomes indicators to monitor project progress, apparently because the project was supposed to represent most of the government’s health investment budget. As the impact of AIDS on health outcomes became more clear, the goals were revised downward. Project design was based on the assumption that improving district infrastructure would lead to increased vaccination coverage and facility deliveries, but it never identified the key constraints to achieving these targets, or whether the project inputs were the most cost-effective way of improving MCH outcomes. Neither project collected facility time-series data. The FHP2 review meetings, however, increasingly served as forums for discussing progress on indicators such as vaccination coverage with the project districts, and became an

43. The baseline survey also collected data on the frequency and quality of supervision in the districts, but no follow-up data were collected, and supervision was dropped as an indicator in FHP2. The Bank’s Project Completion Report (PCR) for FHP1 claimed the project had an impact because the national indicators found in the 1991 survey were higher than those in the SAR. The baseline survey, however, found indicators in most of the target districts to be higher than the averages reported in the SAR.

44. The government’s project completion report was unusually thoughtful, and gleaned a number of lessons from FHP1. Unfortunately, it was not completed until 1995, and as such did not influence either FHP2 design or the World Bank’s PCR.
opportunity for districts and provincial officials to discuss quality and coverage concerns with central MOH officials.

Financial Impact and Sustainability

6.32 **Bank estimates of recurrent burdens from the projects were optimistic.** Both appraisal documents estimated the recurrent burden of the projects and concluded that the projects were affordable. But both made key assumptions that were either overly optimistic or later proved incorrect, including projected growth of the economy and the MOH budget, and the extent of other donor or government-financed health investments outside the project. FHP1 cost overruns were absorbed by the government.

6.33 The Bank’s Project Completion Report for FHP1 rated project sustainability for most project components as likely but noted that economic conditions could be a factor in the future. The government’s PCR was more pessimistic, noting that manpower shortages and budget constraints under the structural adjustment program were already hindering program effectiveness (GOZ 1995).

6.34 Despite the concerns stated in the PCR, government does not maintain a strong link between investment planning and recurrent budgeting. Estimates for recurrent burden of FHP1 and FHP2 were not integrated into government planning. In the year before the handover of the FHP2 hospitals, the government still had not budgeted for staff or equipment. Government also proceeded with several other major hospital construction projects, despite shortages of staff and recurrent funds. Inadequate communication and coordination among key ministries involved in health investments, manpower, and budgeting has hindered effective planning. The National Planning Commission, which is responsible for investment planning, is separate from the Ministry of Finance and Economic Development, which prepares annual budgets. The lack of effective integration of investment and recurrent cost planning is common in Africa and can contribute to investment bias in public expenditure, as has occurred in the Zimbabwe health sector (van de Waal and Johnston 1996).

The Sexually Transmitted Infections (STI) Project

6.35 **The goal of the Sexually Transmitted Infections (STI) Project was to help reduce the incidence and impact of sexually transmitted infections in a cost-effective manner.** The project finances drugs for treating STIs and opportunistic infections associated with AIDS (such as tuberculosis), laboratory equipment, and protective supplies for health care workers. By the early 1990s, the MOH faced an urgent drug financing gap. In response, the Bank kept project design simple—financing only commodities—to facilitate rapid approval. The project became effective in 1993, less than a year after the initial request. British ODA financed a parallel technical assistance project to train providers in STI treatment protocols.

6.36 **The project goals are relevant, addressing a critical link in the transmission of HIV in Zimbabwe, and helping to close a major financing gap for drugs.** STI prevalence rates have historically been high in Zimbabwe, and had been increasing in the 1990s. Research in Zimbabwe and elsewhere in Africa demonstrate that HIV transmission was up to 10 times more likely in the presence of an active sexually transmitted infection (Latif 1995). Clinical treatment of STIs therefore is widely accepted as an important component of AIDS prevention programs (World Bank 1997). Other donors were financing prevention and behavior-change efforts, so the
Bank became the “donor of last resort.” The project financed half of all drugs purchased by the MOH, so the situation would have been dire without the project.

6.37 The STI project introduced international competitive bidding for pharmaceuticals to Zimbabwe, which led to substantial cost savings but also created other problems which, for a time, reduced drug availability. The project helped close the financing gap for STI drugs and drug availability increased to 89 percent in the first year of the project, but then fell to 73 percent in 1996 (ZEDAP 1996). This was still higher than it would have been without Bank financing, but fell short of the requirements for effective treatment. Following corrective measures by government, Bank staff, and other partners, availability increased again to 87 percent in mid-1998 (ZEDAP 1998).

6.38 Declines in drug availability were primarily the result of two factors: the reversal of major government bid awards by Bank procurement specialists, and delays in the registration of drugs. The STI project was the first World Bank pharmaceutical procurement project implemented by government, and also the first pharmaceutical project supervised by the Bank's task team. For the project, all large drug purchases had to be procured by international competitive bidding, in accordance with Bank regulations. These regulations are designed to ensure the lowest possible price and to protect both supplier and purchaser from every possible eventuality. Yet they are complex and can be confusing to those without training and experience. Staff in the government's General Medical Stores (GMS) -- which is responsible for drug procurement and distribution -- did not receive any initial formal training regarding Bank procurement procedures. In one of the first large tenders in 1995, GMS disqualified bidders that did not submit all the information necessary for drug registration. Once the bids were awarded, they were reviewed by Bank procurement specialists, who reversed a number of the awards saying that bidders had been inappropriately disqualified. Some of the originally-disqualified bidders were later awarded contracts, and again submitted incomplete registration packages. Further delays accrued while requesting this information. This process exceeded a year in many cases, and several essential STI drugs ran out of stock during this time.

6.39 Unlike some African countries, Zimbabwe has a functioning Medicines Control Authority (MCA), which requires that all drugs and suppliers go through a registration process. Bank procedures, in turn, require that bids be open to all companies and that the contracts be awarded to the lowest qualifying bidder, regardless of whether they are already registered. As the STI project became better known internationally, the number of unregistered companies winning contracts increased, and the MCA began to experience a backlog in drugs to be registered. Delays were compounded by government's practice of sending all official requests for further information to suppliers by regular mail.

6.40 Several other factors contributed to drug stock-outs. First, the MOH and the General Medical Stores (GMS) had not developed a reliable system for estimating drug needs, with stocks sometimes running out while a new order was prepared. Second, since drugs were loan financed, each procurement had to go through several additional approval stages, including the Ministry of

45. Bank procedures forbid government from contacting bidders regarding the prices, but GMS initially interpreted this to mean that they could not be contacted to request missing information.

46. Although some bilateral donor regulations permit government to hold a pre-registration period early in a drug procurement project and then make registration a requirement for subsequent bidding, Bank staff argue that this would reduce the competition necessary to maximize cost savings.
Finance and a “no objection” from the Bank. Delays of several weeks at each stage added additional months to the process. Third, bottlenecks in the distribution system have also contributed to stock-outs, which are attributable both to management problems and to tight budgets. Finally, the demand for antibiotics, not just to treat STIs, has grown with the AIDS epidemic. Poor prescribing practices also have contributed to depletion of stocks.47

6.41 A 1997 review of the ODA/DFID STI training component expressed strong concern that drug shortages were undermining the effectiveness of the training and of the entire treatment program (DFID 1997). Nurses had been trained to follow a defined protocol for treating STIs, and the absence of one or more of the front-line drugs led to inappropriate substitution, undermining treatment efficacy. Lack of drugs for treating STIs and related infection was a major complaint of providers in focus groups and interviews, and contributed to reducing client confidence in the government health system (Reed and Associates 1997).

6.42 Initial supervision of the project was inadequate to anticipate and resolve problems, but subsequently improved. Although the STI project was designed as a “simple” procurement operation, ensuring that the drugs were procured, registered, and reached facility shelves turned out not to be simple. To reduce administrative burden on the MOH, the Bank initially combined supervision of the STI project with the Second Family Health Project, but this resulted in inadequate attention to drug issues. The Bank’s local procurement officer was relatively new, and the Bank initially was not proactive in resolving problems. When stock-outs increased in 1996, Bank health staff began to devote more time to shepherding procurement bids through the process and explaining Bank regulations to relevant parties.

6.43 GMS staff attended a Bank-sponsored training workshop in 1996, and now report that preparing the bidding documents is no longer a major problem.48 In mid-1997, DANIDA sponsored a seminar that brought together for the first time representatives of all the departments and organizations—including the Bank—involving in drug procurement to discuss how the process can be made more efficient (Kaseke 1997). Although Bank staff had suggested holding the meeting, some delays might have been avoided if such discussions had been held before or soon after project effectiveness. The seminar made a number of recommendations, many of which have now been implemented. These, together with improved Bank supervision, contributed to the availability improvement in 1998.

6.44 International competitive bidding for pharmaceuticals, initiated by the project, resulted substantial savings for government. The initial drug procurement, initially estimated at US$5 million, was eventually won for US$2.1 million. The money saved from this and other procurements was used to purchase 100 ambulances. Now that GMS staff have learned ICB, they have adopted it for non-project procurements as well. With drug purchases constituting a substantial portion of the MOH’s non-wage recurrent costs, these savings are critical both from a budgetary standpoint and for insuring future drug availability at a time of arising demand. Drugs 47. For example, surveys have found that 30 percent of child diarrhea cases are treated with antibiotics, even though only 10 percent show evidence of blood in the stool (MPSLSW 1996).

48. The World Bank drug procurement document is more than 60 pages long, and is designed to cover every eventuality that could arise in any borrower country. The original GMS procurement document was 2 pages long, and contained no provisions to protect government against non-performance by suppliers. GMS has now adapted aspects of the Bank form for the official government form, expanding it to 5 pages (Remedios and Kostermans 1997).
stock-outs also have a cost, however, particularly if they result in untreated STIs and increased likelihood of AIDS transmission. Bank staff have argued that savings could be used to hire additional staff to assist with bid preparation and drug registration. The challenge facing government and the Bank has been to put in place the measures necessary to sustain drug availability, while maintaining the cost savings.

6.45 Attendances for STI treatment in government facilities has declined during the project. It is not yet known if this is because of declining disease incidence or a diversion of STI patients to private or traditional providers. Total attendance at government facilities for STI treatment has declined steadily since the beginning of the project, with more rapid declines in some urban areas. The decreases in attendance could be a result of a decline in prevalence, but attributing the declines to the project is complicated by two factors. First, in some urban areas, intensive programs to change behavior with high-risk groups, particularly reducing partners and increasing condom use, appears to lower STI prevalence (the Bank is providing some support to these programs). STI treatment is part of these programs but is effective because it is combined with behavior change. Second, the declines in facility attendance for STIs may be the result of diversion of STI patients away from government facilities to private or traditional providers, or non-treatment. Focus group interviews suggest a strong preference by clients—particularly women—to seek care from a private or traditional provider for STIs. Clients complained that government facilities lacked privacy and that nurses would often gossip or talk loudly about a patient’s condition. The second portion of a population-based survey on STI incidence should be completed in 1998, which should give evidence on disease incidence.

6.46 Although effective STI treatment can reduce AIDS transmission, there is as yet no evidence to demonstrate the STI treatment program’s impact on the progress of the AIDS epidemic in Zimbabwe. There is still little evidence regarding the effectiveness of STI treatment when scaled up to national level. Clients are reluctant to identify partners, so STI reinfection rates are high. The recurrence of drug shortages reduced treatment effectiveness. Providers are emphatic that the drugs are needed, however, both for treating STIs and other diseases. Yet the clinical approach—without significantly increased efforts toward prevention and modifying behavior—does not ensure a significant impact on the epidemic.

6.47 Neither the Bank nor government devotes sufficient attention to increasing public awareness regarding efficient drug use. Over-prescribing and excessive demand for antibiotics and other drugs remains a problem (ZEDAP 1996), yet the emphasis of government and the Bank has been on increasing drug supply, not managing drug demand. Although the Zimbabwe Essential Drugs Action Program (ZEDAP) monitors drug use and has contributed to improved prescription practices, the government devotes little attention to public education regarding appropriate drug use. Information is an inherent “public good” that should be provided by the public sector. Continued inappropriate use could render first-line antibiotics ineffective, which would significantly increase the costs to purchase more powerful drugs.
7. Lessons and Recommendations

Future Directions

7.1 Both the STI and FHP2 projects are scheduled for completion in late 1998. Bank staff are currently exploring with the MOH the possibility of sector support for the next ministry strategy, which could provide greater coherence and flexibility to address key sector challenges, including health staffing, and serve as a framework for coordinating donor resources. The World Bank and other donors waited through 1997 as the MOH worked internally to prepare a sector strategy. The ministry released the draft document in late 1997. The draft, while it provided a comprehensive overview of the challenges facing the sector, did not clearly articulate priorities for expenditure and investment (MOH 1997).

7.2 Meanwhile, deterioration of the government health sector and inadequate regulation of the private sector are emerging as major political issues in Zimbabwe. In 1997, President Mugabe appointed a review Commission on health to assess the health sector and make recommendations for strengthening it. A World Bank public health specialist is serving on the commission, which began work in early 1998 and is expected to issue a report later in the year.

7.3 The current situation illustrates the tensions among the Bank's various roles and mandates. On one hand, staff appropriately want to facilitate borrower ownership and support a coherent sector strategy, which implies waiting for the government's strategy to emerge. On the other hand, HIV prevalence is increasing and the health sector is deteriorating. Funding shortfalls could prove highly costly in lives and institutional capacity. Meanwhile, political leaders demonstrate little commitment to fiscal control. The president announced huge unbudgeted pension payments to war veterans in late 1997. This caused the currency to drop by 50 percent and heightened political tensions when the government imposed tax increases to fund the pensions. In such a context, the Bank must walk a difficult line between being "hard-nosed" (about enforcing macroeconomic conditions) and "soft-hearted" (toward sustaining the social sectors and addressing poverty).

7.4 The growing public debate over health care, fiscal control, and governance provides an opportunity for the Bank to facilitate informed dialogue over the options facing the country's options and to help build consensus for action. The Bank could engage government and civil society in a substantive discussion about the requirements for macroeconomic stability and growth, poverty reduction, and sustaining public health. These are difficult issues, both politically and technically, on which no one has all the answers, but the Bank could make a valuable contribution in sharing expertise and other country experiences.

Recommendations

7.5 In mid-1998, the World Bank and the government were in the process of negotiating the next phase of Bank support. The following are suggestions that the MOH and Bank might consider for their future collaboration.

- The Bank needs to develop a consistent approach to health staffing and civil service reform, particularly among Bank health and macroeconomic staff. The Bank could then work to facilitate negotiations among the Ministry of Health, Ministry of Finance, and
Public Service Commission, and International Monetary Fund regarding priorities. The Bank might also consider initiating a broader assessment on social sector staffing and civil service reform within the Bank’s Human Development Network, in collaboration with Bank macroeconomists, to improve coherence in Bank policies globally. The Bank also could encourage government to develop effective negotiation, dispute resolution, and consultation mechanisms between government and health workers.

- Even if the Bank continues to act as “donor of last resort” for funding STI drugs, emphasizing the importance of HIV/AIDS prevention in its project lending, macroeconomic dialogue, and discussions with political leaders and civil society is vital.

- In any project with a major pharmaceutical component, up-front training for both government and Bank staff—with periodic follow-up training—is essential to avoid bottlenecks that could interrupt drug availability. The Bank should continue to explore ways to better adapt its procurement procedures to local capacities. But the cost savings achieved through international competitive bidding are also essential to ensure drug availability in a time of tight budgets and growing demand for drugs.

- The Bank could consider supporting pilot activities to renew community mobilization for health in urban and rural areas, or to improve health service access and nutrition for the urban poor. These could also include pilots of community management of user fees, or of community AIDS prevention and care programs.

Box 7.1: Considerations for Health Sector Reform

As Zimbabwe begins to consider options for sector reforms, this study suggests that the following questions should be addressed:

- Can the proposed reforms be administered?
- What are the financial implications, and are they affordable without increasing the budget deficit?
- Will the actually achieve the intended results?
- What will happen if it is only partially implemented, or if key assumptions prove incorrect?
- Is the reform the most cost-effective means to achieve the maximum impact on health?
- What groups are likely to support or oppose the reforms? How can supporters be mobilized and opposition mollified?
- What few measures are most important? What can wait?
- How will reforms affect the poor?
- How will the impact of reform be measured?

In light of these questions, the government and its partners might consider whether the current plans to eventually transfer MOH health facilities and staff to Rural District Counsels as part of the decentralization process would lead to improved health services, given that (i) clients and providers currently rate RDC clinics as having the lowest quality, and (ii) many providers in focus group discussions said they would not want to work under the RDCs (Reed & Associates 1997). Decentralization can be a means to achieve certain objectives, but could lead to better or worse health services, depending on how it is implemented. The MOH is proceeding with plans to further decentralize within the health sector. Giving district health executives greater discretion over budgets and maintenance of vehicles and buildings could improve local health service efficiency and effectiveness. Government is also actively exploring the establishment of universal social health insurance. While the need for improved health coverage for the poor is manifest, government might consider whether such a scheme is viable, given that administrative capacity in the public sector is limited and less than 20 percent of the population is formally employed.

- Government is currently grappling with challenge of private sector regulation and balancing public and private roles in the provision of health services. Countries in Latin
America and Asia have confronted similar issues, and government might usefully learn from approaches tried elsewhere. Depending on MOH interest, the Bank could help provide advice or share experiences from other client countries.

- The MOH has begun to explore ways to link district and facility funding to workloads and performance, and to improve the linkages between health information and decisionmaking. The World Bank as an institution is considering how to better link its investments to improved health system performance and health outcomes. This could be an area for fruitful collaboration between MOH and the Bank.

- Improving management and cost-recovery at central hospitals will require coordination among the MOH, MOF, hospital boards, professional associations, and private insurance companies. The challenge will be to establish effective management systems, strong leadership, and appropriate incentives to improve billing and cost recovery, improve morale, reduce absenteeism, and improve the quality of care. MOH has identified improved hospital management as a priority for reform, and the Bank may be able to provide assistance for this process, if desired.
References

Background Papers

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