ZIMBABWE

Realizing the right to health for mothers and children

A multi-donor Heath Transition Fund helps to revitalize Zimbabwe's health system

With the first pangs of labour pain, Mercy Muchero started out on the long walk from her village to the nearest hospital. But she miscalculated how long it would take her to get there on time. "Suddenly, I felt my waters break. I couldn't walk further. The child was on its way," the 26-year-old woman from Chivi district in Zimbabwe's south-east recalls.

Halfway to the hospital, an aunt who accompanied her spread a thin blanket on the ground. A few minutes later, Muchero gave birth to a baby boy on the side of the road. Her aunt cut the umbilical cord with a razor blade and tied it with string, unaware that Muchero's uterus had prolapsed during the delivery.

Barely able to walk, carrying the newborn wrapped in her arms, the young mother and her aunt continued slowly until they reached Chivi District Hospital where a doctor instantly took Muchero to the operating theatre. "Her infection risk was extremely high. She could have died if a physician had not been available," the hospital's district medical officer, Dr Emmanuel Chagondah, who was on duty that day, explains.

Just over a year ago, Muchero wouldn't have been so lucky. Back then, the district hospital did not have a single doctor on staff, and many nursing positions were vacant. Such dire conditions were no exception. Many other health facilities in the southern African nation faced similar shortages of skilled personnel. According to Zimbabwe's Ministry of Health and Child Welfare, 69% of doctor positions, 80% of midwife posts and 62% of nursing tutor positions were vacant in 2011.

Zimbabwe's health sector – in the 1980s one of the best in sub-Saharan Africa – had nearly collapsed when a major economic crisis caused hyperinflation of more than 230 million per cent in 2008. Over the next years, chronic under-investment in the health sector made a bad situation even worse. "There was lack of equipment. Drug supply had dried up completely, apart from donor-funded

Mercy Muchero, 26, gave birth while walking to the hospital. Her uterus prolapsed and her life was saved by the doctor on call. In this photograph, her baby boy is a day old.

"Our goal is to have at least three doctors in each of Zimbabwe's 62 districts and one midwife per 5,000 people."

Aboubacar Kampo, Chief – Young Child Survival and Development at UNICEF Zimbabwe.

medication, even in the private sector. Public hospitals had to close. Most health workers left the country for better opportunities in other countries," remembers Zimbabwe's health minister, Dr Henry Madzorera.

Mothers and babies suffered the most under the crumbling health system. Maternal and child mortality rates shot up.

Every day, around eight women die of pregnancy related complications, according to the 2010–2011 Zimbabwe Demographic Health Survey. In addition, an estimated 80 children under the age of five die each day from mainly preventable causes such as common newborn disorders, paediatric HIV, diarrhoea, pneumonia and malnutrition. Newborn disorders – including babies being born pre-term, asphyxia and infections – are the main causes of under-five deaths.

Three quarters of newborn deaths occur in the first week after delivery due to lack of basic services and because fewer than 30 per cent of women and their babies receive immediate post-natal care.

Eventually, the international donor community stepped in. Through a Health Transition Fund (HTF), led by the Ministry of Health and Child Welfare and managed by UNICEF, a group of donors committed to ploughing $435 million between 2011 and 2015 – or about $80 million a year – into Zimbabwe's health system. The money goes towards maternal and child health and nutrition, provision of essential medicines, vaccines and basic equipment and human resources, as well as assistance in health policy and financial planning.

One of the most urgent goals of the HTF is the retention of the few skilled health workers who are left in the country. In collaboration with the Global Fund to fight AIDS, Tuberculosis and Malaria, the HTF tops up health workers' low wages to keep them in the system and ensure that not only positions in urban but also in rural areas are filled. "Our goal is to have at least three doctors in each of Zimbabwe's 62 districts and one midwife per 5,000 people," explains Aboubacar Kampo, UNICEF Zimbabwe's chief of young child survival and development.

Since the first rounds of funds were disbursed in 2011, progress has been steady but hampered by administrative hurdles. "We now have at least two doctors in every district. We have improved the training of midwives. But we are not yet there. We still need to see some improvement," the health minister admits. "Biggest challenges remain the conditions of service, [low] basic salaries and allowances and little access to continuing education."

In mid-2013, many health worker posts continue to be vacant, the workload of health workers is excruciatingly high, and it is difficult to convince doctors and nurses to take up positions in remote rural areas where quality of life is poor.

Since the HTF is meant to be a transitional mechanism to set minimum standards for health care, it is critical that

THE HTF – HOW IT WORKS

The Health Transition Fund (HTF) is a $435 million, five-year programme (2011-2015) that aims to revitalize Zimbabwe's health sector by improving the lives of children and women. It is funded by multiple donors, including the European Union, Canada, Ireland, Norway, the United Kingdom and SIDA Sweden, and managed by UNICEF in cooperation with the Zimbabwean Ministry of Health and Child Welfare (MoHCW).

THE HTF HAS FOUR PILLARS:

1. **IMPROVEMENT OF MATERNAL, NEWBORN AND CHILD HEALTH AS WELL AS NUTRITION**
2. **PROVISION OF ESSENTIAL MEDICINES, VACCINES AND TECHNOLOGIES**
3. **HUMAN RESOURCES, INCLUDING ASSISTANCE WITH HEALTH WORKER MANAGEMENT, TRAINING AND RETENTION**
4. **HEALTH POLICY, PLANNING AND FINANCE**

Its main goals are to reduce maternal mortality by three quarters and under-5 mortality by two thirds (as stated in the Millennium Development Goals) and eliminate user fees for children under the age of five and pregnant and lactating women by 2015. It also wants to help halve the number of underweight children under five as well as combating, halting and reversing trends in HIV/AIDS, malaria and other diseases.

A steering committee, chaired by the permanent secretary of the Ministry of Health and Child Welfare, oversees and directs the rollout of the HTF and defines priority interventions within each of the four thematic areas. Donors and UNICEF provide support to monitoring, evaluation and technical expertise.

"I knew there hadn't been a doctor in Chivi for more than four years. I wanted to help my community."

Dr Emmanuel Chagondah, 29, district medical officer at Chivi District Hospital, at the Madamombe rural health centre in Chivi district.

the Zimbabwean government works hand in hand with UNICEF and other development partners to improve the health system further and assure long-term sustainability, notes Kampo. Most importantly, it needs to substantially increase the national health budget, which in 2013 remains low at $380 million. "That means government only spends $26 per person on health, less than half of what they should allocate," he explains.

The shortfalls of the current financial outlays become obvious as soon as one leaves Zimbabwe's urban centres to visit outlying provinces and rural areas where health facilities have been running on shoestring budgets over the past five years. At Chivi District Hospital in Masvingo province, district medical officer Dr Emmanuel Chagondah walks through the echoing corridors of the maternity and labour ward, pointing out the dire circumstances under which he has to run the facility that services 174,000 people.

Most days, there is no running water. Power outages are frequent, but the only generator isn't strong enough to service the entire hospital, and money to buy fuel is limited, he says. To make matters worse, the incinerator hasn't been operational for the past four years and the hospital kitchen is out of order; so are the washing machines. Resuscitation machines and other life-saving equipment are broken, too.

Despite all these struggles, Chagondah also illustrates a range of positive developments that have taken place since

Government's role

Zimbabwe's Ministry of Health and Child Welfare (MoHCW) has publicly acknowledged the major lack of financial, human and material resources. Although in 2011 government budgeted $256 million (9% of the total national budget) for health, the actual disbursement depends every year on the availability of resources. In 2009, for example, only 10% of the originally allocated budget of $150 million was disbursed to the MoHCW.

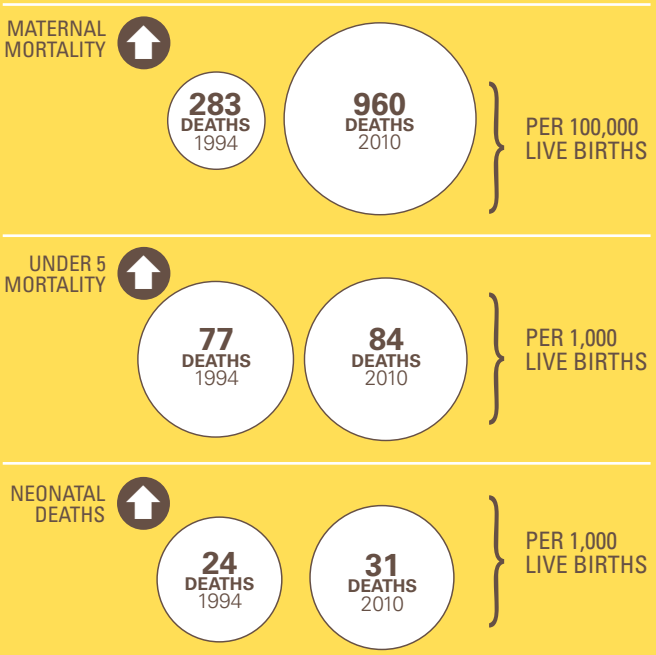
The recent improvement in the economic climate and the significant support of the donor community have made human resources for health, essential medicines and medical supplies more available. However, health facilities are not yet functioning effectively. They remain unable to cover costs for basic services (such as electricity, water and communications) as well as for regular maintenance of infrastructure and equipment.

To reach the Millennium Development Goals, Zimbabwe needs to spend at least $34 per capita per year to provide minimum essential health services to all citizens. The budgetary allocation, including donor contributions, is currently $7 per capita per annum on health – only a fifth of what is required. If government does not substantially increase its health spending, it will not be able to maintain and further build on the improvements the HTF is achieving.

Improving maternal and newborn health

Zimbabwe's decade-long economic crisis (2000–2010) led to a significant reduction in health expenditure, which diminished institutional capacity and caused infrastructure deterioration and commodity shortages. As a result, maternal and newborn death rates skyrocketed. This is largely attributed to pregnant women not being able to afford the user fees to access critical services.

Since 2010, the Ministry of Health and Child Welfare's top priority has therefore been resource mobilization.



THE NUMBER OF INSTITUTIONAL DELIVERIES
72% in 1999 to 65% in 2010/11

PROPORTION OF BIRTHS ATTENDED BY A SKILLED MIDWIFE
73% in 1999 to 66% in 2010/11

Source: Zimbabwe's Demographic Health Survey and the World Health Organization.

Madamombe, a poverty-stricken community, where locals mainly survive from subsistence farming

The Madamombe rural health centre lies in an area of arid farmland in south-eastern Zimbabwe, where the population mainly survives from subsistence agriculture and cattle.

he took up his position as district medical officer in May 2012. Because government has started to remove user fees for pregnant and lactating mothers and children under the age of five, barriers to access health services have been considerably lowered, he says. And since the HTF started to top up salaries in collaboration with the Global Fund, some additional staff has been hired and health workers have generally been more motivated. "The quality of services has improved a lot," says Chagondah.

The 29-year-old doctor is himself a prime example for some of the early successes of the HTF. After graduating and completing his internship, he decided to return to rural Chivi, a small town near where he grew up.

"I knew there hadn't been a doctor in Chivi for more than four years. I wanted to help my community," he says. The HTF retention scheme, which substantially boosts his salary, made the move possible. Since his return to Chivi, Chagondah, who has recently been joined by two other doctors, has worked relentlessly, without taking a single day off. "It's hectic, but what can you do when you're the only one around?" he shrugs.

Among his many duties are monthly visits to each of the district's 18 rural clinics. Today, he has travelled to Madamombe, a poverty-stricken community roughly 30 kilometres outside of Chivi, where locals mainly survive from subsistence farming.

The health centre is a basic structure of two rows of red brick buildings with broken windows and an outdoor waiting area with a washed-out blackboard where two community health workers in brown and white chequered shirt-dresses and matching sun hats educate waiting mothers about health and nutrition. One of them is Shandzirai Koreka, who has for the past three years been taking care of 150 households in the area, visiting an average of 20 patients a day. At the end of the month, she is paid $14, a salary with which she has to support four children. "It's just enough to

KEY INTERVENTIONS INCLUDE:

- Health care workers being trained in emergency obstetric and essential newborn care services including neonatal resuscitation
- Procurement of essential maternal and newborn health laboratory and medical equipment, drugs and other supplies, including blood
- Improvement of transport and communications systems for patient referral
- At least three postnatal care visits within the first week of life in rural clinics

Provision of essential medicines

Through the HTF, donors procure essential medicines for district and provincial hospitals in the form of primary health care packages (PHCP) and bulk medicines.

Bulk essential medicines are disbursed through a pull system, where hospitals and clinics place monthly orders to the Zimbabwe's National Pharmaceutical Company (NatPharm).

The PHCPs, in contrast, are distributed through a push system to almost 1,400 primary health care facilities from six NatPharm warehouses in Bulawayo, Chinhoyi, Gweru, Harare, Masvingo and Mutare. District pharmacy managers deliver the medicines and collect consumption and stock status data on a quarterly basis. The data is then analysed and used to adjust quantities for the next distribution round as well as to forecast the country's needs.

Donors, the Ministry of Health and Child Welfare and supply chain partners regularly review the composition of the PHCPs to remove medicines that are moving too slowly and increase quantities of medicines that are moving fast. To date, almost 90% of all health facilities had at least 80% of selected medicines and health commodities in stock. However, stock pile-ups and stock-outs still occur in some facilities.

Community health worker Shandzirai Koreka (left) teaches Senzeni Kwangware, 29, about antenatal care. Kwangware, who lives in Mashoko village in Chivi district, is eight months pregnant with her third child and plans to give birth at the Madamombe rural health centre.

make ends meet," she says, but expresses hope that she will receive further training and perhaps even additional allowances through the HTF.

After she has seen to the mothers in the clinic's waiting area, Koreka heads out to visit patients in their homes. Her main job is to encourage pregnant women to register at the clinic, go for regular antenatal check-ups and eventually give birth at the health facility, under the supervision of skilled staff, she says.

Today, her first stop is the home of Senzeni Kwangware in nearby Mashoko village, who is eight months pregnant with her third child. The 29-year-old sits cross-legged in her simple mud hut, cooking a pot of corn on the fire as the health worker walks in. The two women greet each other warmly.

"Mrs Koreka visits me regularly. She advises me on how to eat healthily and on sanitation. She also told me to get weighed once a month at the clinic and to track the weeks of my pregnancy so I know when I can expect to give birth," the young mother says. It's the first time she has received health care during a pregnancy, she adds, and she says she is much calmer when thinking about the upcoming delivery.

Based on anecdotal evidence, Koreka has noted similar mindset changes in many other patients. "I think, generally, the health of mothers and children in the area has improved," she says. "Before there were trained community health workers, like myself, women didn't even know the basics about nutrition, vaccinations or how to bath the baby."

It's exactly this right to basic health care the HTF wants to promote, says EU Ambassador to Zimbabwe, Aldo Dell'Ariccia, who chairs the donor group which funds the HTF: "It boils down to the fact that the mother survives, that the child survives. It's an approach to health as a right. We accompany Zimbabwe in the process of transformation it is engaged in."

The five-year transition period during which the HTF is making monies available is meant to help the Zimbabwean government to gradually increase it's health budget to

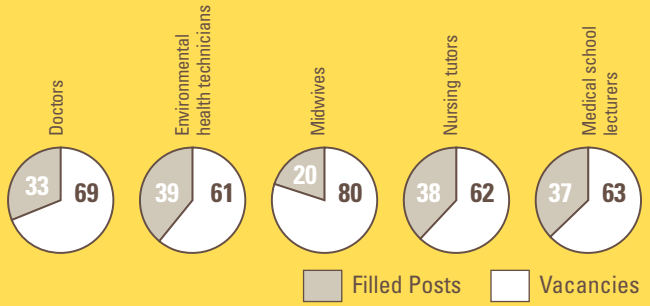
Human resources

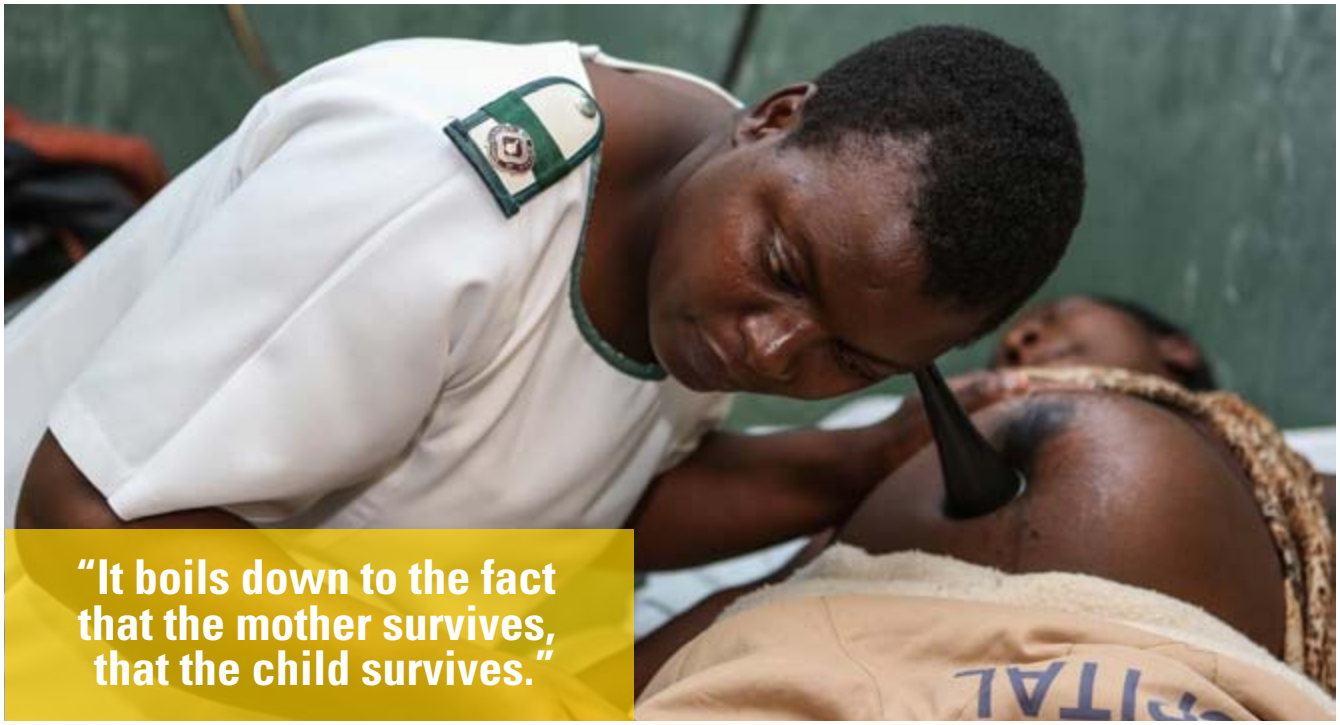
Ten years of limited health spending led to a severe loss of skilled health workers. Most of Zimbabwe's hospitals and clinics are understaffed, operating with a skeleton staff burdened with heavy workloads. Due to urban migration, the shortage is most critical in rural areas where health workers are generally less qualified and receive lower pay. Needless to say that the quality of health services suffered, too. At the height of the crisis, in 2008, most hospitals and clinics had to close down, while a cholera epidemic ravaged the country.

To halt the decline of health services, the Zimbabwean government launched a Human Resources for Health Retention Scheme in collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria and other funding partners, in late 2008. The scheme aims to reduce clinical and managerial turnover, vacancy rates of essential staff nationwide and retain skilled workers by providing them with top-up payments to their salaries.

The HTF support to the scheme complements existing funding from the Expanded Support Programme, bilateral donor institutions and the Global Fund (although there remains a 7% payment shortfall).

Top-ups are paid based on a list of "most critical posts" provided by the Ministry of Health and Child Welfare to retain and motivate staff. Those working for the Human Resources Directorate, front-line professionals, like doctors and operating theatre nurses, as well as village health workers qualify. Already, there has been a reduction in vacancy levels in all positions as well as more equitable distribution of health workers in urban and rural areas. However, there have been some delays in the provision of the health worker lists, which has led to holdups in payments, and many crucial health worker posts remain vacant, including:





Anna Mungara, a midwife in training at the midwifery school at Masvingo Provincial Hospital, checks up on a woman in the early stages of labour.

a level where it can take over and sustain the expenses currently carried by the HTF. "It's not something the government can do from one day to the other. It's a long process. But the important thing is that we are progressing," says Dell'Ariccia.

Meanwhile, in the maternity ward at Chivi district hospital, Muchero is recovering from the operation to repair her uterus. Even though she is still in moderate pain, she is able to sit up in bed to breastfeed her one-day-old baby. "The nurses treated me very well. They were very knowledgeable," she says with a shy smile.

Muchero, who gave birth to her second-born child almost three years ago at the same hospital, says she can note a marked difference in the services that were provided to her: "The last time I was here, there was no doctor. I never thought I could be fortunate enough to be treated by a doctor. I felt very safe since I arrived here. I definitely want to deliver here again." ■

Human resources continued

Ultimately, the goal is to employ at least three doctors per district (or a total of 186 doctors), train 550 primary care nurses in midwifery, 500 environmental health assistants and operating theatre nurses and 20,000 village health workers, so that 95% of health facilities and health management offices will be staffed with the minimum required number of qualified health professionals by 2015, by which time the Zimbabwean government is expected to have increased wages and taken over full payment of all salaries.

User fees

In the 1980s and early 1990s, Zimbabwe had one of the best primary health care systems in sub-Saharan Africa. It was also at the forefront of regional and global initiatives on child survival.

As part of the country's Economic Structural Adjustment Programme, however, user fees were introduced in the 1990s, which hampered access to health care, especially for the poor. The 2003 Poverty Assessment Study Survey showed that a lack of money was the main reason patients did not seek treatment for illnesses or injuries. Although the user fee policy gave free access to children under the age of five, pregnant women and the elderly, those exemptions were not broadly implemented. The 2007 Maternal and Perinatal Mortality Study found user fees were the main reason for lack of access to ante-natal, post-natal and institutional delivery services.

Even when user fees were universally removed, the struggle of health facilities to cover running costs resulted in a non-standardized system of fees, levies, registration payments and incentives. The Vital Medicines and Health Services Surveys suggest that only half of all health facilities provide a full maternity service free of charge. Other facilities charge fees varying from $3 to $50, with higher prices in urban locations. User fees also continue to be charged on an ad hoc basis for emergency services, such as Caesarean sections or blood transfusions.