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# ASSESSMENT OF THE PRIVATE MEDICAL SECTOR IN ZIMBABWE

by

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# ASSESSMENT OF THE PRIVATE MEDICAL SECTOR IN ZIMBABWE

## TABLE OF CONTENTS


ACKNOWLEDGEMENTS . . . . . i
EXECUTIVE SUMMARY . . . . . ii
ACRONYMS . . . . . iv

Chapter 1 FAMILY PLANNING IN THE PRIVATE SECTOR IN ZIMBABWE

1.1 Background . . . . . 1
1.2 Introduction . . . . . 2
1.3 Defining the Private Sector . . . . . 3
1.4 Prior USAID Support for Private Sector Activities . . . . . 3
1.5 Methodology . . . . . 4
1.6 Organization of Report . . . . . 4

Chapter 2 INDIVIDUAL PRIVATE HEALTH CARE PROVIDERS

2.1 Medical Practitioners and Nurses: Private Sector Size . . . . . 5
2.2 Medical Practitioners: Size and Location of Practices . . . . . 7
2.3 Nurses and Midwives: Type of Practice . . . . . 8
2.4 Nurses and Midwives: Impediments to Practice . . . . . 8
2.5 Organization of Medical Professionals . . . . . 9
2.6 Provision of Family Planning Services . . . . . 9
2.7 Constraints to Family Planning Service Provision . . . . . 12
2.8 Information Gaps . . . . . 13
2.9 Opportunities for Expansion . . . . . 14

Chapter 3 RETAIL PHARMACISTS

3.1 Pharmacists: Number and Distribution . . . . . 15
3.2 Organization . . . . . 15
3.3 Provision of Family Planning . . . . . 16
3.4 Constraints . . . . . 16
3.5 Opportunities for Expansion . . . . . 17

Chapter 4 WORK-BASED HEALTH FACILITIES

4.1 Number and Location of Sites . . . . . 18
4.2 Delivery of Family Planning Services . . . . . 19
4.3 Constraints . . . . . 19
4.4 Financial Incentives . . . . . 20
4.5 Information Gaps . . . . . 20
4.6 Opportunities for Expansion . . . . . 20

Chapter 5 PRIVATE SECTOR CONSUMERS

5.1 Consumer Use of the Private Sector . . . . . . . . . . . . . . . . . . . . . 21
5.2 Consumer Characteristics . . . . . . . . . . . . . . . . . . . . . . . . . . . . 21
5.3 Opportunities for Expansion . . . . . . . . . . . . . . . . . . . . . . . . . . 23

Chapter 6 MEDICAL AID SOCIETIES

6.1 Description of Medical Aid Societies . . . . . . . . . . . . . . . . . . . 24
6.2 Coverage of Family Planning Services . . . . . . . . . . . . . . . . . . 25
6.3 Constraints . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . 27
6.4 Opportunities for Expansion . . . . . . . . . . . . . . . . . . . . . . . . . . 28

Chapter 7 COORDINATION OF PUBLIC AND PRIVATE SECTORS

7.1 Coordination of Sectors . . . . . . . . . . . . . . . . . . . . . . . . . . . . 29
7.2 Low Public Sector Costs as Disincentive to Private Sector . . . . . . . . . . 29
7.3 Public Sector Policies . . . . . . . . . . . . . . . . . . . . . . . . . . . . . 31
7.4 Conclusion . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . 31

APPENDICES

Appendix 1 Bibliography . . . . . . . . . . . . . . . . . . . . . . . . . . . . . 33
Appendix 2 Persons Contacted . . . . . . . . . . . . . . . . . . . . . . . . . . 38
Appendix 3 Organization of Medical Sector . . . . . . . . . . . . . . . . . . 40
Appendix 4 Medical Aid Societies and Members . . . . . . . . . . . . . . . 44

LIST OF TABLES

Table 1 Registered Health Practitioners . . . . . . . . . . . . . . . . . . . . . 5
Table 2 Registered Health Practitioners and MOH Staff . . . . . . . . . . . . 6
Table 3 Location, Number and Percent of NAMAS-Registered General Practitioners and Obstetrician-Gynecologists, DCC-Registered Dispensing Physicians, and Percent Distribution of the National Population . . . . . . . . . . 10
Table 4 Doctors Wishing Additional Family Planning Training . . . . . . . . 11
Table 5 Location of Pharmacies . . . . . . . . . . . . . . . . . . . . . . . . . . 15
Table 6 Private and Industrial Hospitals and Clinics by Province and Registration Source . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . 18
Table 7 Percent Distribution of Private and Public Sector Family Planning Users by Education, Age Group, Residence and Number of Children . . . . . . . . . 22
Table 8 Percent Distribution of Private Practice Patients by Occupation Category . 23
Table 9 Medical Aid Societies: Total Beneficiaries (as of 1 June each year) and Growth . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . 24

Table 10 Medical Aid Societies Reimbursing Family Planning by Provider Type . . 26
Table 11 Percent Distribution of Economically Active Persons by Rural and Urban Areas and by Activity, Zimbabwe 1992 Census . . . . . . . . . . . . . . . . . . . . . . 28
Table 12 Comparative Contraceptive Commodity Costs by Source . . . . . . . . . . . 30

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## EXECUTIVE SUMMARY

This report presents the findings of the baseline needs assessment carried out in August through November 1995 to determine the current scope and magnitude of private sector family planning service provision and opportunities for expansion. The private health sector in Zimbabwe includes medical practitioners, nurse-midwives in private practice, pharmacists, employment-based services, non-governmental organizations (NGOs), and medical aid societies (MAS).

According to the 1994 Zimbabwe Demographic and Health Survey 12% of women obtain contraceptive services from the private medical sector, and 2% from other private sector sources. The private sector is particularly important in the provision of IUDs and female sterilizations.

The main reasons cited for using private sector sources reflect actual or perceived convenience: services are closer to home or place of work, there are shorter waiting times, and the client is able to use other services offered at the same site.

The size of the private medical sector was estimated from several sources. There are approximately 958 medical practitioners, 448 pharmacists, and 5400 nurses operating in the private sector, but these figures likely overestimate currently practicing professionals. A disproportionate share of medical personnel are located in Harare and Bulawayo, leaving large portions of the country underserved by the private medical sector. Sixty percent of pharmacies and 77% of pharmacists are also concentrated in these two cities.

Most doctors in family practice provide some family planning services, though the range of services and the volume of the practice devoted to this varies greatly. Doctors do not report services provided to either the Ministry of Health (MOH) or the Zimbabwe National Family Planning Council (ZNFPC). Contraceptive supplies are most often obtained from commercial suppliers and pharmacies. Doctors cited cost issues and the limited availability of some methods as inhibiting factors in the provision of services.

Few nurse-midwives had private practices, although many seem keen to do so. Nurses interviewed cited lack of information on requisite procedures and insufficient capital as obstacles to start-up. Nevertheless, more than half the participants in 4 focus groups indicated that they did some nursing outside their normal hours, implying a "grey market" in informal practices.

Virtually all pharmacists stock contraceptive supplies that reflect the range of commodities currently registered in Zimbabwe. Pharmacists are authorized to start women on oral contraceptives, but few do so. They expressed an interest in participating in technology updates, and in obtaining updated screening tools and consumer information.

More than 200 industries and businesses have on-site clinics for employees. Many provide some basic family planning services and supplies, particularly condoms and oral contraceptives. Expanded services appear to be constrained by inconsistent technical support from ZNFPC or the MOH, and by perceptions that health care in general, and family planning in particular, is the responsibility of the public sector. More investigation of the potential for expanded services in this segment of the private sector is needed, but it appears that at the minimum, sites offering OCs should be targeted to add injectable contraceptives to their programs.

Medical aid societies (MAS) are private, pre-paid, not-for-profit health insurance programs. 24 companies provide coverage for 731,350 members and beneficiaries, approximately 7% of the population. Most family planning commodities excluding condoms are reimbursed, whether they are provided by physicians, ZNFPC or pharmacists. Today virtually all MAS provide some level of coverage for family planning services and supplies. Expanding family planning coverage through medical aid implies either increasing the number of medical aid members, or improving the utilization of benefits by existing members.

Opportunities for expanding private sector participation in family planning service delivery exist. Doctors and pharmacists have requested additional training and updates on contraceptive technology. Nurse-midwives are anxious to open private practices, but lack knowledge of the process they must follow and the capital needed to do so. Medical Aid Societies already offer comprehensive coverage for family planning services and commodities, but their members are often unaware that these benefits are part of their packages. A wide variety of industries provide services, but it is often on an ad hoc basis, with little or no coordination or systematic means of obtaining supplies, training, or commodities. Improvements can be made in public-private collaboration, especially in the areas of program planning, distribution of commodities, and dissemination of informational materials.

## ACRONYMS

| | |
|---|---|
| AVSC | Association for Voluntary Surgical Contraception |
| CFU | Commercial Farmers Union |
| CIMAS | Commercial and Industrial Medical Aid Society |
| CPCP | College of Primary Care Physicians |
| CZI | Confederation of Zimbabwe Industries |
| DCC | Drugs Control Council |
| EPI | Expanded Program of Immunization |
| ESAP | Economic Structural Adjustment Programme |
| FP | Family Planning |
| GOZ | Government of Zimbabwe |
| GP | General Practitioner |
| HPC | Health Professions Council |
| IUCD | Intra-Uterine Device |
| MAS | Medical Aid Society |
| MASCA | Medical Aid Society of Central Africa |
| MOH | Ministry of Health and Child Welfare |
| NAMAS | National Association of Medical Aid Societies |
| NGO | Non-Governmental Organization |
| NSSA | National Social Security Authority |
| OC | Oral Contraceptive |
| PROFIT | Promoting Financial Investments and Transfers |
| PSMAS | Public Service Medical Aid Society |
| PSZ | Pharmaceutical Society of Zimbabwe |
| RPA | Retail Pharmacists Association |
| SEATS | Family Planning Service Expansion and Technical Support |
| TIPPS | Technical Information on Population in the Private Sector |
| USAID | United States Agency for International Development |
| ZDHS | Zimbabwe Demographic and Health Survey |
| ZFPP | Zimbabwe Family Planning Project |
| ZiMA | Zimbabwe Medical Association |
| ZINA | Zimbabwe Nurses Association |
| ZNFPC | Zimbabwe National Family Planning Council |

Chapter 1

# FAMILY PLANNING IN THE PRIVATE SECTOR IN ZIMBABWE

## 1.1 Background

Zimbabwe's family planning program is considered one of the most successful in Africa. Despite its accomplishments, the program faces serious challenges. Levels of unmet need for family planning information and services are high, and public sector financial resources are decreasing. Supply of information and services will not meet demand unless the government shares more of the burden with private sector providers, both for profit and not-for-profit. For the past decade, the private sector has played a modest but important role in family planning service delivery, supplying between 9 and 12 percent of users. By late 1994, when the most recent Zimbabwe Demographic and Health Survey (ZDHS) was carried out, 85% of contraceptive users were served by public sector sources, 12% by private medical sources, and 2% by other private sources (CSO and Macro International, 1995). Rural and municipal clinics were the most important source, serving 32% of users, followed by the Zimbabwe National Family Planning Council (ZNFPC) clinics and community based distributors (CBDs), with 23%. Government hospitals and clinics served 15%. Private hospitals and clinics served 4% of users, private doctors 4% and pharmacies 5% (ZDHS, Table 4.15).

The government's vision of the role of different providers is discussed in the Five-Year (ZNFPC) Strategy, which calls for an increase in the share of services delivered by the private sector from 12% to 17%. The bilateral Zimbabwe Family Planning Project (ZFPP) of the Government of Zimbabwe (GOZ) and the United States Agency for International Development (USAID) was developed in response to, and seeks to assist in achievement of, goals articulated in the ZNFPC strategy.

Concern was expressed about ZNFPC's plans to move quickly to decentralize private sector activities to the provinces, where staff had minimal private sector experience. ZFPP evaluators recommended integrating private sector activities with a comprehensive private sector family planning financing initiative (Huber, et al., 1994a). The PROFIT Project, managed by Deloitte Touche Tohmatsu, was contracted by USAID to conduct a baseline needs assessment, develop a comprehensive private sector strategy and workplan for further action, and to implement the project.

This report presents the findings of the baseline needs assessment carried out in August through November 1995 to determine the current scope and magnitude of private sector family planning service provision and financing, and opportunities for expansion. The results of the assessment will be discussed at a workshop organized by the PROFIT Project in January 1996, with the participation of Zimbabwean private sector representatives, professional associations, Ministry of Health, ZNFPC, USAID and other donors. Following the workshop, the strategy and workplan will be developed.

## 1.2 Introduction

This report is the first activity undertaken in the development of a private sector sub-project to the Zimbabwe Family Planning Project (ZFPP). The project seeks to diversify contraceptive method mix and to increase program sustainability, in part by increasing the contribution of the private sector to family planning service delivery. The purposes of the sub-project are:

- To develop a comprehensive data base on current family planning activities or related activities in the private sector, the possible channels for delivery of family planning and related services, and information on their potential and constraints

- To implement activities that will increase private sector participation in the provision and/or financing of family planning services, particularly through:

    - provision of employer-based family planning services
    - provision of services by private practitioners
    - provision by private pharmacists
    - financing by private medical aid (insurance) associations.

A recent analysis of the health sector in Zimbabwe noted a serious lack of data, particularly for the private sector (Schwartz and Zwizwai, 1995). Specifically, the authors noted the limited information available to describe:

- The number, type, and characteristics of private sector facilities

- The supply and types of private sector human resources

- The private/public sector mix regarding the public practitioner supply of services to the privates sector, or use of public facilities for private patients

- The level of household expenditure in the private health sector

- The benefits paid by medical aid societies, employer based plans, and the private resources of Mission facilities and non-governmental organizations (NGOs).

Also, information on privately owned surgeries and utilization rates are excluded from Ministry of Health and Child Welfare (MOH) data. While time constraints and limited resources for primary data collection did not permit fully addressing these limitations, this report represents the first effort to describe the size, nature and distribution of private sector health resources in Zimbabwe using existing data from a mix of sources not commonly used for this purpose.

## 1.3 Defining the Private Sector

The private health sector in Zimbabwe is assumed to include medical practitioners, nurse-midwives in private practice, pharmacists, employment-based services, non-governmental organizations (NGOs), and medical aid societies (MAS). Mission facilities are not included, as most of the 105 church-affiliated hospitals and clinics in Zimbabwe receive significant government grants that cover salaries, drugs and running costs. Also, since there is only one NGO, Population Services, engaged in family planning (FP) service delivery, they are mentioned only briefly and for comparative purposes.

## 1.4 Prior USAID Support for Private Sector Activities

USAID provided support to develop private sector activities under three earlier projects. Through the Enterprise Project (1986-1989), work-based family planning activities were introduced in 5 major sites: Triangle and Hippo Valley sugar estates; Lonrho mines; two districts with commercial farms, in collaboration with the Commercial Farmers Union; and the BAT Tobacco Company. Most activities have been sustained, and are discussed more fully in Chapter 4.

Identification and recruitment of new companies was undertaken under the subsequent SEATS Project (Family Planning Service Expansion and Technical Support I). However, unfavorable economic conditions precipitated by the drought of 1991-92, coupled with a belief that such services are the responsibility of government, discouraged potential industry partners from investing in what was perceived as a non-essential benefit for their workers.

The TIPPS Project (Technical Information on Population in the Private Sector; 1986-1989) worked with CIMAS (Commercial and Industrial Medical Aid Society), the largest of the approximately 30 MAS then operating in Zimbabwe, to conduct a cost-benefit analysis of family planning and maternity and pediatric costs. The object of the study was to persuade CIMAS of the benefits of including family planning as part of its benefits packages. In 1989 CIMAS added the benefit to its packages, and today nearly all of the other MAS in the country have also done so (see Chapter 6).

Private sector projects were not given a high priority by either USAID or ZNFPC in the years after these activities. While ZNFPC established a post of Private Sector Coordinator, there has been repeated turnover of staff in the position, insufficient resources and technical support were provided, and the incumbent is often pressed into service carrying out other tasks, leaving new interventions to languish.

Spurred by the findings of two USAID reviews carried out during 1994 (Huber, et al., 1994a; 1994b), USAID/Harare decided to re-energize efforts to expand private sector participation, and awarded a contract to the PROFIT Project to plan and implement a new project.

## 1.5 Methodology

Research for this report was carried out from August through November, 1995. A variety of quantitative and qualitative research methods were used. A literature review of recent documents provided contextual information and national data. Data requests were made of a variety of organizations, including the Health Professions Council (HPC), the National Association of Medical Aid Societies (NAMAS), and the Zimbabwe Medical Association (ZiMA). Spot interviews were conducted with urban pharmacists, four focus groups elicited information from nurse-midwives, and 15 in-depth interviews were carried out with medical practitioners and obstetrician-gynecologists[1]. In addition, more than a dozen interviews were held with other key informants in both the private and public sectors. The 1994 Zimbabwe Demographic and Health Survey (ZDHS) data were analyzed to identify consumer characteristics. Finally, existing and draft legislation pertaining to private sector health care were reviewed.

## 1.6 Organization of the Report

Each component of the private sector is discussed in the following chapters. For each, its current size and salient characteristics are described. Current family planning service delivery roles are noted. Constraints to and opportunities for expanding service delivery are identified, and possible project interventions are listed.

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[1] The focus groups and in-depth interviews with medical practitioners were carried out by the company of Barbara Reed, Market Research Consultant. Reports summarizing the research findings are cited in the bibliography. Copies are available on request from the PROFIT Project.

Chapter 2

# INDIVIDUAL PRIVATE HEALTH CARE PROVIDERS

## 2.1 Medical Practitioners and Nurses: Private Sector Size

This chapter summarizes the scope and current role of individual private health service providers, e.g. medical practitioners (doctors) and nurses, in the delivery of family planning services.

It is virtually impossible to accurately determine the size and distribution of the private medical sector in Zimbabwe. For the most part, records do not differentiate sector of employment, thus estimates must be derived from several different sources. The best source of information on size of the total medical sector is the register of all health professionals maintained by the Health Professions Council (HPC)[2]. Registration is mandatory in order to legally practice in Zimbabwe. New registrants are initially listed on a provisional register for three years, and then moved to the main register. As of August 1995, the registers included 1632 medical practitioners, 485 pharmacists, and more than 14,000 nurses (Table 1). Fifty percent of the nurses registered with the HPC qualify as midwives or maternity nurses.

Table 1: Registered Health Practitioners

| Profession | Main Register | Provisional Register | Total |
|---|---|---|---|
| Medical Practitioners* | 1310 | 322 | 1632 |
| Pharmacists | 457 | 28 | 485 |
| General Nurses | 7094 | 84 | 7178 |
| State Certified Nurses[3] | 6839 | 20 | 6859 |

Source: Health Professions Council (1995)
* Includes 363 Specialists

[2] The HPC is a independent statutory body established by Government. It receives no public financial support, but is subject to the directives of the Minister of Health. Of 19 members of the Health Professions Council, 1 is the Chief Medical Officer of the MOH, and 3 are appointed by the Minister.

[3] State Certified Nurses are a cadre comparable to Licensed Practical Nurses; they are being phased out through upgrading and attrition.

Professionals are listed regardless of their sector of employment, thus these figures include staff deployed in both the public and private sectors as well as mission and industrial facilities. The figures over-state the size of the active medical profession, in that individuals may maintain their registration while they are out of the country, retired, in advanced training, or ill. The register also includes expatriate personnel. Figures for March 1995 indicate that there are at least 141 expatriate doctors in government district hospitals and mission hospitals (Manpower Monitor, 1995:8).

The size of the private sector can be estimated by subtracting the number of staff in Ministry of Health positions from the total registered with HPC (Table 2). The resulting figure underestimates the total for doctors, in that many employed in the public sector also maintain part-time private practices (offset by the inclusion of some inactive members). Doctors must request permission to do this, but MOH does not maintain any central roster of those approved. Instead, authorizations are merely filed in individual personnel files.

Table 2: Registered Health Practitioners and Ministry of Health Staff

| Profession | Register | MOH Staff | Difference |
|---|---|---|---|
| Medical Practitioners | 1632 | 674 | 958 (59%) |
| Pharmacists | 485 | 37 | 448 (92%) |
| General Nurses | 7178 | 4370* | 2808 (39%) |
| State Certified Nurses | 6859 | 4265 | 2594 (38%) |

Source: Health Professions Council (1995); MOH Establishment Control and Personnel Information (1995)
* Includes Directors of Nursing (6), Matrons (105) and Tutors (71).

To estimate the number of nurses in the private sector, the figures should be further reduced by the number employed by municipalities and towns, by other government bodies such as the military service, and parastatals such as ZNFPC. Unfortunately, the employment figures are not reported centrally, and must be obtained from each individual employer. This was not possible during the time allocated for this research. It is known that together Harare, Bulawayo and Gweru employ about 1200 nurses (SEATS, 1996a; 1996b; City of Harare, 1995), and that ZNFPC has an additional 75 on its staff (Lunga, 1996). The remaining towns and government bodies may employ a like number, reducing the number of nurses not employed by MOH by about half.

Perhaps the most efficient proxy for size and distribution of the private sector is the register maintained by the National Association of Medical Aid Societies (NAMAS). Zimbabwe has a well-organized system of not-for-profit medical aid. All providers who wish to be reimbursed by medical aid for services rendered must register with NAMAS annually. As of August 1995, 924 medical practitioners were registered including 707 general practitioners and

obstetrician/gynecologists (NAMAS, 1995). This is 57% of those registered with the HPC, and closely approximates the estimate provided in Table 2.

Zimbabwe Medical Association (ZiMA) records provide one final estimate of the number of private practitioners. ZiMA is a voluntary professional organization with a membership of about 757 doctors. Of these, 502 (66%) are in private practice (including part-time), and 232 are either Senior or Junior government staff.

It is even more difficult to estimate the number of individual private nursing or midwifery practices, but consensus among knowledgeable informants is that there are very few. Most responded to the question by replying, "Yes, I know three ladies in Harare, and two in Bulawayo who are doing this". In other words, there are so few that they are individually known. We can assume that those who are practicing in the private sector are most likely employed by private clinics or hospitals, or doctors' practices.

## 2.2 Medical Practitioners: Size and Location of Practice

Fifteen doctors (including 2 gynecologists) in private practice in Harare and nearby towns were interviewed using a structured interview guide (Reed, 1995b). While the doctors were selected to represent a variety of characteristics (location of practice, race, specialization), clearly the results of the interviews are not generalizable to all practitioners. Nevertheless, the findings provide a snapshot of the relevance of family planning to urban medical practices.

Of those interviewed, half practiced in high density suburbs, and half in low density areas. Half (7) were licensed as dispensing physicians. Eight had a nurse-midwife working in their practice.

To determine the extent to which doctors worked simultaneously in both the public and private sectors, they were asked whether in the course of their practice they also worked in a hospital or clinic. None worked in public hospitals and 6 worked in a private hospital less than 5% of their time. One spent about 20% of his time in a public clinic, and one about 30% of his time in a private clinic. The majority (9) worked in only one surgery (office), while 4 worked in two sites and 1 worked in 3.

Doctors practicing in low density areas saw about 150 patients a week, while those working in high density areas saw nearly three times as many, an average of 432 per week. About one-fourth of the low density patient visits were for contraceptive services, while only one in 7 (14%) of the low density patient visits were for this purpose. On average, two-thirds of the low density and 85% of the high density patients were covered by medical aid.

## 2.3 Nurses and Midwives: Type of Practice

Twenty-six nurse-midwives participated in 4 focus groups to investigate their current and desired participation in private practice. Two groups included women from Harare and Chitungwiza, and were held in Harare; participants represented both public and private sectors. Two other groups were composed of women working near the growth points of Zvimba and Mahusekwa; all were public sector employees (Reed, 1995a).

Almost half of the respondents in Harare were in full-time private practice on their own with the supervision or collaboration of a doctor[4]. They operated two types of practice: midwifery services only; and multi-purpose clinics offering a variety of medical services, including primary health, family planning, pediatric care and general medicine. More than two-thirds of the women reported seeing patients outside their work situation, although most claimed not to be paid for it. Eighty-five percent provided maternity-related services, 57% did family planning, and 54% assisted deliveries.

## 2.4 Nurses and Midwives: Impediments to Practice

Almost half the respondents were not aware that midwives could open their own practice. Once they learned it was feasible, the nurse-midwives not currently in private practice expressed interest in starting one. When asked why they had not set up a practice, almost all cited lack of funding and knowledge of the requisite procedures. A few were concerned by the fact that a doctor had to supervise them.

The nurses contend that one needs a supervising doctor through which one refers patients to hospitals, dispenses drugs, and obtains medical aid payments. Identifying such a sponsor was seen as a frustrating process, but the women in private practice found the doctors with whom they were affiliated helpful.

The participants were very unclear about the legal requirements for establishing a practice (see Section 2.7 below). Even one participant who represents the Midwifery Association was not aware of all the necessary procedures. Of those in private practice, most started their services from their homes, and merely informed the Health Professions Council by letter of their activities. Overall, procedures were seen as confusing, with contradictory requirements among different organizations such as the City Health Department, Department of Works and MOH.

Capital to start practices came from savings, bank loans and retrenchment packages. Financing specialized equipment and supplies was problematic as most nurses did not have much money to invest in their practices as they started out. As the midwifery practices were

[4]. These women were deliberately recruited to participate; their prevalence in the focus groups far exceeds their presence in the general population.

mainly run from home, little major equipment was required, and the nurses mainly obtained it from friends abroad or from the clients themselves.

Developing an initial client base was difficult, but once patients became aware of the services offered news spread by word of mouth. Location of the clinic, ease of access and convenience were important in expanding the client base.

## 2.5 Organization of Medical Professionals

The health sector of Zimbabwe is well organized, with a number of professional organizations representing the interests of members. The main organizations are described in Appendix 3. Reference has already been made to the HPC, which in addition to its licensing responsibilities also monitors education, provider performance and disciplines registrants.

The Zimbabwe Medical Association (ZiMA) is the largest voluntary professional organization of medical practitioners; its members include both general practitioners and specialists. ZiMA supports continuing education opportunities for its members, and its National Tariff and Liaison Committee negotiates annually with the NAMAS to determine fees paid by Medical Aid. ZiMA corresponds with members through a monthly newsletter, and distributes monthly issues of the Central African Journal of Medicine.

In addition to ZiMA, there are nine other professional associations for medical practitioners (see Box 1 in Appendix 3). Most relevant for this review are the Gynecological Association and the College of Primary Care Physicians. Membership of most of the associations is quite small; for example the Gynecological Association had about 45 members in August 1995, with only 5 or 6 gynecologists in the country not members.

The College of Primary Care Physicians (CPCP) is the largest specialty association, with about 200 members. It is the only professional association that requires its members to sit for an examination in order to be admitted. It stresses continuing education, and conducts a series of weekly seminars held every Tuesday at ZiMA headquarters.

The Zimbabwe Nurses Association (ZINA) is the main representative body for nurses. There are several smaller specialty organizations that function independently, yet are linked to ZINA as sub-committees. One such organization is the National Association of Occupational Health Nurses, which has about 300 members. There is also a newly established Midwives Association.

## 2.6 Provision of Family Planning Services

The President of the College of Primary Care Providers believes that most doctors in family practice are providing family planning services (Parirenyatwa, 1995). They are not formally organized to report services, so there is no systematic way of knowing how many do so. The Drugs Control Council has registered 207 doctors as dispensing physicians (Table 5);

this means that they are able to distribute oral contraceptives (OCs), in addition to administering injectable contraceptives as all doctors are permitted to do.

According to the President of the Gynecological Association, all specialists provide full range of family planning services (Muchenga, 1995). He suggests that more general practitioners in small towns be trained to do insertions of intrauterine contraceptive devices (IUCD), to relieve the workload among specialists, and to make service provision more convenient for women.

Table 3 shows the number of dispensing physicians licensed by the Drugs Control Council to dispense prescribed substances (including oral contraceptives), and the percent distribution of the national population. Comparing the distribution of doctors and dispensing physicians with the national population clearly shows the disproportionate share of medical personnel in the large cities of Harare and Bulawayo. While home to only 12% of the population, Harare has 56% of GPs and 74% of Ob/Gynaes. Bulawayo, with only 6% of the national population, has 18% of the GPs and 9% of dispensing physicians. The heavy weighing in favor of the urban centers causes a major gap in meeting the needs of the more rural provinces; in virtually no cases does the percentage of private GPs, and to a lesser extent the dispensing physicians, approximate the share of the population.

Table 3: Location, Number and Percent of NAMAS-Registered General Practitioners and Obstetrician/ Gynecologists, Drugs Control Council-Registered Dispensing Physicians and Percent Distribution of National Population

| Location | General Practitioners | Obstetrician Gynecologist | Dispensing Physicians | Percent Pop. |
|---|---|---|---|---|
| Harare | 372 (56.0) | 25 (73.5) | 90 (43.5) | 12.1 |
| Chitungwiza | 19 (2.8) | | 15 (7.2) | 2.7 |
| Bulawayo | 120 (17.8) | 7 (20.6) | 18 (8.7) | 5.9 |
| Mashonaland W | 31 (4.6) | | 22 (10.6) | 10.7 |
| Mashonaland C | 9 (1.3) | | 4 (1.9) | 8.3 |
| Mashonaland E | 13 (1.9) | | 6 (2.9) | 9.8 |
| Midlands | 48 (7.1) | 2 (5.9) | 24 (11.6) | 12.7 |
| Manicaland | 27 (4.0) | | 8 (3.9) | 14.7 |
| Masvingo | 22 (3.0) | | 18 (8.7) | 11.4 |
| Matabeleland N | 8 (1.2) | | | 6.1 |
| Matabeleland S | 4 (0.6) | | 2 (1.0) | 5.7 |
| TOTAL | 673 (100.0) | 34 (100.0) | 207 (100.0) | 100.0 |

Sources: National Association of Medical Aid Societies Register, 1995; Drugs Control Council Register, 1995; Ministry of Health, Health Information Systems.

## Family Planning Services Available

All respondents to the in-depth interviews provided family planning services. Only the 2 gynecologists performed tubal ligations, done in private clinics or hospitals. Ten doctors provided oral contraceptives, 10 offer injectables, 6 dispense condoms and 6 insert IUDs. Two doctors stock no contraceptives. Depo Provera and OCs were most often obtained from Geddes, IUDs from pharmacies and private dealers, and condoms from a variety of sources including pharmacies, ZNFPC and the NGO Population Services. Nine of the 15 respondents stated that they are not visited by pharmaceutical representatives. For the remainder, visits were infrequent.

When asked a series of attitudinal questions, the doctors responded favorably overall to the advantages of family planning. Doctors were less favorable when asked about providing services to teens and about recommending sterilization for women who want no more children, mainly in expressing the need to consider the situation of the individual patient.

One gynecologist trained in minilap with local anesthetic reported that he rarely does the procedure anymore. He found that about 20% of his patients required heavier sedation or a general anesthetic once the procedure was underway, and so now he has returned to doing mostly laparotomy with full anesthesia. He indicated that several of his colleagues experienced the same situation, and have also ceased doing mini-laps.

## Family Planning Training

Of the 15 doctors, virtually all had theoretical training in family planning methods and counselling. Ten had theoretical training in vasectomy, but only one had completed clinical training. Reflecting its limited availability in Zimbabwe, only 6 doctors had theoretical training in Norplant, and only one had been trained in insertions.

With the exception of Norplant, vasectomy and female sterilization, fewer than a third of the doctors were interested in additional family planning training.

Table 4: Number of Doctors Wishing Additional FP Training

| FP Method | Training | Refresher |
|---|---|---|
| Norplant: Theoretical | 7 | 2 |
| Norplant: Clinical | 12 | 1 |
| Vasectomy: Theoretical | 5 | 4 |
| Vasectomy: Clinical | 4 | 3 |
| Tubal Ligation: Theoretical | 3 | 4 |
| Tubla Ligation: Clinical | 4 | 3 |

Seven doctors preferred training in the evenings, and three each selected weekdays, afternoons or weekends. Seven would make 2 or 3 hours per week available for training, and 4 would choose between 4 and 10 hours.

## 2.7 Constraints to Family Planning Service Provision

One perceived constraint frequently cited by professional sources are the restrictions imposed by the DCC under the Drugs and Allied Substances Control (General) Regulations, 1991 (Statutory Instrument 150 of 1991). These regulations stipulate that persons must pass a forensic exam set by the DCC, or satisfy the Council that he is familiar with the regulations regarding safe custody and dispensing. They also do not permit physicians within 5 km of a pharmacy to dispense drugs. In terms of FP, registration as a Dispensing Physician only affects the ability to dispense oral contraceptives. Doctors need not be registered as dispensing physicians in order to administer injectable contraceptives or to insert IUDs; both methods can be carried out by appropriately trained professionals with no additional certifications.

Doctors interviewed were asked to identify factors that discouraged their offering more family planning services in their practices. Most common responses included the limited availability of some methods and cost related issues, such as medical aid not paying for certain types of contraceptives. This may be a misperception: NAMAS has recommended tariffs for all methods except condoms, but actual reimbursement may vary by medical aid society. About one-third found no discouraging factors.

Only two doctors cited low profit margins and limited demand from patients as impediments, and only three cited competition from the public sector or the belief that it is the responsibility of the public sector to provide FP services. Most frequently cited obstacles were lack of training (9), limited supply of products (8), and restrictions on types of services (8). (Unfortunately respondents were not probed for an explanation of this latter reason, so it is not known to what restrictions they were referring.)

Nurses face more constraints in providing family planning services. In theory, nurses are permitted to engage in private practice in Zimbabwe. In practice, many nurses find it difficult to establish their own practices. Inaccurate beliefs and misunderstanding of legal regulations appear to be influencing development of private nursing and midwifery practices.

As of September 1995, nurses and doctors must pay Z$200 to register for 3 years with the HPC. The application is reviewed, and they are issued a current practice certificate. The Medical, Dental and Allied Professions Act states that local authorities (Rural District Councils or Municipal Councils) may supervise private midwives, maternity nurses and maternity assistants (1971: Section 65). Bulawayo registers nurse-midwives, but Harare has ceased doing so. One official with the Harare Health Department stated categorically that "No one in Zimbabwe can set up a private practice," and indicated that although the Municipality received many applications from nurses wishing to go private, none were being approved (Ndoro, 1985).

He also indicated that approval of nurses with links to referral centers would lead to a mushrooming of services, with no municipal control.

Medical practitioners, fearing competition particularly in urban areas, contend that nurses should practice under their supervision, yet are reportedly reluctant to schedule regular monitoring visits. However, review of relevant legislation, including the Medical, Dental and Allied Professions Act, the Midwifery Practice Regulations (No. 819 of 1970 and amendments), and the Nurses and Midwives (Professional Conduct) Regulations (Statutory Instrument 340 of 1982) shows that no such requirement is stipulated, nor does the HPC have such regulation (Ziwocha, 1995).

Others believe the MOH fears that if nurse-midwives considered private practice as a viable option, large numbers would leave public service. As it is, many are starting to mimic the trend of doctors to emigrate to neighboring countries[5].

At least two other sets of legal regulations affect the establishment of private nursing practices. The Drugs and Allied Substances Control (General) Regulations (1991) does not permit nurses to prescribe or dispense most drugs. The Nurses and Midwives (Professional Conduct) Regulations forbid advertisement of nursing or midwifery services, but do indicate that those in private practice may advertise name, address, telephone number, qualifications and hours of operation.

Nurses also face economic constraints in establishing their own practices. Few have the collateral needed to secure commercial loan, and so cannot afford to refurbish facilities or purchase needed equipment.

## 2.8 Information Gaps

There appears to be a gray market among nurse-midwives. Although few are registered in private practice, more than half attending the focus groups reported that they did some work outside their normal hours. The nature and extent of these side "practices" should be investigated.

More accurate estimates of the size of the private medical sector would be useful, although not imperative for project implementation. Simple modifications to the record keeping systems of the MOH and the HPC would facilitate easier assessments of the size and distribution of private medical care vis-a-vis public services.

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[5]. An advertisement recently appeared in Zimbabwe's largest daily newspaper, recruiting 20 nurses to work in Botswana with salaries 50 - 100% higher and conditions of service far more favorable than those in Zimbabwe (Herald,1995).

## 2.9 Opportunities for Expansion

There is limited opportunity for expanded services among doctors, as most are already providing some family planning services. The greatest potential appears to be in the area of additional training in long-term and permanent methods, and in improving consistent access to competitively priced contraceptive commodities through commercial vendors or ZNFPC.

The nurses interviewed showed great interest in developing official practices, but were clearly unaware of the procedures they must follow to do so. Procedures are not standardized, and are not compiled in a single reference document. National and municipal health authorities are often unfamiliar with requirements, and need to be informed about them.

Nurses also did not know the cost of establishing and maintaining practices; estimates should be calculated. Most nurses lack the capital needed to open practices, and lack the collateral needed to meet stringent lending requirements of commercial banks.

Chapter 3

# RETAIL PHARMACISTS

## 3.1 Pharmacists: Number and Distribution

The HPC lists 485 pharmacists on its register (Table 1, above). The vast majority are in the private sector, as MOH reports only 37 employed with them (Table 2, above). The President of the Pharmaceutical Society of Zimbabwe (PSZ) estimates that about 400 are currently practicing in Zimbabwe, and that about 70% of them belong to PSZ.

Table 5: Location of Pharmacies

| Location | Number | Percent |
|---|---|---|
| Harare | 95 | 44 |
| Bulawayo | 35 | 16 |
| Mutare | 11 | 5 |
| Kwekwe/Redcliff | 13 | 6 |
| Gweru | 9 | 4 |
| Other | 54 | 25 |
| TOTAL | 217 | 100 |

Source: Drugs Control Council Register (1995)

Pharmacies are concentrated in Harare and Bulawayo. Sixty percent of pharmacies and 77% of pharmacists are concentrated in these two cities (Manpower Report, 1995). Johnson & Johnson reports that about 130 pharmacies nation-wide are active in its social marketing of condoms program (Crockart, 1995).

## 3.2 Organization

There are two professional organizations that address the needs of pharmacists. The PSZ is a voluntary organization that works closely with the HPC on matters of training, continuing education and discipline. The PSZ publishes a monthly journal, Pharmaceutical Journal of Zimbabwe. The Retail Pharmacists Association (RPA) has about 200 members working in 90 pharmacies around the country (more than half in Harare, a dozen in Bulawayo, and the rest in other locations).

## 3.3 Provision of Family Planning

According to key informants, virtually all pharmacists stock contraceptive supplies. Stocks reflect a range of the commodities currently registered in Zimbabwe, including more than 10 brands of oral contraceptives (OCs), 2 types of IUDs, DepoProvera, and a variety of condoms. A recent study in Bulawayo found that of 23 pharmacies visited, all stocked condoms, 90% carried Nordette OCs and DepoProvera, and fewer stocked other methods (CAFS, et al., 1995). Fewer are stocking diaphragms and spermicidal jelly, apparently due to low demand coupled with supply problems.

"Hormones, all oral contraceptives and vaginal preparations" are included on the Eleventh Schedule of the Drugs and Allied Substances Control (General) Regulations, 1991 as Pharmacist Initiated Drugs (PID), and so pharmacists are authorized to start a woman on a course of OCs. Few do so, however, mainly using this authority to continue a woman on an established program once the initial physician's prescription has expired.

In part, the reluctance to initiate OCs stems from the lack of materials available to private pharmacists, both for their own use and for their clients. The checklist they use today was issued in 1982, and has not been updated or redistributed since. One pharmacist interviewed was using a pamphlet that he acquired during training in 1979. Indeed, all pharmacists trained at the University of Zimbabwe receive 3 to 4 days of training on contraceptives, but the Bulawayo study found the training took place an average of seven years ago.

Many pharmacies also lack a quiet corner for counselling. Pharmacists and their clients find it difficult to discuss such a personal matter as contraception standing at the main counter in a busy shop.

## 3.4 Constraints

Retail pharmacists face several constraints to expanded FP service delivery. First, consumer demand is low. Many consumers do not know that pharmacists can initiate OCs, and they do not request the service. Pharmacists are not reimbursed directly by medical aid, and customers may be reluctant to complete the paperwork required to submit claims. Also, customers may perceive the dispensing fee charged on all prescriptions to be high, although the normal dispensing fee of Z$7.00 per item has been lowered for contraceptive products to Z$2.00 (and some pharmacists charge even less)[6]. This highlights a second constraint, competition

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[6] US$1.00 = Z$8.30 in August 1995. Although the pharmacists have taken the initiative to reduce the dispensing fee, the largest medical aid society, CIMAS, has not altered its computer program to take this into account. Thus, medical aid subscribers who seek reimbursement for contraceptives purchased in pharmacies automatically have $7.00 deducted from their claim, as they would for any pharmaceutical product.

from the very low, subsidized public sector commodities. Finally, pharmacists cite a lack of clear, updated information to which they can refer in counselling situations.

### 3.5 Opportunities for Expansion

Pharmacists are interested in expanding their role in providing family planning services. Several months prior to the start of this project, the RPA had approached ZNFPC for training and supply of contraceptive products. RPA, in turn, agreed to submit service statistics to ZNFPC and would make efforts to ensure private areas in each shop for counselling. This suggestion, in addition to other opportunities to promote family planning through private pharmacies, should be explored.

Pharmacists interviewed expressed keen interest in participating in contraceptive technology update courses as part of their program of continuing education. They requested educational materials, both for themselves to use as patient screening tools and as information to distribute to consumers. The suggestion was made that once pharmacists received training, they could be issued with an insignia or logo sticker that could be posted in their shop, informing consumers that family planning services were available at that location. A media campaign could be mounted simultaneously to make consumers more aware of the services.

Chapter 4

# WORK-BASED HEALTH FACILITIES

## 4.1 Number and Location of Sites

Another source of private sector health service are industrial, mining and private hospitals and clinics. The figures shown in Table 6 indicate that there are no definitive estimates of the size of this sector. The NAMAS figures are clearly conservative; many companies do not register with NAMAS for services provided on-site, simply absorbing the costs as part of company operating expenses.

Table 6: Private and Industrial Hospitals and Clinics by Province and Registration Source

| Province | Ministry of Health* | Drugs Control Council# | NAMAS+ |
|---|---|---|---|
| Mashonaland West | 28 | 26 | 8 |
| Mashonaland Cent. | 14 | 9 | 6 |
| Mashonaland East | 12 | 3 | 1 |
| Midlands | 48 | 42 | 17 |
| Masvingo | 12 | 10 | 6 |
| Manicaland | 42 | 35 | 10 |
| Matabeleland North | 18 | 13 | 9 |
| Matabeleland South | 22 | 7 | 4 |
| Harare | 7 | 76 | 42 |
| Bulawayo | - | 55 | 18 |
| TOTAL | 204 | 275 | 117 |

Sources: Drugs Control Council Register (August 1995); NAMAS Register (August 1995); Ministry of Health (1994: Table 1.1).

* MOH figures include: industrial hospitals and clinics; private hospitals and clinics; mine hospitals and clinics.
# DCC figures include: industrial clinics.
+ NAMAS figures include: mining and industrial hospitals (13); private and industrial clinics (88), private hospitals (16).

The National Social Security Authority (NSSA) also maintains a roster of about 300 industrial hospitals and clinics. It includes the name and address of the company, the clinic category (defined by its staff pattern), the name of visiting doctors, and the frequency of their visits.

### 4.2 Delivery of Family Planning Services

Work-based family planning programs were first given attention by ZNFPC in 1987 and 1988, though a number of large industries, particularly mining, had previously offered services. Under the auspices of the Enterprise Project, and later SEATS, ZNFPC provided technical and material support to five companies: Lonrho Zimbabwe Ltd., Triangle Ltd., British American Tobacco (BAT), Hippo Valley Estates, and the Commercial Farmers Union (CFU). Each continues to provide FP services, although the CFU has evidently reduced it FP focus, and now devotes greater attention to AIDS education and condom distribution.

In 1991 ZNFPC again turned its attention to work-based programs, and identified 30 companies as potential partners to develop programs. Of these, 9 were chosen for detailed negotiation, but due to the impact of the drought and the imposition of the Economic Structural Adjustment Programme (ESAP), a contract was developed with only one company, Union Carbide.

Two brief and non-systematic surveys carried out for this study revealed that about 70 companies are providing some family planning services on-site. Information was collected through random telephone interviews with about 50 of Zimbabwe's largest companies, and ZNFPC Nursing Officers in each province identified local companies with which they were familiar.

Of 67 companies identified:

- All provide condoms
- 38 (57%) provide oral contraceptives
- 17 (25%) provide Depo Provera
- 5 (7%) insert IUDs
- 5 (7%) perform tubal ligations.

### 4.3 Constraints

Lack of consistent support by either ZNFPC or the MOH has probably constrained the development and expansion of work-based family planning services, but this must be confirmed through more in-depth analysis. While a number of companies have introduced some services, it is likely that the majority are providing condoms for AIDS prevention rather than for contraceptive purposes. Industry managers may believe that the provision of family planning services is the responsibility of the public sector, particularly at times when they are asked to increase contributions to national pension funds and are losing preferential industry supports. Prior research in Zimbabwe has also identified the following constraints, particularly in the agricultural sector:

- residual political sensitivity to family planning in agricultural settings

- preoccupation with input costs, and with the immediate concerns with AIDS and needed medical care

- balancing the long term benefits of family planning against the short term conditions imposed by the recent drought

- concerns about the future of commercial farming in view of land reform measures (Huber, et al., 1994b).

Nevertheless, a number of industry leaders cite their social obligations in maintaining a healthy workforce as justification for the provision of primary care services. It would be useful to conduct a wider survey of large Zimbabwean industries better understand the reasons for and against the provision of FP services.

## 4.4 Financial Incentives

In his recent budget address, the late Minister of Finance, Mr. A.M. Chambati proposed a new allowance for clinics built on farming and mining areas, increasing it from Z$250,000 to Z$500,000 (Chambati, 1995). This is an effort to spur more private sector support for basic infrastructure, and provides the first increase since allowances were adjusted for inflation in 1992.

## 4.5 Information Gaps

A systematic review of large companies should be done to determine exactly what, if any, services are provided, whether they are offered to employees, dependents, and/or the surrounding community, whether they have an interest in offering or expanding services, and if so, what inputs are required. Reasons for disinterest should also be explored. Listings of companies registered with the DCC or NSSA should provide fairly comprehensive identification of possible work-based sites. These can be cross-referenced with lists of large companies registered with CIMAS or the Congress of Zimbabwe Industries, or identified as "top companies" in the annual review carried out by the Financial Gazette.

## 4.6 Opportunities for Expansion

Many companies are now providing some level of on-site services. There appears to be ample room for diversification of the method mix available, for example making DepoProvera available in the sites that now offer OCs. Before expansion can be planned, however, an inventory of companies now providing coverage and the range of services they provide should be conducted.

## Chapter 5

## PRIVATE SECTOR CONSUMERS

### 5.1 Consumer Use of the Private Sector

According to the 1994 Zimbabwe Demographic and Health Survey (ZDHS, CSO and Macro International, 1995) 12% of women obtain contraceptive services from the private medical sector, and 2% from other private sector sources (ZDHS, Table 4.15). The private sector is particularly important in the provision of IUDs and female sterilizations, where the proportion obtaining services in the private sector compares favorably with those turning to ZNFPC clinics, government clinics, and rural health clinics.

The main reasons cited for using private sector sources seem to reflect actual or perceived convenience: services are closer to home or place of work, there are shorter waiting times, and the client is able to use other services offered at the same site (ZDHS, Table 4.16).

### 5.2 Consumer Characteristics

The 1994 ZDHS also contains information on characteristics of private sector family planning users. Table 8 compares public and private sector users by level of education, age group, place of residence, and number of children.

Private sector users are more highly educated than are women obtaining contraceptives from the public sector. Almost two-thirds of women using private sector sources had a secondary level education or higher, compared to just over one-third of public sector users. More than half of the private sector users are within the ages of 25 to 34, with more public sector users found in the younger and older age groups.

Not surprisingly, more than 60% of private sector users are urban residents, reflecting the accessibility and distribution patterns of private services. Finally, private sector users generally had fewer children than did public sector users.

Doctors interviewed reported that the majority of patients attending practices in low density suburbs were employed as professional, managerial and skilled workers. High density patients were almost equally represented in skilled and unskilled occupations.

| Table 7: Percent Distribution of Private and Public Sector Family Planning Users by Education, Age Group, Residence and Number of Children | | |
|---|---|---|
| Characteristic | Private Sector | Public Sector |
| Level of Education | 100.0% | 100.0% |
| None | 4.5 | 10.0 |
| Primary | 32.1 | 50.0 |
| Secondary or higher | 63.4 | 40.0 |
| Age Groups | 100.0% | 100.0% |
| 15-24 | 25.0 | 30.9 |
| 25-34 | 52.7 | 41.3 |
| 35-44 | 19.9 | 23.8 |
| 45+ | 2.4 | 4.1 |
| Residence | 100.0% | 100.0% |
| Urban | 60.9 | 35.4 |
| Rural | 39.1 | 64.6 |
| Number of Children | 100.0% | 100.0% |
| 0 | 7.1 | 1.8 |
| 1 | 21.2 | 21.0 |
| 2 | 23.3 | 21.6 |
| 3 | 17.2 | 13.9 |
| 4+ | 33.3 | 41.7 |

Source: ZDHS, 1994. Special tabulation.

| Table 8: Percent Distribution of Private Practice Patients by Occupation Category | | |
|---|---|---|
| Occupation Category | Low Density | High Density |
| Professional, Management | 28 | 9 |
| Skilled white collar | 43 | 39 |
| Unskilled blue collar | 21 | 41 |
| Unemployed | 8 | 11 |
| Total Percent | 100% | 100% |

Source: Self-reported estimates given by doctors (Reed, 1995b).

### 5.3 Opportunities for Expansion

Numerous surveys during the past decade have shown that Zimbabwean men and women are familiar with family planning concepts and methods. They are often less familiar with the range of sources of contraceptive supplies. Consumer education campaigns that target different market segments would serve to increase awareness of private practitioners and pharmacists as possible sources, and to make more people aware of the benefits offered by medical aid (see following chapter). More information is needed to understand factors that affect provider selection, and patterns of use. This might be obtained through qualitative data collection techniques such as focus groups or spot interviews with satisfied users.

Chapter 6

# MEDICAL AID SOCIETIES

## 6.1 Description of Medical Aid Societies

Medical aid societies (MAS) are private, pre-paid, not-for-profit health insurance programs. Medical aid is well-organized in Zimbabwe, with 24 companies providing coverage for 731,350 members and beneficiaries (see Appendix 4). Growth has been steady since independence. Coverage is provided for approximately 7% of the estimated national population of 10.4 million or 23% of the urban population of 3.2 million.

Table 9: Medical Aid Societies: Total Beneficiaries (as of 1 July each year) and Growth

| Fiscal Year | Beneficiaries | Growth % |
|---|---|---|
| 1982 | 245,679 | -- |
| 1985 | 303,033 | 23.4 |
| 1990 | 526,266 | 57.6 |
| 1995 | 731,600 | 30.2 |

Source: NAMAS (1995)

Two companies dominate the industry: the Commercial and Industrial Medical Aid Society (CIMAS) and the Public Service Medical Aid Society (PSMAS) (Appendix 4). They provide coverage for 43.4% and 32.6% of all beneficiaries, respectively.

Three companies are commercial, open to membership of any company or individual: CIMAS, MASCA (Medical Aid Society of Northern Africa), and Northern Medical Aid Society. Together they cover half of all beneficiaries. The 21 non-commercial societies administer in-house schemes which provide medical benefits to the employees of a particular company or industry. The majority of firms (17) each cover fewer than 10,000 beneficiaries; five firms cover fewer than 1000.

Only CIMAS and RAILMED offer a choice of schemes or benefits packages to their subscribers. CIMAS, for example, has five packages available: Basicare, Primary, General, Private and Medexec. Monthly member subscriptions for 1994/95 range from only Z$12.00 for the Basicare package, to Z$260.00 for Medexec.

Although CIMAS often takes the lead in offering coverage for new benefits, smaller societies which are more individual-oriented in some cases provide more comprehensive

coverage than the larger firms, and are able to be more flexible and more personal in claims awards. All societies belong to NAMAS, which serves as an clearinghouse and coordinating body representing the interests of the medical aid societies (Adamchak, 1995b).

The scale of fees reimbursable by the medical aid societies is negotiated annually in collaboration with physicians, represented by ZiMA. This tariff code is known as the Zimbabwe Relative Value Schedule. While not all physicians charge according to the tariff code, most do so.

All medical aid societies are registered as non-profit funds for tax purposes, with

> "...any surplus income retained by the funds and used either as reserves against future claims cost, for increased benefits, or as investment income to strengthen their viability. Contributions are levied at either a flat rate, or are based on the income of the employee. In most instances, the employer meets fifty percent of his employee's contributions" (NAMAS, 1988:2).

Companies and industries that provide medical aid coverage for employees can deduct 100% of subscription costs from their pre-tax profits. While in the past individuals could also deduct a portion of their medical aid subscriptions, this is no longer allowed. Individuals are permitted to deduct medical expenses that exceed Z$240.00 out-of-pocket from their taxable income.

### 6.2 Coverage of Family Planning Services

During the 1980s, only two MAS provided coverage for family planning, and this was very limited. In 1989 CIMAS introduced coverage for services provided by ZNFPC, and soon after expanded coverage to include services offered by private physicians, and later those provided at municipal clinics. During the following years, additional MAS followed suit and added coverage to their respective benefits schemes, although some limited reimbursement to services provided in company-run hospitals and clinics (Table 10). Some societies impose an annual limit for family planning claims, but these are generally within the context of their maximum limits for drugs or medical services. Most commodities excluding condoms are reimbursed, whether they are provided by physicians, ZNFPC or pharmacists. (Reimbursements for supplies obtained from pharmacists do not include the dispensing fee; this must be paid by the consumer.) Today virtually all MAS provide some level of coverage for family planning services and supplies.

| Table 10: Medical Aid Societies Reimbursing Family Planning by Provider Type | | |
|---|---|---|
| Society | ZNFPC | Private Physician |
| Anglo American | Yes | Yes* |
| Bankmed | Yes | Yes |
| B.O.C. Zimbabwe** | Yes | Yes |
| BP & Shell | No | No |
| Chibuku | Yes | Yes |
| CIMAS | Yes | Yes |
| Construction Industry | N/A | N/A |
| David Whitehead | N/A | N/A |
| Engineering | Yes | Yes |
| Fidelity Life | Norplant, VSC | Norplant, VSC |
| First Mutual | No | Yes |
| Harare Municipality | Yes | Yes |
| Hippo Valley | Yes | Yes |
| Industrial Steel & Pipe | Yes | Yes |
| MASCA | Yes | Yes |
| Masvingo Municipality | Yes | Yes |
| Municipality of Bulawayo | Yes | Yes |
| Northern | Yes | Yes |
| PSMAS | Yes | Yes |
| RailMed | Yes | Yes |
| Rio Tinto Group | Yes | Yes |
| Triangle Ltd. | Yes | Yes |
| ZIMASCO | N/A | N/A |
| ZISCO | Yes | Yes |

Source: ZNFPC, 1994; updated, August 1995.
* Visits only, not supplies ** Formerly Oxyco
N/A: information not available

## 6.3 Constraints

### MOH View of Medical Aid

A recent administrative assessment of the MOH pointed out the MOH intention to expand the coverage of health insurance (Adamchak, 1995a). The MOH Corporate Plan states that "in order to broaden the financial base, the Ministry of Health together with Medical Aid Societies, Employers Associations, Trade Unions and other Government departments will seek to ensure that all those people employed in the formal salaried sector are covered with some form of Health Insurance" (MOH, 1992: section 8.1).

Two years ago, it appeared that the MOH planned to actively engage the MAS in meeting this goal. Following discussions with Ministry officials, CIMAS introduced its Basic Care package, targeting the lowest levels of formal sector employees. The package provides benefits for services delivered by municipal and government health facilities, and reimbursement of some drugs. Within 9 months of introduction, the scheme had enrolled 15,000 members, clearly tapping an unmet demand among these workers.

MOH had indicated that it would press to reform labor laws to make it mandatory for all employers to provide health coverage for their workers. This has not taken place, and MOH is now promoting regulation of the medical aid industry, and planning to develop a national health insurance program. They are proposing to undertake a pilot scheme in a single province to understand its impact, and to develop the administrative and legal framework for national implementation (MOH, 1995).

Participation will be mandatory for formal sector employees, with wage-based contributions. Those employed in the non-formal sector will make fixed contributions during periods of highest income, i.e. after harvests. People too poor to pay will be exempt, but will still be entitled to services. Non-exempt non-contributors will pay on a fee-for-service basis.

Services beyond the primary and core hospital care authorized under the plan will be available on a fee basis, or through continued payment of private insurance. Introduction of a national health insurance program is likely to have a depressing effect on the Medical Aid industry, particularly among the three commercial firms.

### Consumer Awareness

An additional constraint to expanded payment for family planning claims is lack of consumer awareness. Most MAS do not advertise particular benefits. Members are provided with a pamphlet that describes their benefits when they first enroll, and are notified of changes as they occur through newsletters, letter enclosures, etc. There is little direct promotion of benefits, so many consumers are not aware that family planning services are covered. Therefore an opportunity exists to expand usage of family planning through reimbursed services. An

awareness-raising campaign targeting medical aid beneficiaries would result in an increased demand for these benefits. Efficient means to reach this audience already exist though mailings to employers and individual members, and regular society newsletters.

6.4 Opportunity for expansion

There are two kinds of expansion of family planning coverage through MAS. First, increase medical aid coverage in general, and hence increase access to FP beneficiaries; second, expand utilization of this benefit. Increasing medical aid coverage is beyond the scope of this project. Nevertheless, it is informative to understand the growth possible for this sector, and its implications for the size of the pool of family planning users.

Table 11: Percent Distribution of Economically Active Persons by Rural and Urban Areas and by Activity, Zimbabwe 1992 Census

| Activity | Rural | Urban | Total % | Total Pop. |
|---|---|---|---|---|
| Paid Employee | 44.03 | 55.97 | 100.0 | 1 558 248 |
| Employer | 47.44 | 52.56 | 100.0 | 13 351 |
| Own Account | 85.49 | 14.51 | 100.0 | 856 310 |
| Unpaid Family Worker | 97.48 | 2.52 | 100.0 | 309 490 |
| Unemployed | 59.47 | 40.53 | 100.0 | 764 199 |
| Total Percent | 62.27 | 37.73 | 100.0 | 3 501 798 |

Source: Central Statistical Office (1994:Table 6.1)

Growth of medical aid could potentially be greater than the 600,000 estimated in a recent World Bank report (World Bank, 1992). Of the current 731,350 beneficiaries, an estimated 215,103 are employed members, while 516,247 are spouses and other dependents[7]. Deducting unpaid family workers and unemployed from the economically active population, the total of paid employees, employers and own account workers is 2,737,559. Subtracting again 1.2 million agricultural workers leaves 1.57 million workers and employers in Zimbabwe (Central Statistical Office, 1994: Table 6.18). Estimated employees covered by medical aid are only 13.7% of the remaining formal sector employees, employers and own account workers, implying that an additional 1.3 million, or 86.3% are still not covered by medical aid.

[7] CIMAS uses a ratio of 1:2.4 to estimate members to beneficiaries; these figures represent the same ratio. This may slightly underestimate employees, given that some MAS are dominated by male, employed members. Also, some dependents may themselves be employed.

## Chapter 7

## COORDINATION OF THE PUBLIC AND PRIVATE SECTORS

### 7.1 Coordination of Sectors

The degree of overlap between the public and private sectors has not been systematically investigated. As noted in Chapter 2, many doctors in the public sector maintain part-time practices in the private sector. Many work several hours a week as an in-house practitioners for large industries and parastatal organizations. The salaries of most doctors working in mission hospitals are paid by grants from the Ministry of Health.

Few, if any, private practitioners are employed by the public sector, although in some isolated cases private doctors may take a turn on the casualty (emergency) department in return for hospital privileges. However, when the CPCP recently developed a roster of GPs willing to do this, coordination with the hospital broke down and the system fell into disuse. Public sector practitioners will occasionally refer patients to the private sector for specialist services, but this occurs infrequently for FP.

Few private doctors provide public health interventions such as vaccines. Vaccines are supposed to be distributed at no cost, so they are unable to charge patients for the service. Some doctors are not equipped to handle the cold chain properly, or may not have adequate nursing staff to assume responsibility for it. Some doctors will invite Expanded Programme of Immunization (EPI) sisters to their facilities to provide vaccinations on a regular basis.

The public sector (mainly through ZNFPC) provides commodities to private sector, particularly individual doctors and industrial sites. Limited information on this can be obtained from the Stores Dept of ZNFPC, but it is not aggregated to include data from each province.

Little information sharing takes place. Public sector communication with the private sector is notoriously poor, usually characterized as antagonistic. Decisions are made with little input from private providers.

Private pharmacies send some information monthly to ZNFPC but these records appear to be incomplete. It does not appear that private doctors do much more than report contagious diseases and some key illnesses.

### 7.2 Low Public Sector Costs as Disincentive to Private Sector

Low cost or free availability of services in the public sector is a disincentive to doctors and pharmacists.

| Table 12: Comparative Contraceptive Commodity Costs by Source (in Zimbabwe dollars) | | | | | |
|---|---|---|---|---|---|
| Method | ZNFPC Clinics* | ZNFPC to Doctors** | Population Services (NGO)* | Suggested Retail Prices | NAMAS Reimburse -ment |
| Ovrette | 1.10 | 2.10 | 1.80 | 2.10 | 4.00 |
| Micronor | 2.10 | 25.00 | -- | 17.58 | 23.00 |
| LoFemenal | 1.10 | 2.10 | 1.80 | 4.00 | 4.00 |
| Trinordiol | 2.10 | 15.00 | -- | -- | 22.00 |
| CuT380a | 6.50 | 10.00 | 10.00 | -- | 12.00 |
| Multi-load | 13.00 | 50.00 | 10.00 | -- | 29.00 |
| D-Provera | 4.00 | 10.00 | 14.00 | 14.66 | 17.00 |
| Diaphragm | 5.00 | | | | 13.00 |
| Norplant | 113.00 | 300.00 | -- | -- | 197.00 |
| T-Ligation | no charge | | no charge | | 96.00 |

Sources: ZNFPC, 1995; Population Services, 1995; Huber, et al, 1994b:31; NAMAS, 1995.
* Exclude fees for service.
** Exclude doctor's mark-up charged to patient.

ZNFPC has come to serve as the de facto supplier of most contraceptive methods in the country, providing commodities to a number of doctors, industries, commercial farmers, and occasionally, pharmacies. They sell their donated or heavily subsidized products at a higher rate, in turn using the proceeds to cross-subsidize other programs. Commercial pharmaceutical vendors have imported contraceptive products at different times, but generally find them to be extremely unprofitable in view of the low prices charged by ZNFPC and the small number of commercial outlets.

Prices charged to doctors range from one to six times higher than the price charged to ZNFPC clients. NAMAS reimbursements for the most part fully cover the commodity costs, with the exception of multi-load IUDs and NORPLANT kits, which have shortfalls of 33 to 40 percent of the doctors' costs. (There is also a smaller shortfall noted for Micronor OCs.) For these products, patients are usually referred to a pharmacy to purchase their supplies, and then return to the doctor for insertion.

## 7.3 Public Sector Policies

Most government policies that affect the private sector have been referred to in the relevant sections of this report. It appears that government is moving to increase its emphasis on regulation and to exert greater oversight of the private sector. Some provisions are being made to increase the self-regulating authority of the medical and health professions by a recent overhaul of the Medical, Dental and Allied Professions Act (described in Appendix 3).

MOH has drafted new "enabling" legislation, the Medical Services Bill (Draft), that will give it power to pursue the following objectives:

- Ensure the equitable provision and maintenance of comprehensive hospital services
- Provide for admission of persons to government hospitals and the fixing of fees in respect of services provided thereat
- Provide for the granting to medical and dental practitioners the privilege of access to certain hospitals and the appointment of consultants
- Authorize the establishment and maintenance of medical aid societies, health fund organizations and private hospitals (Medical Services Bill (Draft), 1995).

This Bill has been sent to Parliament by the Ministry, and is waiting to be read.

Some of the material contained in the bill is not new; for example, the MOH already fixes fees for services provided in government hospitals. However, several sections of the bill may have implications for the functioning of the private sector. The fixing of fees in government facilities may, for example, imply that MOH intends to set fees for private patients entering public hospitals under the care of a private doctor, regardless of the tariffs negotiated between NAMAS and the medical profession.

Similarly, the clause that grants medical and practitioners access to public hospitals may be seen as reinforcing an existing situation, or it may be interpreted as an opportunity for the MOH to limit access to public facilities by private or semi-private practitioners. Finally, the Bill gives the Minister of Health the power to introduce regulations to the Medical Aid industry, providing for their registration. It is not specified what that registration will entail, or what possible costs or restrictions might be placed on medical aid societies.

Neither NAMAS nor the major medical aid societies were consulted as this legislation was drafted.

## 7.4 Conclusion

Opportunities for expanding private sector participation in family planning service delivery exist. In part, an effort should be made to systematize what is currently being done. An impressive amount is already underway, but is not monitored for its scope or impact. Data

collection undertaken by this project will provide a more objective and systematic view of the actual situation than currently exists. This may enable the public sector to better target health care users so that the sectors will complement, rather than compete with, each other. However, this new project must be careful not to stifle the participation of providers in this diverse sector by fostering over-regulation or new mandated actions.

A number of discrete, readily defined activities can go far to expand private sector services. Doctors and pharmacists have requested additional training and updates on contraceptive technology. Nurse-midwives are anxious to open private practices, but lack knowledge of the process they must follow and the capital needed to do so. Medical Aid Societies already offer comprehensive coverage for family planning services and commodities, but their members are often unaware that these benefits are part of their packages. A wide variety of industries provide services, but it is often on an ad hoc basis, with little or no coordination or systematic means of obtaining supplies, training, or commodities. Improvements can be made in public-private collaboration, especially in the areas of program planning, distribution of commodities, and dissemination of informational materials. Each of these issues can be addressed under the terms of the new ZFPP subproject.

APPENDIX 1

BIBLIOGRAPHY

Adamchak, Susan Enea. "An Institutional Analysis of the Zimbabwe Ministry of Health and Child Welfare." Harare, Zimbabwe: USAID. August 1995a.

Adamchak, Susan Enea. "Introducing Family Planning Benefits in Medical Aid: A Case Study in Zimbabwe." Providence, Rhode Island: PhD Dissertation. May 1995b.

Bennett, Sara and Ellias Ngalande-Banda. "Public and Private Roles in Health: A Review and Analysis of Experience in sub-Saharan Africa." Geneva: World Health Organization, Division of Strengthening Health Services, SHS Paper No. 6. 1994.

Bennett, Sara, George Daxpallah, Paul Garner, Lucy Gilson, Sanguan Nittayaramphong, Beatriz Zurita and Anthony Zwi. "Carrot and Stick: State Mechanisms to Influence Private Provider Behaviour." Health Policy and Planning, 9(1):1-13. 1994.

Bennett, Sara and Anne Mills. "Health Insurance and the Private Sector." Pp. 73-90 in "Report of the Workshop on The Public/ Private Mix for Health Care in Developing Countries." 11-15 January 1993. London, England: London School of Hygiene and Tropical Medicine, Department of Public Health and Policy.

Bennett, Sara and Anthony Zwi. "The Private Sector and Public Health." Pp. 44-60 in "Report of the Workshop on The Public/ Private Mix for Health Care in Developing Countries." 11-15 January 1993. London, England: London School of Hygiene and Tropical Medicine, Department of Public Health and Policy.

Berman, Peter. "Health Sector Reform: Making Health Development Sustainable." Boston, MA: Data for Decision Making. n.d.

Berman, Peter and Ravindra Rannan-Eliya. "Factors Affecting the Development of Private Health Care Provision in Developing Countries. Phase 1: Review of Concepts and Literatures, and preliminary field design." Bethesda, MD: Abt Associates. 1993.

Center for African Family Studies, John Snow, Inc., Center for Population and Family Health in collaboration with Bulawayo City Health and Zimbabwe National Family Planning Council. "Findings from the Sub-Saharan Africa Urban Family Planning Bulawayo City Report." March 1995.

Central Statistical Office. "Census 1992: Zimbabwe National Report." Harare, Zimbabwe. 1994.

Central Statistical Office. "Quarterly Digest of Statistics." Harare, Zimbabwe. June 1995.

Chambati, A.M. "Budget Statement, 1995." Harare, Zimbabwe: Republic of Zimbabwe. July 1995.

Chandiwana, Stephen K. (ed.). "Proceedings of the First Consultative Meeting, Public/Private Sector Mix for Health Care." Harare, Zimbabwe: Blair Research Laboratories, Ministry of Health. 1992.

Chandiwana, Stephen K. and Angeline Chiutsu. "The Public/Private Mix for Health Care in Zimbabwe." Pp. 258-270 in "Report of the Workshop on The Public/Private Mix for Health Care in Developing Countries." 11-15 January 1993. London, England: London School of Hygiene and Tropical Medicine, Department of Public Health and Policy.

Chatora, R.R. "Health Sector Reform in Zimbabwe: Concept Paper on Decentralization." Harare, Zimbabwe: Ministry of Health and Child Welfare.

CIMAS. Pulse. No. 40. June 1995.

City of Harare. "Annual Report of the City Health Department 1994." Harare, Zimbabwe. 1995.

Financial Gazette. "Top Companies Survey 1995." Harare, Zimbabwe: Modus Publications (Pvt) Ltd.

Fort, Catherine. "The Enterprise Program Follow-Up Study: Were Private Sector Family Planning Services Sustained?" Arlington, VA: John Snow, Inc. Working Paper No. 6. March 1994.

Fort, Catherine. "Enterprise in Zimbabwe: A Strategic Approach to Private Sector Family Planning." Arlington, VA: John Snow, Inc. June 1990.

Government of Rhodesia. "Midwifery Practice Regulations, 1970 Cap 214." Government Notice No. 819 of 1970. Salisbury, Rhodesia.

Government of Zimbabwe. "Report of the Secretary for Health and Child Welfare for the Year Ended 31st December 1992." Harare, Zimbabwe: Government Printer. n.d.

Government of Zimbabwe. "The Medical, Dental and Allied Professions Act, Chapter 224." Salisbury, Rhodesia: Government Printer.

Government of Zimbabwe. "Drugs and Allied Substances Control (General) Regulations; Statutory Instrument 150 of 1991." Harare, Zimbabwe.

Government of Zimbabwe. "Nurses and Midwives (Professional Conduct) Regulations 1982; Statutory Instrument 340 of 1982." Harare, Zimbabwe.

Government of Zimbabwe. "Health Professions (Registration of Health Institutions) Regulations 1995; Statutory Instrument 132 of 1995." Harare, Zimbabwe.

Griffin, Charles C. "The Private Sector and Health Care Policy in Developing Countries." International Finance Corporation. n.d.

Griffin, Charles C. "Strengthening Health Services in Developing Countries through the Private Sector." Washington, D.C.: The World Bank and International Finance Corporation. Discussion Paper No. 4. 1989.

Hanson, Kara and Peter Berman. "Non-government Financing and Provision of Health Services in Africa: A Background Paper." Boston, MA: Data for Decision Making. 1994.

Herald. "Medical Association Rejects Proposed Bill." May 18, 1995.

Huber, Sallie Craig, Laurie Emrich, Caroline Marangwanda and Lazarus Zanamwe. "Evaluation of the Zimbabwe Family Planning Project (613-0230)". Arlington, VA: Population Technical Assistance Project. June 1994a.

Huber, Sallie Craig, Susan Enea Adamchak, John L. Fiedler, Craig Naudé, Lazarus Zanamwe. "Zimbabwe Population Sector Assessment." Arlington, VA: Population Technical Assistance Project, Report No. 94-008-017. December 1994b.

Kasilo, O.M.J. and C.C. Maponga. "Manpower Survey of Zimbabwe's Pharmacy Profession." Manpower Monitor, March 1995:5-7.

Lunga, Lois. Personal Communication. February 1996.

McPake, Barbara and Charles Hongoro. "Contracting out in Zimbabwe: a Case Study of a Contract between Wankie Colliery Hospital and the Ministry of Health." London School of Hygiene and Tropical Medicine, Department of Public Health and Policy, Health Policy Unit. n.d.

McPake, Barbara and Elias E. Ngalande Banda. "Contracting Out of Health Services in Developing Countries." Health Policy and Planning, 9(1):25-30. 1994.

Ministry of Health and Child Welfare. "Medical Services Bill (Draft)." Harare, Zimbabwe. 1995.

Ministry of Health. 1992. "Planning for Equity in Health." Harare, Zimbabwe: Department of Health Services, Planning and Management.

Ministry of Health and Child Welfare. "Health Sector Reforms." Harare, Zimbabwe. August 1995.

Ministry of Health and Child Welfare. "Health and Human Resource Master Plan Part I 1993-1997." Harare, Zimbabwe. n.d.

Ministry of Health and Child Welfare. "District Core Health Services for Zimbabwe." Harare, Zimbabwe: Division of Health Care Services. March 1995.

Ministry of Health and Child Welfare. "Zimbabwe Health Facilities Report 1993." Harare, Zimbabwe: Epidemiology Department. July 1994.

Muchenga, Dr. Steven. Personal Communication. August 1995.

NAMAS. "National Medical Aid Tariff for Family Planning Services Effective March 1995." Harare, Zimbabwe. 1995.

Ndoro, Dr. Personal Communication. September 1995.

Parirenyatwa, Dr. David. Personal Communication. September 1995.

Phiri, Alford and Ityai Muvandi. "Zimbabwe Attitudinal Survey." Zimbabwe National Family Planning Council Evaluation and Research Unit. Harare, Zimbabwe. July 1993.

Reed, Barbara. Family Planning Survey. Survey No. 950922. Harare, Zimbabwe. October 1995a.

Reed, Barbara. Family Planning Survey: In-Depth Interviews. Survey No. 950922. Harare, Zimbabwe. October 1995b.

Rupare, Catherine. Personal Communication. October 1995.

Schwartz, J. Brad and Benson M. Zwiswai. "Economics of the Health Sector in Zimbabwe." Harare, Zimbabwe: USAID. May 1995.

SEATS. "Bulawayo Family Planning Training." SEATS Subproject Document with the Bulawayo City Health Department. Harare, Zimbabwe. January 1996a.

SEATS. "Gweru Family Planning Training." SEATS Subproject Document with the City of Gweru Public Health Department. Harare, Zimbabwe. January 1996b.

UNICEF. 1994. "Children and Women in Zimbabwe, A Situation Analysis." Harare, Zimbabwe: United Nations Children's Fund.

Vaughn, Andrew. Personal Communication. August 1995.

Watts, T.E. "Can our People Afford to Live? The Effect of Changing Economic Conditions on

High Density Urban Dwellers around Harare, March 1992 to June 1993." Central African Journal of Medicine, 40(10):272-275. October 1994.

Woelk, G. "Who are the Zimbabwean Loop Users? The Social and Demographic Characteristics of Zimbabwean IUCD Users." Central African Journal of Medicine, 41(4):113-118. April 1995.

Woelk, Godfrey B. "Primary Health Care in Zimbabwe: Can it Survive?" Social Science and Medicine, 39(8):1027-1035. 1994.

World Bank. "Zimbabwe: Financing Health Services." Washington, D.C. 1992.

Zimbabwe Medical Association. Correspondence, April 4, 1995.

--- "Staffing Situation for Medical Doctors in District and Mission Hospitals." Manpower Monitor, March 1995.

Zimbabwe National Family Planning Council. "Revised Prices for Drugs: November 1993."

## APPENDIX 2

## PERSONS CONTACTED

### USAID/Zimbabwe

| | |
|---|---|
| Mary Pat Selvaggio | Health, Population, Nutrition Officer |
| Roxana Rogers | Family Planning Advisor |

### GOVERNMENT OF ZIMBABWE

### Ministry of Health and Child Welfare

| | |
|---|---|
| Simon Chihanga | Assistant Secretary, Planning |
| Mr. Niemo | Chief, Missions and Councils Section |
| Gill Cripps | ODA Finance and Accounting Advisor |
| David Brown | ODA Health Management/Organization Advisor |
| Jan Dik | Danida Technical Advisor |
| Mr. Ranga | Personnel Attachments |

### Zimbabwe National Family Planning Council

| | |
|---|---|
| Alex Zinanga | Executive Director |
| Tandy Nhliziyo | Chief Nursing Officer |
| Mrs. Bosch | Chief Training Officer |
| Lois Lunga | Private Sector Coordinator |
| F. Gwatidzo | General Stores Controller |
| J.K. Muchemwa | Nurse, Lister Clinic |

### OTHERS

| | |
|---|---|
| MacDonald Chaora | CIMAS General Manager, Marketing |
| Robin Tonkin | National Association of Medical Aid Societies |
| David Parirenyatwa | President, College of Primary Care Physicians |
| Stephen Munjanja | President, Gynecological Association |
| Mr. Bessant | Registrar, Health Professions Council |
| Elizabeth Vushe | Secretary, Zimbabwe Medical Association |
| Charles Hongoro | Researcher, Blair Research Laboratory |
| Dr. Ndoro | Harare City Health Department |
| Andrew Vaughn | Vice President, Retail Pharmacists Association |
| Jealous Nderere | President, Zimbabwe Pharmaceutical Society |
| Carrie Crockart | Senior Product Manager, Johnson & Johnson |
| Gugu Mahlangu | Consultant, Drugs Control Council |
| Susan G. Brechin | Consultant, JHPIEGO |

| | |
|---|---|
| Richard Sullivan | Training Director, JHPIEGO |
| Catherine Rupare | Population Services |
| Clara Nondo | Zimbabwe Nurses Association |
| Margaret Makadzange | National Association of Occupational Health Nurses |
| Nancy Ziwocha | Assistant Registrar, Health Professions Council |
| Brian Mons | Group Personnel Manager, Lonrho |
| Matthew Wazara | Medical Director, Triangle Estates |
| Wilson Mujere | Group Employee Relations Manager, BAT |
| Craig Naude | Consultant |
| Mary Lee Mantz | Senior Technical Advisor for MAPS |

## Appendix 3

## ORGANIZATION OF HEALTH PROFESSIONS

### A.1 Health Professions Council

In addition to maintaining a register of 50 professions (medical practitioners, dentists, pharmacists, nurses, midwives, opticians environmental health officers, meat inspectors and others), the HPC oversees education, monitors provider performance and investigates charges of malpractice. If warranted, it disciplines registrants (Adamchak, 1995). The register does not include traditional healers, or "nyangas", nor "natural therapists" such as chiropractors, osteopaths or homeopaths.

The HPC has separate committees for the various practitioners which report to the Executive Committee. Among them are:

- Medical-Dental Committee
- Nurses Committee
- Pharmacy Committee
- Therapists Committee
- Environmental Health Committee
- Radiographers Committee.

Practitioners pay an annual fee and are issued an Annual Practicing Certificate. The register includes the name, address and qualifications of health professionals. Persons are first listed on a provisional register for 3 years, and then moved to the permanent register. The registry does not distinguish employment in the public or private sectors, nor does the address listed necessarily conform with the registrant's physical address. Registrants may maintain their listing when retired or out of the country, and so the list also may not accurately reflect the number of active practitioners.

In its education role, the HPC approves any training programs conducted in the country. Training programs are by the respective committees and representatives of the appropriate training institutions, and approved by the HPC. Training institutions may be inspected to ensure adequate facilities, program implementation, and adherence to standards.

As a disciplinary body the HPC can take action against any registered person engaging in "improper" or "disgraceful" conduct. While a few restrictions are stipulated, such as prohibitions against advertising medical practices, the Disciplinary Committee has broad powers in considering possible acts of negligence or malpractice. Penalties for improper conduct range from fines, suspensions, practice with restrictions, or removal from the registry. Investigations are usually based on complaints from patients or next of kin; few practitioners make charges against their peers.

Until recently the only medical premises registered with HPC were nursing homes. Legislative changes in effect from September 1995 authorize HPC to register all facilities. including hospitals, clinics, laboratories and private medical rooms.
Medical, Dental and Allied Professions Act (Chapter 224, 1971)

A major overhaul of the bill that authorizes the Health Professions Council is underway. Under the new legislation, separate councils will be formed for each of the major medical professions, with all reporting to a "Supreme Health Council."
The bill calls for the registration of health facilities (Part XV), including government hospitals, private and missionary hospitals, teaching hospitals of the University of Zimbabwe Medical School, and other hospitals or medical institutions as determined by the Supreme Health Council. Private surgeries and medical rooms are not listed specifically, but it is implied that they would be covered by this legislation as well.

Medical professionals complain that they were not engaged in the drafting process, and were only consulted once a draft was prepared so that the MOH could demonstrate that it had some contact with the professions (Herald, May 18, 1995).

Complaints were raised about the composition of the individual councils. Pharmacists objected to being grouped with homeopaths, aroma therapists, naturopath, etc. (Under current scenarios, they may form a council with opticians.) A major source of contention has been the proposed inclusion of traditional healers under the authority of the Health Council. For the past 15 years they have been sanctioned under separate legislation, which suited both them and "Western" medical practitioners. Both groups question their integration with the more formal medical sector, and given the new bill's greater emphasis on accreditation and discipline, remain dissatisfied with proposals for joint review committees and testing.

A.2 Zimbabwe Medical Association (ZiMA)

ZiMA is a voluntary professional organization of medical practitioners; its membership currently stands at just over 1000. Its objectives are to:

- Promote the interests of the medical profession
- Promote the health of the community
- Represent the medical profession in negotiations
- Hold meetings for members and other medical professionals.

Headquartered in Harare and with an office in Bulawayo, ZiMA has four provincial branches. The Association is directed by a 14-member Executive Council that meets quarterly. Standing committees such as the National Tariff and Liaison Committee and the Continuing Education Committee meet periodically to consider particular issues; the former negotiates annually on behalf of ZiMA with the National Association of Medical Aid Societies (NAMAS) to determine fees paid by Medical Aid. ZiMA also coordinates a group membership scheme for a medical indemnity (malpractice) policy with a company in the U.K. (Adamchak, 1995).

Annual membership subscriptions are Z$375 for medical practitioners either full-time or part-time in the private sector, Z$120 for senior medical officers in the Ministry of Health and faculty of the University of Zimbabwe Medical School, and Z$60 for new medical graduates. ZiMA corresponds with its members through a newsletter that is meant to be sent monthly, but in fact goes out less frequently. It also distributes monthly copies of the Central African Journal of Medicine. The Association also convenes a bi-annual Congress and National General Meeting.

In addition to ZiMA, there are nine other professional associations for medical practitioners (Box 1)

| Box 1: Medical Associations in Zimbabwe |
| --- |
| Anaesthetic Association |
| College of Primary Care Physicians |
| Gynecological Association |
| Pediatrician's Association |
| Pathologists Association |
| Psychiatric Association |
| Radiological Association |
| Surgical Association |
| Urological Association |

Membership of most of the associations is quite small; for example the Gynecological Association had about 45 members in August 1995, with approximately 5 or 6 gynecologists in the country not members. It corresponds with members through a quarterly newsletter. The College of Primary Care Physicians (CPCP) is the largest specialty association, with about 200 members.

## A.3 College of Primary Care Physicians

The CPCP is the only professional association that requires its members to sit for an examination in order to be admitted. It stresses continuing education, and conducts a series of weekly seminars held every Tuesday at ZiMA headquarters. The College recently suspended its examination requirement for one year (until May 1996) in an effort to enlarge its membership[8]. Its president is expecting an upsurge in membership applications as people apply under this "grandfather" clause, particularly as doctors become aware of the Ministry of Health plans to implement an accreditation process.

[8] Some medical practitioners still perceive the CPCP as associated with the White medical establishment, and the open year is also being instituted in order to develop racial diversity.

The CPCP plans to develop training programs for three areas of medicine: Government Medical Officers (GMO), medical specialists, and family practitioners; its target date is January 1996. It hopes to develop internships in each area to ensure doctors have more clinical experience before practicing on their own. In the near future the CPCP expects to become increasingly involved in peer reviews and medical audits, which it identifies as "non-threatening quality assurance". It is not clear to what extent this will complement the extended role of the HPC.

## A.4 Zimbabwe Nurses Association

The Zimbabwe Nurses Association (ZINA) has been actively seeking greater autonomy for nurses for several years. In 1994, ZINA drafted a new Nurses Act for submission to Parliament, with the goal of divorcing themselves from the provisions of the existing Medical, Dental and Allied Professions Act (1971). They believe their roles are not well defined under the current act, and that "their professional needs are not being well served by the Health Professions Council" (Huber, et al., 1994:8). They cite as an example the fact the Act restricts the presidency and vice-presidency of the HPC to medical practitioners, i.e., doctors; the Executive Committee of the Council is also dominated by medical practitioners. This despite the fact that general and state certified nurses comprise 73% of HPC's 19,400 registrants.

APPENDIX 4

| National Association of Medical Aid Societies: Beneficiaries and Percent Distribution, July 1995 | | |
|---|---|---|
| Society | Beneficiaries | Distribution (%) |
| Anglo American | 1,374 | 0.2 |
| Bankmed | 17,940 | 2.5 |
| B.O.C. Zimbabwe | 824 | 0.1 |
| BP & Shell | 1,780 | 0.2 |
| Chibuku | 4,915 | 0.7 |
| CIMAS | 317,169 | 43.4 |
| Construction Ind. | 2,874 | 0.4 |
| David Whitehead | 653 | 0.1 |
| Engineering | 19,484 | 2.7 |
| Fidelity Life | 1,140 | 0.2 |
| First Mutual | 1,225 | 0.2 |
| Harare Municipality | 12,000 | 1.6 |
| Hippo Valley | 1,269 | 0.2 |
| Ind. Steel & Pipe | 493 | 0.1 |
| MASCA* | 42,776 | 5.8 |
| Masvingo Mun. | 320 | 0.0 |
| Mun. of Bulawayo | 5,810 | 0.8 |
| Northern | 8,853 | 1.2 |
| PSMAS | 238,324 | 32.6 |
| RailMed | 38,409 | 5.3 |
| Rio Tinto Group | 1,328 | 0.2 |
| Triangle Ltd. | 1,310 | 0.2 |
| ZIMASCO | 2,065 | 0.3 |
| ZISCO | 9,015 | 1.2 |
| Total | 731,350 | 100.2** |

Source: National Association of Medical Aid Societies, 1995
** Includes ZimGlass.
**Does not add to 100.0% due to rounding.