FIRST SESSION – EIGHTH PARLIAMENT

FIRST REPORT

OF THE PORTFOLIO COMMITTEE ON HEALTH AND CHILD CARE ON THE STATE OF AFFAIRS OF THE HEALTH DELIVERY SYSTEM IN ZIMBABWE

Presented to Parliament February 2015

(S.C2, 2015)

ORDERED IN TERMS OF STANDING ORDER No. 159:

- At the commencement of every session, there shall be as many committees to be designated according to government portfolios as the Standing Rules and Orders Committee may deem fit.
- It shall be the function of such committees to examine expenditure administration and policy of government departments and other matters falling under their jurisdictions as Parliament may, by resolution determine.
- The members of such committees shall be appointed by the Standing Rules and Orders Committee, from one or both Houses of Parliament, and such appointments shall take into account he expressed interests or expertise of the Members and Senators and the political and gender composition of Parliament.

TERMS OF REFERENCE OF PORTFOLIO COMMITTEES S.O 160

Subject to these Standing Orders, a portfolio committee shall-

- consider and deal with all Bills and Statutory Instruments or other matters which are referred to it by or under a resolution of the House or by the Speaker;
- consider or deal with an appropriation or money bill or any aspect of an appropriation or money bill referred to it by these Standing Orders or by or under resolution of this House;
- monitor, investigate, enquire into and make recommendations relating to any aspect of the legislative programme, budget, policy or any other matter it may consider relevant to the government department falling within the category of affairs assigned to it, and may for that purpose consult and liaise with such a department; and
- consider or deal with all international treaties, conventions and agreements relevant to it, which are from time to time negotiated, entered into or agreed upon.

On Thursday, 17 October 2013, the Speaker announced that the Committee on Standing Rules and Orders nominated the following members to serve on the Portfolio Committee on Health and Child Care

Hon. Chibagu G.

Hon. Chivamba K.

Hon. Dr. Labode R.

Hon. Mahiya M.

Hon. Makweya M.

Hon. Dr. Mataruse P.

Hon. Mathe G.

Hon. Matuke L.

Hon. Moyo L.

Hon. Munengami F.

Hon. Dr. Musiiwa M.

Hon. Ndlovu M.S

Hon. Ndoro L.

Hon. Nkomo M.

Hon. Sibanda L.

Hon. Simbanegavi Y.

Hon. Tshuma D.

Hon. Vutete M.

Hon. Zhou P.

Hon. Zwizwai M.

Hon. Dr. Labode to be Chairperson

1. INTRODUCTION

As part of its oversight role over the Ministry of Health and Child Care, the Portfolio Committee on Health and Child Care resolved to enquire into the state of affairs of the health delivery system in Zimbabwe. The public outcry over poor health services and lack of access to the same led to the Committee's decision to conduct an inquiry into the management of the five central hospitals as a way of ensuring that the health provision as enshrined in the constitution is upheld.

2.0 OBJECTIVES

The objectives of the enquiry were:

2.1 To understand and establish the state of the health delivery system in Zimbabwe.

2.2 To appreciate challenges being faced by the Ministry of Health and Child Care in fulfilling its mandate.

2.3 To recommend strategies that may enhance the health services delivery system.

3.0 METHODOLOGY

The Committee used four methods of data collection namely: oral evidence, site visits, focus group discussions through workshops and literature review.

3.1 Oral Evidence Sessions

3.1.1 Ministry of Health and Child Care, Chief Accounting Officer, Dr. Gwinji presented the ministry's 5-Year-Strategic Plan and the implementation challenges.

3.1.2 Minister of Health and Child Care, Dr. Parirenyatwa, appeared before the Committee to clarify the misconception surrounding the policy on the user fees and to set the record straight on the disputed Ekhusileni Medical Centre ownership.

3.1.3 The Committee received oral evidence from the board of Zimbabwe National Blood Transfusion Service on the operations and challenges of the organisation.

3.1.4 The Premier Service Medical Aid Society management appeared before the Committee to clarify issues of poor access to health services for their members and maladministration of the subscriptions collected.

3.1.5 The Health Service Board, a board responsible for services, recruitment and promotion of health workers, also presented a paper before the Committee on the status of the establishment of health workers and the challenges faced by health institutions due to shortage of manpower.

3.2 Focus Group Discussions

This was done through workshops on targeted health issues.

3.2.1 Community Working Group on Health assisted the Committee on Budget Formulation and Prioritisation.

3.2.2 National AIDS Council disseminated information on HIV/AIDS, Sexual and Reproductive Health, Cervical Cancer and the distribution of the Global funds by the Country Coordination Mechanisms.

3.2.3 The Disability, HIV/AIDS Trust sensitised the Committee on Sexual, Reproductive Health and HIV/AIDS issues in relation to the people living with disability.

3.2.4 The SNV (Stichting Nederlandse Vrijwilligers) or Netherlands Development Organisation, disseminated information on menstrual hygiene as an impediment to the empowerment of the girl child.

3.2.5 The National Health Care Trust disseminated information on Water, Sanitation and Hygiene (WASH) programme and the water situation in Harare.

3.2.6 Zimbabwe Women's Resource and Network Centre capacitated the Committee on budget monitoring and tracking.

3.2.7 Ministry of Health and Child Care in conjunction with UNICEF capacitated the Committee on Child Rights.

3.3 Fact Finding Visits

The Committee undertook fact finding visits to the following central hospitals:

- Parirenyatwa Group of Hospitals
- Harare Central Hospital
- Mpilo Central Hospital
- United Bulawayo Hospitals
- Ingutsheni Central Hospital
- Ekhusileni Medical Centre.

-Please note that the Committee took advantage of being in Bulawayo to also visit the hospitals in the vicinity like Esigodini District Hospital and Thorngrove Infectious Disease Hospital.

-The National Pharmaceutical Company of Zimbabwe (Natpharm) was also visited to appreciate its capacity to procure and distribute drugs in the country.

3.4 The Committee made reference to the following documents:

- The Census (2012).
- The Demographic Health Survey (ZDHS) of 2012.
- The MoHCC Annual Reports
- Health Transition Fund Manual (2011).
- The 2012 Ernst and Young Audit Report for the National Blood Service
- The Zimbabwe Health Development Partners Group Report (2013).
- The National Medicine Survey (2013).
- The Zimbabwe National Cancer Registry Annual Report (2011).
- The World Health Organisation: *Public Sector Reform: Downsizing, Restructuring Improving Performance (1996).*
- Hospital Reports.

4.0 THE COMMITTEE FINDINGS

4.1 HEALTH STATUS

4.1.1 Although Zimbabwe has realized a remarkable decline in HIV prevalence from the peak of 20.1% in 2005 to 14.9% (2013 HIV Estimates) amongst the 15-49 age group in 2013, the prevalence remains too high. HIV incidence has also declined from 1.21% in 2011 to 0.98% in 2013, however the number of new cases are still very high with an estimated 69,105 new infections per year. HIV mortality is estimated at 63,853 per year. With the adoption of new WHO guidelines, clients on Anti-Retroviral Treatment (ART) have up-scaled to 724,299. Of the total clients on ART, adults constitute 51.8% and Children 45.8% .New Sexually Transmitted Infections (STIs) cases from January to June 2014 were 50,524

4.1.2 There is a decline in all forms of Tuberculosis (TB). Evidence shows that there was drop in TB cases from 325 per 100 000 in 2011 to 298 per 100 000 in 2012.

4.1.3 The annual malaria incidence has also reduced from 136 I 2011 per 1000 population to 22 per 1000 population in 2012.

4.1.4 Life expectancy at birth has slightly increased from 45 (2002 census) to 47 years for males and 50 for females according to 2010/11 ZDHS.

4.1.5 However, the ZDHS shows that neonatal, postnatal, infant and child mortality rates have increased (2010/11 ZDHS).

4.1.6 Maternal mortality has increased from 283 in 1994 to 960 deaths per 100 000 in 2012.

4.1.7 Non-Communicable diseases are on the increase, in particular diabetes and hypertension. Prostrate Cancer is the leading cancer among Zimbabwean black men, accounting for 16.5% of the new cases in 2011. The most frequent cancer among black women were cervical cancer (37%) followed by breast cancer (11%).

4.2 FINANCE

4.2.1 The Ministry of Health and Child Care submitted a budget of US$712 million and received US$337 million inclusive of salaries. The allocation received is 47% of the submission and 11.6% decrease from the 2013 allocation. The MoHCC set aside US$43 million out of the US$337 million allocation for recurrent expenditure and by August 2014 only US$7.8 million (18%) has been disbursed. The hospitals' total allocation in the budget was US$23 million against a debt of US$36.4 million. This means that effectively, the institutions received no budget for 2014 and still need to finance the gap of US$12 million.

4.2.2 Health Service Fund (HSF)

Health Service Fund gets revenue from user fees collected by institutions. The revenue collected ranges from US$3 million at Mpilo Central Hospital to US$10 million at Parirenyatwa Group of Hospitals annually. For some strange reasons neither does the Ministry of Finance nor the Minister of Health reflect the revenue from user fees on their budget statements. Good corporate governance demands that these fees be properly accounted for.

4.2.3 Donor Funds

The Committee acknowledges the continued support from donors. Zimbabwe Health Partners Group injected US$415 million into the Health Sector in 2014. The following is the breakdown of contribution by country or organisation and amounts:

Global Fund	US$110 million
USAID	US$97 million
DFID	US$66 million
UNICEF	US$42 million

CDC-Zimbabwe	US$32 million
European Union	US$23 million
UNFPA	US$18 million
Sweden Embassy	US$14 milliom
Embassy of Switzerland	US$5 million
Irish AID	US$4 million
Norwegian Embassy	US$2.5 million
GIZ (Germany)	US$1.3 million

-It is important to note that the bulk of this money goes towards preventive services and purchasing of drugs.

4.2.4 Health Transition Fund (HTF)

This is another fund that has kept the MoHCC from the Intensive Care Unit, yet it is not acknowledged in the budget statement. The HTF is a multi-donor pooled fund, managed by UNICEF to support the MoHCC to achieve the highest possible level of health and quality of life for all Zimbabweans. The Fund was launched in 2011 and will run up to 2015. The fund pooled approximately US$435, 336, 586 at inception. The donors were the governments of Canada, Sweden, Ireland, Norway and the United Kingdom as well as the European Commission.

5. HUMAN RESOURCES

The staff establishment of 1981 has not been reviewed despite the growth in the population and increase in disease burden. Instead, the existing inadequate posts are being frozen as they fall vacant. The nurse patient ratio is now sitting on below 2 nurses per 1000 population. Even if the posts were to be unfrozen, conditions of service are not attractive to qualified personnel because of the pathetic salaries.

6. INFRASTRUCTURE

The infrastructure in hospitals is dilapidated. Most of the central hospitals are overcrowded, with broken beds and benches, and obsolete hospital equipment. The buildings are falling apart and all need a face-lift. There is water shortage because of old leaking pipes. There is also lack of linen and staff accommodation. However, Chitungwiza Central Hospital is an exception with its phenomenal infrastructure, cleanliness and ambiance which it has achieved through the effective application of the Public-Private-Partnership (PPPs) ventures.

7. REFERRAL SYSTEM

The referral system between District Hospitals and tertiary institutions, City Council Clinics and tertiary institutions has broken down. Lack of ambulances to ferry patients from rural areas to the tertiary institutions means that the patients prefer to go straight to tertiary institutions while they are strong enough to use public transport. On the other hand, because of the indiscriminate charging of user fees by City Council Clinics, urban dwellers by-pass their local clinics and present themselves with minor ailments at tertiary institutions. This also is compounded by lack of district hospitals in urban centres.

8. DRUG MANAGEMENT

Multi donor funds have provided support to the vital medicines and vital health services for the district health system. The programme supplies more than 75% of the country selected package of essential medicines. The programme excludes the five central hospitals, hence, the lack of essential drugs at the tertiary institutions. It is essential to note that 98% of the drugs being distributed to various hospitals are donated by donors and do not seem to be purchased with morbidity pattens in mind and have very short shelf life +/- 3 months in most cases.

Natpharm, a quasi-government company mandated with procurement and distribution of drugs is incapacitated by lack of finance and has been converted into a warehouse management company for donors.

9. 0 HEALTH SERVICE MANAGEMENT

9.1 Uncontrolled unit price for blood products—a unit price of blood is US$200.00 per unit within a society where the average wage is US$150.00 monthly.

9.2 Lack of adherence to MoHCC policies e.g user fees policy by government hospitals.

9.3 Lack of supervision:

-Abuse of cell-phone and fuel allowances for Chief Executive Officers at central hospitals

-Poor utilisation of scarce resources by renting cars at exorbitant prices

-Uncoordinated training of District Health Workers (over workshopping)

-Allowing drugs to expire

10. COMMITTEE OBSERVATIONS

The Committee observed that:

1. Government is not showing commitment to access to health of the nation as shown by the percentage of money disbursed for health delivery. Of the 8% allocated to the MoHCC, in the 2014 budget (which is below the 15% of the Abuja Declaration) only 18% was disbursed by August 2014.

2. The Health Service Fund is not mentioned in the MoHCC budget.
3. Central Hospitals ate left to fend for themselves through the HSF.
4. The referral system has broken down.
5. Drugs are expiring at Rural Health Centres and District Hospitals whilst the Central Hospitals are in need of the same.
6. Staff establishment is still frozen.
7. Poor corporate governance e.g the Zimbabwe National Blood Transfusion Services board Chairman has been in the post since 1981.
8. Esigodini District Hospital was a farm house that was turned into a Rural Health Centre and eventually upgraded into a district hospital without improving the infrastructure, rendering it grossly inadequate for its function.
9. Ekhusileni Medical Centre is falling apart without being used yet pensioners' monies were used to construct this hospital.
10. Thorngrove Hospital is grossly underutilised.

11. RECOMMENDATIONS

The Committee recommends:

1. That government must endeavour to disburse 100% of the allocated budget to the central hospitals.
2. That government must immediately unfreeze all frozen posts and review the establishment up-wards in line with population growth and increase in morbidity, and in accordance with the President's pronouncement.
3. The Minister of Health and Child care should re-engage donors to extend their support to central hospitals.
4. That the pharmacy directorate in the MoHCC must as a matter of urgency start a workable redistribution system of the distributed drugs to reduce the quantities of drugs expiring.
5. That capitalisation of Natpharm by both government and donors is paramount.
6. That the MoHCC needs to strengthen its monitoring system for effective drug management.
7. That Natpharm should sell excess stocks of drugs to private sectors and also donate to the schools, clinics, prisons and mission hospitals to minimise expiries.

8. That the Minister of Health and Child Care must use powers vested in his office to ensure that Ekhusileni Medical Centre opens by March this year.

9. That all hospitals must adhere to the strict terms of office for board members.

10. That district hospitals should be constructed in Bulawayo and Harare to ease congestion in the tertiary institutions. The Committee proposes that Thorngrove Infectious Disease Hospital be converted into a district hospital to ease congestion at Bulawayo central hospitals.

11. That a new district hospital in Umzingwane district should be budgeted for in the 2016 national budget. The Committee further recommends that government builds district hospitals in all districts that have mission hospitals designated as district hospitals by 2017. These districts are Mbire, Guruve, Mberengwa, Lupane, Hwange and Gutu among others.

12. That Ministry of Finance and Economic Development must assume the debts the hospitals owe to suppliers of services in the 2016 national budget.