

DEVELOPMENT AND HUMANITARIAN MIDDLE GROUND: AN
ANALYSIS OF HEALTH REHABILITATION IN POST CRISIS
RECONSTRUCTION (2009-2011) IN ZIMBABWE

by

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ABSTRACT

The study was an assessment to determine the health rehabilitation interventions employed by Zimbabwe health actors between 2009 and 2011. It also was to ascertain the extent to which the interventions met criteria for effective rehabilitation, and that includes, health rehabilitation should ease the transition between health humanitarian and health development. Data was collected through interviewing health actors and review of policy documents while a vulnerability analysis approach was applied. The study revealed that, while the implemented health recovery interventions resulted in halting the health crisis, their role in facilitating progress towards health development was marginal. There were clear humanitarian residual issues and evidence of weak areas of the health system. A clear pathway needed to be mapped by actors, particularly policy makers to ensure effective rehabilitation. However, this seemed to lack in some areas. There were numerous overlapping and repetitive policies with little detailed guidelines.

KEY TERMS

- Development and humanitarian
- Linking Relief, Rehabilitation and Development (LRRD)
- Health LRRD
- Health humanitarian
- Health rehabilitation
- Health development
- Health recovery
- Zimbabwe health crisis
- Health post crisis Zimbabwe
- Zimbabwe health recovery

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- Workmates and other colleagues who contributed to the studies in different ways.
- The interview respondents for their participation in the study.

DECLARATION

I declare that **Development and humanitarian middle ground: An analysis of health rehabilitation in post crisis reconstruction (2009-2011) in Zimbabwe** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references. I declare that this work has not been submitted before for any other degree at any other institution.

SIGNATURE



10 September 2014

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VHUMANI MAGEZI

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DATE

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AU	African Union
BHASO	Batanai HIV and AIDS Support Organisation
CAF	Country Assistance Framework
CAP	Consolidated Appeals Process
CECC	Commission of the European Communities Communication
CERF	Central Emergency Response Fund
DCs	Developed Countries
DFID	Department for International Development
DMOs	District Medical Officers
DOMCCP	Diocese of Mutare Community Care Programme
ECHO	European Community Humanitarian Office
ECLA	United Nations Economic Commission
ECSA	East, Central and Southern Africa
EHA	Environmental Health Alliance
EHTS	Environmental Health and Trading Standards
EMA	Environmental Management Agency
EMON	Emergency Management of Neonatal
EO	Executive Order
ESAP	Economic Structural Adjustment Programme
EU	European Union
FACT	Family AIDS Caring Trust
FAO	Food and Agriculture Organisation
FGDs	Focus Group Discussions
GDP	Gross Domestic Product
GHD	Good Humanitarian Donorship
GNU	Government of National Unity
GoZ	Government of Zimbabwe
GPA	Global Political Agreement
GRC	German Red Cross
HC	Humanitarian Coordinator
HIP	Humanitarian Implementation Plan
HIV	Human Immunodeficiency Virus
HR	Human Resources
HTF	Health Transition Fund
HTF	Health Service Fund
IASC	Inter-Agency Standing Community
ICRC	Economic Security Unit for the International Committee of the Red

	Cross
IEC	Information, Education and Communication
IEEPA	International Emergency Economic Powers Act
IFIs	International Financial Institutions
IFRC	International Federation of Red Cross and Red Crescent Societies
IMF	International Monetary Fund
INGOs	International Non-Governmental Organisations
IOM	International Organisation for Migration
IRC	International Rescue Committee
JEROF	Joint Early Recovery Opportunities Framework
JROA	Joint Recovery Opportunity Assessment
LDCs	Less Developed Countries
LNGOs	Local Non-Governmental Organisations
LRRD	Linking Relief, Rehabilitation and Development
MDC	Movement for Democratic Change
MDG	Millennium Development Goals
MDTF	Multi-donor Trust Funds
MNCs	Multinational Corporations
MoH&CW	Ministry of Health and Child Welfare
MTP	Medium Term Plan
NGOs	Non Governmental Organisation
OCHA	Office for the Coordination of Humanitarian Affairs
OFDA/USAID	Office of Foreign Disaster Assistance
ORS	Oral Rehydration Solution
PMD	Provincial Medical Director
PMTCT	Prevention of Mother-to-Child Transmission
PRSP	Poverty Reduction Strategy Papers
QDA	Qualitative Data Analysis
RC	Resident Coordinator
SADC	Southern African Development Community
SIDA	Swedish International Development Cooperation Agency
SOPs	Standard Operating Procedures
SORs	State Owned Enterprises
SPSS	Statistical Package for Social Science
STERP	Short Term Economic Recovery Program
TB	Tuberculosis
TEC	Multiagency Tsunami Evaluation Coalition
TNCs	Transnational Corporations
UN	United Nations

UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Fund
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Education Fund
UNISDR	United Nations International Strategy for Disaster Reduction
UNOCHA	United Nations Office for the Coordination Humanitarian Affairs
US	United States
USAID	United States Agency for International Development
USD	United States Dollar
VAM	Vulnerability Assessment Mapping
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
ZACH	Zimbabwe Association of Church-related Hospitals
ZANU-PF	Zimbabwe African National Union-Patriotic Front
ZUNDAF	Zimbabwe United Nations Development Assistance Framework

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CHAPTER 1: INTRODUCTION; RESEARCH BACKGROUND AND OUTLINE

1.1 Introduction

This chapter provides the research framework. It outlines background to the research, the problem statement, research question, research objectives, theoretical framework for the study, limitations and scope of the study, importance of the study and layout of chapters.

1.2 Research background, problem statement and research question

Research background

Zimbabwe experienced a decade long gradual collapse of services from 2000-2009. The collapse reached a humanitarian peak in 2008/9. The crisis was multifaceted. It included poor access to health care, collapsed infrastructure, a high prevalence of HIV, political violence, internal displacement, food shortages, and malnutrition (Zingoni 2010:1; Tren, Richard , Ncube Pius, Urbach Jasson and Bate Roger 2007:2; Ministry of Health and Child Welfare & WHO.2009). However, the focus of this research is on health care.

Zimbabwe health care system has been on a recovery path starting from 2009 after a decade-long gradual decline. Zimhealth (2012:2) observed that, following the formation of the Government of National Unity in 2009, the Ministry of Health and Child Welfare developed a National Health Strategy. The Ministry also instituted policies targeted at financing and introducing programmes that improve health care. During the decade 2000 – 2010, state investment in health varied from 4.2% of the state budget in 2001 to 8.5% in 2009 and 2010. Consolidated Appeal Process (CAP) (2012:58) reported that, while the humanitarian situation in Zimbabwe continued to be stable, there were still many humanitarian needs. There was continued threat of disease outbreaks, rates of chronic and acute child malnutrition stood at 34% and 2.4%, respectively. While cholera incidences had significantly decreased compared to prior years leading to 2008 crisis, localised outbreaks continued in 2011. There was also persistent low coverage of basic

health care that was leading to rising maternal and child mortality and overall excess morbidity and mortality.

The above situation indicated that, to ensure long term effective health delivery, the health system should progress from relief (humanitarian) and early recovery levels to a long term sustainable path. The road to a long term sustainable path entails a clear linkage between humanitarian (relief) and development, called rehabilitation. Furthermore, it entails a discernible progress pathway from humanitarian -to rehabilitation (recovery) -to development. In Zimbabwe, the humanitarian (emergency) needs are covered through short term funds raised through Consolidated Appeal Process (CAP), while long term recovery and development activities are covered through Zimbabwe United Nations Development Assistance Framework (ZUNDAF) (2011) mechanism and Health Transition Fund (HTF) (CAP 2012:60; The Zimbabwe Health Sector Investment Case 2010: 21-22; Zimbabwe Rural Livelihoods Assessment 2012; Zimbabwe Vulnerability Assessment Committee (ZimVac) (2011).

To restore Zimbabwe's health care services, various interventions were proposed as a priority. Haines (2007) and Pereira, Cumbi, Malalane, Vaz, McCord, Bacci, Bergström (2007) reported that some practitioners argue for the re-establishment of district health systems based on primary health care, while others argue that international advocacy is needed to rapidly secure increased resources from donors and governments. At the same time, proponents of the Health Services Fund that was originally established in the 1990s argue for the resuscitation and retention of user fees at local health delivery level. Proponents of the Health Services Fund argue that this would provide directly accessible funds for district health teams to maintain effective health services. The other mooted intervention is the training of specialist mid-level workers, such as, clinical officers and nurse anaesthetists (Haines 2007).

Haines (2007); Macheso and Thetard (2004); Pereira et al (2007); and Zenenga (2012) noted that the above stated services should be rapidly restored and expanded, taking the lead from Malawi and Mozambique where such health workers perform key frontline health functions. They added that there are also some doctors who help poor people by

running clinics from their homes and dispense drugs donated by friends abroad. However, despite this valuable spirit of volunteering being crucial to encourage bridge-building with excluded communities, interventions remain fragmented. Thus, from the above mixture of proposed interventions, there seems to be no clearly agreed ones. Different actors tow different lines.

Notwithstanding the prioritised interventions by the government of Zimbabwe (Ministry of Health and Child Welfare), it seems unclear as to what interventions should be prioritised under health emergency to contribute to development. At the same time, it was unclear as to what development interventions should be implemented to reduce health emergencies. In addition, the health rehabilitation interventions that ease the transition between health emergency and development were unclear. Unfortunately such a situation causes confusion and duplication of services. This then hinders health rehabilitation progress. Furthermore, progress from health emergency - to rehabilitation (recovery) –to development may not be discerned as there would not be an evaluable pathway. CAP (2012:5) maintains that there has to be sustained engagement by all actors for long term recovery- and development-oriented interventions focusing on the underlying root causes of the emergency. There has to be clear complementarities and linkages between humanitarian, recovery and development components.

Buchanan-Smith and Maxwell (1994:14) and Büttner (2008:3), advise that what is needed to ensure effective rehabilitation is a common understanding of how linking relief, rehabilitation and development (LRRD) is to be achieved, shared by all actors involved – local and international aid agencies, government authorities and donors. There has to be a shared understanding between actors on objectives, procedures, time frames, partners, and types of interventions that characterise rehabilitation. In such a situation, it is imperative to determine the activities that are being implemented to rehabilitate the health care system by the actors. These activities would fall within the LRRD contiguum model. This would entail an assessment of the extent to which the implemented emergency relief interventions contribute to development; development

interventions reduce health emergency; and health rehabilitation interventions ease the transition between health emergency and development.

Problem statement

There was disharmony regarding health recovery (rehabilitation) interventions in Zimbabwe and yet for effective and measurable LRRD progress to be achieved, there has to be a shared understanding of activities among the health actors. A shared understanding was needed by health actors on objectives, procedures, time frames and types of interventions that characterise rehabilitation in order to prioritise and evaluate development progress. Hence, it is critical to conduct an exploratory assessment to determine the health rehabilitation activities and the extent to which these activities satisfy the criteria for effective LRRD, that is; better 'development' can reduce the need for emergency relief, better 'relief' can contribute to development and better 'rehabilitation' can ease the transition between development and relief.

Research question

Considering the diverse health rehabilitation interventions proposed by various actors, what are the health rehabilitation (recovery) activities implemented and to what extent did these activities satisfy the criteria for effective LRRD, that is; "better 'development' can reduce the need for emergency relief, better 'relief' can contribute to development and better 'rehabilitation' can ease the transition between development and relief?"

1.3 Research objective

Study objective

The study was an exploratory assessment that sought;

⇒ To determine the health rehabilitation interventions employed by health development actors contributing to the public health sector between 2009 and 2011 in Zimbabwe, as well as ascertain the extent to which the interventions (1) fostered 'health development' that reduced the need for future health emergency; (2) focused on

'health relief' that contributed to health development; and (3) 'rehabilitated' health care in a way that eased the transition between health development and relief.

Sub objectives

To achieve the above study objective, the following sub objectives should be achieved;

- ⇒ Analyse health policy positions developed to address health recovery (rehabilitation) needs between 2009 to 2011;
- ⇒ Analyse health development and humanitarian interventions implemented during the 2009 to 2011 period to determine development and humanitarian needs constituting health rehabilitation;
- ⇒ Analyse health actors' interventions to determine their focus on health rehabilitation; and
- ⇒ Determine the common elements that characterised Zimbabwe's 2009-2011 health rehabilitation as well as discern a shared understanding of health LRRD.

1.4 Theoretical framework for the study

1.4.1 LRRD theoretical frameworks

A theoretical framework is a collection of interrelated concepts like a theory, even though it is not thoroughly worked, that serve as a basis for conducting research (Borgatti 1999:1). A theoretical framework guides your research, determining what things you will measure, and what statistical relationships you will look for. Babbie (2010:59) advises that a theoretical framework functions in three ways in research. First, it helps one to avoid flukes. Second, it helps the researcher make sense of observed patterns. Third, it shapes and directs research efforts.

In assessing LRRD, an approach that was deemed relevant was employed. It drew from three LRRD frameworks namely vulnerability, risk reduction and livelihoods (Buchanan-Smith and Fabbri 2005:24).

The vulnerability framework was promoted by Anderson and Woodrow (1989:18). The approach focuses on addressing the structural factors making a community susceptible

to disasters as well as affecting their ability to respond to such disasters. The approach goes beyond the assessment of humanitarian needs to seeking understanding as to how people have become vulnerable. These vulnerabilities arise from areas such as political and international economic systems. LRRD therefore focuses on the development of public policy to protect rather than exploit people and nature (Blaikie, Cannon, Davis, and Wisner 2004:9). Darcy and Hofmann (2003:10) observed that the contribution of vulnerability analysis is that it seeks to understand trends that lead to humanitarian needs. The framework has also a predictive ability to anticipate a disaster or to identify particular groups that will be most vulnerable to particular threats. Such an approach that emphasises vulnerability has direct implications for development work as it focuses on reducing vulnerability to hazards, shocks and build assets, social inclusion, and asserting rights. It is intimately linked to poverty reduction, as poor people are usually the most vulnerable to both.

Risk reduction is closely linked to vulnerability. Risk is a product of hazard and vulnerability (risk = threat/hazard x vulnerability) (Blaikie, Cannon, Davis, and Wisner 2004:9). Thus UNISDR (2002:11) defined risk as the probability of harmful consequences, or expected loss. The approach argues that risk management should be central to aid programming (Twigg 2003: 2-3).

The livelihoods approach focuses on sustainable livelihoods approach. It focuses on people's assets (tangible and intangible), their ability to withstand shocks (the vulnerability context), and policies and institutions that reflect poor people's priorities. Twigg (2003:3) maintains that, paying attention to the extent and nature of poor people's livelihood assets, and their vulnerability to hazards and other external forces, should make it possible to identify entry points for protecting those assets that are most at risk, or that could be most valuable in a crisis. However, although the livelihoods approach has been widely adopted by some key international donors such as Department for International Development (DFID), the potential for using a livelihoods approach for risk reduction work does not appear to have been realised.

1.4.2 LRRD theoretical framework for the study- a holistic approach to risk and vulnerability

Roxana, Schröter and Glade (2013:12), advised that a relevant LRRD approach is one that adopts a functional approach and considers the end-user of the assessment results. Particularly commenting on the vulnerability assessment approach, which is employed in this study, they stated that different vulnerability frameworks serve for different disciplinary groups and consequently there is no generally applicable model that can satisfy all specific needs. Broadly however, the vulnerability framework focuses on addressing the structural factors, making a community susceptible to disasters as well as affecting their ability to respond to such disasters. As pointed out above, the approach goes beyond the assessment of humanitarian needs to seeking understanding as to how people have become vulnerable. These vulnerabilities arise from areas such as political situations and international economic systems.

While the collapse of the Zimbabwe health care system affected many Zimbabweans, it was the most vulnerable people who were severely affected. The value of a vulnerability approach therefore is that it provides a window to the structural factors that made poor people to be most vulnerable. And to address the situation, the vulnerability approach provides an understanding of the underlying causes of vulnerability that inform the designing and planning of appropriate responses. However, a number of vulnerability assessments have been pioneered by different agencies.

There are nine vulnerability conceptual models (Roxana, et al, 2013:12). Roxana, et al (2013:7-12) named and described the models as indicated below. They are the double structure of vulnerability, vulnerability within the context of hazard and risk, vulnerability in the context of global environmental change community, the Pressure and Release Model, a holistic approach to risk and vulnerability assessment, the Sustainable Livelihood Framework, the UNISDR framework for disaster risk reduction, the 'onion framework', and the BBC conceptual framework. The particular vulnerability assessment model being applied in this study is the holistic approach to risk and vulnerability.

A holistic approach to vulnerability has three categories of factors that expose people to vulnerability. The first category is physical exposure and susceptibility, which is regarded as hazard dependent. Second is fragility of the socio-economic system, which is non hazard dependent. Third is lack of resilience to cope and recover, which is also non hazard dependent. The holistic approach emphasises the importance of measuring vulnerability from a comprehensive and multidisciplinary perspective. The model takes into account the consequences of direct physical impacts, namely, exposure and susceptibility, as well as indirect consequences, that is socioeconomic fragility and lack of resilience to potential hazardous events. Within each category, the vulnerability factors are described with sets of indicators. The model includes a control system which indirectly alters the level of risk through corrective and prospective interventions, that is, risk identification, risk reduction and disaster management (Roxana, et al 2013:12).

Thus, notwithstanding the multiplicities of vulnerability assessment approaches, the framework that is more useful and applicable in health recovery in Zimbabwe is the holistic approach to vulnerability. The advantages of the holistic vulnerability framework should be noted. First, it goes beyond the assessment of humanitarian needs to seeking understanding as to how people have become vulnerable. UNC Institute for the environment (2011: 16-20), Roxana, et al (2013:7-12) and Carreño, Cardona and Barbat (2007: 52) explain that vulnerabilities arise from physical, economic, cultural and historical as well as structural factors. Second, within the context of LRRD, the holistic vulnerability analysis seeks to understand trends that lead to humanitarian needs. Thus the framework has also a predictive ability to anticipate a disaster or to identify particular groups that will be most vulnerable to particular threats. Third, the holistic vulnerability approach has direct implications for development work as it focuses on reducing vulnerability to hazards and shocks and built assets, social inclusion, and asserting rights. However, while a holistic approach to vulnerability will predominantly be used, the other vulnerability assessment approaches will be employed eclectically.

The International Federation of Red Cross and Red Crescent Societies (IFRC) (2012:1) explain that vulnerability assessment employs various participatory tools to gauge people's exposure to and capacity to resist natural hazards. It is hugely employed in

disaster preparedness and contributes to the creation of community-based disaster preparedness programmes at the rural and urban grass-roots level. It enables local priorities to be identified and appropriate action taken to reduce disaster risk and assists in the design and development of programmes that are mutually supportive and responsive to the needs of the people most closely concerned. It assesses the risks and hazards facing communities and draws up action plans to prepare for and respond to the identified risks. In doing so, risk-reduction activities that prevent or lessen the effects of expected hazards, risks and vulnerabilities are identified. The International Federation of Red Cross and Red Crescent Societies (IFRC) (2012:1) note that vulnerability assessment has been used in several countries, which include Nepal, in dealing with local hazards, Yemen in 2005, to respond to areas badly affected by flash floods and Solomon Islands in the 1940s, to improve community relations.

Chiwaka and Yates (2009:11), spell out the step-by-step approach to vulnerability assessment by clarifying that it systematically analyses the causes of vulnerability by;

- Tracking hazards to determine the level of exposure to risk, causes and effects.
- Examining unsafe conditions (factors that make people susceptible to risk at a specific point in time).
- Tracking systems and factors (dynamic pressures) that determine vulnerability, resilience and root causes.
- Analysing capacities and their impact on reducing vulnerability.

The assessment thus identifies conditions that cause vulnerability though these conditions are always changing and progressing, if not stopped. Employing this approach to the Zimbabwe health rehabilitation (recovery) situation, the framework provides an understanding of the extent to which the health activities being implemented will prevent or lessen the effects of expected future health hazards, risks and vulnerabilities through analysing capacities and their impact on reducing vulnerability.

1.5 Limitations to and scope of the study

Daniel and Clark (2000:1), describe study delimitation as the characteristics that limit the scope of the inquiry as determined by the conscious exclusionary and inclusionary decisions of the research study. Study delimitation essentially defines the boundaries of the research. The study elements that delimit a study include problem statement, research objective and question, variables of interest, and alternative theoretical perspectives that have been adopted. Hofstee (2006:87) adds that delimitations explain to your reader exactly what you are responsible for by detailing what you are not responsible for and why.

This study focused on analysing health actors' humanitarian and development (interventions) pertaining to health recovery (rehabilitation) between 2009 and 2011. The actors are Government of Zimbabwe (GoZ), represented by Ministry of Health and Child Welfare (MoH&CW), two UN agencies that contributed to developing the country early recovery framework (JEROF 2010), that is, the United Nations Development programme (UNDP) and Office for the Coordination of Humanitarian Affairs (OCHA), two bilateral donors (European Community Humanitarian Office - ECHO and United States Agency for International Development -USAID) and six NGOs (three international and three local NGOs). The Ministry of Health and Child Welfare (MoH&CW) is responsible for policy formulation and overseeing implementation of health in Zimbabwe. The MoH&CW was represented by Provincial Medical Director (PMD) and respective District Medical Officers (DMOs). United Nations agencies, donors and NGOs, were represented by their respective organisational leaders.

The analysis focused on the period from 2009 to 2011, which was the period when health rehabilitation discussion started post the decade long gradual collapse of Zimbabwean health system from 2000 to its peak at the end of 2008 and early 2009 before formation of Government of National Unity (GNU). This period has been described as early recovery phase by the government of Zimbabwe and UNDP (JEROF 2010:5). The analysis focused on rehabilitation (recovery) in the context of health relief

(humanitarian) and health development. These two concepts were considered in so far as they shed light and clarified health rehabilitation in Zimbabwe.

1.6 Importance of the study

This study sheds insight through a detailed analysis of the features that characterised health rehabilitation as a development and humanitarian middle ground in Zimbabwe to promote constructive health LRRD. This entailed outlining common elements that characterised Zimbabwe's 2009-2011 health rehabilitation (recovery) phase as well as recommend a shared constructive understanding of the same. Alongside the CAP (2011), JEROF (2010) and ZUNDAF (2012-2015), this study highlighted some health rehabilitation priorities. And through recommendations, the study minimises duplication of efforts among actors as well as pursue coordinated activities that are aligned to country health priorities. Furthermore, the study provided a concise delineation of the health rehabilitation context that informs policy makers and development actors, as well as contributing to the understanding of health rehabilitation in countries undergoing health reconstruction in post health disaster crisis contexts such as Zimbabwe.

1.7 Chapter layout

The study is presented in seven chapters. Chapter one presents the study outline; chapter two provides an overview and discussion of LRRD; chapter three frames the Zimbabwean LRRD context; chapter four analyses health rehabilitation in Zimbabwe; chapter five outlines the empirical research methodology followed in the study; chapter six presents findings and discussion of the study; and chapter seven presents the study conclusion and recommendations.

1.8 Conclusion

This chapter introduced the study by outlining the research background, problem statement and research question, research objectives, theoretical framework for the study, limitations of the study, importance of the study and laying out the chapter outlines. Having laid that background, the next chapter provides an overview of rehabilitation and development and discusses LRRD.

CHAPTER 2: TOWARDS UNDERSTANDING REHABILITATION “LRRD” WITHIN HUMANITARIAN AND DEVELOPMENT CONTEXT

2.1 Introduction

The concept of “rehabilitation” rightly denoted as LRRD can properly be understood only within the context of humanitarian and development discussion. Therefore, arguably, any attempts to understand LRRD should depart from a thorough understanding of humanitarian and development concepts. This chapter discusses the definition and meaning of the concepts of humanitarian and development, and proceeds to locate LRRD within the application and operational continuum of these concepts. This conceptual delineation then sheds light on the history of LRRD, definition of LRRD, theories of LRRD and how LRRD has been applied in other countries.

“Humanitarian” and “Development” are words or concepts that are widely used in both humanitarian and development discussion. However, while humanitarian is an agreed concept, development conjures up varied ideas among people. This chapter first discusses the more agreed concept of humanitarian (2.2), and proceeds to discuss the concept of development (2.3) in detail. After discussing humanitarian and development concepts, the chapter proceeds to discuss “rehabilitation and LRRD”, as middle ground between humanitarian and development (2.4). Lastly, the chapter provides an overview of areas and countries where LRRD has been applied (2.5). From the discussion, a common understanding on these terms would thus lead to appropriate analysis and positioning of the health rehabilitation debate in Zimbabwe.

2.2 Towards understanding the concept of humanitarian

Humanitarian refers “to efforts to help people who are living in very bad conditions and are suffering because of war, flood, earthquake, etcetera” (Macmillan dictionary 2012:80). It denotes devotion to the promotion of human welfare and to social reforms marked by humanistic values as well as devotion to human welfare. However, technically, the term humanitarian has come to mean emergency relief to people requiring emergency assistance, such as those experiencing floods, earthquake and other forms of disaster. Another way to understand humanitarian is to focus on aid

classification. “A generic term used to describe the aid and action designed to save lives, alleviate suffering and maintain and protect human dignity, during and in the aftermath of emergencies”, is humanitarian aid or assistance (Global Humanitarian Assistance 2011:1). Humanitarian action is different from humanitarian intervention. Humanitarian intervention refers to a state using military force against another state when the chief publicly declares aim of that military action as ending human-rights violations, perpetrated by the state against which it is directed (International Commission on Intervention and State Sovereignty 2001:5).

Important to note is that, while development as a concept is contested, humanitarian is unanimously agreed with clear objectives and guiding principles. According to Good Humanitarian Donorship (GHD) (2013:1) and Breguet, Dubois, Jaboyedoff and Sudmeier-Rieux (2011:112-16), the objectives of humanitarian action are to save lives, alleviate suffering and maintain human dignity, during and in the aftermath of man-made crises and natural disasters, as well as to prevent and strengthen preparedness for the occurrence of such situations. Humanitarian action is guided by the humanitarian principles of humanity, meaning the centrality of saving human lives and alleviating suffering wherever it is found. The following principles undergird humanitarian action. First, impartiality- meaning the implementation of actions solely on the basis of need without discrimination between or within affected populations. Second, neutrality - meaning that humanitarian action must not favour any side in an armed conflict or other dispute where such action is carried out. Third, independence - meaning the autonomy of humanitarian objectives from the political, economic, military or other objectives that any actor may hold with regard to areas where humanitarian action is being implemented (Good Humanitarian Donorship (GHD) 2013:1).

Notwithstanding this general understanding of humanitarianism, there is a difference between classic humanitarianism and new humanitarianism (Armiño 2002:2). Armiño (2002:2) noted changes in humanitarian aid principles, objectives and operational implementation from the end of Cold War. He also observed that prior to this period humanitarian aid was delivered mostly to areas affected by natural disasters to save

lives and alleviate suffering. But in the early 1990s humanitarian aid was increasingly delivered to areas affected by conflict, areas characterised by very complex, violent and insecure climates.

Another important dimension of new humanitarianism is the realisation of humanitarian aid potential beyond relief. Armiño (2002:2) observed that in response to the new international political context, donor governments, UN agencies and NGOs, humanitarian aid objectives are being expanded to include the promotion of future development as well as bring about peace and protect human rights. Thus, by engaging in a more integrated approach, humanitarian aid can help tackle the causes of crises, and therefore, help prevent future occurrences.

Clearly, since the 1990s, the nature of humanitarian aid has changed considerably resulting in a clear distinction between ‘new humanitarianism’ and what preceded it, namely classic humanitarianism.

This new focus in humanitarian aid, is to “bridge” relief (short term) and development (long term). The challenges that emerge in attempting to bridge this gap has given rise to the LRRD discussion, which is assumed under rehabilitation discussion in the next sections. The differences between humanitarian and development aid are outlined below.

Difference between humanitarian and development

Differentiation	Humanitarian	Development
Type of aid	Incidental	Structural
Aim	Relief	Development
Time span	Short term	Long term
Prime focus	Humanitarian	Economic
Targets	Disaster areas	Poor countries

(Box Louk 2009:8).

In view of the above understanding of humanitarian, it is imperative to understand what is also meant by the concept of development.

2.3 Towards understanding the concept of development: Debate and developments

Development is a fluid term to underpin because people conceive it differently. Cloete, Groenewald and van Wyk (1996:184), in their practical guide to community development, rightly state; “Development is a difficult term to define. What is accepted for one person as development might be interpreted by another as no development or even as a decline”. It entails value judgement. But what Cloete et al, other scholars and practitioners agree upon is that, development is often seen in conjunction with other terms such as change, growth, progress, reformation, transformation or even revolution (Anderson 1996, Cloete, et al 1996). Development should be seen in relation to a specific aspect of human existence in order to understand it. The aspect could be physical, economic, social or political. However, to have conceptual clarity, we should review the historical thinking of development as captured by development theorists.

Development theory is relatively new. Moll (1986:22) and Treurnicht (1997:17) affirm that scientific inquiry into the theory of development started in the 1950s and early 1960s. This era was dominated by the modernisation theory. The late 1960s and early 1970s were characterised by the dependency theory, and in the late 1980s emphasis shifted from these two macro-theories of development to micro-theories focusing specifically on people and communities. These theories are not rigidly sequential but they overlap. In fact, the existing theories led to the rise of new theories.

Dauids (2005:4-18), locates the different theories in an insightful sequence starting with merchant capitalism (pre-1950s), followed by Modernisation (1950s to early 1960), Neo-colonialism and dependency (late 1960s and early 1970s), and Humanist – people centred development (late 1980s to the present). Dauids further explains that during the sixteenth to the late eighteenth century, merchant capitalists accumulated wealth through trading and slave trade, while colonialism provided the political instrument.

Without delving into a detailed discussion, Davids summarises that merchant capitalism and colonialism resulted in a distorted or imbalanced character of developing economies because of their early association with Western capitalism and exploitation. With millions of the people in poverty, most of them became dependent.

The modernisation theory arose after the Second World War. The thinking was that if less developed countries (LDCs) follow the path taken by developed countries (DCs) over the past 100-200 years, their economic problems would be resolved. The prescription was that LDCs should do as the DCs did. This regarded Western culture as superior and can also be seen as a continuation of the old colonial style where values other than the Western, were viewed as primitive, backward and unsophisticated. Davids (2005), noted that the Stages of Growth theory were championed by Rostow and they are; stage 1- traditional society, stage 2 – preconditions for take-off, stage 3 – take off, stage 4 - drive to maturity, and stage 5 – age of high mass production.

Davids (2005) and Websters' (1984:62-63) criticism of modernisation is that, it reflects Western arrogance by assuming that the only civilised way of life is that of Western society; that traditional life is primitive; and that backward societies will eagerly and unquestionably accept Western norms, values, and lifestyles. It fails to see any form of tension or conflict between Western and traditional values. Western materialism is wrongly regarded as the ultimate goal of development. Modernisation sees development as a process that can be controlled, where certain inputs produce a specific output (Davids 2005). This approach disregards or has little regard for the complex and integrated nature of development; it ignores the impact of colonialism on developing countries. Thus Webster summarises that this theory is an oversimplified model that lacks adequate historical input and structural perspective.

Neo-colonialism claims that though a state may be independent, when it subscribes to international economic systems, its internal policy is directed from outside (Davids 2005; Moll 1986; Treurnicht 1997). Neo-colonialism means a new form of colonialism – a form of economic domination from outside that does not rely on direct political control (Davids 2005). The growth of multinational corporations (MNCs) and transnational corporations

(TNCs) after the Second World War was seen as the principal feature of neo-colonialism. MNCs and TNCs use their worldwide business structure to control production, raw materials and retailing (Davids 2005). They represent the increasing concentration of capital in the hands of a few hundred corporations. Thus Merchant capitalism, colonialism, the consequences of modernisation and neo-colonialism, all represent the increasing penetration of developing countries by capitalism from the industrial centres of world economy (Davids 2005).

Davids (2005), Moll (1986) and Treurnicht (1997) indicate and explain that dependency paradigm originated in Latin America during the late 1960s as a result of the failure of the modernisation paradigm and was popularised by Paul Baran, the United Nations Economic Commission (ECLA) and the advocacy of Andre Gunder Frank. The dependency theorists explain under-development as a result of unfavourable economic structures, which govern developed countries (DCs) and less developed countries' (LDCs) relationship. For example, the poor countries (LDCs) export less expensive primary products that have fluctuating prices and they are obligated to import expensive manufactured goods from richer industrialised (DCs) countries. These theorists describe the world as consisting of a core or centre of dominant nations and a periphery of dependent ones (Davids 2005). Thus the underdevelopment of certain countries or regions is created and maintained by the international capitalist economic system, which sucks resources from the periphery to the centre. This takes place both at national level, that is, urban and rural areas of developing countries, and international level, that is, the developed countries and less developed countries. The periods of merchant capitalism and colonialism forced a specialisation of production on developing countries that was primarily export orientated, of limited range and geared to the raw material needs of the first world (Davids 2005).

Though much elaboration could be one on the dependency theory, for the sake of space, its argument can be summed as follows; dependency theory views underdevelopment as a historical process and not a condition intrinsic to LDCs. The dominant developed world and the dependent developing countries, form a capitalist

system whereby underdevelopment is a consequence of the functioning of the world system. The periphery is plundered of its resources by supporting development of the core, hence, underdevelopment of the periphery.

According to Davids (2005:16), the criticism of the dependency theory falls into three categories. Firstly, the theory pays too much attention to external variables and ignores internal factors that could also explain the underdevelopment of LDCs. Secondly, the delinking strategy which the theory proposes in order to overcome underdevelopment could, if implemented by LDCs, lead to self-destruction rather than the sought self-reliance especially considering small countries with few natural resources, limited technological base and access to a harbour. If those countries delink from the capitalist World system, the consequences would be catastrophic. Thirdly, the dependency theory's advocacy of Socialism in less developed capitalist countries has been criticised by those who believe that the transition from a capitalist system to a socialist system would create more problems than it would solve.

Despite criticism of the dependency theory, it significantly contributed to thinking about development. It brought back complexity into development discourse by entrenching the notion of global interdependence in development thinking. It also enabled countries and people who had been negatively defined by modernisation theory as backward to redefine themselves and reverse or reapportion the blame for lack of development.

Thus, it should be noted that from the 1950s to the late 1980s development thinking was locked into modernisation and dependency theories' thinking. Though these theories have different philosophical and ideological underpinnings, they are both prescriptive in nature and both propose oversimplified macro solutions. They also uncritically assume a universally applicable, predetermined path of development and a predictable fixed outcome.

Modernisation theory views underdevelopment as being internally caused with an external remedy (diffusion of capital), while dependency theory views underdevelopment as caused by external (Western) exploitation and an internal remedy

(self-reliance). Davids (2005), observed that the failure of modernisation and dependency paradigms made development theories and practitioners realise that merely concentrating on theories and macro strategies cannot bring development. Development should be more human-centred. In the late 1980s, therefore, there was a shift from the macro theories of modernisation and dependency to a micro approach focused on people and the community. Davids (2005), adds that people increasingly became the focus of development to such an extent that people-centred development became a buzz word of the 1990s and the early 21st century.

Theron and Barnard (1997:37), Coetzee (1989:100), and many other development thinkers asked four fundamental questions about micro-development or human development; development- from what? By whom? From whom? and, in what way? This led to the emergence of the following micro-development concepts; community development, people-centred development, participatory development and capacity building, etcetera. Humanist development views development as more than economic growth as in the macro theories, but should encompass the analysis of different levels, systems and structures in interaction and between society (Hains 2000:45). Its premise is that development is about people.

Coetzee (2001:122-126), explains that the human development approach emphasises the following values; first, people can be more than they are - people should improve their lives to reach humanness. Second, people should have the will to lead a meaningful life, in order to participate in their own development. Third, there should be an emphasis on the experience of the life, world development should incorporate the specific meaning of people's social reality or meaning giving context. Fourth, development should incorporate indigenous knowledge systems and appropriate development technology. Fifth, development should be grounded in people's consciousness, that people confronted with development should have the right to make decisions for themselves either to accept or reject interventions. Sixth, there should be public participation and self-reliance, dismantling top-down prescriptive and arrogant knowledge transportation by outsiders. In linking these values to development, human

development redefines development that has people and their experience and social reality as its point of departure (Coetzee 2001:127).

The rise of micro-development or human development led to emergence of several people centred development themes (Coetzee 2001; Theron and Barnard 1997). The themes that are used to understand micro-development include community development, integrated rural development and basic needs approach. These participatory development approaches emphasise self-reliance, social justice, the autonomy of the poor, poor people's right to decisions, empowerment and elimination of poverty. Stated differently, these themes underline that, "people can lead their own change process. They can be the actors, not merely the subjects of change" (Gran 1983:345).

A humanist approach to development thinking shows that there are no hard and fast rules and conditions for development. Theron (2005:108), rightly states that there are seldom universal recipes for development problems. Reaching a synthesis between what change agents know and like to do and what communities know and want will take critical reflection and a search for alternatives and sharing. In fact, practitioners often still do not comprehend the meaning-giving social context and dynamics of the communities in which they intervene. The questions that can be posed to human development, however, are; who will act as the voices for the excluded? How does one manage community empowerment? When and how could one put the first, last?

In summary, therefore, it should be underlined that development, as the above discussion has shown, is difficult to capture in a single short definition. The macro approaches with their prescriptive tendencies fail to realise the crucial influence of people's social and meaning-giving contexts. The micro approaches positively emphasise the centrality of people in development both as means and end. When the grassroots implementation approaches of micro development are probed, they leave a trail of dissatisfaction. Therefore, it suffices to say a thorough definition of development should incorporate all the various development thoughts outlined above, rather than concentrating on one approach. In doing so, it is more useful to concentrate on the

characteristics of development, rather than attempting to coin a definition. Development is about change, not just any change, but a definite improvement – a change for the better. At the same time, it is also about continuity (sustainability). Because development takes root in people and among people, it should have something in common with the community or society in question. It must make sense to the people and be in line with their values and their capacity. It must be appropriate; culturally, socially, economically, technologically, and environmentally. It is achieved by people and is for people. It is more than economics; it is about human development, the quality of human life as people themselves define it (Davids et al 2005, Kotze 1997; 1996; Rubin and Rubin 1986).

Though the above description can be expanded, it captures the central meaning of development. It is this kind of development that development agents strive to achieve. The question then is; how is development linked or merged with humanitarian? The next section addresses this question.

2.4 Rehabilitation middle ground: Merging development and humanitarian

Debate on linking humanitarian and development has been raging since the 1980s. The origin of the debate on linking relief, rehabilitation and development (LRRD) is traced back “to the African food crises of the mid to late 1980s” (Smillie and Minear 2004). Smillie and Minear (2004:6) and Buchanan-Smith and Maxwell (1994:5), explain that the discussion arose as a result of increased “awareness that emergencies were growing in number and intensity, hence, rapidly absorbing a growing proportion of aid resources”. The emergencies were then perceived as displacing or disrupting development. Thus Buchanan-Smith and Maxwell (1994:4), add that, “the differences between short-term humanitarian assistance and long-term development cooperation were thrown into sharp focus, not only in terms of objectives, but also in the way that aid is channelled”. Buchanan-Smith and Paola (2005:5) and Commission of the European Communities Communication on LRRD (1996 and 2001), state that this discussion triggered a preoccupation with the ‘grey zone’ between humanitarian and development assistance, accompanied by a certain amount of confusion about the potential role of

rehabilitation aid. Macrae and Harmer (2004:3), described the debate focusing on linking relief and development at this stage as “first generation of linking relief and development debate”, which was concerned with ‘managerial’ aspects of aid particularly how relief could be more developmental and sustainable. Macrae and Harmer (2004:3), add that the debate shifted in the 1990s to focus on links between aid and security policy. This shift in the debate to focus on the political motivations behind aid policy has been called ‘second generation debate’. Our discussion is largely located in the first generation debate.

To capture the linear sequence from relief (humanitarian) - to rehabilitation - to development, the term “continuum” was coined (Harmer and Macrae 2004:7). However, the concept of continuum was quickly rejected. It is argued that LRRD is not (just) about ensuring the linear transition from the relief phase to that of development, a notion which inspired the “continuum model” thinking. Büttner (2008:10), maintained that it is usually impossible to have a straightforward transition except may be in stable development situations where governments dispose of relatively strong emergency response capacities. However, even in such transition situations, Büttner (2008:1), argued that it would not be linear in the sense of rehabilitation succeeding the relief phase, followed by that of development. A practical LRRD situation “is best pursued if rehabilitation and (return-to) development measures are implemented immediately *after* the start of and *alongside* relief activities”. This has been coined the “contiguuum” model of LRRD.

The contiguuum model is generally considered more appropriate than the original “continuum” model of LRRD because it acknowledges that progress from humanitarian to rehabilitation is a pendulum that keeps swinging back and forth (Harmer and Macrae 2004).

The other concept that was coined after the rejection of the continuum notion is ‘developmental relief’, which came into use and is still widely applied. Lindahl (1996:9) reports that “the Red Cross is credited with coining this term in the mid-1990s and the concept was further developed by the Swedish International Development Cooperation

Agency (SIDA)". The essence of developmental relief, Buchanan-Smith and Paola (2005:6) added, is that it sees acute needs as part of the whole life situation of those affected. Furthermore, developmental relief looks for long-term solutions as well as responding to immediate and acute needs and builds on survivors' capacities and on local institutions, setting sustainable standards for services and encouraging participation and accountability. Nonetheless, the "contiguuum" model is generally considered more appropriate than the other models (Büttner 2008; Harmer and Macrae 2004).

Notwithstanding the usefulness of these conceptual categories of development, humanitarian and rehabilitation, Moore (2010:3), noted that the dichotomy in humanitarian and development thinking has resulted in humanitarian agencies not designing their work adequately to meet long-term goals, while development organisations fail to design theirs to deal with fragile and volatile circumstances. Therefore, Moore (2010:3), maintained that this dichotomy results from "unrealised symbiosis between emergency relief assistance (humanitarian) and sustainable development", which has led to preoccupation with efforts to understand the link between humanitarian (relief) and development "middle ground". As indicated above, Box (2009:8) and other voices identify the link or middle ground termed "the grey zone" as rehabilitation.

Armino (2002:3), Buttner (2008:4) and Buchanan-Smith and Maxwell (1994:2) explain that the link between relief (humanitarian), rehabilitation and development (LRRD), is needed on objectives, procedures, time frames, partners, and types of interventions. LRRD programmes progressively take over from emergency aid (relief) so as to stabilise the economic and social situation and facilitate the transition towards medium and long-term development strategies. Thus the argument for middle stage 'rehabilitation also called LRRD' is that 'better 'development' can reduce the need for emergency relief; better 'relief' can contribute to development; and better 'rehabilitation' can ease the transition between the two'.

Rehabilitation concept is further clarified by the UN Humanitarian guidelines, Article 159, on continuum from relief to rehabilitation and development. It states that “where emergency situations arise, rapid provision of humanitarian assistance by the international community remains imperative” (UN Humanitarian guidelines article 159). However, this form of assistance must be planned with a view to an equally rapid transition to rehabilitation and reconstruction and be part of the continuum concept which aims at resuming development at the earliest opportunity.

The challenge of straddling between development and humanitarian, which compels humanitarian and development actors to adopt “rehabilitation” middle ground, is a fit description of the Zimbabwean health situation (as discussed in the next chapter, Chapter 3).

2.5 Example of LRRD challenges in other contexts

LRRD discussion and practice has increased over the last twenty years due to a number of factors. Save The Children UK (2010:6), observed the following trends that are increasing LRRD cases. First, are the environmental and demographic trends. This includes climate change, population growth and urbanisation, that are increasing the number of vulnerable people in the world and changing the nature of emergencies faced by children and their communities. Second, political and societal trends that are threatening the ability of humanitarian agencies to work on the basis of core principles of impartiality, neutrality and independence. Third, humanitarian agencies that are being criticised for the choices they make in complex political environments, and for their ability to deliver aid in a way that is effective, coordinated and accountable. The above challenges are shared by Young and Osman (2006:3) in their report on challenges to Peace and Recovery in Darfur. The report presents a situation analysis of the ongoing conflict and its continuing impact on livelihoods.

The response to the devastating earthquake that hit Northern Pakistan on 8 October 2005 by the German Red Cross (GRC), in partnership with the Economic Security Unit of the International Committee of the Red Cross (ICRC), implemented a complex livestock restocking programme combined with structural interventions in the basic

animal health sector. The project activities are an example of an agency's move to facilitate a transition from relief measures to lasting development, with the aim of reducing the frequency, intensity, and impact of livelihood shocks, while simultaneously reducing the need for emergency relief. The question remains however whether the project's rehabilitation efforts succeeded in connecting the end of relief with the establishment of sustainability in the livestock sector, including the support of local livestock production, processing, and marketing systems (Schütte and Kreutzmann 2010:7; Sudmeier-Rieux, Jaboyedoff, Breguet, and Dubois 2011:9; Juventine 2012: 35-48).

Similarly, the Tsunami disaster in South Asia in 2005/06 also raised questions and challenges that persist about the concept of LRRD. As a result, LRRD was one of the five key themes that were explored in the sector-wide evaluation of the international response to the Tsunami, launched by the Multiagency Tsunami Evaluation Coalition (TEC) (Buchanan-Smith and Paola 2005:2).

The above examples indicate the complexity of LRRD and yet it is still a critical phase in humanitarian and development.

2.6 Conclusion

The chapter discussed humanitarian, development and LRRD. LRRD is a concept that links humanitarian and development. Humanitarian is a generic term used to describe the aid and action designed to save lives, alleviate suffering and maintain and protect human dignity during and in the aftermath of emergencies. Development is about change. The change should entail a definite improvement for the better and must also be about continuity (sustainability). Development takes root in people and among people; hence it should have something in common with the community or society. Rehabilitation on the other hand is the stage between humanitarian and development denoted by the term LRRD. The argument for middle stage 'rehabilitation - LRRD' is that, 'better 'development' can reduce the need for emergency relief (humanitarian); better 'relief' can contribute to development; and better 'rehabilitation' can ease the transition between the two'.

Having discussed the concepts of humanitarian, development and LRRD, the next chapter frames the Zimbabwe health context in order to understand the health LRRD situation.

CHAPTER 3: FRAMING THE ZIMBABWE HEALTH CONTEXT: TOWARDS UNDERSTANDING FACTORS THAT CONTRIBUTED TO HEALTH COLLAPSE

3.1 Introduction

There is inter-relationship between health, economy and politics. The health situation of a population is influenced by the economic situation and political environment. These factors interplay to affect health provision and access. This chapter provides a context for the understanding of the factors that contributed to health collapse in Zimbabwe. It discusses the general health collapse and steps to recovery (3.2), focusing on collapse as a result of sanctions from the perspective of economic collapse and the health situation itself (3.3). It also discusses steps from health collapse to recovery (3.4).

3.2 Zimbabwe collapse and steps to recovery: from sanctions and bad governance to rehabilitation; from economic contraction of negative 45% (2000 – 2008) to positive growth of 21% (between 2009-2011)

The decade 2000 to 2010 saw Zimbabwe undergoing an unprecedented collapse for a country not at war (Mlambo and Raftopoulos 2010:4). The collapse affected all facets of society and institutions. While the factors that contributed to the collapse of the country are debated, there are clear pointers that indicate some of the major contributors. The factors are both internal and external. Internally, bad governance is cited as the leading factor that led to the collapse of the country's services while externally, sanctions are noted as a major contributor to Zimbabwe's challenges.

The European Union and United States of America imposed sanctions on Zimbabwe in 2002 and 2003 respectively. The European Union (EU) suspended development cooperation assistance with Zimbabwe under Article 96 (Cotonou) in February 2002, a suspension which has been renewed every subsequent year until in February 2011 (Humanitarian Implementation Plan-HIP 2011:1). The Office of Foreign Assets Control, U.S. Department of the Treasury (2003) stated on March 7, 2003, that, as a result of actions and policies by certain members of the government of Zimbabwe, and its supporters to undermine democratic institutions and processes in Zimbabwe, President

Bush issued Executive Order (EO) 13288 imposing sanctions against specifically identified individuals and entities in Zimbabwe. And on November 23, 2005, the President (Bush) issued a new Executive Order superseding E.O. 13288. The new Executive Order (E.O. 13391) expanded the list of sanctions targets to include immediate family members of any designated individual on the Zimbabwe sanctions, as well as those persons providing assistance to any sanctions target. Providing statutory authority for these sanctions was the International Emergency Economic Powers Act ("IEEPA"), the National Emergencies Act and sections 301 of title 3 of the United States Code. The sanctions prohibited transactions and block property of persons undermining democratic processes or institutions in Zimbabwe (Office of Foreign Assets Control, U.S. Department of the Treasury 2003).

The negative effects of the sanctions imposed on Zimbabwe were substantial due to US influence over financial institutions as well as limited trade and market access by key individuals in Zimbabwe and some businesses. Hondora (2009:1), rightly observed that the US influence over the IMF, World Bank and Africa Development Bank, among others, was immense because of the size of its shareholding, vote and major donor status, respectively. While the imposition of the "smart sanctions" seemed to target a small number of top level Zimbabweans, the effects were countrywide. It should be noted that the economic sanctions that were imposed due to President Mugabe's policies of expropriating white farmland, rigging elections and human rights violations, the sanctions blocked Zimbabwe from the international credit markets as punishment (Hondora 2009:1). This resulted to the country's deterioration, which caused the suffering of many Zimbabweans.

As Zimbabwe operated under the world sanctions, the EU adopted a Short-Term Strategy for Zimbabwe dubbed the Short Term Economic Recovery Program (STERP 2009) which endorsed the priorities identified in the GNU's strategy for the stabilisation of Zimbabwe. Food, humanitarian assistance and health were identified as key priority areas under the social protection flag in the STERP document. The STERP document clearly outlined how sanctions against Zimbabwe had negative impact on the de-

facilitation of sustainable solutions to the challenges that the population was facing. Issues such as denying Zimbabwe the right to access credit facilities from international financial institutions and denying Zimbabwean companies access to credit lines were singled out as toxic and destructive in the resuscitation and rehabilitation efforts to critical institutions such as the health delivery system. STERP advocated for the lifting and repulsion of sanctions against Zimbabwe so that facilitation of lasting solutions to Zimbabwe's crucial entities could be reached. Sadly though, the sanctions were not repelled but renewed each successive year until late 2013.

According to the Zimbabwe Health System Assessment Report (2010:3), the economic collapse in Zimbabwe over the past decade contributed to significant emigration. The emigration included skilled health workers in senior positions that left their posts for better wages and conditions, abroad or in neighbouring African countries. The Zimbabwe Association of Church-related Hospitals (ZACH) (2009:5), observed that a human resources shortage was part of the main reasons why Zimbabwe's public health care system was functioning at limited capacity. The shortages put increased pressure on staff in other types of clinics and hospitals, and on junior staff in general.

The Zimbabwe Health System Assessment Report (2010:3) and CAP (2011:4) further indicated that, by 2008, hyperinflation was causing serious disruptions to health financing. ZACH stated in a 2009 report that, "Budgets have lost their meaning as prices increase daily, reducing the buying powers of institutions" (ZACH 2009:3). At that point, basic goods and services such as food, linens, electricity and water, were difficult to obtain. Shortages of resources, affordable commodities, and transportation had a huge impact on the health system (ZACH 2009:3). Food shortages became a major problem, and hospitals had their budgets dramatically reduced.

However, the advent of the United States dollar at the beginning of 2009, stabilised the economy, although it continued to complicate the situation for health care workers and patients. During hyperinflation, people received wages in Zimbabwean dollars, but hyperinflation meant those dollars had little value. Since US dollarisation, workers

started earning wages in foreign currency, but the prices of goods and services remained significantly high. Without decent salary and decent work conditions, health workers had few incentives to stay in their posts, and those who stayed were overburdened. The government introduced retention schemes, but these had mixed results.

The Health Transition Fund (2011:14) document, noted that hyperinflation and dollarisation had impacted patients as well. Some sick people were unable to pay the user fees that hospitals were allowed to charge. However, as enforcement of user fees was not standardised across provinces and across different types of health facilities, it was unclear what impact these fees had on poor and vulnerable populations.

The Health Transition Fund (2011:14) also recorded that another issue that patients and health workers faced was the lack of resources to access transportation to the hospitals and clinics. At the same time, the delivery of health commodities to health facilities was compromised by the lack of funds for vehicles and fuel. Thus, while US dollarisation brought an end to hyperinflation and stabilising the economy, general poverty continued to complicate health workers' wages, the functioning of health facilities, and patients' abilities to access services.

The above state of affairs indicated that, to ensure long term effective health delivery, the health system should be weaned from a relief (humanitarian) and early recovery situation to a long term sustainable path (development). Buchanan-Smith and Maxwell (1994:14) and Büttner (2008:3), advised that the road to a long term sustainable path involves a clear linkage between humanitarian (relief) and development usually termed rehabilitation. Furthermore, it demands a distinct progress pathway from humanitarian - to rehabilitation -to development.

Remarkable improvements started to be noted in the economic situation of Zimbabwe due to dollarisation and liberalisation. However, this development could not be fully

matched by progress on the political front especially on Linking Relief, Rehabilitation and Development (LRRD).

Zimbabwe's economy started to recover in 2009, from a decade-long crisis that saw economic output decline every year during the period 1999 to 2008. During this period, the cumulative decline was more than 45% (The World Bank 2012:2). The World Bank (2012:2) further reported that Zimbabwe's real gross domestic product (GDP) grew by 20.1% between 2009 and 2011. This was due to support from strong recovery of domestic demand and government consumption. The GDP was a result of strong growth in the mining sector (107%); agriculture (35%) and services (51%). The manufacturing sector also showed some remarkable improvement towards the growth of the GDP of Zimbabwe between 2009 and 2011.

The World Bank (2012:2) outlined the Zimbabwe economic situation in detail as spelt out below;

The strong external demand for primary commodities like platinum, gold, cotton and tobacco has supported higher production levels, which have recovered to pre-2000 levels in terms of values. There was a noticeable increase in the value of mineral exports and agricultural exports by 230% and 101% respectively over the 2009-2011 periods. In 2011, real GDP was estimated to have grown by 9.3% following a nine percent growth in 2009. Growth in 2011 was led by strong growth in mining (50.5%), agriculture (17.1%) and services (16.3%). Growth in manufacturing sector (5.3%) performed below expectations. Services remain the biggest GDP contributor (46.1%), with mining (22%) now surpassing agriculture (15.6%). Transport and communications (13.8%) grew ahead of manufacturing (11.9%). Nominal GDP as of end 2011 was estimated at US\$9.9 billion, with GDP per capita at US\$698. However, the 2009-2011 economic rebound is slowing down, with growth estimated at five percent in 2012, being weighed down by the poor agricultural season, binding credit constraints, fiscal revenue underperformance and slow pace of economic reforms (The World Bank 2012:2).

The Reserve Bank of Zimbabwe (2011:2-5) and The World Bank (2012:2), added that; [t]he annual average inflation remained moderate at 4.9% in 2011 and 4% percent in the first eight months of 2012. The external position remained unsustainable. While supported by favourable international commodity prices, merchandise exports increased markedly by 35% from US\$3,317 million in 2010 to US\$4,496 million in 2011, imports grew faster (46.5%) and reached US\$6,365 million in 2011 following a 60.7% increase in 2010 and 22.2% increase in 2009. Imports demand was dominated by fuel (16.5%), chemicals (15.4%), machinery (14.5%), and manufactured goods (12.1%). The current account deficit in 2011 remained elevated at 32% of GDP, financed by short-term capital inflows and accumulation of arrears. Foreign exchange reserves remain low at 0.6 months of import in 2011, well below the benchmark levels for dollarised economies. Errors and omissions remain high (US\$1 billion), reflecting increase in unregistered remittances, unreported exports and unidentified financing. Foreign direct investment (US\$125 million) and portfolio investment (US\$80 million) are still subdued mainly due to poor business conditions and concerns over political instability (The World Bank 2012:2; Reserve Bank of Zimbabwe 2011:2-5).

The World Bank (2012:2) and Reserve Bank of Zimbabwe (2011:2-5) further reported that Zimbabwe experienced strong fiscal recovery between 2009 and 2011, but the momentum was slowing down. Central Government Revenues increased from US\$970 million in 2009, to US\$2.9 billion in 2011 (excluding diamond revenues), and representing 29.4% of the 2011 estimated nominal GDP. In real terms (constant 2009 prices), the 2011 fiscal revenues surpassed the 1998-2001 average. Better than expected revenue performance in 2011 (US\$2977 million), and lower capital expenditures helped manage the growing total expenditures of US\$2,895 million. As a result, the government managed to generate a small cash-surplus of US\$41 million in 2011, largely offset by accumulation of domestic arrears to state-owned enterprises (SOEs), estimated at about US\$150-200 million. Increase in the current expenditures

was largely fuelled by increasing employment costs, which absorbed 63% of current expenditure, and corresponded to 12.8% of GDP in 2011. 2012 saw the pace of revenue growth slowing down on the back of less than expected performance of diamonds revenues. At the same time expenditures were rising fast, being driven by employment costs (69% of current expenditure between January and August 2012) (The World Bank 2012:2; Reserve Bank of Zimbabwe 2011:2-5).

The September 2012 debt sustainability analysis confirmed that Zimbabwe was in debt distress, with arrears to most creditors continuing to accumulate. At the end of 2011, total external debt was estimated at US\$10.7 billion (113.5 percent of GDP). Growth in total credit to the private sector was levelling off. After sustained growth of 84.3% or US\$1,317 million, up from US\$1,563 million in November 2010 to US\$2,881 million in November 2011, credit to private sector stabilised at US\$3,233 million in July 2012 (The World Bank 2012:203; Reserve Bank of Zimbabwe 2011:2-5).

The economic recovery in Zimbabwe thus remained fragile as a number of issues stood in the way of sustainable economic growth. These related to downside risks in agriculture, continued political uncertainty around the roadmap to elections resulting in low business confidence, lack of domestic liquidity and very high real interest rates on short-term credit, high wage costs and unrealistic wage demands driven by transportation, accommodation, utilities, weak infrastructure (lack of resources to rehabilitate infrastructure and unreliable power supply). Downside risks also included possible compression for exports due to the unfolding slowdown of the global economy, potential destabilising effects of the indigenisation programme on the economy and disorderly unwinding of vulnerabilities in the banking sector (Reserve Bank of Zimbabwe 2011:3).

In 2011, the government presented a Medium-Term Plan for 2011-2015, which attempted to set the stage for Zimbabwe's further recovery. Economic management however became more difficult and fractured, with some policy setbacks associated with

the fast-track indigenisation on the key sectors of the economy, increased vulnerability of the banking sector, and financing of non-priority expenditures.

Thus as briefly pointed out above, the economic situation of the country had significant impact on the Zimbabwean health situation from 2000 to the peak of the humanitarian crisis in 2008 as well as the rehabilitation and recovery process of 2009-2011. The effect of these developments on the health situation is discussed in detail in the next section.

3.3 Health situation in Zimbabwe: From collapse (in 2000 – 2008) to rehabilitation and recovery (in 2009-2011)

The overall impact of Zimbabwe's decade-long economic decline and cuts in public health expenditure detrimentally affected the health system (Health Transition Fund 2011:8; The Zimbabwe Health Sector Investment Case 2010:6). This resulted in deterioration of health care facility infrastructure at all levels, resulting in reduced access to basic health care. In addition, key activities such as out-reach services, referral of patients, drug distribution, surveillance and monitoring and evaluation of local health centres were hampered by shortage of transport, poor road network and lack of communication. Moreover, the flight of human resources further compounded the decline of critical public health programmes, quality and coverage of services such as emergency preparedness and response. The economic downturn also resulted in declines of water and sanitation coverage in both urban and rural areas.

CAP (2011:8) and Zimbabwe Food Security and Nutritional Assessment (2007:5), reported that drought conditions in Zimbabwe contributed to decreased dietary intake in most rural areas. In addition to compromised dietary intake, rates of diarrheal disease throughout the country exceeded epidemic thresholds in 2008 – 2009. During the same period, such high rates of disease placed the population at even higher risk for development of malnutrition.

According to The Zimbabwe Health Sector Investment Case (2010:6-7), Zimbabwe's health system was experiencing a critical shortage of not only drugs, but equipment and trained staff, which was a result of an economic meltdown characterised by hyperinflation, shortages of basic commodities and a brain drain. The impact on the country's social services was compounded by a political crisis which saw Zimbabwe isolated by many governments, international financial institutions and donors.

With the introduction of multi-currency in Zimbabwe, the health situation showed some signs of improvement. Health response was showing significant signs of progress as shown by the gradual improvement in availability of drugs and improved capacity of the health sector to respond to outbreaks as a result of more donor support through the transition funds (Health Transition Fund 2011:12; CAP 2012:5). However, there was need for support for health surveillance and response to disease outbreaks and other public health emergencies. Without such support, there was potentially a high risk for disease outbreaks which were a result of poor capacity for early detection and rapid response to public health emergencies. Zimbabwe's health delivery system was on the road to recovery and it is hoped that soon, every Zimbabwean would be able to exercise the basic human right of access to quality health care (Health Transition Fund 2011:12).

According to the 2009-2013 National Health Strategy, the Government of Zimbabwe's desire is to have the highest possible level of health and quality of life for all its citizens. This will be attained through the combined efforts of individuals, communities, organisations and the government, allowing them to participate fully in the socio-economic development of the country.

This vision would be attained through guaranteeing every Zimbabwean access to comprehensive and effective health services. Extending from this vision, the mission of the Ministry of Health and Child Welfare (MoH&CW) is to provide, administer, coordinate, promote and advocate for the provision of equitable, appropriate, accessible, affordable and acceptable quality health services and care to Zimbabweans while maximising the use of available resources, in line with the Primary Health Care Approach. As part of its mandate to give strategic direction in health sector

development, the MoH&CW developed the National Health Strategy 2009 – 2013, “Equity and Quality in Health - A People's Right”. This document succeeded the National Health Strategy, 1997 – 2007, “Working for Quality and Equity in Health”, whose major thrust was to improve the quality of life of Zimbabweans and set the agenda for launching the health sector into the new millennium. Recognising that improvement in the health status of the population would not depend on health sectorial actions alone, the 1997 National Health Strategy sought to pull together all national efforts which had potential to enhance health development into a promising new era.

Whilst the situation analysis carried out at that time showed a worrying decline in health status indicators, the optimism associated with the dawn of a new era provided hope and conviction for improvement. Similarly, the identified weaknesses in the performance of the health system were thought to be temporary, in the hope that the holding capacity of the economy to support a robust health system would improve.

On the contrary, the challenges facing the health sector continued and in fact, became worse. During the second half of the implementation period of the National Health Strategy (1997 – 2007), Zimbabwe experienced severe and escalating economic challenges which peaked in the year 2008. The economic decline resulted in a sharp decrease in funding for social services in real terms (Health Transition Fund 2011:12). This directly contributed to an unprecedented deterioration of health infrastructure, loss of experienced health professionals, drug shortages and a drastic decline in the quality of health services available for the population (The Zimbabwe Health Sector Investment Case 2010:8).

The main thrusts of the 2009-2013 National Health Strategy are therefore; firstly, to provide a framework for immediate resuscitation of the health sector (Health System Strengthening), and secondly, to put Zimbabwe back on track towards achieving the Millennium Development Goals (National Health Strategy 2009). The strategy is based on information from several studies carried out, namely, the Study on Access to Health Services; Vital Medicines and Health Services Survey; Community Working Group on Health surveys; Zimbabwe Maternal and Perinatal Mortality Survey; existing national

plans and programmes as well as existing programme specific policy and strategic documents (National Health Strategy 2009:4). However, the document does not cover all details since it is a policy and strategic document. Furthermore, the strategy has taken into consideration regional and international policies, strategies and commitments made by the country such as the Millennium Development Goals, the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, as well as other international, continental and regional health protocols including the African Union (AU) Health Plan, the East, Central and Southern Africa (ECSA) Health Community Agreements, and the Southern African Development Community (SADC) Health Sector Protocol.

3.4 Conclusion

The foregoing discussion revealed that there were several factors that contributed to the collapse of health care in Zimbabwe. The factors included bad governance and resultant policies as well as economic sanctions. The collapse occurred over a decade-long economic decline from 2000 to a humanitarian peak in 2009. This situation resulted to cuts in public health expenditure, which detrimentally affected the health system. The deterioration of health care was experienced at all levels. It reduced access to basic health care. Key activities such as out-reach services, referral of patients, drug distribution, surveillance and monitoring and evaluation of local health centres, were hampered by shortage of transport, poor road network and lack of communication. Furthermore, the flight of human resources further compounded the decline of critical public health programs and quality and coverage of services such as emergency preparedness and response. The economic downturn also resulted in declines of water and sanitation coverage in both urban and rural areas leading to disease outbreaks.

Having analysed the health situation and the factors that interplayed to affect health provision and access, the next chapter considers rehabilitation from the United Nations framework and how the framework is applied to health rehabilitation, particularly in Zimbabwe.

CHAPTER 4: UNDERSTANDING HEALTH REHABILITATION (RECOVERY) IN ZIMBABWE

4.1 Introduction

There is growing interest to understand LRRD both theoretically and practically. The United Nations established an early recovery cluster among its clusters as an attempt to provide guidance on managing and coordinating rehabilitation activities. This chapter provides an understanding of rehabilitation from the UN framework and how the framework can be applied to health rehabilitation (4.2). The chapter proceeds to discuss the Zimbabwe health rehabilitation situation in view of the UN health rehabilitation framework (4.3). The words recovery, early recovery and rehabilitation are used to refer to the same phase that is between humanitarian and development.

4.2 Understanding United Nations (UN) rehabilitation framework and application to health rehabilitation (recovery)

4.2.1 UN rehabilitation framework

Smillie and Minear (2004:5), Buchanan-Smith and Maxwell (1994:4), Buchanan-Smith and Paola (2005:6) and Commission of the European Communities Communication on LRRD, (1996 and 2001) usefully describes the meaning of rehabilitation and the terms associated with it, that is, LRRD, humanitarian and development. Rehabilitation refers to the middle phase between humanitarian and development, the process of recovering from humanitarian situation (short term) to development (long term). It embraces the terms such as 'early recovery, recovery, reconstruction, transition, grey zone and middle ground', that lie between humanitarian and development. Thus, for this discussion, all the said terms would be used interchangeably to denote a phase between humanitarian and development, which also links these two concepts. UN Humanitarian guidelines describe rehabilitation as a middle phase from humanitarian assistance towards development resumption. It is a bridge that links humanitarian assistance with development during the process of recovery. WHO (2011:9) and OCHA (2008:9) applying the rehabilitation concept to health, naming it health recovery, defines health recovery as "the restoration and improvement" where appropriate facilities and systems

(including health), livelihoods and living conditions of disaster-affected communities, including efforts to reduce disaster risk factors. WHO (2011:9) adds that recovery of health systems are much more complex, takes a longer time and are more expensive than disaster responses. Below is an illustration of the three phases adapted from WHO (2008a:10). **Early recovery in the context of transition (below – figure 4.1).**

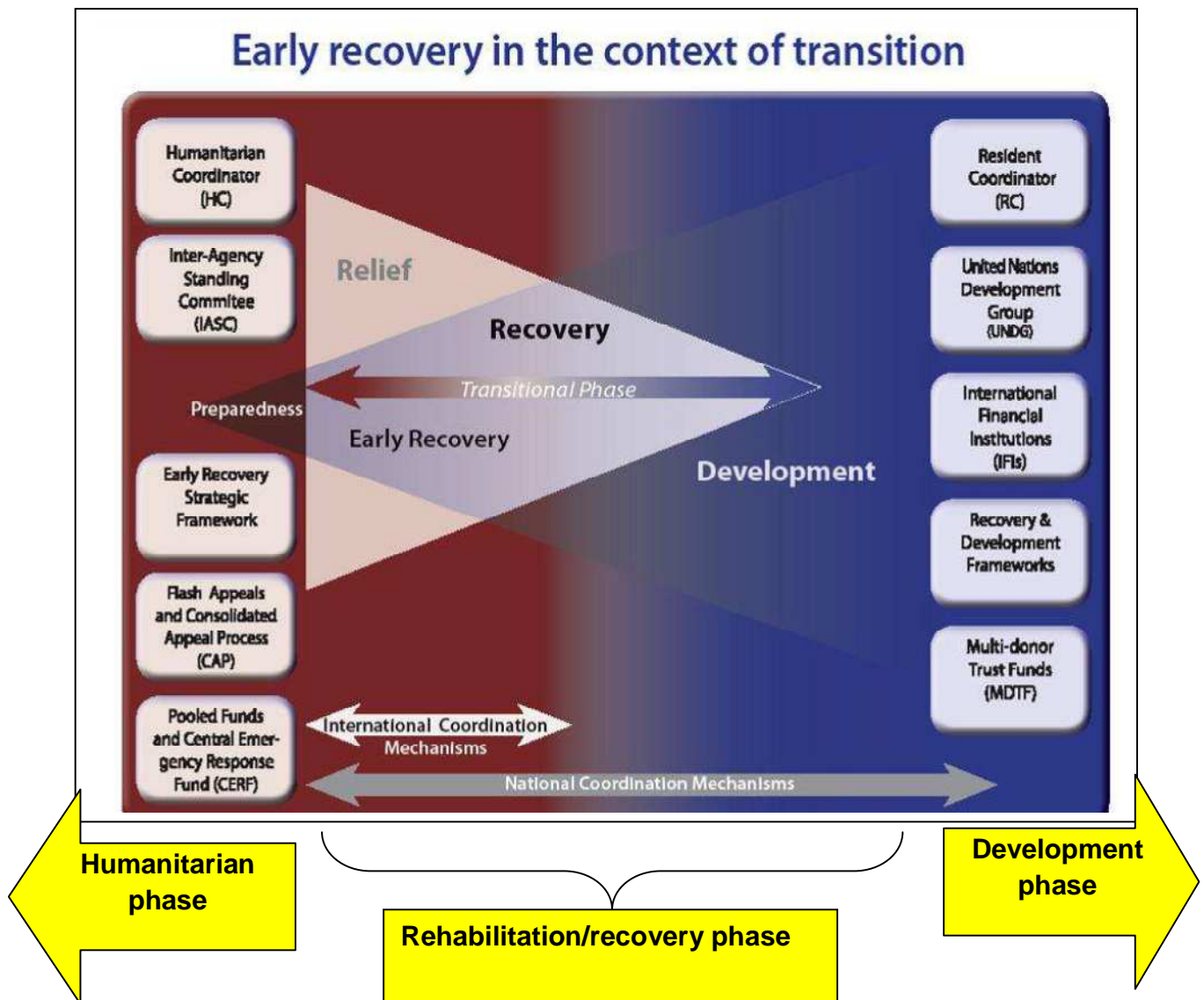


Figure 4:1 Diagram showing early recovery in the context of transition (LRRD)

WHO (2008a:5) explained that recovery phase, which is also called rehabilitation, is the process of restoring the capacity of the government and communities to rebuild and recover from crisis and prevention of relapses. In doing so, recovery seeks not only to catalyse sustainable development activities, but also to build upon earlier humanitarian programmes to ensure that their inputs become assets for development. There will be parallel needs to ensure the humanitarian imperative, that is, to plan and carry out activities aimed at protecting lives and reducing disease, malnutrition and disabilities among the vulnerable populations in the affected areas, and to set the foundations for the developmental imperative. The latter should strengthen the institutional capacity to pursue longer term health development goals, to discharge the essential public health functions and development of the health care delivery system within an environment of good governance, to assure human security and extend social protection in health.

On the other hand, early recovery efforts need to be activated in all sectors from the initial phases of relief interventions. The foundations for a fully fledged recovery work takes place during the prolonged periods of protracted emergencies and the long transition that follow the aftermath of disasters and the post conflict situations (WHO 2008a). There is no clear-cut boundary between the relief and the recovery periods. Therefore, it is important to emphasise that the disaster management cycle is an unbroken chain of human actions whose phases overlap.

WHO (2008a:5) Guidance Note on Early Recovery and WHO (2008b:6) Global Health Cluster Guidance Note on Health Recovery, outline in detail a framework for health recovery (rehabilitation). WHO (2008a:2) Guidance Note on Early Recovery explains that early recovery is a multidimensional process of recovery that begins in a humanitarian setting. It is guided by development principles that seek to build on humanitarian programmes and catalyse sustainable development opportunities. It aims to generate self sustaining, nationally owned, resilient processes for post crisis recovery. It encompasses the restoration of basic services, livelihoods, shelter, governance, security and rule of law, environment and social dimensions, including the reintegration of displaced populations.

The UN has various clusters that aim at responding to various humanitarian challenges as well as manage the respective transitional issues. The clusters are as indicated below; Agriculture, Education, Health, Nutrition, Protection, Water Sanitation and Hygiene (WASH), Coordination, Early Recovery and Emergency Telecommunications. Below is an indication of UN Clusters;



WHO (2008a:16)

Figure 4.2 - Early recovery network

Applying recovery (rehabilitation) to health, WHO (2008b:4) states that after health disaster or crisis (humanitarian), the health sector focuses on reducing morbidity and mortality through a set of appropriate health services, primarily guided by the well-known humanitarian principles of humanity and impartiality. In these situations, rapid

humanitarian interventions are needed. As soon as the immediate needs are addressed, other activities become possible that aim to restore or even improve pre-existing health services. Those recovery activities, small or big, should not wait for formal, large scale reconstruction and development programmes that are likely to be implemented in a later phase. These are activities that should already take place during the humanitarian relief phase and will continue in the period thereafter. They will assist in the recovery of the health sector, prepare for the return of normality, and create building blocks for future development.

During health humanitarian situation there is need to carry out activities aimed at protecting lives and reducing disease, malnutrition and disability; and setting the foundations for strengthening the national capacity to pursue long-term health related development goals. These activities overlap in the recovery phase. Challenges emerging during transition should be addressed strategically in order to minimise the deterioration of health services, enable the introduction of initiatives for the recovery of health systems, and allow for a smooth transition within the reconstruction and development phase.

WHO (2011:8) spells out the three objectives of health recovery (rehabilitation) as follows; first, to augment emergency health programmes and ensure that their inputs become long-term assets. Second, strengthen health systems; and third, establish foundation for long-term development of the health system. The health system building blocks that get affected in a health crisis are leadership and governance, human resources, information, medicines and technologies, service delivery and financing. Therefore, disasters therefore impact on all these building blocks of the health system (WHO 2011:8).

WHO (2008b:5), explains how the three objectives of health recovery, namely, augmenting emergency health programmes to ensure inputs become long-term assets (objective one), strengthen health systems (objective two), and establish foundation for

long-term development of the health system (objective three), are applied. In a natural disaster, humanitarian health relief is implemented but is stopped once the crisis subsides. This will be taken over by the pre-existing health services. The latter may or may not need reconstruction to its former level of operation, but it will require substantial changes. However, following more protracted crises, the closure and hand-over of humanitarian health relief is usually more complex. While pre-existent, usually government run health services would have collapsed during a health disaster leading to humanitarian relief organisations to start running clinics and other health activities. Recovery interventions build on these early interventions within the existing health infrastructures (WHO 2008b:5).

4.2.2 Transition towards health recovery, development and financing

Against a background of still existing humanitarian health needs, the health sector needs to make a transition towards a health recovery and development approach. Health recovery ensures that health services are gradually run by or on behalf of a legitimate government. Health services are usually vulnerable during health recovery period and may even contract into a post-crisis period (WHO 2008b:9). Apart from the need to transit from humanitarian health provision to renewed government engagement, the health sector faces another problem during the recovery phase after a protracted crisis. WHO (2008b:10) states that it is rare that health services can be rebuilt as they were before the crisis. More or less extensive reforms are needed, causing further difficulties to deliver basic health services during the recovery period, while health needs as well as population expectations are high. While the many uncertainties during the recovery phase may make it difficult to have a longer term outlook, the health MDGs may provide a useful standard to assess strategies and programmes during recovery.

In attempting to implement health recovery and development interventions, funding is a usual challenge. Funding for crisis situations vary from one phase to the next. WHO (2008a:10), observed that funding is a major issue in health efforts during transition periods. There is little or no funding to bridge between the humanitarian phase and the

fully fledged rehabilitation stages as well as financing of the development phase. The process of mobilisation of funds for the health efforts in transition and recovery does not have the same response to urgency as the acute humanitarian aid phase. The funding for the three phases (i.e. humanitarian, rehabilitation and development) is sourced from the sources indicated in the categories below.

Funding sources for each phase

Phase	Funding source	Funding description and purpose
Humanitarian (relief/emergency)	<ul style="list-style-type: none"> Flash Appeals Central Emergency Response Fund (CERF) Consolidated Appeal Process (CAP) 	Provision of quick initial funding for life-saving assistance at the onset of humanitarian crises
Rehabilitation/recovery	<ul style="list-style-type: none"> Bilateral and multilateral agreements Multi donor trust funds (MDTF) - administered by World Bank 	<ul style="list-style-type: none"> Provided to fit the Country Assistance Framework (CAF). The CAF builds on needs assessment but plan the activities as strategies to achieve MDG and to respond to priorities identified in the Poverty Reduction Strategy Papers (PRSP) of the affected country. Funding aligned to United Nations Development Assistance Fund (UNDAF) to achieve MDGs
Long- term development	Bilateral and multilateral donors	Funding aligned to United Nations Development Assistance Fund (UNDAF) to achieve MDGs

Table 4.1 Funding sources for each developmental phase

4.2.3 UN health system rehabilitation (recovery) framework: health system rehabilitation areas

During re-establishment of disrupted health system resulting in a health humanitarian situation, interventions should focus on rebuilding blocks that would have been affected, namely leadership and governance, human resources, information, medicines and

technologies, service delivery and financing. WHO (2008b:6) advises that decisions and investments made in the initial phases of a crisis may have detrimental long term consequences that extend to the recovery and reconstruction phases. First, health units may be built or expanded in towns or safer areas and become redundant when the situation reverts to normal. Second, low level health workers may be formed with ad hoc, short courses and their expectations of being integrated in the health system will have to be dealt with. Third, multiple drug supply channels may be used to the detriment of the official ones. Fourth, multiple information systems may be put in place undermining the functioning of a uniform one; and others. Therefore, recovery interventions have to be implemented in a coordinated way within government frameworks.

WHO (2008b: 13-21), delineates the six health system recovery intervention building blocks as summarised in the table below;

Health system recovery building block	Focal areas
Leadership and governance	<ul style="list-style-type: none"> • Capacity building • Formulating policies and strategies • Developing coordination platforms with all critical stakeholders around District Master Plans using the cluster approach • Decentralisation and strengthening planning and managerial capacity at provincial and district level • Contracting
Human resources	<ul style="list-style-type: none"> • Health worker stock • Plan early for human resources • Training of health staff • Financial aspects of human resources
Financing	<ul style="list-style-type: none"> • Public Financing • External assistance • Forecasting the future resource envelope in a recovery perspective • User Fees • Consider the long term financial implications of policies and strategies
Medicines and Technology	Factors impeding drug supply

Information	Putting together a sound information basis- mainstream epidemiologic surveillance and early warning systems
Service delivery	<ul style="list-style-type: none"> • Basic health packages • Vertical programmes • Ensuring equity, effectiveness and efficiency (<i>compromises are inevitable</i>)

Table 4:2 Health systems and focus areas

According to WHO (2008b: 13-21), early health recovery (rehabilitation) interventions should fall in the categories indicated in the six health system building blocks above. Thus, any country undergoing health rehabilitation has to align its recovery interventions according to these guidelines.

While health rehabilitation (recovery) is a phase that should be carefully managed, there are challenges associated with operationalising it. WHO (2011:5), observes nine challenges. First, is timing. The question of timing is ‘when does one start the recovery process?’ The second challenge is coordination. With coordination the question is, ‘which coordination mechanism should be used of the two, humanitarian or development coordination?’ Third, there are difficulties in linking recovery planning to national processes. Fourth, there are difficulties in linking humanitarian and development actors. Fifth, it is unclear how residual humanitarian gaps are handled during the transition and recovery process. Sixth, the funding mechanism, source and budgetary control issues are unclear. Seventh, the slow and tedious process of consultations and consensus building takes time. Eighth, accurate planning is difficult due to lack of information. Ninth, expectations of people may be raised and then fail to be met.

Notwithstanding the above health recovery process challenges, there are clear guidelines for effective health system recovery. WHO (2011:12) recommends that health recovery process must be guided by a strategy and plans that are integrated into existing national, regional and district plans and budget process. It should be within the framework of the overall sector strategy; be consultative and evidence-based; describe

actions and activities needed to restore normalcy in the sector and give options. Also, it should prioritise key actions and activities; clearly identify funding mechanisms, sources and resource envelope; propose how to address budgetary control issues; comprise a strategy and implementation plans with detailed costing.

4.3 Health recovery policies in Zimbabwe

4.3.1 Health rehabilitation (early recovery) interventions and policies

Following the decade long massive economic decline and humanitarian situation in Zimbabwe, the United Nations Country Team (UNCT) and Government of Zimbabwe (GoZ) consultatively agreed, as early as February 2010, to develop a Joint Recovery Opportunities Framework (JROF 2010) to move towards recovery. Health, Education, Nutrition, Food Security, WASH and Agriculture, were identified as priority sectors of response in Zimbabwe (JROF 2010:1). The purpose of the assessment was to jointly identify early recovery opportunities in the selected sectors so as to allow both the GoZ and partners to have a framework from which to draw early recovery interventions. The JROF (2010:1) described early recovery interventions as the actions that are undertaken as early as possible after the crisis, to address the critical gap in coverage between humanitarian relief and long-term recovery, that is, between reliance and self-sufficiency phases.

The early recovery framework facilitated an integrated and sustainable approach to attaining resilience and disaster risk reduction through capacity building of those affected by the decade long crisis. The JROF (2010:1-5), presented key joint recovery priority opportunities for Zimbabwe, that reflect and restore the capacity of affected national institutions and communities. It sought to build on humanitarian efforts and promote sustainable transition to recovery and development direction. The early recovery framework emphasised the coming out of the humanitarian focus towards sustainable development through identifying early recovery opportunities for Zimbabwe, to enable the country to “build back better”. Thus the JROF is clearly a LRRD framework.

The JROF (2010:12), states that the main focus of early recovery in Zimbabwe is to restore the capacity of national institutions and addressing a broad range of needs such as livelihoods, social welfare and protection, governance, security and rule of law, environment and socio-economic issues. The aim is to kick-start nationally owned processes for recovery that is sustainable, seeking to build back better. Thus, the early recovery process focused on strengthening institutional and human capacity addressing the underlying causes of the prolonged crisis to avoid future relapse, thereby building resilience. The early recovery in Zimbabwe was therefore about strengthening the ability of affected institutions such as health, the local government and civil society to take charge of their recovery process.

The Zimbabwe early recovery framework has sector specific programmatic goals and needs which is the basis of the specific interventions for each sector. For the health sector, the JROF (2010:9) spells out the following priority early recovery opportunities;

“Strengthening and supporting the training and retention of more specialised health personnel, improving conditions of service for specialised health personnel, rehabilitating tertiary health training institutions, supporting local pharmaceuticals to produce medicines locally, supporting importation of medicines and equipment to complement local supplies, improving health infrastructure, transportation and communications equipment and medical services and improving management capacity at all levels of the health system for quality service provision”.

While the JROF (2010) provides the overall country early recovery (rehabilitation) framework including the health sector, there are particular health policy frameworks that were developed to address health issues. These policy frameworks have different aims but they all targeted health rehabilitation (early recovery). The policies are; The 100 days Plan, Consolidated Appeal Process (CAP) documents (2009, 2010, 2011, 2012, 2013), Joint Early Recovery Opportunities Framework (JROF), STERP 1 and 2, Zimbabwe Medium Term Plan (2011-2015), The National Health Strategy 2009 – 2013, The Zimbabwe Investment Case (2010-2012), The Health Transition Fund (2011 –

2015, and Zimbabwe United Nations Development Assistance Framework (ZUNDAF) 2012 – 2015.

Reflecting on the extent to which some of the developed policies have been implemented to address health recovery needs, Nderere (2010:2), the Chief Executive Officer of Harare Central Hospitals, presented a review of the results on implementation of Emergency Health Summit recommendations (100 days plan). He noted that the overall results for the implementation of 100 days performance assessment were not very encouraging. There was increased functionality of health institutions but still far below expected levels. Second, there was increased utilisation of health services but still far below expected levels. Third, there were increased levels of promises to support health sector resuscitation, but very little tangible support was received. Fourth, although the plan had very good revival strategies and proposals, it had very little financial support.

Further to the 100 days Plan, all the above stated policy documents outline the early recovery (rehabilitation) interventions including health, which needed to be implemented to ensure Zimbabwe transitioned to a long term health development situation. For instance, the Zimbabwe Health Transition Fund (HTF) (2011:9), ZUNDAF (2011:13), JROF (2010: 14), The Investment Case (2010) and the other health recovery policy documents indicated above, as well as the other country implementation frameworks, stated that Zimbabwe health sector had collapsed and the period starting the formation of the Inclusive Government (GNU) in 2009 began the recovery process. The documents pointed out that, against a background of near collapse of the health sector due to severe deterioration in infrastructure, lack of investment, low wages, decreasing motivation and capacity of the civil service and absolute shortage of essential supplies and commodities in late 2008 and early 2009, a path to health recovery started with signing of the GNU. This set the health care on a rehabilitation (recovery) process after the peak of humanitarian situation in 2008 and early 2009 (The 100 days Plan 2009). The goal of the above health recovery policies is rightly summarised by the Health Transition Fund. The goal was to provide a guide for a planned progress towards

achieving the highest possible level of health and quality of life for Zimbabweans (Health Transition Fund 2011:9).

The HTF fund document and the other documents recognised the rehabilitation and recovery phase of the health care system. The HTF (2011), Zimbabwe Health Sector Investment Case (2010) and CAP (2010 and 2011), capturing the early recovery framework, stated that it aimed to support the continuation of national-scale health services delivery in critical areas. The critical areas indicated by the policy documents are; the residual health humanitarian challenges from the peak of the crisis in 2008 and early 2009, which persisted during the recovery (rehabilitation) phase of 2009-2011 and beyond. The ZUNDAF (2011), JROF (2010) and HTF (2011) documents in their language, while having a long term health development perspective, were cognisant of the humanitarian challenges associated with rehabilitation phases. The HTF clearly stated that it provided strengthened capacity in government to take on sector budget support “should the situation improve”, while “mitigating risks and enhancing preparedness, should humanitarian situations require response” (HTF 2011:9). Based on gaps analysis, the HTF recognised that, “investment in health needs to be embedded in broader development planning and needs long-term” predictable funding from donors as well as mechanisms to hold all partners accountable (HTF 2011:9).

4.3.2 Health Policies in Zimbabwe within overall country policy framework

While there has been no systematic health policy evaluation, the health policies are intertwined with other government policies particularly economic policies, which have been rudimentarily appraised. Chitambara (2011:1-2), commented that MTP is one of the plethora of economic development strategies, which applies to health that the government has crafted in the past, including among others; Growth with Equity (1981); Transitional National Development Plan (1982-85); 1st Five Year National Development Plan (1986-90); Economic Structural Adjustment Programme - ESAP (1991-1995); Zimbabwe Programme for Economic and Social Transformation - ZIMPREST (1996-2000); Millennium Economic Recovery Programme - MERP (2000); Ten Point Plan, with

an emphasis on agriculture (2002), National Economic Revival Programme - NERP (2003); Macroeconomic Policy Framework (2005–2006); 'Towards Sustained Economic Growth'; Expansionary Monetary Policies (2003–2008); National Economic Development Priority Programme - NEDPP (2007) and Short-term Emergency Recovery Programme (2009).

The MTP targets an economic growth rate of at least 7.1% from 2011-2015. However, the policy does not spell out how the high political risk premium will be dealt with. Chitambara (2011:1-2) comments that the high political risk premium is the millstone around the Zimbabwean economy's neck. Economic uncertainties and political volatility affects the implementation of MTP. The MTP requires a funding of USD9.2 billion and yet there is no clearly outlined strategy to raise the funding. Chitambara (2011:1-2), added that the MTP does not have an implementation matrix detailing what needs to be done and by whom and the time frames. There is also no role for business, labour and civil society in the monitoring and evaluation of the MTP.

Considering health policies geared towards mobilising health funding to boost health recovery, Shamu (2012:1), observed that apart from the Health Transition Fund, which explicitly stated that it was a response to the Investment Case, other external funders bringing funds into the health sector were not as clearly tied to the Zimbabwe Health Investment Case. Shamu (2012:1), observed that the impact of the Investment Case was possibly weakened because it did not set any mechanism for raising and spending resources, did not stipulate how it was going to operationalise the resource mobilisation effort, nor how it was going to track and account for the resources.

Notwithstanding the fact that the above health policies have clear gaps to achieve the intended rehabilitation efforts, the frameworks clearly indicated rehabilitation (LRRD). The indication in the HTF (2011) that investment in health needs should be embedded in broader development planning and long term health needs, makes this point clear. As Moore (2010), Buchanan-Smith and Paola (2005), Büttner (2008) de Armiño (2002), Macrae and Harmer (2003), and others noted, the LRRD argument is that, "better

‘development’ can reduce the need for emergency relief; better ‘relief’ can contribute to development; and better ‘rehabilitation’ can ease the transition between the two”.

Accordingly, the three objectives of health recovery (rehabilitation) that are summed up by the LRRD framework are; first, to augment emergency health programmes and ensure that their inputs become long-term assets; second, strengthen health systems; and third, establish foundation for long-term development of the health system (WHO 2011:6). As already indicated earlier, the health system building blocks that get affected in a health crisis are leadership and governance, human resources, information, medicines and technologies, service delivery and financing. Disasters therefore impact on all these building blocks of the health system. The JROF (2010:7) noted that there is gross underutilisation of public sector institutions due to non-functionality of the health care system. The Zimbabwe health system is not performing to a level that will enable it to address the country's burden of disease. Therefore, re-establishment of disrupted health system should entail implementing interventions that focus on rebuilding blocks that would have been affected. Therefore, the health recovery in Zimbabwe should be understood within a context of LRRD discussion. The three distinct phases of health LRRD are indicated below;

Humanitarian	Rehabilitation/recovery	Development
<ul style="list-style-type: none"> Near collapse of the health sector due to severe deterioration in infrastructure, lack of investment, low wages, decreasing motivation and capacity of the civil service and absolute shortage of essential supplies and commodities as in Zimbabwe late 2008 and early 2009. 	<ul style="list-style-type: none"> Focus is on improving situation to mitigate risks and enhancing preparedness so that the improvement path is sustained and if humanitarian situations arise there will be swift response. 	<ul style="list-style-type: none"> Investment in health is embedded in broader development planning and long-term needs.

The Zimbabwe recovery process as summarised by the HTF (2011), focuses on four thematic areas, but according to the burden of diseases and available financial resources, this could be extended to other areas included in The National Health

Strategy for Zimbabwe (2009-2013). The initial first year focus areas are the three core health system reforms required to support the removal of user fees, and a comprehensive programme implementation area on maternal, newborn, and child health and nutrition to support quality of care improvements.

Thus the four focus thematic areas for the HTF that are aimed to boost recovery of the health care system are; Maternal, Newborn and Child Health and Nutrition; Medical Products, Vaccines and Technologies (Medicines and Commodities); Human Resources for Health (including Health Worker Management, Training and Retention Scheme) and Health Policy, Planning and Finance (Health Services Fund Scheme and Research) (HTF 2011:10).

The Zimbabwe health policies indicate that the health system is under rehabilitation or early recovery. Important, however, is that health is one of the United Nations response clusters established to respond to early recovery challenges. Rehabilitation is a bridge that links humanitarian assistance with development during the process of recovery. Applied to health strengthening, health rehabilitation aims at restoring and improving health facilities and systems, which are summarised in the six building blocks; leadership and governance, human resources, information, medicines and technologies, service delivery and financing. The three objectives of health rehabilitation are to augment emergency health programmes and ensure that their inputs become long-term assets; strengthen health systems; and establish foundation for long-term development of the health system.

The above discussion indicated that health recovery in Zimbabwe as aligned to the UN health recovery framework, identified priority early recovery areas, which are; Maternal, Newborn and Child Health and Nutrition; Medical Products, Vaccines and Technologies (Medicines and Commodities); Human Resources for Health (including Health Worker Management, Training and Retention Scheme) and Health Policy, Planning and Finance (Health Services Fund Scheme and Research).

The policies that guide health recovery activities in Zimbabwe were developed as a joint consultative effort between Government of Zimbabwe (GoZ) and UN Country Team (UNCT). Notwithstanding their usefulness, the policies are numerous, repetitive and often have duplicate information, which suggest the “fuzziness” of rehabilitation process. With these numerous recovery policies in place, it is critical to probe whether these policy initiatives have resulted to significant health improvement. From the evaluation of Zimbabwe health priority recovery interventions outlined in the 100 Days Plan Guiding document, which is the policy document that has been evaluated, it has been noted that the overall results for the implementation of 100 days performance assessment were not very encouraging. There was increased functionality of health institutions but still far below expected levels. Second, there was increased utilisation of health services but still far below expected levels. Third, there were increased levels of promises to support health sector resuscitation, but very little tangible support received. Fourth, although the plan has had good revival strategies and proposals, very little financial support materialised.

The above results from the implementation of Zimbabwe rehabilitation attests to the challenges associated with early recovery. The nine challenges that have been noted during rehabilitation are; timing, coordination, difficulties in linking recovery planning to national processes, difficulties in linking humanitarian and development actors, lack of clarity on how residual humanitarian gaps are handled during the transition and recovery process, lack of clarity on funding issues, slow, tedious and time consuming process of consultations and consensus building, lack of information for accurate planning, and raised expectations of people that may fail to be met.

4.4 Conclusion

The chapter presented and discussed rehabilitation theoretically and practically, particularly at policy level. It revealed that indeed rehabilitation is complex hence the term “contiguuum model”. A contiguuum model captures the complex nature of rehabilitation middle ground and its associated challenges (Buchanan-Smith and Paola 2005; Macrae and Harmer 2004).

Having outlined and discussed the policy documents that informed health rehabilitation (LRRD) interventions, it is critical to determine activities that were being implemented in communities by the various actors as well as determine the extent to which the interventions satisfied the conditions for effective LRRD. To do so however, a clear methodological approach is required to guide the empirical study. Therefore, the next chapter, Chapter 5, outlines the methodology followed in conducting the empirical study, followed by the results and findings of the empirical study (Chapter 6).

CHAPTER 5: RESEARCH METHODOLOGY

5.1 Introduction

This chapter describes the methodology followed in conducting the study. It outlines the research design (5.3), sampling method employed (5.4), data collection (5.5) and data analysis methods used (5.6), and approaches followed to ensure credibility of the research and data analysis processes (5.7).

5.2 Methodological approach

The study focused on two research areas, that is, health rehabilitation policy and health field operation. At policy level, Government of Zimbabwe (GoZ) represented by Ministry of Health and Child Welfare (MoH&CW)) and UN agencies. Their perspective on health rehabilitation as a link between health development and humanitarian was assessed. Since MoH&CW is both a policy maker and implementer, interview discussions were held with two categories of people namely policy makers, represented by Medical Officers and Provincial Medical Director, and implementing staff represented by nursing staff. At policy level, the assessment sought to determine the extent to which MoH&CW viewed health rehabilitation (recovery) interventions from the perspective of policy makers. At operational level, focus group discussions were held with nursing staff working in government health facilities as well as interviews with health Non-Governmental Organisation leaders. The interviews sought to determine health rehabilitation interventions that were implemented, determine views and perceptions on intervention effectiveness as well as extent to which the rehabilitation met effective health LRRD criteria. Donors were also interviewed to determine the health rehabilitation priorities which they funded. Thus the study analysed the factors that caused health collapse and health actors' interventions that were implemented in response to the collapse. Also, the study assessed the effectiveness of interventions in relation to critical health system blocks, and the extent to which interventions met effective health LRRD criteria.

The development actors that were interviewed were Government of Zimbabwe (GoZ) represented by Ministry of Health and Child Welfare (MoH&CW), UN agencies and

WHO that participated in health recovery processes namely UNOCHA and WHO, two bilateral donors (ECHO and USAID), and six NGOs (three international and three local NGOs). The Ministry of Health and Child Welfare (MoH&CW) is responsible for policy formulation and overseeing implementation of health in Zimbabwe. At policy level, the MoH&CW was represented by Provincial Medical Director (PMD) and respective District Medical Officers (DMOs), while at operational level it was represented by nursing staff. UN agencies, WHO and donors were represented by health recovery coordinators, while NGOs were represented by respective organisational leaders.

5.3 Research design

5.3.1 Types of research designs

A research design is a set of logical steps to find solutions to the problem statement (Brink, Van der Walt, and Van Rensburg 2006:8). Babbie and Mouton (2003:53) define a research design as a blueprint of how one intends conducting the research. This implies that a research design refers to how a researcher situates a study to respond to a question or a set of questions. Stated differently, a research design shows a systematic plan outlining a study's methods of compiling and analysing data that will be used to arrive at a conclusion of the research problem. Creswell (1998:62), conceptualises a research design in a qualitative framework as the entire process of research from conceptualising a problem to writing the narrative. Thus a research design is the outlined plan of action that a study uses to collect and utilise data so that desired information can be obtained from specified intended sources. The main purpose of a research design is to allow the study to forestall what suitable research decisions should be initially made. so as to capitalise on the validity and trustworthiness of the eventual outcome. Mouton (2001:30) explains and differentiates research design and methodology. Research design focuses on the kind of evidence required to address the research question adequately while research methodology refers to the research process, that is, the tools and procedures to be employed. Thus, research methodology refers to procedures used in making systematic observations or otherwise obtaining

data, evidence, or important information required as part of a research project or study. Research methodology is informed by a research design.

Essentially there are two schools of thought about science and knowledge – positivism (quantitative) and phenomenology (qualitative or interpretivism) (Saunders Lewis and Thornhill 2003:101-107). However, researchers may develop research designs that combine both paradigms in a single research design. The positivist research strategy mostly uses surveys while the phenomenology research strategies mostly employ a case study, action research, grounded theory and ethnography. In selecting a research approach, its advantages or strengths and disadvantages or weaknesses should be noted and proper plan put in place to overcome the weaknesses.

The advantages of qualitative research include the following;

- a) It produces more in-depth, comprehensive information;
- b) It uses information and participant observation for in-depth description of the context of variables under consideration and interactions of the different variables in the context;
- c) It seeks a wide understanding of the entire situation; and
- d) The findings often have greater validity and less artificiality (Krishnaswamy, Sivakumar and Mathirajan 2006:171).

Notwithstanding these advantages, the disadvantages of qualitative research are well documented. The disadvantages of qualitative research include the following;

- a) The very subjectivity of the inquiry leads to difficulties in establishing the reliability and validity of the approaches and information;
- b) It is very difficult to prevent or detect researcher induced bias;
- c) Its scope is limited due to the in-depth, comprehensive data gathering approaches that are required; and
- d) Inconclusive results (Sekaran and Bougie 2009:103).

On the other hand, the advantages and disadvantages of quantitative research are also well documented by many scholars such as Babbie and Mouton (2003:280); Creswell (1998:80) and Sekaran and Bougie (2009:104). The advantages include the following;

- a) Observations are used throughout studies;
- b) Formulating hypotheses allows for speculation about outcomes; applicable instrument;
- c) It safeguards or minimises or eliminate bias;
- d) It predicts correlation between objects;
- e) Ensures systematic data collection and analysis;
- f) Results are generalisable to other institutions for further research (Babbie and Mouton 2003:280; Creswell 1998:80; Sekaran and Bougie 2009:103-4).

The disadvantages of quantitative research are that:

- a) It should only be used if data can be measured by numbers, results quantified;
- b) The instrument or method chosen is subjective and research is dependent upon tool chosen;
- c) Lack of independent thought by researcher when dependent on instrument or mathematics used to extract or evaluate data;
- d) Individuals' decisions are not evaluated based on their culture or social interactions;
- e) Decisions are made without regard to individual human thought or choice to predict behavior; and
- f) All individuals are measured the same way with little room for their differences.

Noting the weaknesses of each research approach, where possible, it is advisable for researchers to combine both approaches. Combined approaches are commonly called *mixed designs* where elements of quantitative and qualitative approach are combined in various ways within different phases of the study. These approaches could be combined in three ways, namely, sequential procedures, concurrent procedures and

transformative procedures (Creswell 2003:44). Creswell (2003:44) described the mixed approaches as follows:

- A sequential procedure is where the researcher seeks to elaborate on or expand the findings of one method with another method. The researcher may start with qualitative method for exploratory purpose and follow up with quantitative method for generalising results to a population. Alternatively, the study may begin with a quantitative method in which theories or concepts are tested, to follow by a qualitative method involving detailed exploration with a few cases or individuals. This entails three options namely sequential explanatory, sequential exploratory and transformative.
- A concurrent procedure is whereby the researcher converges quantitative and qualitative data in order to provide a comprehensive analysis of the research problem. In this design, both forms of data are collected at the same time and then are integrated in the interpretation of the overall results.
- Transformative procedures are whereby the researcher uses a theoretical lens as an overarching perspective within a design that contains both quantitative and qualitative data. This lens provides a framework for topics of interest and methods for collecting data.

However, mixed methods are criticised by some researchers. Cronholm and Hjalmarsson (2011:89) observed that there are at least two arguments against mixed methods. The first argument is that research methods carry epistemological commitments, and the second argument is that, the two approaches represent separate paradigms. The argument concerning epistemological commitments is based on the fact that every research method is embedded in a specific way of perceiving the world. That is, to use a questionnaire, to be an observer or to measure something is to be involved in conceptions of the world which allow these methods to be used for their purposes.

Therefore, the argument concerning separate paradigms views qualitative and quantitative research methods as incompatible (Cronholm and Hjalmarsson 2011:89).

In response to the criticism of mixed methods, Teddlie and Tashakkori (2009:62) and Cronholm and Hjalmarsson (2011:89), maintain that mixed method is an alternative to the dichotomy of qualitative and quantitative approaches. This integration should not be done in a simplistic way resulting in compromised results. The sharing has to be carefully done in order to reduce undesired connotations that could emerge from poorly transferred concepts from one specific context to another. Thus instead of viewing the two approaches as an either-or-position, Cronholm and Hjalmarsson (2011:89) believe it is more productive to perceive them as complementary. The approaches indeed support each other either as a sequential or as a parallel process.

5.3.2 Selection of research design and approach

The study adopted an evaluation research approach, whereby the inquiry is conducted in a very practical context where the design is not aligned to a particular meta-theory. Cresswell (2008:25) and Babbie and Mouton (2003:54), note that evaluation studies utilise eclectic research approaches. Accordingly, the study employed a mixed research approach whereby quantitative and qualitative approaches were integrated (Creswell 2003:18; Cronholm and Hjalmarsson 2011:30). An exploratory concurrent procedure was used. However, the design employed a concurrent triangulation approach where slight emphasis was placed on a qualitative approach even though quantitative was integrated. The research collected both forms of data at the same time and then integrated the interpretation of the overall results in order to provide a comprehensive analysis of the research problem.

Mouton (2001:57), De Vos (1998:193) and Cresswell (2008:26) point out that the factors to be considered when choosing a research approach include the field of study, nature of study, purpose of the study, population of the study, amount of human interaction or characteristics to be studied, desired implications and results. Thus, because the study falls under pragmatic paradigm where it deals with real world of practice (Cresswell

2008:26), a mixed research design was preferred which included taking into consideration the above factors as described below.

5.4 Sampling and sampling method

Sampling is the act, process, or technique of selecting a suitable sample, or a representative part of a population for the purpose of determining parameters or characteristics of the whole population (Trochim 2006:6). There are two main types of sampling. These are non-probability sampling and probability sampling. The difference between these two is that non probability sampling does not involve random selection while probability sampling does (Trochim 2006:6). Babbie and Mouton (2003:112) add that probability sampling is a sampling method that uses statistical methods to select research subjects that are representative of large known populations. Researchers tend to prefer probabilistic or random sampling methods over non-probabilistic ones because they are considered more accurate and rigorous. However, as Babbie and Mouton (2003:112) advised that in applied social research, there may be circumstances where it is not feasible, practical or theoretically sensible to do random sampling. Hence, a wide range of non-probabilistic sampling should be applied. As this study was conducted within a practical context where different health development actors are practically involved, the study falls under applied research. Accordingly, non-probabilistic sampling was the most appropriate sampling approach.

Babbie and Mouton (2003:166) divides non-probabilistic sampling into four: reliance on available subjects, purposive or judgemental, snowball and quota sampling. Trochim (2006:30) divides non-probability sampling methods into two broad types namely accidental or purposive. Babbie and Mouton (2003) and Trochim (2006) explain that applied research sampling methods are purposive in nature because they approach the sampling problem with a specific plan in mind. Thus for this study, non probability sampling approach of purposeful sampling was employed. Purposeful sampling selects information rich cases for in-depth study. Size and specific cases depend on the study purpose (Trochim 2006:7). Babbie and Mouton (2003:112) and Berg (2009:15), add that in purposive sampling the researcher uses his own judgement in the selection of sample

members. Therefore, as health development and humanitarian actors in Zimbabwe were easily determined, a purposive sample was drawn.

A purposive sample was drawn from the following categories of health actors;

- ⇒ **Government of Zimbabwe (GoZ)** represented by Ministry of Health and Child Welfare (MoH&CW).
- ⇒ **UN (multilateral agencies)** that partnered with the GoZ to develop Joint Early Recovery Opportunities Framework for Zimbabwe namely UNOCHA and WHO.
- ⇒ **Donors:** Two bilateral donors were studied. These are ECHO and United States Agency for International Development (USAID). ECHO is the main funder for humanitarian interventions while USAID provides the most funding support to national programmes. Thus USAID is the overall top donor for Zimbabwe while ECHO provides most humanitarian funding. From 2009 to 2011 USAID spent over US\$516 million on Zimbabwe projects (USAID Zimbabwe 2011). It funded activities that included global health and child survival.
- ⇒ **NGOs:** three (3) International NGOs (INGOs) and three (3) local NGOs (LNGO) were studied. The selection of the organisations was based on their involvement in implementing health early recovery (rehabilitation) projects. Directors or Programme Manager of the respective NGOs were interviewed. The three health INGOs that were studied are Plan International, Mercy Corps, and International Rescue Committee (IRC). These INGO were actively involved in implementing health recovery interventions. The local NGOs that were studied are Family AIDS Caring Trust (FACT), Rujeko Home Based Care and Batanai HIV and AIDS Service Organisation (BHASO). These three NGOs were also actively involved in health recovery interventions in the geographical area of Manicaland, which is under consideration. These NGO were selected based on their level of involvement in health recovery interventions, of which they were highly involved.

5.5 Data collection methods

Babbie and Mouton (2003:288-304) identified three principal ways of gathering qualitative data. These were interviews, observation and document review. They explain that interviews take various forms, which are; basic individual interviewing, depth individual interviews and focus group interviews. Basic individual interviewing is an open interview whereby the subject speaks for him/herself. Depth individual interview is an interview process where focus is on the process through which the content of the conversation comes into being. A focus group is a representative group of people interviewed together about their opinions (Krueger and Casey 2000:305). Babbie and Mouton (2003:310) view focus group interview as having an advantage of providing similarities and differences in participants' opinions and experiences. Observation is divided into two types, namely, simple and participant observations. Simple observation is whereby a researcher remains an outsider while in participant observation the researcher is simultaneously the member of the group. Document analysis is a technique that relies heavily upon a variety of written materials for data, insights, and judgments about programmes, policies or events.

From the above methods, the principal methods that were used are interviewing and document analysis. Under interviews, depth individual interview and focus group discussions were used. Six (6) focus group discussions of ten (10) people per group were held with nursing staff. The total number of nursing staff who participated in focus group discussions is sixty (60). Different interview guides were used in collecting the data and conducting interviews. Data collection instruments were developed and piloted before they were used.

In choosing interviewees, Babbie and Mouton (2003:302) suggested three criteria, namely, enculturation, current involvement and adequate time. Enculturation entails that interviewees should have been in a programme for a while (enculturated) rather than someone who has been involved for a short time. Current involvement ensures having people who are currently involved in the programme with inside information and insights. With regards to adequate time, respondents should have the time to provide

interviewer with information. Accordingly, the respondents who were sampled were the most appropriate people from the respective organisations to provide informed information.

The PMD is the highest representative at Provincial level representing MoH&CW, while DMOs are District health managers. Both the PMD and DMOs input in health policy formulation was at national level, nursing staff focuses on implementation. PMDs and DMOs are therefore the most appropriate people to provide a policy perspective at provincial level, while nurses provide implementation perspective. Leaders from donor organisations and NGOs are also more positioned to provide informed information than their junior counterparts. Quantitative data collection was collected through a questionnaire that was administered to operation level respondents, namely, Nurses and NGO leaders (Director's or Head of programmes). Both quantitative data was gathered during focus group and key informant interview discussions through a tool that had qualitative questions and quantitative rating scales. A questionnaire that rated statements of respondents was used. The nurses discussed issues in focus groups and then were asked to rate the issues confidentially. After all the issues had been discussed in the focus group and ratings done confidentially, the data was stored in a secure place for analysis. The focus group discussions constituted qualitative data while the ratings constituted quantitative data. The process of rating was done with all key informants interviewed. A questionnaire with rating scale was completed by each key informant after discussions. Thus the discussions and ratings were analysed together. An example of the rating questionnaire that was used is indicated below.

5.6 Data analysis

5.6.1 Qualitative data analysis

The interview responses collected through in-depth interviews and focus group discussions were analysed using qualitative data analysis approaches. Qualitative data analysis (QDA) is the range of processes and procedures whereby one moves from the qualitative data that has been collected into some form of explanation, understanding or interpretation of the people and situations one is investigating (Lacey and Luff 2001:8).

QDA is usually based on an interpretative philosophy. The idea is to examine the meaningful and symbolic content of qualitative data. The stages in the analysis of qualitative data begins with familiarisation of the data, transcription, organisation, coding, analysis (grounded theory or framework analysis) and reporting (though the order may vary).

Statements, meanings, themes, general description of health interventions and experiences were coded. Codes were developed using a framework analysis approach. The predetermined categories 'codes' were generated from the interview questions with particular reference to its relationship to the concept of health rehabilitation.

5.6.2 Document analysis

Policy and minutes of meeting documents were analysed using a document analysis approach. Document analysis is a systematic process whereby relevant documents are identified through tracking, verified through triangulation, content analysed by guided coding and category construction, which leads to judgements and interpretations of events under investigation (Babbie and Mouton 2003:50).

5.6.3 Quantitative data analysis

The quantitative data analysis was done through epi info. Data was entered into excel spreadsheets and then imported to epi info for analysis. Analysis graphs showing relationship of various variables were generated.

5.7 Credibility of research and data analysis

To ensure quality of analysis, the research process should be valid, reliable and generalisable (Babbie and Mouton 2003:112). Validity refers to the idea that the account truly reflects what actually happened, that is, it is accurate. Reliability refers to the fact that results of the analysis should also be obtained if a different researcher repeated the research and analysis on another occasion. Generalisability means that the results of

the research and analysis apply to a wider group of people, social situations and settings than just the ones investigated in the original study.

However, validity, reliability and generalisability in the above sense occur in quantitative research. Qualitative research follows procedures that minimise mistakes and simple misinterpretations to ensure research credibility. These approaches are reflexivity, triangulation, auditability and constant comparison (Mouton 2001:56; Creswell 2003:13). Reflexivity is the recognition that a researcher's background and prior knowledge have an unavoidable influence on the research they are conducting. This means that no researcher can claim to be completely objective. Triangulation means combining two or more views, approaches or methods in an investigation in order to get a more accurate picture of the phenomena. Auditability or audit trail entails ensuring retraceable steps leading to a certain interpretation or theory to check that no alternatives were left unexamined and that no biases had any avoidable influence on the results.

The ways to ensure research credibility in qualitative research is through considering negative cases, constant comparison, inter-rater reliability, and member validation (Babbie and Mouton 2003:200). Negative cases is whereby a researcher constantly looks for cases, settings and events that are out of line with his/her main findings or even that directly contradict his/her explanations and then respond to such cases. Constant comparison is checking the consistency and accuracy of interpretations and especially the application of codes by constantly comparing one interpretation or code with others both of a similar sort and in other cases and settings. This ensures both consistency and completeness in analysis. Inter-rater reliability is whereby one person or team is coding and then compare how they have coded the transcripts. Member or respondent validation is about involving participants and respondents during the later analysis stages of a project, about the adequacy of transcription of interviews and about the kind of interpretations and explanations the data analysis has generated.

Other qualities that should be considered in qualitative research are trustworthiness and transferability (Creswell 2003:8). Trustworthiness refers to the degree to which different observers and researchers make the same observations from the same data about the

same object of study. A way to engender trustworthiness is by including evidence in one's analysis reports in the form of quotations from interviews and field notes, along with detailed descriptions of episodes, events and settings. Transferability or generalisability refers to the extent that the account can be applied to other people, times and settings other than those actually studied. In qualitative research, generalisability is based on the assumption that it is useful to begin to understand similar situations or people, rather than being representative of the target population. It is achieved by ensuring that any reference to people and settings beyond those in the study are justified. This is usually done by defining, in detail, the kind of settings and types of people to whom the explanation or theory applies based on the identification of similar settings and people in the study.

The approaches employed for the research to minimise mistakes was that the researcher declared his background and prior knowledge (reflexivity). The researcher is a senior development practitioner who holds higher degrees in Humanities. His development experience particularly in HIV and AIDS work could skew analysis of development towards donor funding in that direction. However, this was avoided through constant comparison of actors' responses. Triangulation was done through comparing the findings from interviews and quantitative data obtained from health cluster document reports. Review of actors' documents provided information regarding the accuracy of interview information and interpretation. Transcribed scripts and coded themes were indicated on transcripts and transcripts were safely kept in a home library to ensure auditability in case they are required. Short incisive quotes from research findings were included in the research report to engender trustworthiness. The findings were broadly generalisable among development and humanitarian actors particularly the predominant actors' view on health rehabilitation. This was ensured through clearly describing the connecting threads of thinking among development actors as well as comparing and contrasting them leading to informative conclusions that foster constructive LRRD.

Thus, reflexivity, triangulation, auditability, constant comparison, member validation and critical consideration of negative cases were the ways employed to ensure research credibility.

5.8. Ethical considerations

Research ethics is concerned with what is right or wrong in conducting research since scientific research is a form of human conduct. Hence, such conduct has to conform to generally accepted norms and values (Mouton 2001:238). Research ethics, Mouton (2001:239) added, are decided by scientific communities themselves through codes of conduct that are enforced through professional societies and associations.

Research ethics is important for all people who conduct research projects to ensure the safety of research subjects and to prevent sloppy or irresponsible research. Therefore, the duty lies with the researcher to seek out and fully understand the policies and theories designed to guarantee upstanding of research practices.

Major research ethics consideration for this study included; right to privacy, right to anonymity and confidentiality, right to voluntary participation and the right to withdraw, right to voluntary informed consent, and right not to be harmed. A comprehensive list of ethical principles that guided this research, as summarised by Mouton (2001:239-246) fall under the above categories.

Verbal or written informed consent was sought from research subjects. The subjects were all mature and educated to degree level while all the nurses hold Diplomas. Data gathered, analysed and reported was assigned pseudo names to ensure privacy. All research information was treated confidentially to ensure that there was no harm to the subjects.

Research participants' rights, values and dignity, were respected throughout data collection. Their right to privacy, the right to anonymity and confidentiality, the right to be informed about the research, the right to participate voluntarily and without coercion, the right to withdraw from the research at any time, the right not to be harmed and the right to be treated with dignity and respect was respected at all times. If for some reason individuals felt uncomfortable to share internal organisational views, they were not

pressured. Mouton (2001:243) rightly states that, research inevitably involves people, and they have rights that must be respected and protected. Research is the collection of information and material that is provided to the researcher on the basis of trust and confidentiality, and it is vital that the participant's feelings, interests and rights are protected at all times.

CHAPTER 6: PRESENTATION OF FINDINGS AND DISCUSSION

6.1 Introduction

This chapter presents results of the data gathered through in depth interviews, focus group discussions and documents review. This is done to determine the health rehabilitation (recovery) interventions employed by health development actors between 2009 and 2011 in Zimbabwe as well as ascertain the extent to which the interventions fostered 'health development' that reduced the need for future health emergency. Health development that reduces the need for future health emergency entails that, 'health relief' should contribute to health development while health rehabilitation (recovery) should be implemented in such a way that eases the transition between health relief and health development.

The chapter first presents an analysis of the sample, followed by health recovery policies and interventions implemented by health players. The sample was analysed using various graphics while health recovery policies were analysed using a document analysis approach whereby health recovery interventions were categorised into themes (thematic codes) using both inductive and deductive (framework) approaches. The themes were then presented in thematic maps followed by summarised descriptions. The themes or categories of recovery interventions are clustered based on summarised themes.

6.2 Results

6.2.1 Data presentation: Sample analysis

Data was collected from four categories of health development actors. These are; donors, NGOs, UN and WHO, and GoZ (represented by MoH&CW). The actors represent the major players that were involved in health recovery in Zimbabwe. A total number of seventy eight (78) people indicated in table 6.1 below were interviewed using in-depth interviews and focus group discussions (FGDs). The sample is divided into two main groups, namely, those involved at health policy level and operational level. The actors involved at policy level are the following; GoZ represented by MoH&CW (Provincial Medical Director (PMD), District Medical Officers (DMOs)) and UN and WHO

representatives. The actors at operational level are nursing staff and NGOs while donors interact with actors both at policy and operational levels. The breakdown of interview respondents is indicated on the table below (6.1).

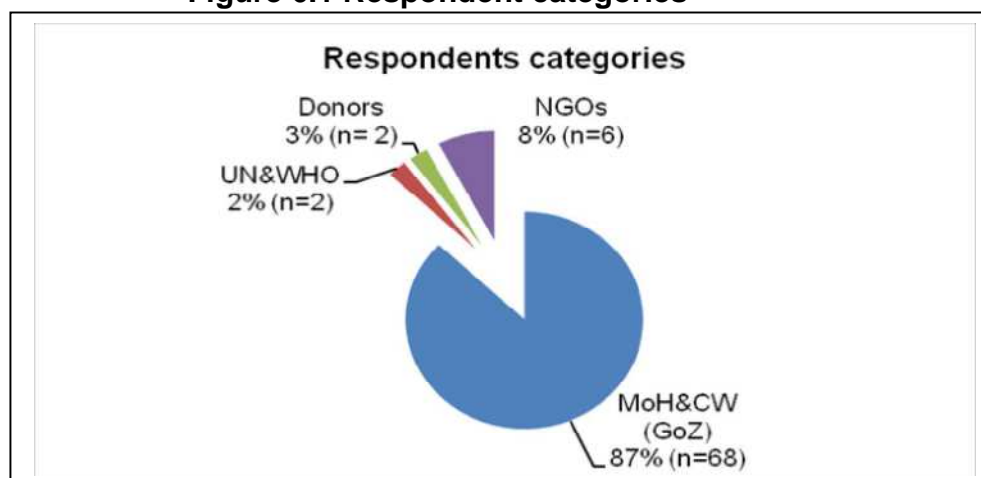
Table 6.1 Breakdown of interviewed sample

Unit of analysis category	Interview Respondent	Total	Data collection	Level
GoZ (MoH&CW)	Provincial Medical Director (PMD)	1	In-depth interview	Policy
	District Medical Officers (DMOs)	7	In-depth interview	
UN Agencies and WHO	UNOCHA and WHO representatives	2	In-depth interview	
Donor	Country Director (or Head of Programmes)	2	In-depth interview and rating questionnaire	Operation
NGOs	3 INGOs and 3 LNGOs (Director or Head of Programmes)	6	In-depth interview and rating questionnaire	
GoZ (MoH&CW)	Nursing staff	60	<ul style="list-style-type: none"> Focus group discussions (6 FGD of 10 people). Questionnaire - rating of questionnaire 	
Total		78		

6.2.1.1 Respondents categories

A wide spectrum of health development actors was important to provide diverse perspectives on the health recovery process.

Figure 6.1 Respondent categories

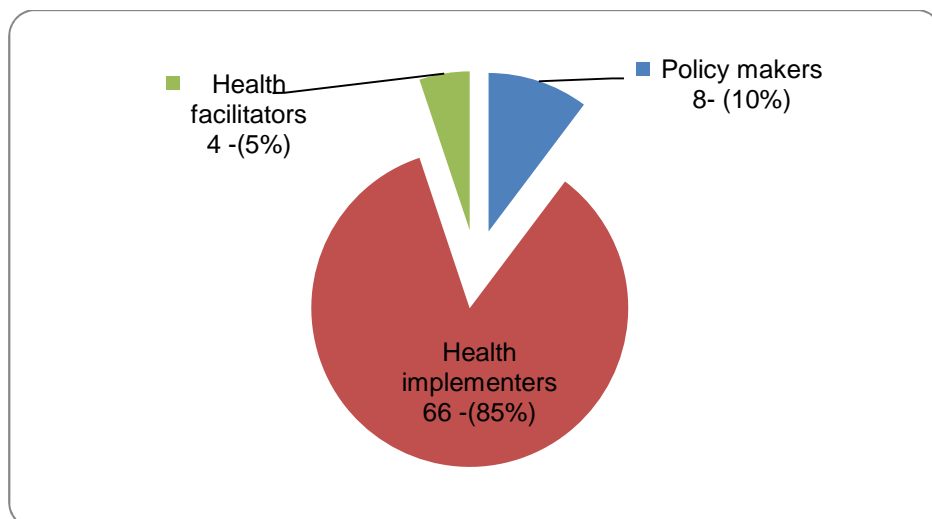


Government of Zimbabwe (GoZ), namely, Ministry of Health and Child Welfare (MoH&CW) represented the highest number of respondents (87%). It was important to have significant representation from MoH&CW because it is both policy maker and implementer. The NGOs constituted the second highest (8%) number of respondents. NGOs complement GoZ in implementing health services hence they also provide insightful information regarding health recovery processes. These respondents provided critical insights and experiences on health recovery policy issues and grassroots health recovery activities. While NGOs complemented MoH&CW in implementation, donors financed interventions and they determined financing priorities in consultation with the government (MoH&CW). UN and WHO coordinated development actors for effective recovery interventions.

6.2.1.2 Respondents role in health interventions

The role of each respondent in health interventions influenced his/her view on the recovery process. From the sample, 85% of respondents represented health implementers who directly implemented health recovery interventions. These were nursing and NGO staff. Policy makers represented 10% and these were MoH&CW officials, that is, the PMD and DMOs, while facilitators (UN and WHO) represented 5% (figure 6.2).

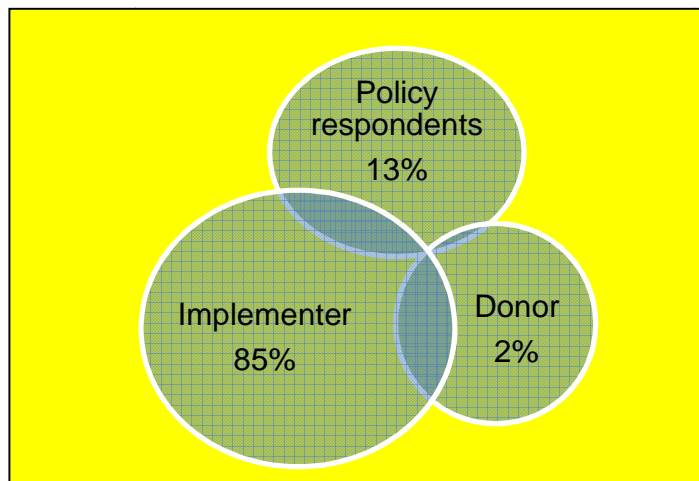
Figure 6.2: Respondents role in health interventions



6.2.1.3 Interaction of respondents (health actors) in health recovery

During health recovery interventions, the actors interacted with each other in various ways. The actors' interactions are reflected on the diagram below (figure 6.3).

Figure 6.3 Health actors' interactions during recovery



The policy makers, donors and implementers interacted in dynamic ways to foster health recovery. For instance, experiences of donors with health managers slightly differed from their experience with NGO implementers. The interactions of actors during implementation resulted to experiences and views on the recovery processes being exchanged thereby influencing each other. The actors influenced each other during the health recovery period as a result of brushing with one another. The 2% sample of donors interacted largely with policy makers and NGO implementers while generally the nursing staff did not (figure 6.3) since donors engaged health managers in MoH&CW. The above interactions were important in shaping interview respondents hence the need to determine the nature of their interactions.

6.2.2 Study objective 1 - Analyse health policy positions developed to address health recovery (rehabilitation) needs between 2009 to 2011

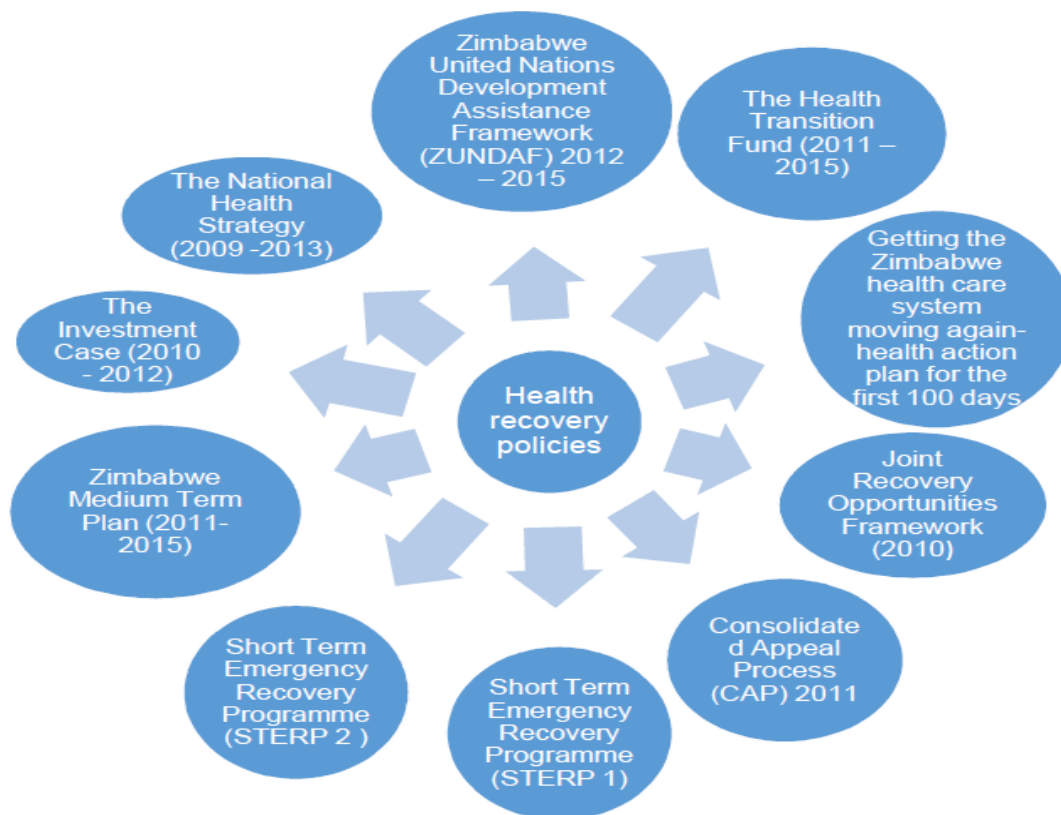
This section addresses the first objective of the study which aims to analyse health policies developed to address health recovery (rehabilitation) needs between 2009 and 2011. The section analyses health recovery interventions proposed in health recovery

policies and other guiding documents. The documents were analysed using a document analysis approach. Health recovery interventions were categorised into themes (thematic codes) using an inductive approach. The themes were then presented in a thematic map followed by summarised descriptions. Thus the themes or categories of recovery interventions were clustered based on summarised themes. The section first identifies the various health policies and then proceeds to determine the recovery interventions proposed in the policies.

6.2.2.1 Health recovery (LRRD) policies during 2009- 2011 and their goals and policy documents thematic map)

The review of health recovery policies and other guiding documents revealed that there are at least ten policies (including guiding documents) that were developed between 2009 and 2011 to guide the health recovery process. The policy documents are shown in a thematic map below (figure 6.4).

Figure 6.4: Health recovery policies and frameworks developed (2009-2011)



The policies and framework documents outlined in figure 6.4 spell out health recovery interventions that were to be pursued between the period of 2009 and 2011. Some explicitly outline the interventions while others do so implicitly. The policies' objectives and reasons for development are indicated below.

Policy	Policy description and goal
The 100 days Plan	<p>Zimbabwe country studies, reports and observations over 10 years (2000-2009) pointed to poor health service delivery due to gradual decline reaching a peak in 2008 and early 2009. Therefore the GoZ and The Ministry of Health and Child Welfare (MoHCW) responded as follows:</p> <ul style="list-style-type: none"> • Requested Emergency Funding to Resource the Public Health Sector: Jan-Dec 2009. • Getting the Zimbabwe Health Care System Moving Again: Health Action Plan for the First 100 Days: March – June 2009 (Product of Health Summit). • The Govt. of Zimbabwe 100-Day Plan: Getting Zimbabwe Moving Again: 29 April – 6 August 2009. <p>The Health Sector – MOHCW 100-Day Plan was aimed at accelerating Human Resources recruitment to 60%; ensure 60% drug provision to hospitals and clinics; building capacity of NatPharm; restoring functional infrastructure to 60% at all central hospitals.</p>
Consolidated Appeal Process (CAP) documents (2009, 2010, 2011, 2012, 2013)	<p>Though not a policy document, consolidated appeals comprise a common humanitarian action plan and concrete projects necessary to implement that plan. It served as an ongoing frame of reference and detailed workplan for large-scale, sustained humanitarian action; efficient and effective life saving; and protection and promotion of livelihoods. An appeal helped to bring relief to as many people as possible, as fast as possible.</p>
Joint Early Recovery Opportunities Framework (JROF)	<p>The JROF is a framework developed to allow both the GoZ and partners to have a framework from which to draw early recovery interventions. This early recovery framework facilitated an integrated and sustainable approach to attaining resilience and disaster risk reduction through capacity building of those affected by the decade long crisis. The framework outlined key joint recovery priority opportunities for Zimbabwe that reflected and restored the capacity of affected national institutions and communities. It sought to build on humanitarian efforts and promote sustainable transition to recovery and development direction. The framework emphasised the coming out of the humanitarian focus towards sustained development through identifying early recovery opportunities for Zimbabwe to enable the country to “build back better”.</p>

<p>STERP 1&2</p>	<p>Short Term Emergency Recovery Programme (STERP) - February to December 2009 was an emergency short term stabilisation programme, whose key goals were to stabilise the macro and micro-economy, recover the levels of savings, investment and growth, and lay the basis of a more transformative midterm to long term economic programme that would turn Zimbabwe into a progressive developmental State. This was STERP 1.</p> <p>Due to outstanding issues regarding economic growth and development guided by the vision of transforming the country into a vibrant, democratic, prosperous and functional nation, the Government of Zimbabwe launched the Three Year Macroeconomic Policy and Budget Framework: 2010-2012 (STERP II).</p> <p>The STERP documents also addressed health recovery issues on human resources, drugs, medical equipment and preventable diseases.</p>
<p>Zimbabwe Medium Term Plan (2011-2015)</p>	<p>The Medium Term Plan (MTP) is economic and social policy document of Zimbabwe, which responds to the mandate set out in Article III of the Global Political Agreement (GPA) to support the restoration of economic stability and growth in the country. It built on the foundations laid by the Short Term Emergency Recovery Programme (STERP) (February – December 2009) and the 3 Year Macroeconomic Policy and Budget Framework (STERP II). The MTP guided all other government policy documents and set out the national priorities and investment programmes for 2011-2015.</p> <p>The MTP's main goal is to transform the economy, reduce poverty, create jobs, maintain macroeconomic stability and restore the economy's capacity to produce goods and services competitively, building upon the gains achieved since the launch of STERP in March 2009.</p> <p>Against the health collapse that reached a peak in 2008/2009, the plan had a health section that set out government health investment. The health plan for the period was to achieve 100 percent access and utilisation of comprehensive quality primary health care services and referral facilities by 2015.</p>
<p>The National Health Strategy 2009 - 2013</p>	<p>The 2009-2013 National Health Strategy provides a framework for immediate resuscitation of the health sector (Health System Strengthening). It aims to put Zimbabwe back on track towards achieving the Millennium Development Goals. The policy document is informed by information from several studies carried out from 2006 – 2009, which included Study on Access to Health Services; Vital Medicines and Health Services Survey; Community Working Group On Health surveys; Zimbabwe Maternal and Perinatal Mortality Survey, and others as well as existing national plans and programmes on existing programme. The 2009-2013 National Health Strategy is a successor policy to the National Health Strategy (1997 – 2007).</p>

<p>The Investment Case (2010-2012)</p>	<p>The Health Sector Investment Case (2010-2012) outlined the key package of health services, the key health system bottlenecks to be overcome, the desired coverage targets, the incremental costs and the expected achievements in relation to the health MDGs. The investment case validated the historical focus of the Ministry of Health and Child Welfare on Primary Health Care, with a strong focus on community-based approaches, complemented by referral systems and facilities. The investment case aimed to raise an additional investment of 700 million USD over 3years (2010-2012), which is required to achieve a reduction in under 5 and maternal mortality of 38% and 17% respectively.</p>
<p>The Health Transition Fund (2011 – 2015)</p>	<p>The Health Transition Fund (HTF) is a multi-donor pooled fund, managed by UNICEF, to support the Ministry of Health and Child Welfare (MoH&CW) to achieve planned progress towards achieving the highest possible level of health and quality of life for all Zimbabweans. The HTF was developed against a background of a decade long health care deterioration (2000-2009). It supports the efforts to mobilise the necessary resources for critical interventions to revitalize the sector and increase access to care. The HTF aims to raise a pooled donor contribution amount of approximately US\$80 million per year over five years.</p>
<p>Zimbabwe United Nations Development Assistance Framework (ZUNDAF) 2012 – 2015</p>	<p>The 2012-2015 ZUNDAF is the UN's strategic programme framework to support national development priorities for the 2011-2015 cycle as well as the achievement of the Millennium Development Goals (MDGs) by 2015. Jointly led by the Government of Zimbabwe and the UN Country Team (UNCT), the ZUNDAF provides a framework for responding and adapting in a holistic manner to the evolving national context. It incorporates principles of recovery and development.</p>

Below is a picture of the rehabilitation situation of the health care system in Zimbabwe between 2009-2011 against developments within the country.

Period	LRRD stage	Features of health sector (Zimbabwe)	Indications LRRD stage
1980 to 1989	Development (positive development)	<ul style="list-style-type: none"> • Has best primary health care systems in sub-Saharan Africa • On forefront of regional and global initiatives on child survival • Government launching the first child survival revolution in 1988 • Determined programme to provide health for all by the year 2000. • Health care both preventive and curative health care provisioning. • Massive health infrastructure programme linked to service delivery targets of a health facility within walking distance (eight kilometres) for every person, including rural areas. • Government started health professional training programme. 	Long term health planning (developmental state)
1990 to 1999		<ul style="list-style-type: none"> • Government stopping health professional training programme in the early 1990s when Economic Structural Adjustment Programme (ESAP) induced cuts in public expenditure began to affect investment in the health sector. • By late 1990s, about 85 per cent of Zimbabweans lived within 10 kilometres of a health facility. 	Long term health planning (developmental state)
2000 to 2007	Development (negative development)	<ul style="list-style-type: none"> • From the ESAP period in the 1990s to early 2000s, progress in health care stagnated and began to gradually decline. • Decade long gradual collapse • Economic challenges • Chronic underinvestment in the health sector • Significant deterioration in the health indicators • Introduction of user fees leading to additional barrier to health care, impacting the most vulnerable • By 2005 there was rapid deterioration in health provisioning 	Slowing down and stagnation – reversal from development towards humanitarian
2008 to early 2009	Humanitarian crisis	<ul style="list-style-type: none"> • Worst public health disasters the country has ever known • By May 2009, outbreak of cholera infected 98,424 people and claimed the lives of 4,276 of these • Hospitals operating at below 50% capacity • Chronic lack of health workers - out of an establishment of 51 Specialist Consultants the hospital had only 13; one Government Medical Officer out of an establishment of 40 was in post 	Disruption - humanitarian effortsto help people who are suffering and limited to health care access and

		<ul style="list-style-type: none"> • Mortuary with a carrying capacity of 70 was overflowing with more than 250 bodies mostly for pauper's burial. • The companies contracted to undertake burial services abandoning the hospital due to non-payment • Lack of essential drugs and clean water and sanitation at health facilities 	disease outbreaks
End 2009 to 2011	Rehabilitation (recovery)	<ul style="list-style-type: none"> • February 11, 2009, A Government of National Unity (GNU) was formed • New cabinet was sworn in on February 13, 2009. • Coalition government restoring macro-economic stability • The health sector received a kick-start with donors pledging substantial funds for infrastructure resuscitation • World Bank agreeing to resume financial assistance to Zimbabwe for the first time since 2000 • Funding for the health sector streaming from donors providing substantial funding that includes retention allowances for health workers, essential drugs, vaccines, laboratory supplies, and HIV commodities • Halting of the health care collapse and setting the health sector on a path of recovery (rehabilitation). • 2 million children vaccinated in June 2009 through national immunisation days. • The cholera epidemic finally controlled • October 2010, the government of launched a Health Sector Investment Case. • October 2011, the government launched the Health Transition Fund 	Health recovery (rehabilitation) transitioning from humanitarian to health development. Focus on restoration and improvement of facilities and systems to ensure that their inputs become long term assets, strengthen health systems and establish long term development of the health system.
2012 to current	Rehabilitation (recovery) continuing		

The health sector developments in Zimbabwe indicating that the sector is undergoing LRRD processes are shown above.

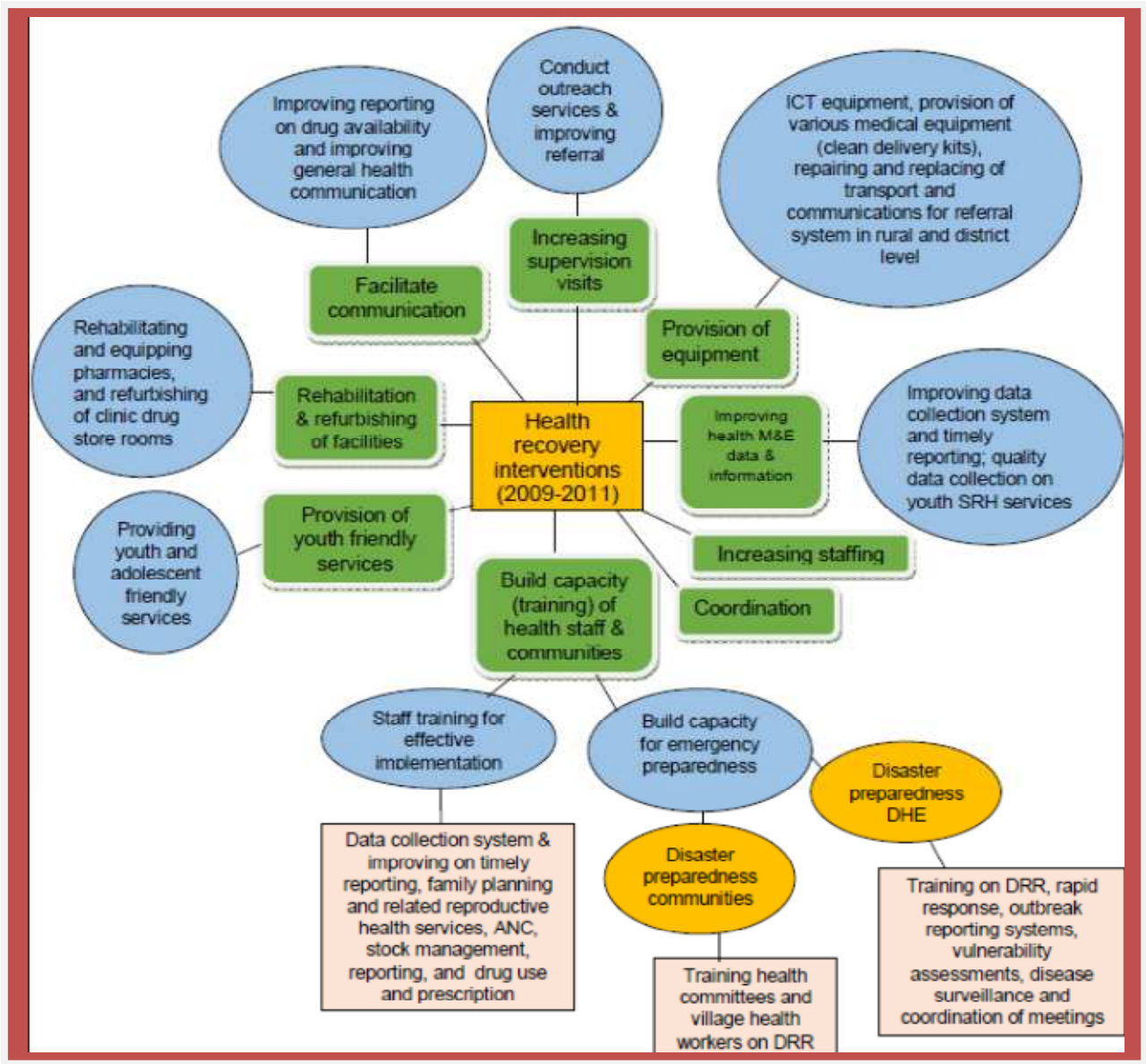
6.2.2.2 Health recovery interventions outlined in policy documents to be pursued

An analysis of the health recovery policies between 2009 and 2011 revealed the interventions that are summarised on the thematic content map shown below (figure 6.5). The interventions are drawn from all the policy documents developed. While each document has a thrust that may merit significant consideration, only policies that outline substantial health recovery interventions are highlighted.

The CAP (2011), which was compiled in consultation with other health players particularly MoH&CW, outlines interventions that fall into three categories. First, reducing morbidity and mortality of mothers and their newborns through strengthening service provision and referral system for reproductive health. Second, increasing the availability of vital drugs by strengthening the district drug management systems, including the supply chain mechanism, supporting drug rationalisation and capacitating health staff as well as improving communication within the supply chain mechanism by the end of 2011. Third, contributing to reduction in excess morbidity and mortality caused by communicable disease outbreaks and other public health emergencies (CAP 2011:48-49). The detailed interventions that fall under each category are outlined in significant detail but nonetheless falling under the above health recovery priority categories (CAP 2011:48-49).

The Joint Recovery Opportunities Framework 2010 (JROF) doesn't outline any particular activities but in a cursory way refers to the destruction of the six health system building blocks (human resources; medical products, vaccines and technology; health financing; health information; service delivery and leadership and governance) and the need to resuscitate them (JROF 2010:14). The Zimbabwe Medium Term Plan (2011-2015) and Short Term Emergency Recovery Programme (STERP 1&2) mention health recovery in passing but focus on economic recovery. The detailed outline of recovery interventions stipulated in the policies is indicated below (6.5).

Figure 6.5 Thematic categories (map) of health recovery interventions stipulated by policy documents



The Zimbabwe Emergency Recovery Programme (2009) document that was prepared under the Multi-Donor Trust Fund (MDTF) administered by the World Bank (2009:24-26) does not outline recovery interventions but only identifies health gaps. The document simply made recommendations for the development of a health matrix to identify areas requiring improvement or development. The Zimbabwe Health Sector Investment Opportunities developed by MoH&CW (2009:1-2) listed six categories of health

recovery interventions. These are; health workers retention, improving health infrastructure, improving communications, supporting service delivery, ensuring community participation and involvement, and support coordination.

The Zimbabwe Health Sector Investment Case (2010 – 2012), identified gaps and responsive interventions to address the gaps. The interventions fall under community health, primary health centre level, secondary health centre, and specialist services (Zimbabwe Health Sector Investment Case 2010: 9-14). The interventions focus on availability of essential commodities, availability of human resources, physical accessibility, utilisation, and quality of services. The 100 days Plan - Getting the Zimbabwe Health Care System Moving Again- Health Action Plan for the first 100 days – March to June 2009 (2009: 9-12), listed the following health recovery interventions; human resources (recruitment), ensuring drug provision to hospitals and clinics, building capacity of national pharmaceutical company (NatPharm), and restoring functional infrastructure at all central hospitals.

6.2.3 Study objective 2: Analyse development and humanitarian interventions implemented during the 2009 to 2011 period to determine development and humanitarian needs constituting health rehabilitation

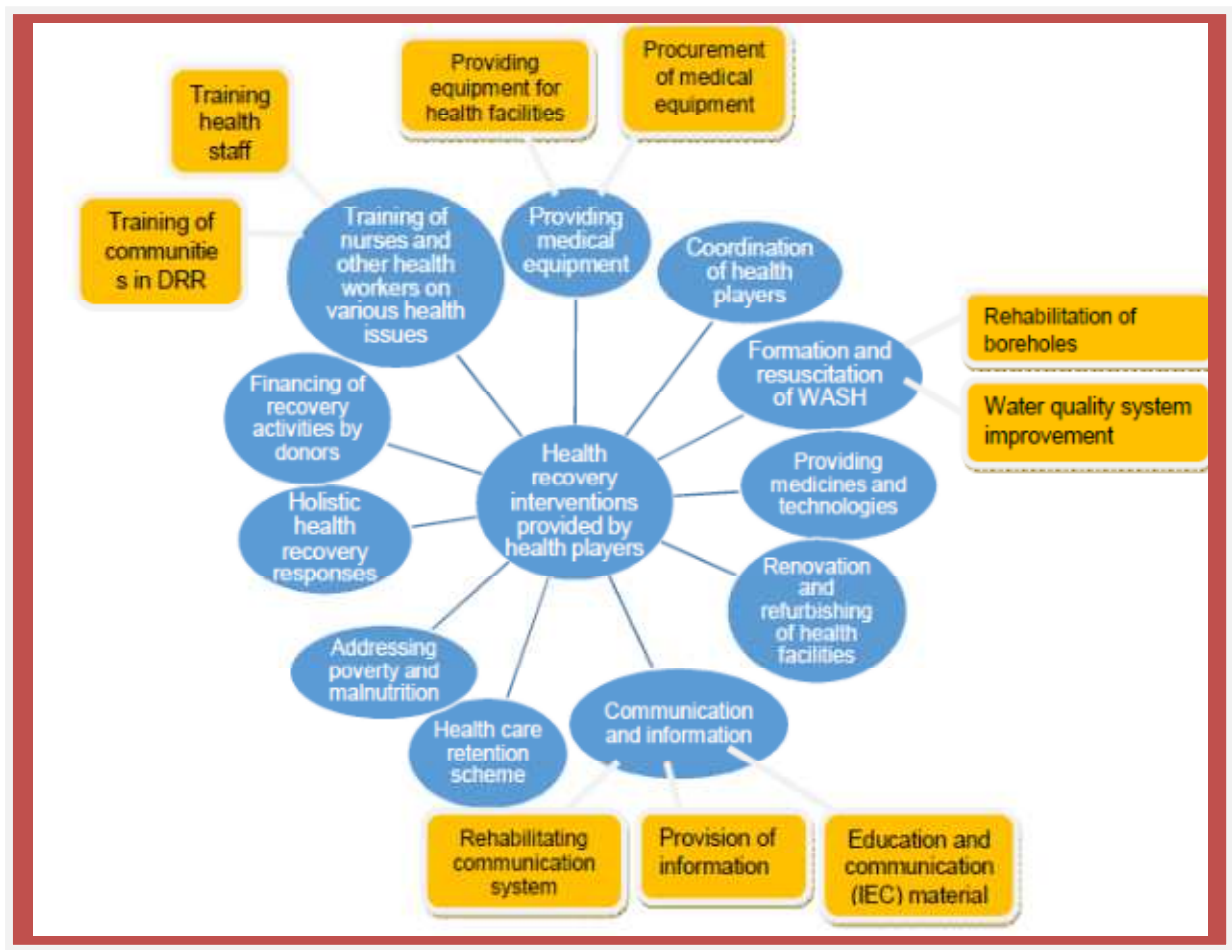
This section presents results of the interviews conducted among health players. The section addresses the second objective, which aims to analyse development and humanitarian interventions implemented during the 2009 to 2011 period to foster health recovery (rehabilitation). The analysis is done in two ways. The first part uses an inductive coding approach while the second part uses deductive coding.

Interview responses are analysed using inductive thematic content approach whereby responses are clustered into categories based on their theme. Second, the developed themes or categories of interventions will be linked to the six health building blocks. The six health building blocks are the frame or deductive codes that all health recovery interventions are aligned.

6.2.3.1 Health recovery interventions implemented from 2009 – 2011 (inductive thematic network)

The health recovery interventions implemented by health development actors to address the health disaster between 2009 and 2011 are indicated below (figure 6.6).

Figure 6.6: Implemented health recovery interventions by health actors (thematic network)



The health recovery interventions implemented by health players are; coordination of health players, formation and resuscitation of WASH, rehabilitation of boreholes, equipping of health facilities, training of nurses and other health workers, financing of recovery activities by donors, refurbishment of health facilities, procurement of medical equipment, rehabilitating communication system, water quality system improvement,

provision of information, education and communication (IEC) material, providing medicines and technologies, and interventions to address poverty and malnutrition.

6.2.3.2 Qualitative analysis of health recovery interventions implemented from 2009 – 2011 (inductive themes)

Coordination: Coordination of health players was a major activity conducted during the health recovery period. Coordination was particularly evident during the cholera outbreak in 2008 and 2009 as well as in subsequent sporadic outbreaks. The WHO Coordinator commented that,

To arrest the health collapse and ensure recovery, various development and humanitarian actors combined efforts under the Zimbabwe Health Cluster. Leadership was provided by the Health Cluster Coordinator. The actors included Donors, UNOCHA, WHO, MoH&CW (Government of Zimbabwe), International and National NGOs. The donors that contributed large amounts of money to the response included the European Community Humanitarian Office (ECHO), The Office of US Foreign Disaster Assistance - OFDA/USAID, and UNOCHA through Emergency Response Funds (ERF). WHO together with MoH&CW through the Health Cluster Coordinator coordinated health disaster needs, conducted health situation analysis and priority setting, developed a health recovery strategy, planned programme activities, provided support to supervision, monitoring, and evaluation of health issues (WHO Coordinator).

The interventions were guided and buttressed through development of various policies and strategy documents highlighted above (section 6.2.2.1).

Formation and resuscitation of WASH: The other prominent intervention entailed WASH activities that were implemented by various health actors to avert the health crisis. The interventions included health disaster risk reduction. NGOs and MoH&CW indicated that the implemented WASH interventions included;

Formation or resuscitation of Water, Sanitation and Hygiene (WASH) cluster to mobilise funds for building latrines, rehabilitation of boreholes, water tanks and pumps at health facilities across the country (IRC, Mercy Corps respondents and MoH&CW officials).

Provision of equipment to health facilities: This was also an intervention that was reported by respondents. Various types of equipment were provided to health facilities. MoH&CW officials reported that;

Emergency Management of Neonatal (EMON) kits, Cholera kits and communication equipment, vehicle for transport with cholera kits and many other materials were provided (MoH&CW official).

Training of health staff and critical community people: Training of health staff and community people was also a major intervention that was implemented during the health recovery process. Health staff and communities were trained on several health areas to ensure effective health response as well as prevent future health disaster. The discussions with nurses revealed that;

The focus of the training was on integrated disease surveillance, emergency management of neonatal (EMON), HIV and TB targeting, prevention of mother-to-child transmission (PMTCT). This was done in addition to preventive WASH training (FGD nursing staff).

NGOs that implemented health recovery activities reported that;

Community people who include community leaders, Village water committees, and Village Health workers were trained in disease surveillance, disease identification, hygiene, and safe water management (Plan, IRC, Mercy Corps respondents).

There was also training and countrywide support to Environmental Health teams who then cascaded capacity building to communities they service. The intervention was provided to improve the quality of water in communities and upgrading communal water points. For instance in Mutare, Mutasa and Nyanga districts of Manicaland Province, over 700 family wells were upgraded. Rain water harvesting equipment was also provided in 30 schools in Mutare district (IRC and Mercy Crops).

MoH&CW official testified that NGOs partnered with government to implement training activities. The official reported that;

Many NGOs that included IRC, Merlin and Goal were, to varying levels, involved in facilitating training of nurses in midwifery so that they are able to handle emergency disease cases, to strengthen maternal and child care. There was also training of wards personnel on drug management (MoH&CW official).

Renovation and refurbishment of health facilities: Health actors were also involved in renovation and refurbishment of health facilities to deliver health care in clean and safe environments. MoH&CW and NGOs staff stated that structures were built and renovated.

Mothers' waiting shelters were built, refurbishment of Neo-Natal and obstetric care unit for Mutare Hospital was done as well as installation of communication radios (MoH&CW official, Nursing staff FGD, IRC).

Procurement of medical and communication equipment: While MoH&CW is largely responsible for procurement of medicines through national pharmaceuticals (NatPharm), during the health crisis period, other health players were allowed to procure some medication to avert drug shortage and facilitate quick health recovery. There was also relaxation of procurement and supply of health equipment. MoH&CW official and IRC indicated that;

Hospital equipment such as delivery beds, sanitary pads, delivery packs, and bed linen, were procured. The equipment was provided by both IRC and Plan International. IRC also bought an ambulance for Ministry of Health to cater for Mutare District. Two way radio communication control units were also provided for Mutare hospital as the hub that is linked to eight other remote clinics (MoH&CW official and IRC).

Further to the above, IRC procured “procured more than 300 000 drugs mainly quinine, which was in short supply during 2008/9” (IRC).

Communication and information: Information, education and communication (IEC) materials were provided together with community training and dialogues. The

organisations that were involved in direct frontline interventions included provision of information, education and communication (IEC) as a key intervention. NGOs and nursing staff discussions revealed that, material on hygiene,

Material on hygiene, health education, basic health disaster response and other related health promotional materials were provided to communities and clinics by NGOs (Nursing FGD, FACT, IRC, Plan).

Financing and health recovery: Due to GoZ bankruptcy, health recovery interventions were hugely funded by donors. The health players particularly NGOs were funded by different donors but in many cases the funders overlapped. The Health Cluster Coordinator observed that;

International Rescue Committee (IRC), Plan International, Mercy Cops, Merlin, Family AIDS Caring Trust (FACT) and Goal were funded by OCHA to varying degrees while IRC, Mercy Cops and Plan International, Goal and Merlin all received funding from ECHO (Health Cluster Coordinator).

There was also training and countrywide support to Environmental Health teams who then cascaded capacity building to communities they service. OFDA/USAID and ECHO provided the required funding (IRC; Mercy Corps).

Holistic health recovery responses: To respond to other community issues that impacted on health during the health crisis, NGOs provided subsidised services to communities in areas of caring for survivors of sexual violence at community and clinic levels. The interventions were intended to provide additional community support to complement critical recovery processes.

There was also resuscitation of a one-stop-shop for survivors of sexual violence at Mutare Provincial Hospital. A fund was also created in partnership with Rural District Councils so that those survivors who could not afford to come to Mutare Provincial Hospital could be assisted from the fund to access health care of a higher quality than from their local clinics (MoH&CW; IRC).

Addressing health challenges due to poverty and malnutrition: Further to direct humanitarian and recovery activities, some NGOs were involved in various livelihood packages to mitigate the effect of poverty and malnutrition. The interventions aimed to complement health recovery particularly in children whose diseases were linked to malnutrition. For instance FACT, Batanai HIV and AIDS Support Organisation (BHASO), Plan International, IRC and Mercy Cops, were involved in capacity building of communities on various livelihood interventions.

6.2.3.3 Qualitative analysis - alignment of health system blocks, Zimbabwe health recovery policies stipulation and implemented health recovery interventions by health players from 2009 – 2011 (deductive coding)

This section uses a deductive coding approach to place health recovery interventions stipulated by recovery policies and the actual recovery interventions implemented under each health recovery pillar. The reviewed policy documents and health interventions implemented by the various health players revealed diversity in the way health recovery polices informed interventions. Below is the table (table 6.1) showing the alignment of health system blocks, health recovery interventions stipulated in policies, and actual implemented health recovery interventions by health players.

Table 6.2 Health system blocks, interventions stipulated in policies, and implemented recovery interventions

Health system pillar	Corresponding Recovery policy stipulation		Interventions by health actors	
Leadership and governance	Coordination		Coordination of health players	
Health information	Improving health M&E data and information		Communication and information	Rehabilitating communication system
	Facilitate communication			Provision of information
Human resources	Increasing staffing		Health care retention scheme	
	Build capacity (training) of health staff and communities	Staff training for effective implementation	Training of nurses and other health workers on various health issues	Training health staff
		Build capacity for emergency preparedness		Training of communities in DRR
	Increasing supervision visits			
Medicines and technologies	Provision of equipment		Providing medicines and technologies	
			Providing medical equipment	Procurement of medical equipment
				Providing equipment for health facilities
Service delivery	Provision of youth friendly services			
Financing			Financing of recovery activities by donors	
DRR	Build capacity for emergency preparedness		Formation and resuscitation of WASH	Water quality system improvement
				Rehabilitation of boreholes
Holistic health recovery responses			Addressing poverty and malnutrition	
	Rehabilitation and refurbishing of facilities		Renovation and refurbishing of health facilities	

6.2.3.4 Zimbabwe health recovery interventions during 2009 to 2011 and their focus on health rehabilitation

The previous sections identified the policies that were developed to guide health recovery interventions (6.2.2) and the interventions that were implemented by health actors to foster health recovery (6.2.3). These sections addressed objectives one and two. This section continues to address objective two. The section focuses on determining the extent to which the implemented activities directly addressed health recovery needs.

Notably, health recovery is a complex and multidimensional process that begins in a humanitarian setting. The process is guided by development principles that seek to build on humanitarian programmes and catalyse sustainable development opportunities. It aims to generate self sustaining, nationally owned, resilient processes for post crisis recovery. The criterion for effective health recovery is that it should ease the transition between health development and health relief. Effective recovery aims to generate self sustaining, nationally owned, and resilient processes for post crisis recovery. It generally encompasses the restoration of basic services, livelihoods, shelter, governance, security and rule of law, environment and social dimensions, including the reintegration of displaced populations.

However, to determine the effectiveness of health recovery process, recovery interventions should be interpreted within the context of health humanitarian and health development. Humanitarian is about saving lives of people while development is about investment in health, which is embedded in broader development planning and long-term needs. Health recovery therefore is aimed at improving the situation to mitigate risks and enhance preparedness so that the improvement path is sustained. Thus to gauge the effect of recovery interventions in easing the transition between health humanitarian and development, health recovery interventions should mitigate vulnerabilities and risks of communities but at the same time prepare communities for improvement as well as prepare them to avoid future vulnerabilities and risks that dispose them to health disasters.

This section therefore assessed the extent to which the implemented activities directly addressed health recovery needs through the stated three criteria;

- i. How interventions mitigated the health humanitarian circumstances of communities;
- ii. How interventions prepared communities for improvement from their prevailing condition; and
- iii. How interventions prepared communities to avoid future health vulnerabilities and risks that dispose them to health disaster.

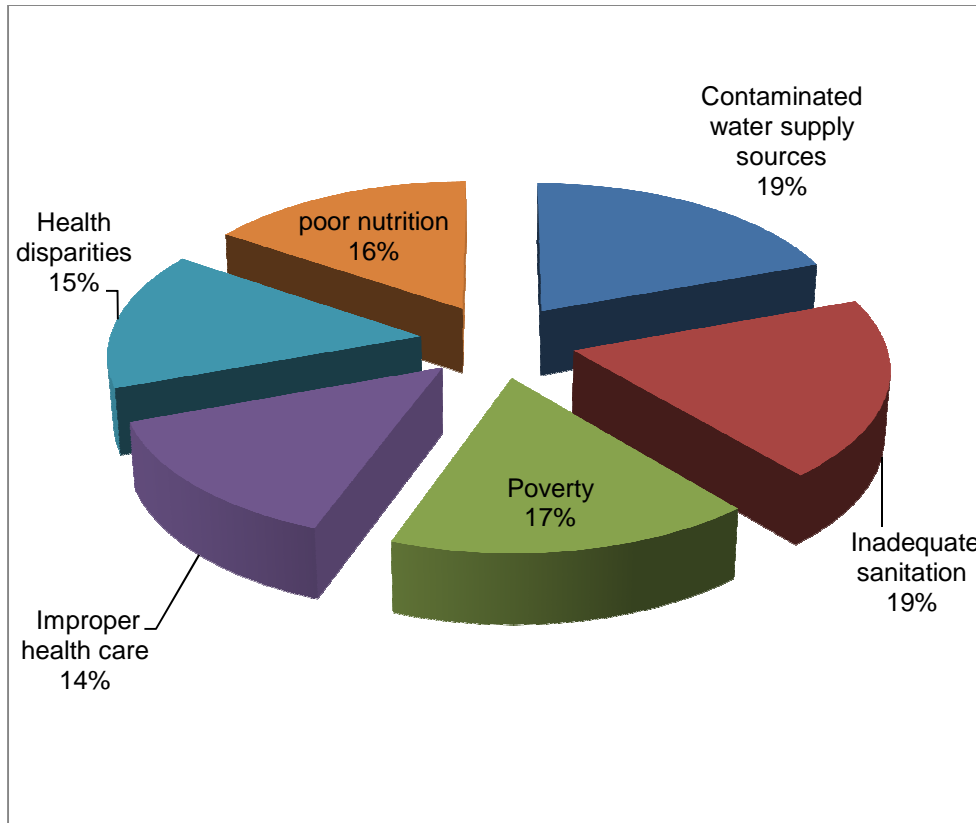
Using an inductive thematic approach, factors that caused as well as predisposed communities to health disaster are identified. Following the identification of causal and predisposing factors, a “factor/cause and intervention” match will be done. A factor/cause and intervention match aims to determine mitigatory appropriateness of interventions (relevance). In addition, various rating scales are used to determine respondents’ views on (1) the extent to which health disaster was mitigated, (2) extent to which interventions sufficiently addressed health disaster causes (relevance), (3) extent to which interventions prepared communities for progress and improvement from their prevailing health disaster situation, and (4) extent to which interventions prepared communities to avoid future vulnerabilities and risks (health disaster risk management).

6.2.3.4.1 How health recovery interventions mitigated the health humanitarian circumstances of communities

6.2.3.4.1.1 Factors that caused health disaster (crisis)

To determine the level of health humanitarian mitigation, the causes of the health crisis should be first determined in order to match them with corresponding interventions. The interview discussions held with the five groups of respondents revealed that the factors that contributed to health disaster are contaminated water supply sources, inadequate sanitation, poor nutrition, improper health care, health disparities and poverty. The magnitude of contribution of each factor to health disaster is indicated in the diagram below (figure 6.7).

Figure 6.7: Factors and magnitude of contribution to health disaster

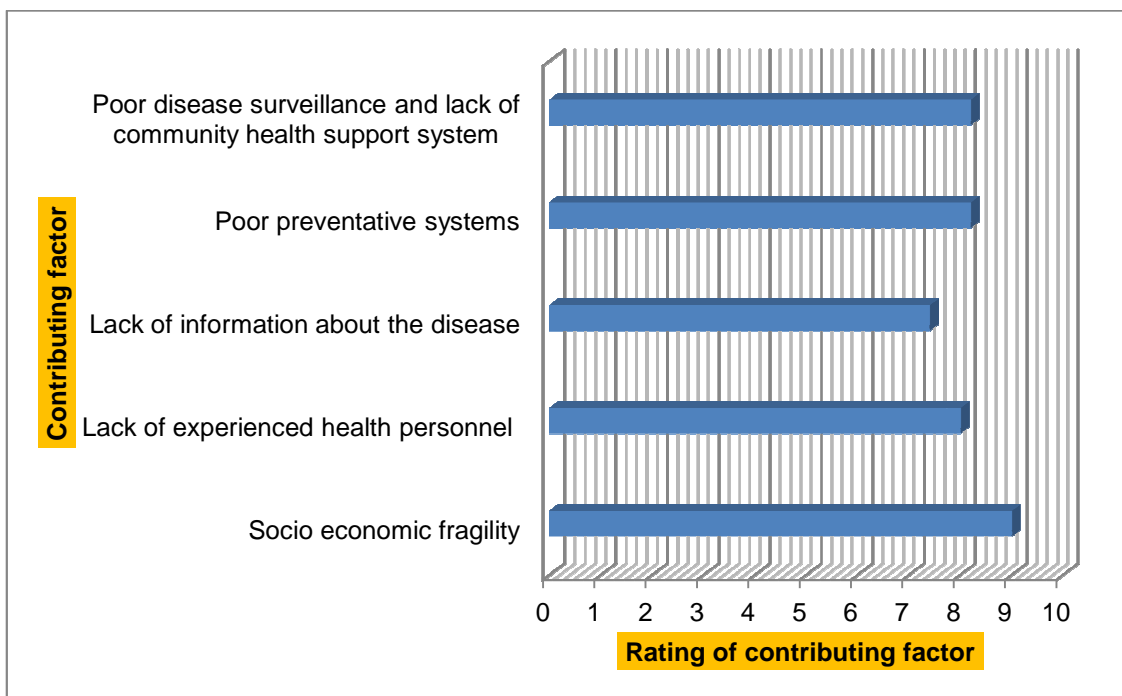


The factors that were identified by respondents as greatest contributors to health disaster were contaminated water sources and inadequate sanitation (19%), followed by poverty level of the people (17%), malnutrition (16%), health disparities (15%), and improper health care (14%). Contaminated water supply sources were a major contributing factor to health disaster as water taps were dry and people resorted to using open wells. As a result, many people died due to lack of access to clean drinking water and poor sanitation. There was also shortage of purification chemicals, such as chlorine, which led to people drinking unclean water. The use of bushes as toilets worsened the situation as open defecation resulted in contaminating water sources. With Zimbabwe experiencing harsh economic conditions, people struggled to buy basic nutritious food. Thus, as the health system collapsed, people increasingly failed to access proper health care and there was no medication in most health facilities.

6.2.3.4.1.2 Predisposing factors that contributed to health disaster

The predisposing factors identified by respondents that exacerbated health disaster included socio economic fragility, lack of experienced health personnel, lack of information about the disease, poor preventative systems, poor disease surveillance and lack of community health support system. Below are the ratings out of 10 by the interviewed respondent groups.

Figure 6.8 Predisposing factors contributing to health disaster



The policy makers (MoH&CW officials) identified lack of experienced staff and information as the least predisposing contributing factors (7/10) while socio economic fragility was identified by respondents as the greatest contributor to health disaster (9/10).

6.2.3.4.1.3 Health recovery interventions and appropriateness in mitigating health humanitarian disaster

The causal (figure 6.7) and predisposal (figure 6.8) factors interplayed to cause health disaster. Therefore, interventions to address the health disaster should aim to holistically respond to these intertwined factors. This section will consider the health

recovery interventions implemented and their appropriateness in mitigating health humanitarian disaster. Health disaster causes are matched with corresponding interventions. The interventions included coordination of health players, formation and resuscitation of WASH, rehabilitation of boreholes, equipping of health facilities, training of nurses and other health workers, financing of recovery activities by donors, refurbishment of health facilities, procurement of medical equipment, rehabilitating communication system, water quality system improvement, providing information, education and communication (IEC) material, providing medicines and technologies, and interventions to address poverty and malnutrition.

Table 6.3 Causes of health disaster and matching interventions implemented by health actors to address the situation

Health disaster cause	Corresponding recovery intervention
Factors causing health disaster	
Contaminated water supply sources	<ul style="list-style-type: none"> • Formation and resuscitation of WASH • Water quality system improvement • Rehabilitation of boreholes
Inadequate (poor) sanitation	
Poor nutrition	<ul style="list-style-type: none"> • Livelihoods projects
Improper health care	<ul style="list-style-type: none"> • Providing medicines and technologies • Providing medical equipment • Renovation and refurbishing of health facilities
Health disparities	<ul style="list-style-type: none"> • Efforts to reduce/remove user fees
Poverty	Livelihoods projects
Factors predisposing communities to health disaster	
Socio economic fragility	Livelihoods projects
Lack of experienced health personnel	<ul style="list-style-type: none"> • Training of health personnel • Health care retention scheme
Lack of information about the disease	<ul style="list-style-type: none"> • Rehabilitating communication system • Provision of information • Education and communication (IEC) material
Poor preventative systems	<ul style="list-style-type: none"> • Training of health staff and communities • Formation and resuscitation of WASH • Water quality system improvement • Rehabilitation of boreholes
Poor disease surveillance	<ul style="list-style-type: none"> • Training of nurses and other health workers in integrated disease surveillance • Training of health staff and community people

	<ul style="list-style-type: none"> • Rehabilitating communication system • Provision of information
Lack of community health support system	<ul style="list-style-type: none"> • Training of HIV and TB targeting nurses, village health workers and community home-based care givers • Training of community water committees • Training of community disease surveillance

6.2.3.4.1.4 Extent of interventions in addressing causes of health disaster

To determine the extent to which interventions addressed causes of health disaster and contributed to rebuilding health system building blocks (recovery), the interventions were linked to corresponding health building blocks. Respondents were asked to indicate appropriateness of intervention in addressing causes using three symbols (as indicated below). The results from respondents are indicated below (Table 6.4).

Table 6.4: Determination of intervention appropriateness

Symbol	Description	
↑	Intervention (s) addressed the factors head on effectively	
⌘	Intervention (s) did not meaningfully address the factors head or effectively or somewhat addressed factors head on.	
≠	Intervention (s) did not address the factors or worsened the health situation	
Health system recovery pillar	Recovery interventions	Extent of addressing health challenge
Leadership and governance	<ul style="list-style-type: none"> • Formation/resuscitation of WASH • WASH and Health Cluster Coordination 	⌘
Human Resources	<ul style="list-style-type: none"> • Training of nurses and other health workers • Health Workers retention scheme 	⌘
Information	Installation of radio communication system in some clinics	⌘
Medicines and technologies	Procurement of medical equipment	⌘
Service delivery	<ul style="list-style-type: none"> • Poverty and malnutrition • Information, Education and Communication 	↑

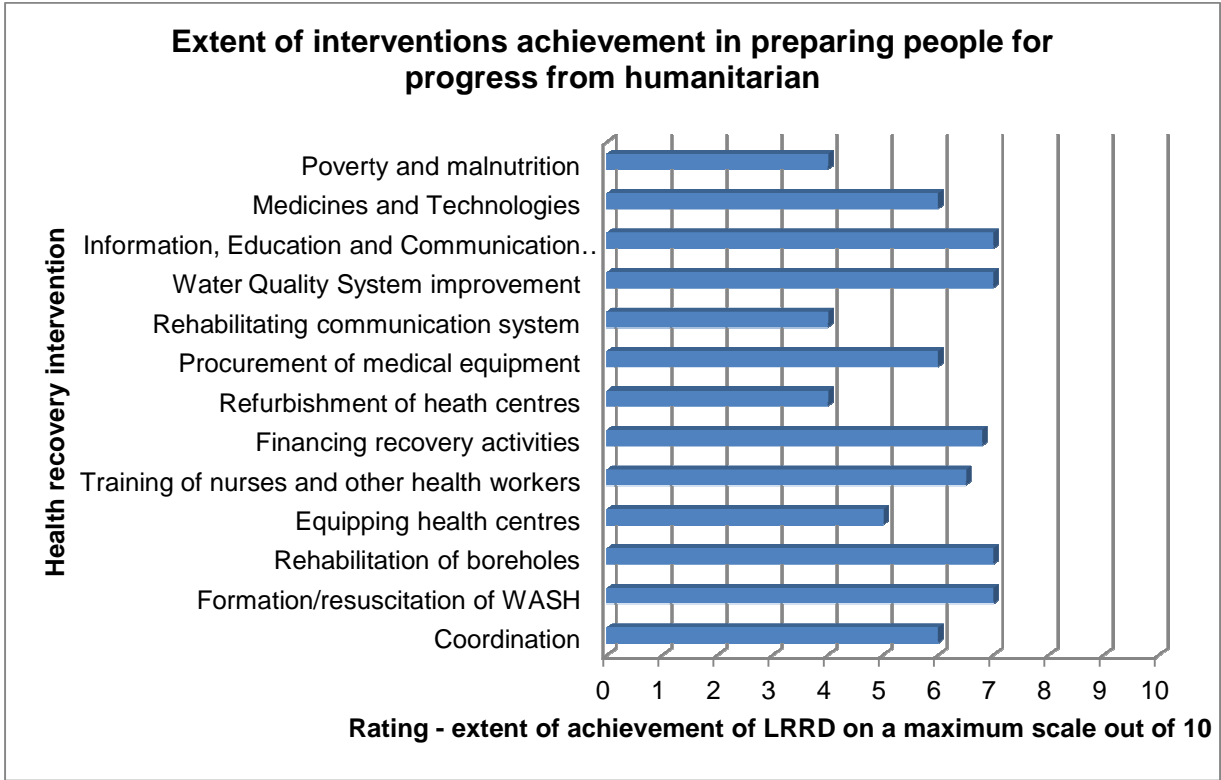
	(IEC) material <ul style="list-style-type: none"> • Water Quality System improvement • Rehabilitating communication system • Refurbishment of health facilities • Equipping health facilities • Rehabilitation of boreholes 	
Financing	Financing recovery activities	8

6.2.3.4.2 How health recovery interventions prepared communities for improvement from their prevailing health disaster condition

6.2.3.4.2.1 Health recovery interventions effectiveness in preparing communities to progress from humanitarian situation

Effective health recovery interventions are expected to prepare communities for progress and improvement from their humanitarian situation to recovery and then to health development. To determine the effectiveness of health interventions in preparing communities to progress from humanitarian to recovery, respondents were asked to rate the effectiveness of each intervention. Data from interview respondents is summarised below (figure 6.9).

Figure 6.9: Health recovery interventions effectiveness in preparing communities to progress from humanitarian situation

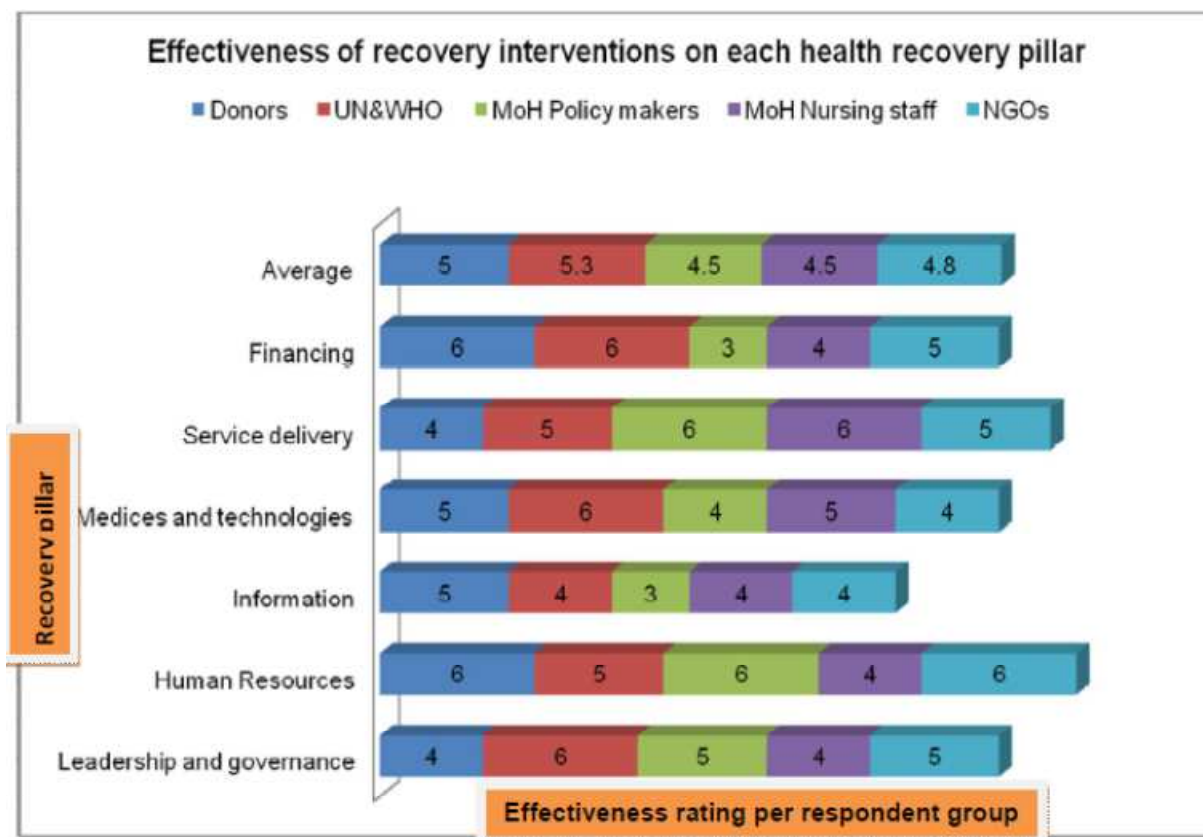


Discussions with interview respondents revealed that the intervention that was viewed as least effective in strengthening health recovery process is information (4/10); followed by leadership, medicines and technologies, and financing (4,8/10); service delivery (5,2/10) and lastly human resources (5,4/10).

6.2.3.4.2 Effectiveness of interventions in preparing communities to progress from humanitarian situation per each health recovery pillar

Health recovery interventions fall under six pillars. To determine effectiveness of progress from humanitarian, the effectiveness of health recovery interventions should be considered under the six pillars. Data from respondents on each pillar is indicated below (figure 6.10).

Figure 6.10 Effectiveness of interventions leading to progress from humanitarian on each health recovery pillar

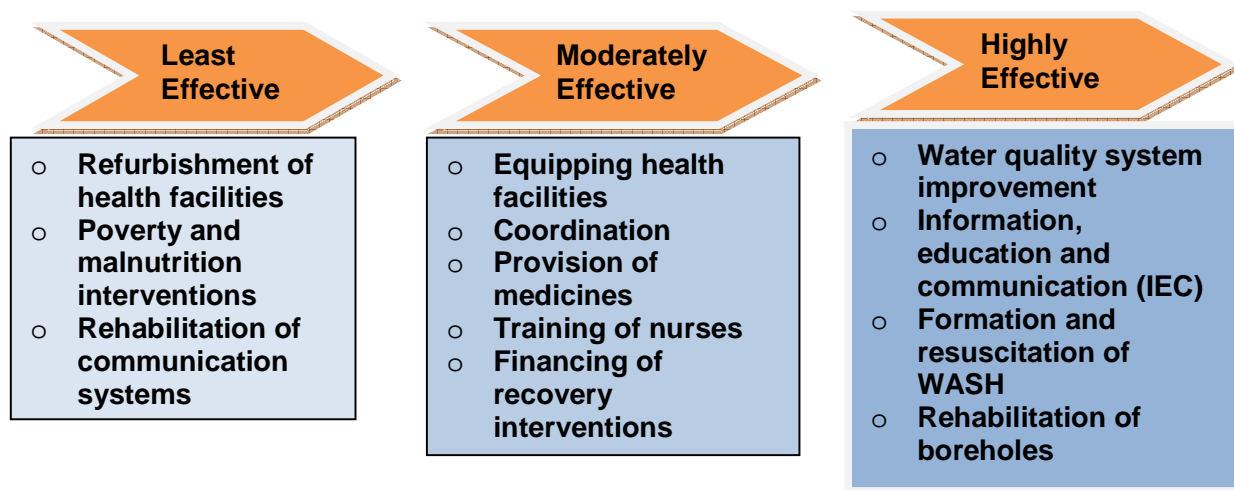


Responses of interview respondents presented above indicate that MOH Officials and Nursing staff recorded the lowest (4.5/10) rating, followed by NGO staff (4.8/10), donors (5/10), and UN and WHO (5.3/10).

6.2.3.4.3 How health recovery interventions prepared communities to avoid future health vulnerabilities and risks that dispose them to health disasters

Respondents’ views on the extent to which interventions effectively prepared communities to avoid future health disaster were placed on a continuum ranging from least, moderate and highly effective. The responses from interview respondents are presented below (figure 6.11).

Figure 6.11 Continuum of responses on effectiveness in avoiding future health disaster



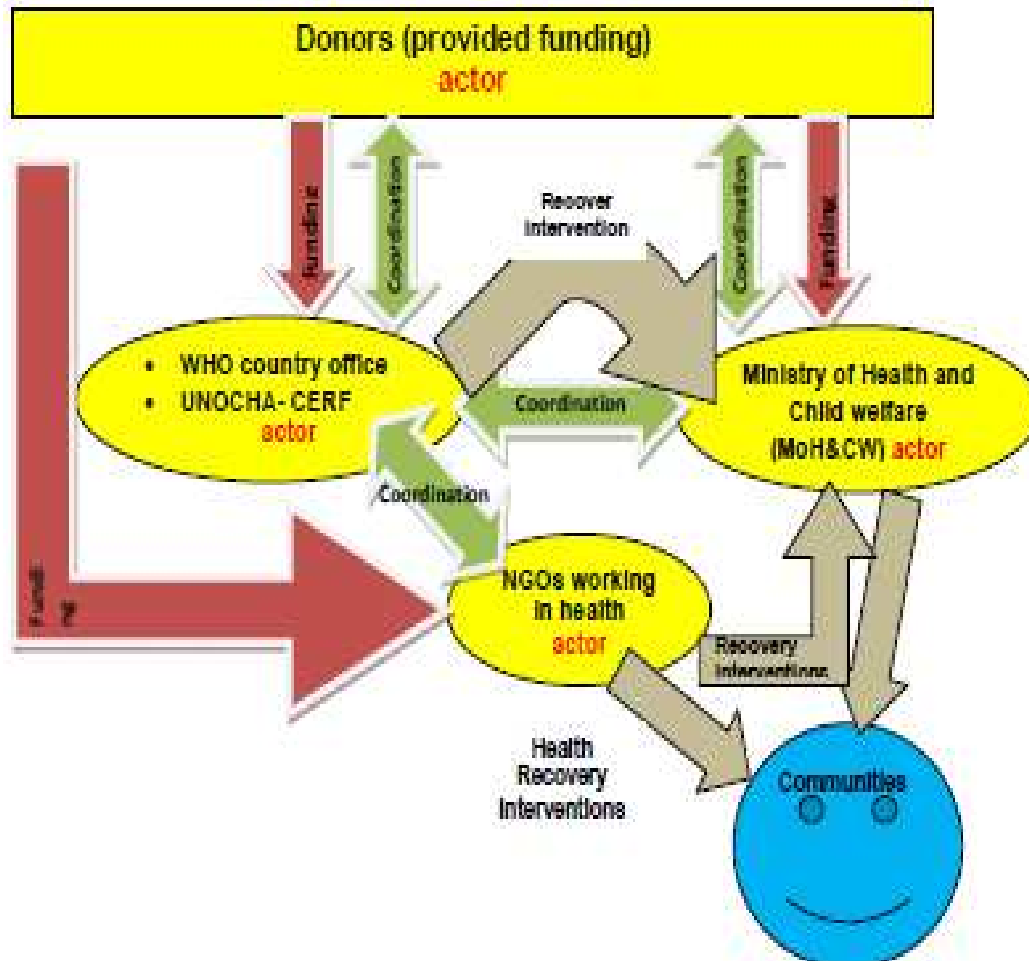
6.2.4 Study objective 3: Analyse health actors' interventions to determine their focus on health rehabilitation

This section presents results of the interviews conducted among health actors. The section addresses the third objective, which aimed to analyse the health actors' interventions that were implemented during the 2009 to 2011 period to determine the focus of each actor on health rehabilitation activities. The analysis is done in three ways. The first part uses health actors' interrelationships link map to indicate the relationship or link of individual actor to the community people who were targeted with recovery interventions. The second part categorises identified health recovery interventions under each respective actor. The second part thus constitutes deductive coding with health actors being the categorising themes. The third part, which is linked to second part, employs an inductive coding approach where the categorised interventions under each health actor are clustered into sub themes.

6.2.4.1 Role and link of health actors with communities in implementing health rehabilitation interventions

The discussions with interview respondents indicated that the health actors were involved in health rehabilitation in different ways. The roles of actors are reflected on the interrelationships link map below (figure 6.12).

Figure 6.12 Interrelationships link map of health actors' rehabilitation interventions to communities



Interventions to correct Zimbabwe health disaster as well as health recovery included:

- Donor financing, policy development, coordination, training of health care staff, providing health financing subsidies to patients, health facility infrastructure improvements, provision of medical equipment, installing communication radios for surveillance, water quality system improvement, community information, education and communication (IEC), providing holistic health responses that includes survivors of sexual violence and livelihoods, and interventions targeting poverty.

6.2.4.2 Health recovery interventions implemented by respective health actors

Interview respondents indicated that the donors provided funding for rehabilitation activities, UNOCHA and WHO provided coordination and some level of financial support. MoH&CW at policy level provided medical products, policy guidance, capacity building, and assisted in improving health facilities while at implementation level the nurses and other frontline staff rolled out community outreach activities in addition to their clinical roles. On the other hand, NGOs participated in improving health facilities infrastructure, conducted community outreach awareness, and run diverse holistic interventions.

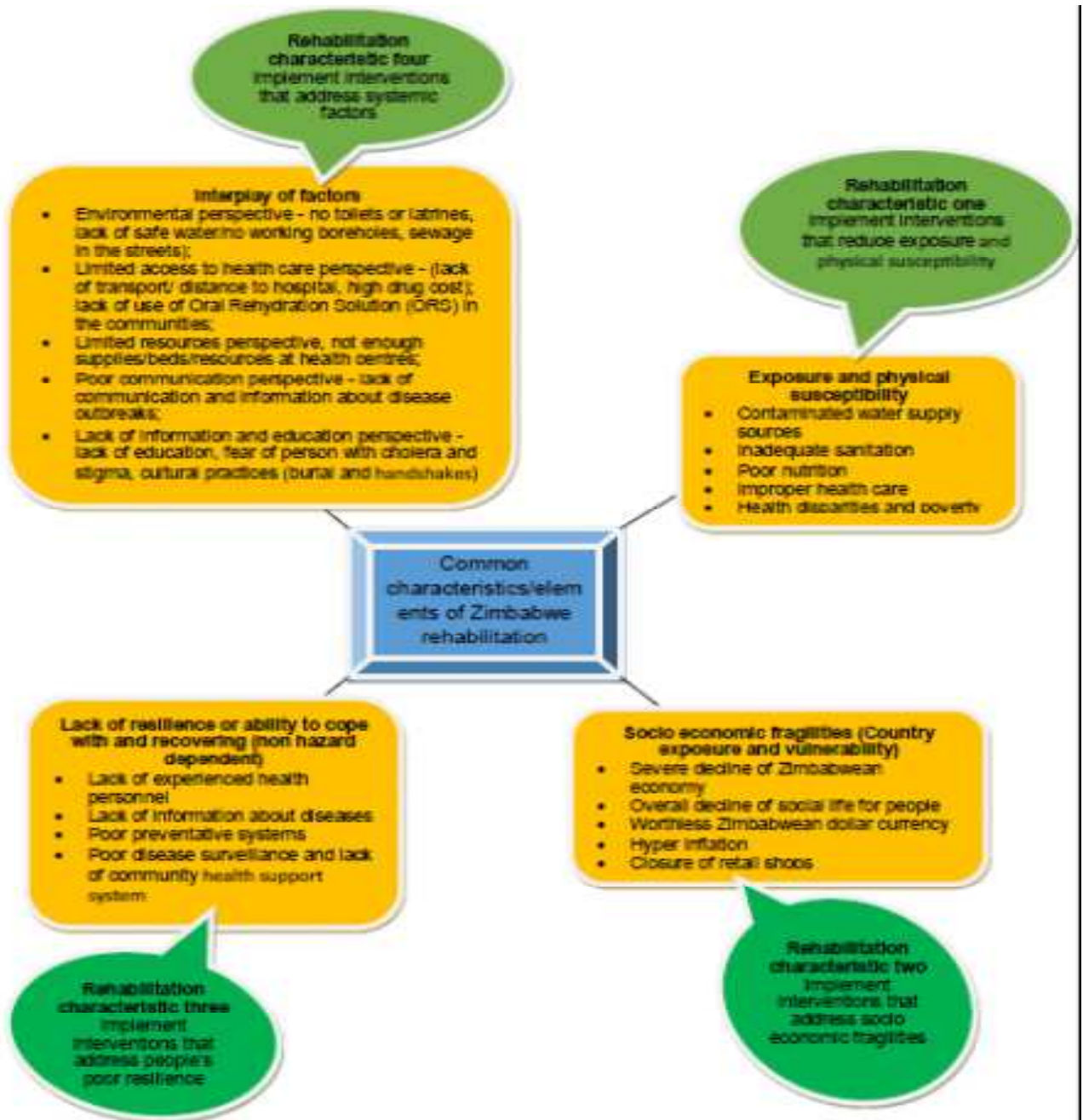
6.2.5 Study objective 4: Determine the common elements that characterised Zimbabwe's 2009-2011 health rehabilitation as well as discern a shared understanding of the same.

This section addresses objective four of the study which aimed to outline the common elements that characterised Zimbabwe's 2009-2011 health care rehabilitation as well as determine existing common understanding among the actors. The analysis focused on interview responses from respondents and health recovery reports submitted by actors. The responses and reports are analysed using a framework thematic approach. Framework (deductive/predetermined) themes are drawn from holistic vulnerability framework. The analysis will align respondents' responses and reports under recovery framework categories to determine the overall common understanding.

6.2.5.1 Thematic presentation of characteristics of rehabilitation interventions

The coded framework themes are indicated on the diagram below (figure 6.13).

Figure 6.13: Common rehabilitation interventions among actors



6.2.5.2 Qualitative analysis of respondents responses

6.2.5.2.1 Exposure and physical susceptibility (hazard dependent)

From the interviews conducted, the respondents indicated that health crisis was caused by factors that would fall under exposure and physical susceptibility. These factors are hazard dependent such that when a hazard occurs, communities will be susceptible to outbreaks. The following prominent exposure and physical susceptibility (hazard dependent) elements were identified; contaminated water supply sources, inadequate sanitation, poor nutrition, improper health care, health disparities and poverty. Rehabilitation interventions therefore should focus on implementing activities that address exposure and susceptibility factors. An NGO leader stated;

Certainly health rehabilitation interventions should focus on addressing exposure and susceptibility factors. If communities were not exposed and vulnerable, disease outbreaks would not have happened (NGO Leader).

6.2.5.2.2 Socio economic fragilities (non hazard dependent)

Interviews conducted and documents reviewed revealed that socio economic fragilities contributed significantly to health crisis. The fragilities included severe decline of Zimbabwean economy, overall decline of social life for people, severely devalued Zimbabwean dollar currency, hyper inflation, closure of retail shops, and prohibitive medical fees. These factors conspired to depress the health situation in the country leading to serious disease outbreaks. A MoH&CW official commented that;

If it wasn't the general decline in the general socio economic situation, the health situation would not have deteriorated that seriously. Now because things are just hard and there is no money and you cannot get any kind of support, people had abandoned their work stations in health facilities. And also those who need care do not have resources to access private care where there is medication (MoH&CW official).

6.2.5.2.3 Lack of resilience or ability to cope with and recovering

Respondents indicated that the health care situation in Zimbabwe would have been better and able to withstand disease outbreaks if resilient systems were in place. However, lack of experienced health personnel, poor information about diseases, weakened preventative systems, poor disease surveillance, and lack of community health support systems resulted to very poor resilient of communities and health systems. A nursing staff commented that:

People were exposed. They had nowhere to run to. They had no basics or skills to withstand the onslaught of disease outbreaks. It was a sobbing situation to realise that communities had no abilities to cope (Nursing staff).

6.2.5.2.4 Interplay of factors causing health crisis

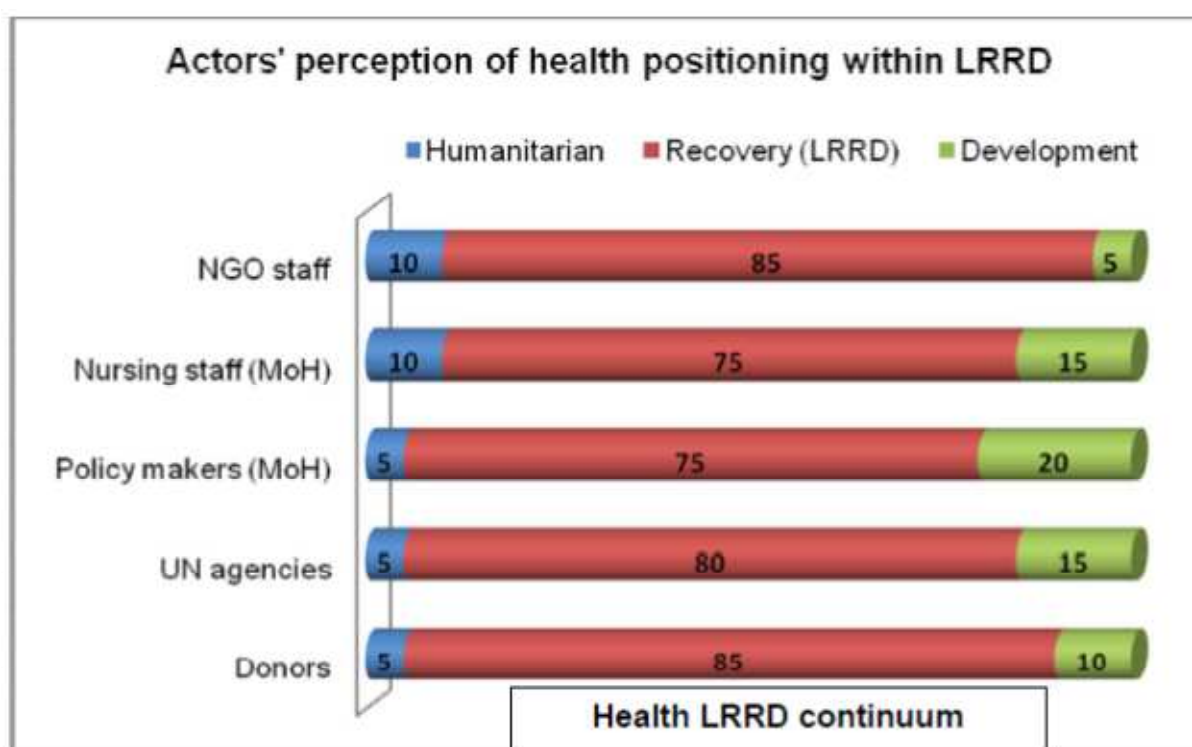
Several factors that fall under the category of factors that interplayed to cause health crisis were identified by actors. These included poor and dirty environment (sanitation), poor health access, limited resources, and limited information. Poor environmental factors included not having toilets or latrines, lack of safe water or no working boreholes, and dirty sewage water flowing in the streets. With regards to limited access to health care, there was lack of transport and long distance to functional health facilities, and high drug cost. Communities had limited resources to meet medical needs while poor information and communication was rampant. The MoH&CW official echoed that;

The situation was chaotic with pressure and needs from every corner. On the one hand you have poorly resourced facilities while on the other hand you have people with no resources to meet health needs. At the same time you felt like you were cut off because communication was not flowing (MoH&CW official).

6.2.5.3 Health recovery progress towards the preferred health development

This section discerns a common understanding of health recovery (rehabilitation). Attempting to develop a common understanding of health recovery entails determining the extent of a shared view among actors regarding health recovery progress towards the preferred health development state. In view of the three progress stages of LRRD within health namely health humanitarian, health recovery (rehabilitation) and health development, the health actors were asked to indicate the position of the country within the continuum. The results from respondents are presented below (figure 6.14).

Figure 6.14 Health recovery progress towards the preferred health development state



NGO staff and Nursing indicated a highest (10%) percentage of health issues that are still reeling under residual humanitarian phase while donors, UN agencies and MoH Health Officials were of the view that residual health humanitarian issues are at 5%. MoH&CW Officials indicated greatest optimism on health recovery progress to the

extent that they view it to be 20% into development state while NGO staff indicated the least optimism with a percentage in development state at 5%. Donors and NGO staff indicated the highest (85%) percentage in recovery (LRRD) phase, followed by UN agencies (80%) and MoH&CW Officials and Nursing staff at (75%).

6.3 Discussion of findings

This section discusses results that have been presented in the previous section (section 6.2). The presented results will be considered in light of the health recovery (rehabilitation) and LRRD literature and theories. The discussion will determine the extent to which results from health actors and health recovery documents reviewed converge or diverge from other health recovery (rehabilitation) and LRRD studies. In doing so, health rehabilitation (recovery) activities implemented in Zimbabwe between 2009 and 2011 will be determined as well as ascertain the extent to which the recovery interventions (i) fostered 'health development' that reduced the need for future health emergency; (ii) focused on 'health relief' that contributed to health development; and (iii) 'rehabilitated' health care in a way that eased the transition between health development and relief.

6.3.1 Study objective 1: Analyse health policy positions developed to address health recovery (rehabilitation) needs between 2009 to 2011

Zimbabwe developed at least ten policies including guiding documents such as CAP between 2009 and 2011 to guide the health recovery process. These documents spell out health recovery interventions that were to be pursued to address the country's health crisis during the period under consideration. The policies significantly vary in content and detail regarding their guidance on health recovery interventions. The policies can rightly be classified into three categories (Table 6.5) namely those that have little guidance, moderate guidance and high (detailed guidance).

Table 6.5 Classification of policies on health recovery interventions guidance

Little guidance	Moderate guidance	High (detailed guidance)
<ul style="list-style-type: none"> • Short Term Emergency Recovery Programme (STERP 1) • Short Term Emergency Recovery Programme (STERP 2) • Joint Recovery Opportunities Framework 2010 (JROF) • Zimbabwe Medium Term Plan (MTP) (2011-2015) • Zimbabwe United Nations Assisted Development framework (ZUNDAF) (2012-2015) 	<ul style="list-style-type: none"> • Zimbabwe Health Sector Investment Opportunities • The Health Transition Fund (2011-2015) • National Health Strategy (2009-2013) 	<ul style="list-style-type: none"> • The Zimbabwe Health Sector Investment Case (2010 – 2012) • Getting the Zimbabwe Health Care System Moving Again- Health Action Plan for the first 100 days – March to June 2009 • Consolidated Appeal Process (CAP) (2011)

The policies that provided little guidance on health recovery interventions are those that did not have a strong health recovery thrust. For instance, the Medium Term Plan (2011-2015) and Short Term Emergency Recovery Programme (STERP 1 and 2) that focus on economic recovery. The Joint Recovery Opportunities Framework 2010 (JROF) refers to health recovery in a cursory way by just listing the affected health blocks while the ZUNDAF (2012-2015) provides a broad country framework. The moderate guiding policies had a focus on health issues not necessarily targeted at health recovery but on other health aspects. The Health Transition Fund (2011-2015) focus is on health fundraising, the Zimbabwe Health Sector Investment Opportunities rudimentarily suggests health investment opportunities without delving into guiding detail, while the National Health Strategy’s (2009-2013) scope is on broad health issues.

However, the significantly detailed guiding policies had different focus in their formulations. The Zimbabwe Health Sector Investment Case (2010 – 2012) outlined gaps and responsive interventions to address the identified gaps. Getting the Zimbabwe Health Care System Moving Again- Health Action Plan for the first 100 days (March to June 2009) policy was aimed at a quick responsive acceleration of critical health humanitarian interventions. The CAP (2011) outlined health recovery interventions that fell into three categories focusing on reducing morbidity and mortality of mothers and

their newborns, increasing the availability of vital drugs by strengthening the district drug management systems, and contributing to reduction in excess morbidity and mortality.

All the above policies, albeit with different emphasis, indicate that Zimbabwe health system require interventions that buttress health recovery. The Zimbabwe Health Transition Fund (HTF) (2011:9), ZUNDAF (2011:13), JROF (2010: 14), The Investment Case (2010) and the rest of the other policies identify health recovery interventions focusing on human resources (recruitment), ensuring drug provision to hospitals and clinics, building capacity of national pharmaceutical company (NatPharm), and restoring functional infrastructure at all central hospitals. However, with the exception of CAP (2011), particular details to guide recovery interventions was lacking.

An important observation that can be made on the policies also is that they are numerous, repetitive and often have duplicate information. Stated differently, the policies are confusing and sometimes lack clarity for health actors to be clearly guided. Arguably though, the apparent confusion and fuzziness is common during rehabilitation phase. However, of concern is the lack of clarity on health recovery guidance at policy level. Buchanan-Smith and Maxwell (1994:14) and Büttner (2008:3) advise that what is needed to ensure effective rehabilitation is a common understanding of how LRRD is to be achieved, shared by all actors involved. There has to be a shared understanding between actors on objectives, procedures, time frames, partners, and types of interventions that characterise rehabilitation, which seem to lack in the majority of the Zimbabwe policies. WHO (2011:12) clearly indicates that health recovery process must be guided by a strategy and plans (policy) that are integrated into existing national, regional and district plans as well as outline a strategy and implementation plans that are detailed.

Furthermore, according to WHO (2011:6), the three objectives of health recovery (rehabilitation) are to augment emergency health programmes and ensure that their inputs become long-term assets; second, strengthen health systems; and third, establish foundation for long-term development of the health system. The health system building blocks that get affected in a health crisis are leadership and governance,

human resources, information, medicines and technologies, service delivery and financing. However, while some of the policies attempted to develop guidance based on the WHO (2011) health recovery framework, some seem to hugely miss the mark. For instance, leadership and governance are critical pieces in health recovery and yet the policies are silent on the issue. Thus Shamu (2012:1) observed that, the policies do not spell out how the high political risk premium will be dealt with and yet leadership and governance is a critical facilitatory factor. Chitambara (2011:1-2) added that governance and the high political risk premium is the millstone around the Zimbabwean economy's neck that will arguably derail health recovery.

Thus while the policy prescriptions to guide health recovery to a considerable extent resulted to halting the health crisis and lurching the health situation to a recovery phase, much more harmonised policies could have resulted to better coordination and clearer guidance to health actors.

6.3.2 Study objective 2: Analyse health development and humanitarian interventions implemented during the 2009 to 2011 period to determine development and humanitarian needs constituting health rehabilitation




6.3.2.1 Health recovery interventions and relevance to health recovery

Rehabilitation (recovery) is the restoration and improvement of facilities and systems, livelihoods and living conditions of disaster-affected communities, including efforts to reduce disaster risk factors (WHO 2011:9; OCHA 2008:9; OCHA 2012). WHO (2008a:5) advises that recovery interventions should focus on restoring the capacity of the government and communities to rebuild and recover from crisis and prevention of relapses. Accordingly, recovery interventions seek not only to catalyse sustainable development activities but also to build upon earlier humanitarian programmes to ensure that their inputs become assets for development. WHO (2008b:4) states that after health disaster or crisis (humanitarian), the health sector focuses on reducing morbidity and mortality through a set of appropriate health services, primarily guided by the well-known humanitarian principles of humanity and impartiality. In these situations, rapid humanitarian interventions are needed.

In view of the above guidelines, it is imperative to probe the extent to which the Zimbabwe health interventions fit under the above framework. During the period between 2009 and 2011, various health recovery interventions were implemented by health players (figure 6.5 and figure 6.6). They included coordination of health players, formation and resuscitation of WASH, rehabilitation of boreholes, equipping of health facilities, training of nurses and other health workers, financing of recovery activities by donors, refurbishment of health facilities, procurement of medical equipment, rehabilitating communication system, water quality system improvement, providing information, education and communication (IEC) material, providing medicines and technologies, and interventions to address poverty and malnutrition.

Notably, some of the above interventions were aimed at addressing the health crisis (humanitarian) while others were more at a health recovery phase. WHO (2008b:5) advised that during health humanitarian situation there is need to carry out activities aimed at protecting lives and reducing disease, malnutrition and disability; and setting the foundations for strengthening the national capacity to pursue long-term health related development goals. These activities however, overlap in the recovery phase. At the point of health collapse leading to health crisis (humanitarian) in Zimbabwe, the health system was not performing to a level that would enable it to address the country's burden of disease leading to many outbreaks. Therefore, interventions were supposed to focus on re-establishment of disrupted health system by implementing interventions that rebuild health blocks that were affected. The three distinct phases of health LRRD that Zimbabwe health recovery interventions should align are indicated below (Table 6.6).

Table 6.6: Health LRRD phases that interventions should fall under

	Health humanitarian	Health recovery (rehabilitation)	Health development
Description of health LRRD phase (stage)	<ul style="list-style-type: none"> Near collapse of the health sector due to severe deterioration in infrastructure, lack of investment, low wages, decreasing motivation and capacity of the civil service and absolute shortage of essential supplies and commodities as in Zimbabwe late 2008 and early 2009. 	<ul style="list-style-type: none"> Focus is on improving situation to mitigate risks and enhancing preparedness so that the improvement path is sustained and if humanitarian situations arise there will be swift response (2010-onwards). 	<ul style="list-style-type: none"> Investment in health is embedded in broader development planning and long-term needs.
			
Implemented health recovery interventions matching with health LRRD phase	<ul style="list-style-type: none"> Coordination of health players Formation and resuscitation of WASH Rehabilitation of boreholes Equipping of health facilities Training of nurses and other health workers Financing of recovery activities by donors Refurbishment of health facilities Procurement of medical equipment Rehabilitating communication system Water quality system improvement Providing information Education and communication (IEC) material Providing medicines and technologies Interventions to address poverty and malnutrition 	<ul style="list-style-type: none"> Coordination of health players Formation and resuscitation of WASH Rehabilitation of boreholes Equipping of health facilities Training of nurses and other health workers Financing of recovery activities by donors Refurbishment of health facilities Procurement of medical equipment Rehabilitating communication system Water quality system improvement Providing information Education and communication (IEC) material Providing medicines and technologies Interventions to address poverty and malnutrition 	<ul style="list-style-type: none"> Coordination of health players Education and communication (IEC) material Interventions to address poverty and malnutrition

The health interventions implemented to address the health disaster (humanitarian) and health recovery (rehabilitation) above indicated that the interventions at the two phases overlap. The above scenario corroborate with WHO (2008a:5) that there is no clear-cut boundary between the health relief and health recovery. It should be noted that the disaster management cycle is an unbroken chain of human actions whose phases overlap. Thus, Buchanan-Smith and Fabbri (2005:5) and Macrae and Harmer (2003:4) commenting on rehabilitation (recovery phase), concur that there is a blurred and unbroken chain between humanitarian and recovery phases, which led to the rejection of the “continuum” model and coining of the term “contiguum” model. A contiguum model captures the complex nature of rehabilitation (recovery) middle ground between humanitarian and development.

6.3.2.2 Health recovery interventions implemented and alignment to health system blocks

WHO (2011:8) spells out the three objectives of health recovery (rehabilitation) as follows; first, to augment emergency health programmes and ensure that their inputs become long-term assets; second, strengthen health systems; and third, establish foundation for long-term development of the health system. The health system building blocks that get affected in a health crisis are leadership and governance, human resources, information, medicines and technologies, service delivery and financing. Health disasters such as the one experienced in Zimbabwe impacted on the building blocks of the health system. Accordingly, early health recovery (rehabilitation) interventions should fall into the six health systems categories (WHO 2008b: 13-21). Table 6.1 outlines the implemented health recovery interventions aligned to health system blocks.

The intervention addressing leadership and governance block focused on coordination of health actors. The coordination was done by WHO through the Health Cluster. According to WHO (2008b: 13-21), effective leadership and governance plays a key role in building capacity of health staff, coordinating and formulating health policies and strategies, coordinating health stakeholders, providing health plans and management at

provincial and district levels. These functions were neglected during the period of health collapse in Zimbabwe. At the time of the health crisis coordination of health stakeholders had ceased, health planning and management at provincial and district levels was almost non-existent. There was also a policy vacuum as the National Health Strategy (1997 – 2007) had come to an end and there were no resources to develop a successor policy, which was later finalised in 2009/10 period, “the 2009-2013 National Health Strategy”. District Medical Officers and health coordinating officials were hardly visiting health care centres to monitor and provide the needed support.

While coordination was effectively done by the Health Cluster coordinator, there were persistent constraints on implementing leadership interventions. For instance, policies and strategies albeit numerous, they lacked clear guidance. At the same time, capacity building initiatives were too short and had no sustained funding support. Thus leadership and governance was subdued.

With regards to health information, the situation at the period of the health crisis was deplorable. Health information is important in putting together a sound information system and mainstream epidemiologic surveillance and early warning systems (WHO 2011). The collapse of the health system seriously affected health information. Production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status were severely compromised. The majority of health staff responsible for data and information monitoring had resigned. Radio and communication infrastructure that was placed in some health care facilities for information coordination had broken down. Thus the generation of strategic information for intelligence epidemiologic surveillance and early warning systems, which is an integral part of health management, was severely curtailed.

To address the situation, policy stipulation focused on improvement of health monitoring and evaluation, health information as well as facilitating health communication. The implemented interventions included rehabilitating communication system, provision of information, providing education and communication (IEC) material.

Human resources health system block entails management of health worker stock, planning for human resources, training of health staff and financial support of human resources. At the peak of the Zimbabwe health crisis in 2008, many health staff personnel had abandoned their stations. Significant majority of health staff had immigrated while some opted to stay at home since their monthly salary could not cover transport expenses for a month. Health recovery interventions therefore focused on health worker retention, training of nurses and other health workers on various health issues and diseases. Training was also conducted on communities concerning disaster risk management. However, while the situation resulted to some improvement on the health situation, there were still high unfilled posts (HTF 2011:19).

Health financing was one of the most affected health block. During the health crisis period financing was hamstrung by many factors. These included poor public financing, lack of external funding assistance, unaffordable user fees, inability to forecast future health resource needs and destructive financial policies. Furthermore, there was insignificant contribution from the fiscus to support health care. There was very little revenue collected to support health care as the economy was almost at a standstill with companies closing daily. Health financing block deals with external funding assistance, future resource envelope and user fees. The financing of recovery activities was done by donors in Zimbabwe (HTF 2011:18). The donors funded various interventions linked to health recovery activities.

Medical products, vaccines and technologies deal with factors that impede drug supply and other medical products. Access to essential medical products, vaccines and technologies of assured quality is critical for health delivery. Zimbabwe experienced huge drug shortages during the period of health deterioration. Immunisation was no longer effectively done in public health institutions, which led to outbreaks such as measles. To address the situation, various health players were allowed to procure medication to complement government stocks.

During the period 2007 to 2008 health services were severely compromised. Hospital infrastructure had dilapidated and the environment and logistics was poor. The health network had collapsed. The referral system was severely hampered by transport costs. People struggled to access health services. However, a good and functional health system provides effective, safe and quality health interventions to those who require them. To respond to the situation diverse interventions were implemented (see figure 6.5 and 6.6).

From the above discussion, there is considerable evidence that the implemented health interventions were aligned to health system pillars. However, effectiveness of the recovery interventions remained varied.

6.3.3 Objective 3: Analyse health actors' interventions to determine their focus on health rehabilitation

The study revealed that donors provided funding for rehabilitation activities. The funding came in two ways namely direct activity financing and providing subsidies for patients. WHO and UNOCHA together with MoH&CW provided coordination. Furthermore, WHO and UNOCHA provided funding for health emergency. At policy level, MoH&CW provided medical products, policy direction, capacity building of implementing staff such as nurses and refurbishment of some health facilities and improvement of water quality system. At implementation level, nursing and other frontline MoH&CW staff implemented interventions that were aimed at improving health facilities. These included installing communication radios for surveillance, health facility infrastructure improvements, water quality system improvement. The health staff were also involved in sharing preventive community information. NGOs on the other hand were involved in improving prevention facilities for communities. These included health facility infrastructure improvements, water quality system improvement, and installation of communication radios. In addition, NGOs implemented community preventive outreach activities that included community information sharing. Together with MoH&CW some NGOs were involved in training health care staff. NGOs also implemented

comprehensive health interventions that included social challenges such as gender based violence and livelihoods.

An observation made from the actors' involvement in implementing activities was that their roles overlapped. For instance, MoH&CW, WHO and UNOCHA coordinated activities. At the same time UNOCHA through CERF also provided funding like a donor. NGOs and MoH&CW implementing staff were involved in community outreach and information sharing. Therefore, this situation caused some confusion. During implementation of recovery interventions there was some degree of confusion among actors. For instance, the implementing partners at some stage were reporting conflicting information from similar districts. They were not discussing with each other. The situation was later addressed through the WHO Health Cluster coordination platform where all implemented activities were mapped and all actors' roles noted and described. This resulted to harmonised reporting and clear tracking of recovery interventions. While confusion is to some considerable extent inevitable during LRRD activities, a clear roadmap and guidance should have been mapped (Buchanan-Smith and Maxwell 1994; Büttner 2008).

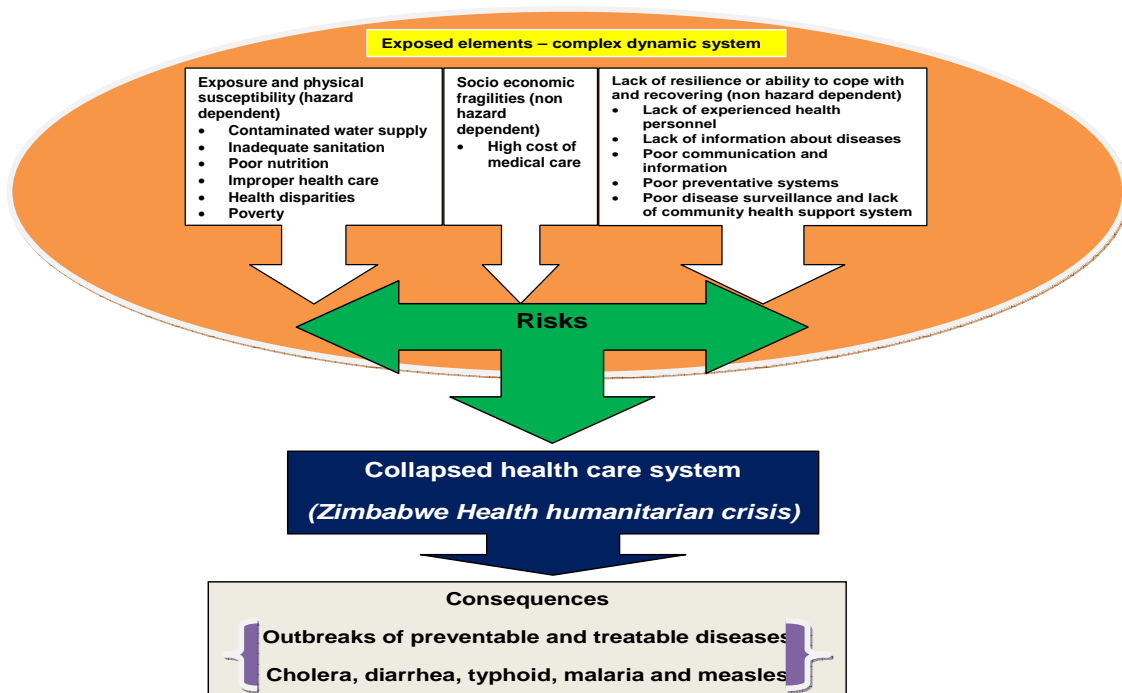
6.3.4 Study objective 4: Determine the common elements that characterised Zimbabwe's 2009-2011 health rehabilitation as well as discern a shared understanding of the same.

The above sections presented results of some factors that exposed, as well as made communities physically susceptible to health hazards, socio economic fragilities that conspired to fan health crisis, factors that weakened communities' resilience or ability to cope with and recover from various diseases. These factors interplayed to contribute to health crisis. The physical susceptibility factors included contaminated water supply, inadequate sanitation, poor nutrition, poor health care, health disparities, poverty, high cost of medical care, lack of experienced health personnel, lack of information about diseases, poor preventative systems, poor disease surveillance and lack of community health support system. Environmental factors included not having toilets or latrines, unsafe water sources, poorly working boreholes, and uncovered sewage in the streets.

Communities also had limited access to health care due to poor and high transport costs, long distance to hospitals, and high drug costs. Poor communication and information about disease outbreaks and poor disease education also contributed. Socio economic fragilities were largely caused poor governance and poor severe economic decline. The health risks and resultant consequences of the above situation was a total collapse of the Zimbabwe health care system. The collapse of Zimbabwe as a country and consequently the health system was described as unprecedented for a country not at war (Mlambo and Raftopoulos, 2010:4). The consequence of the collapse was massive outbreaks of preventable and treatable disease across the country such as cholera, diarrhoea, typhoid, malaria and measles. The cholera killed more than 4,000 people of the 98,000 that were affected rendering it the largest cholera outbreak in Africa for 15 years (Zingoni 2010:1).

The link between the vulnerability exposed elements of the complex dynamic system of the holistic approach to risk and vulnerability framework applied to the Zimbabwe health system described above is summarised in the diagram below (figure 6.15).

Figure 6.15 Interplay of health disaster causes and predisposing causes



Health rehabilitation response to the above situation meant that the health system should have an actuation system that comprise of risk identification, risk reduction, disaster management and risk transfer, as well as corrective actions. The suitability of a health disaster management system is measured by indices that are composed of four factors estimating capacity related to risk identification, risk reduction, disaster management and financial protection (Roxana, et al, 2013:14). Accordingly, therefore, respondents asserted that the four common characteristics of rehabilitation interventions should satisfy the following criteria; reduce exposure and physical susceptibility (risk reduction), address socio economic fragilities, improve people's resilience to health hazards, and address health destructive systemic factors.

Roxana, et al (2013:14) suggests that a disaster risk management system and an actuation system should be viewed as having three dimensions. The first dimension is purely disaster responsive. This deals with corrective actions in terms of stopping the disaster (humanitarian). The second dimension is disaster preparedness in case similar or related disasters occur in short or long-term future (LRRD). The third dimension is preparation to lurch the people or communities to long term stable and sustainable path (developmental state). The UN Humanitarian guidelines Article 159, describes the situation succinctly as follows; where emergency situations arise, rapid provision of humanitarian assistance by the international community remains imperative. However, this form of assistance must be planned with a view to an equally rapid transition to rehabilitation and reconstruction (rehabilitation) and be part of the continuum concept which aims at resuming development (development state) at the earliest opportunity.

Thus health recovery, like any other LRRD situation, can only be understood against a background of health humanitarian situation. During a health humanitarian situation there is need to carry out activities aimed at protecting lives and reducing disease, malnutrition and disability; and setting the foundations for strengthening the national capacity to pursue long-term health related development goals. These activities overlap in the recovery phase. Challenges emerging during transition situations should be addressed strategically in order to minimise the deterioration of health services, enable

the introduction of initiatives for the recovery of health systems, and allow for a smooth transition with the reconstruction and development phase (WHO 2008b:5). The three objectives of health recovery (rehabilitation) that are summed up by the LRRD framework are; first, to augment emergency health programmes and ensure that their inputs become long-term assets; second, strengthen health systems; and third, establish foundation for long-term development of the health system (WHO 2011:3).

From the above discussion, it is clear that the respondents' comments during interviews unanimously revealed that the common thread across all development actors is that rehabilitation interventions should satisfy reduction of exposure and physical susceptibility (risk reduction), address socio economic fragilities, improve people's resilience to health hazards, and address health destructive systemic factors. These comments indicate that interventions should focus on stopping the disaster (humanitarian), prepare communities in case similar or related disasters occur in short or long-term future (LRRD) as well as prepare communities for long term stable and sustainable health development.

However, notwithstanding the focus on preparing people for long term health development through addressing socio – economic fragilities, this area was poorly attended. Governance and leadership in health is an area that was poorly done as government leaders fought for political survival. The situation resulted to the socio-economic situation to support health issues remaining very low. Health financing remained far below 10% against the Abuja Declaration of 15% budget investment in health. Thus while the basic shared characteristics of health rehabilitation were identified by development actors to mark a shared and agreed framework, effective and thorough implementation of the interventions was not very satisfactory.

6.3.5 Summary discussion on objectives 1 to 4

The factors that caused health disaster (crisis) were identified as contaminated water supply sources, inadequate sanitation, poor nutrition, improper health care, health

disparities and poverty. The magnitude of contribution of each factor to health disaster is indicated in figure 6.7. The predisposing factors that exacerbated health disaster included socio economic fragility, lack of experienced health personnel, lack of information about the disease, poor preventative systems, poor disease surveillance and lack of community health support system (figure 6.8). The causal and predisposal factors interplayed to cause health disaster (figure 6.15). Importantly therefore, interventions to address the health disaster should aim to holistically respond to these integrated factors.

In view of the various factors that interplayed to cause health disaster, interventions should target these multifaceted factors. The interventions should strive to meet the following three critical of health recovery. First, mitigation of health humanitarian situation; second, prepare disaster affected communities to improve from their prevailing condition; and third, prepare communities to avoid future health vulnerabilities and risks that disposed them to health disaster (WHO 2011:6). Understandably, therefore, with health recovery as a midpoint within the health LRRD contiguum chain, the interventions should respond to humanitarian needs but at the same time ensuring that a foundation for long term health development is laid while existing health recovery needs are adequately attended. Moore (2010), Buchanan-Smith and Paula (2005), Büttner (2008) de Armiño (2002), Macrae and Harmer (2003), and others summed the LRRD situation thus “better ‘development’ should reduce the need for emergency relief; better ‘relief’ should contribute to development; and better ‘rehabilitation’ should ease the transition between the two”. Thus the three objectives of health recovery (rehabilitation) are summed up as: first, to augment emergency health programmes and ensure that their inputs become long-term assets; second, strengthen health systems; and third, establish foundation for long-term development of the health system (WHO 2011:6). The indication in the HTF (2011) that investment in health recovery needs should be embedded in broader health development planning and long term health needs agrees with above LRRD position.

From the implemented interventions above, the factors that caused and predisposed communities to health disaster were addressed by relevant corresponding interventions (Table 6.2). However, the appropriateness of each response intervention in addressing health disaster cause varied. The variations were clearly revealed by the indication of intervention appropriateness from respondents (Table 6.2). At the same time, the effectiveness of health interventions in preparing communities to progress from humanitarian to recovery also varied (figure 6.14). Similarly, interventions' effectiveness in preparing communities to progress from humanitarian to recovery differed (6.10). The extent to which interventions effectively prepared communities to avoid future health disaster also showed variations ranging from least, moderate and highly effective.

The results indicated that Zimbabwe health system is indeed in a recovery mode with various corrective actions undertaken to address the health disaster. However, the question is: considering the various health recovery (LRRD) interventions implemented by the various actors above, to what extent do these activities satisfy the criteria for effective health recovery (LRRD) namely that "better 'development' can reduce the need for emergency relief; better 'relief' can contribute to development; and better 'rehabilitation' can ease the transition between development and relief? With particular reference to health recovery, the question could be restated as follows: to what extent did Zimbabwe health interventions (1) fostered 'health development' that reduced the need for future health emergency; (2) focused on 'health relief' that contributed to health development; and (3) 'rehabilitated' health care in a way that eased the transition between health development and relief.

A response to the above question is complex. Advising on health recovery (rehabilitation), WHO (2011:3) states that health recovery is a complex and multidimensional process. The process begins in a humanitarian setting. The process is guided by development principles that seek to build on humanitarian programmes and catalyse sustainable development opportunities. It aims to generate self sustaining, nationally owned, resilient processes for post crisis recovery. It encompasses the

restoration of basic services, livelihoods, shelter, governance, security and rule of law, environment and social dimensions, including the reintegration of displaced populations.

The advice of WHO is useful and worth considering concerning the Zimbabwe health recovery situation. The complexity and multidimensionality of health recovery is clearly evident in Zimbabwe. A synopsis of the state of the country health recovery situation provided by the above results and more particularly by Health Cluster workshop held on 09 October 2012 about Humanitarian Appeal, provided a revealing summary. The workshop notes reported many successes that had been realised but with clear humanitarian needs;

There is robust and concerted response effort to the disaster as typified by typhoid outbreak in Harare, Chitungwiza and other parts of the country. There is multi-partner support provided to City Of Harare, Chitungwiza and MoH&CW. There is weekly epidemiological updates by the health cluster, on-going capacity building of districts (20 districts and 99 participants trained in RRT, 25 districts and 67 participants trained in Case Management, Environmental Health Alliance (EHA) weekly monitoring of outbreak response, and Joint MoH&CW, WHO, EHA and ECHO risk assessment of the cholera outbreak. The National Emergency Operations Centre in MoH&CW was launched on 15 May although it still needs SOPs, staff and dedicated funding. This progress should be understood against further achievements scored by the Health Cluster and MoH&CW in health disaster mitigation (Health Cluster workshop notes, 09 October 2012).

Notwithstanding the above achievements and successes that clearly indicated that Zimbabwe was on a recovery path, significant outbreaks of communicable diseases still occurred with predictable seasonality. These included diarrhoeal diseases (cholera, dysentery, rotavirus); typhoid; malaria, and others. Water and sanitation infrastructure (and provision) in urban areas was still poor. There were still outbreaks in Harare, Chitungwiza, Bindura, Chiredzi, Zvimba, Kadoma by end 2012. Furthermore, food

insecurity in some parts of the country, coupled with high rates of diarrhoea and other infections still predisposed population to development of acute malnutrition. HIV prevalence in adult population was still high at 15% (2010 - 11 ZDHS), increasing population vulnerability to effects of disease outbreaks and malnutrition. Government allocation to health in 2012 was about 9% of total budget while the ideal is 15%, according to Abuja declaration (Health Cluster minutes 2011).

Focus group discussions and interview respondents indicated that while Zimbabwe was out of a health crisis, but the path to development state still appeared like a big mirage. There was still evidence of weak health system areas. Responses indicated that there was still abnormally high doctor –patient ratio, high nurse-patient ratio, hurdles and high costs in accessing medical services despite the Health Transition Fund (2011), delays in delivery of basic medicines in rural clinics, low level community engagement as there is currently one Village Health Care per 100 families thereby rendering the cadre ineffective. The communication radios that were provided are no longer functional. Responses on the question of suitability of health care to lurch the health system to development state clearly showed distrust of the state of the health care.

The notes from Health Cluster workshop held on 09 October 2012 cited earlier corroborate responses from NGOs implementing health recovery activities that funding was also a huge constraint being experienced during the recovery phase. The notes indicate that there was no dedicated funding for cluster coordination since March 2011. There was also a diminishing role of the Health Cluster in recovery activities due to a lack of interest in the unclearly defined recovery activities. Health system is still challenged with resource constraints mainly finances, human resources, commodity supplies, and old infrastructure. Interview responses revealed that poor financial support in recovery phase is a common phenomenon. Because recovery (LRRD) is a confusing phase that could neither be aligned to humanitarian nor development, donors struggle to identify and align themselves with LRRD phase. While the meaning of development may be contested compared to the meaning of humanitarian, these two phases are well funded while rehabilitation (recovery) tends to be poorly funded (Good Humanitarian Donorship 2013:1).

The above discussion thus revealed that while efforts were made and achievements scored in responding to the causes of health disaster, progress in lurching the health situation from a health crisis situation to health recovery (rehabilitation) phase was marred with instability and significant relapses back to health crisis situation (humanitarian). This on the one hand fits contiguous situation but the interventions could have been better coordinated. There seemed to be poor coordination as evidence from confusing plethora of health recovery policies.

6.4 Conclusion (summary chapter discussion and findings)

The data presentation and discussion above indicated that Zimbabwe health system is on a recovery path. The results showed that the entire health system had generally collapsed which resulted to a health crisis but responsive interventions were implemented to address the situation.

The underlying factors that made Zimbabwean communities lack ability to cope with and recover from various diseases which caused health disaster (health humanitarian crisis) were contaminated water supply, inadequate sanitation, poor nutrition, poor health care, health disparities, poverty, high cost of medical care, lack of experienced health personnel, lack of information about diseases, poor preventative systems, poor disease surveillance and lack of community health support system. From an environmental perspective (no toilets or latrines, lack of safe water/no working boreholes, sewage in the streets); from perspective of limited access to health care (lack of transport/ distance to hospital, high drug cost); lack of use of Oral Rehydration Solution (ORS) in the communities; from perspective of limited resources, not enough supplies/beds/resources at health centres; lack of communication and information about disease outbreaks; and lack of education, fear of person with cholera and stigma, cultural practices (burial and handshakes). The health risks and resultant consequences of the above sorry state was a total collapse of the Zimbabwe health care system. This led to massive outbreaks of preventable and treatable disease across the country such as cholera, diarrhoea, typhoid, malaria and measles.

The response actions included effective coordination by the Health Cluster, WASH interventions, training of health care staff, providing health financing subsidies, health facility infrastructure improvements, provision of medical equipment, installing communication radios for surveillance, water quality system improvement, community information, education and communication (IEC), providing holistic health responses that includes survivors of sexual violence and livelihoods, and interventions targeting poverty.

The results and discussion also revealed that despite the corrective interventions' successes that indicate that the country is on a recovery path, there were still residual humanitarian issues that required attention. Thus while Zimbabwe may have been out of a health crisis, the path to health development state still remained far away. There was still evidence of weak health system areas such as abnormally high doctor –patient ratio, high nurse-patient ratio, hurdles and high costs in accessing medical services despite the Health Transition Fund (2011), delays in delivery of basic medicines in rural clinics, low level community engagement as there is currently one Village Health Care per household thereby rendering the cadre ineffective. The radios that were provided are no longer functional.

Having noted that Zimbabwe is in a health recovery (LRRD) state, the question to be asked, to which we will turn to in the next chapter, which is the conclusion is: to what extent did the health LRRD interventions (1) fostered 'health development' that reduced the need for future health emergency; (2) focused on 'health relief' that contributed to health development; and (3) 'rehabilitated' health care in a way that eased the transition between health development and relief?

CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

The previous chapter presented, analysed and discussed the findings of the study results from the policy documents reviewed and primary research data collected through interviews, focus group discussions and reviewed documents. Based on the study findings, this chapter draws conclusions and proposes recommendations on the topic studied. The chapter brings to a sharp focus the response to the research study question namely: to what extent did the health LRRD interventions (1) fostered 'health development' that reduced the need for future health emergency; (2) focused on 'health relief' that contributed to health development; and (3) 'rehabilitated' health care in a way that eased the transition between health development and relief? Thus in responding to the study question, the study objective was answered. The study objective was to determine the health rehabilitation interventions employed by health development actors between 2009 and 2011 in Zimbabwe and ascertaining the extent to which the interventions met criteria for effective health rehabilitation (recovery).

7.2 Conclusions

This section draws conclusions on the study objectives. It highlights conclusions on the four individual sub objectives that contributed to answering the main study objective indicated above (7.1).

7.2.1 Study objective 1 - Analyse health policy positions developed to address health recovery (rehabilitation) needs between 2009 to 2011

This objective focused on analysing health policies developed to address health recovery (rehabilitation) needs during the period from 2009 to 2011. The study revealed that there are at least ten policies including guiding documents that were developed to guide health recovery in Zimbabwe between 2009 and 2011. The policies vary in content and detail regarding their guidance on health recovery interventions, but only three of the policies have informative detail to guide interventions. These are the Zimbabwe Health Sector Investment Case (2010 – 2012), Getting the Zimbabwe Health

Care System Moving Again- Health Action Plan for the first 100 days – March to June 2009, and Consolidated Appeal Process (CAP) (2011) (see Table 6.3). Five of the policies had very little guiding information while three contained moderate guidance. Importantly, however, it has been noted with concern that despite having very few (three) policies that had detailed guidance on health recovery interventions, those three lacked a clear matrix and indicators to measure progress except one (Getting the Zimbabwe Health Care System Moving Again- Health Action Plan for the first 100 days – March to June 2009). The Zimbabwe Health Sector Investment Case (2010 – 2012) and Consolidated Appeal Process (CAP) (2011) outline the activities in some detail but they have no indicators of success (see figure 6.5 for health recovery policies stipulated by policies). In addition, the study revealed that the policies were too many, repetitive and with duplicate information. Worryingly, the majority (more than 90%) lack substantial useful detail. It is not surprising therefore that sanity and coordinated interventions were championed by the WHO Health Coordination office while actors lacked clear coordination particularly from government. This situation was regrettable and of great concern. The policy “Getting the Zimbabwe Health Care System Moving Again- Health Action Plan for the first 100 days – March to June 2009” was developed by MoH&CW during the Government of National Unity (GNU) for a short period through the services of a consultant. WHO coordination office interacted with this policy document to inform its coordination activities. However, the gap was that such a useful and focused policy with detailed guidelines was not extended to cover a longer period or at least have a successor policy developed after the short time elapsed.

7.2.2 Study objective 2 - Analyse development and humanitarian interventions implemented during the 2009 to 2011 period to determine development and humanitarian needs constituting health rehabilitation

The focus of this objective was analysing development and humanitarian interventions implemented during the 2009 to 2011 period to determine development and humanitarian needs constituting health rehabilitation (recovery). The study revealed that the health recovery interventions implemented by the health actors to address the health crisis were coordination of health players, formation and resuscitation of WASH,

rehabilitation of boreholes, equipping of health facilities, training of nurses and other health workers, financing of recovery activities by donors, refurbishment of health facilities, procurement of medical equipment, rehabilitating communication system, water quality system improvement, provision of information, education and communication (IEC) material, providing medicines and technologies, and interventions to address poverty and malnutrition. As typical recovery interventions, the activities attempted to address the factors that caused health disaster and the factors that disposed communities to health disaster. The causes and interventions are indicated on the table above (table 6.2).

The study revealed that some of the interventions above were aimed at addressing the health crisis (humanitarian) while others were aimed more at a health recovery phase. The activities however, overlapped. Thirteen of the sixteen interventions implemented (figure 6.6) overlapped between humanitarian (health crisis) and health recovery (rehabilitation) while only three seemed to have a long term health development focus. The interventions clearly indicate that at the point of health collapse leading to health crisis (humanitarian), the health system was not performing to a level that would enable it to address the country's burden of disease leading to many outbreaks. Therefore, interventions were supposed to focus on re-establishment of disrupted health system by implementing interventions that rebuild health blocks that were affected. However, in doing so, recovery interventions should be implemented to consolidate the humanitarian interventions but at the same time implementing rehabilitation activities as well as beginning a process to lurch the health system to development phase (figure 6.6). This resulted to the overlap of interventions between humanitarian and recovery interventions (thirteen out of the sixteen interventions overlapped). Thus according to health recovery, this situation is important so that activities protect lives and reduce disease (that is, humanitarian), and at the same time setting the foundations for strengthening the national capacity (that is, rehabilitation) to pursue long-term health related development goals (that is, development). Health development focused interventions were three out of sixteen..

The implemented interventions were to varying extents aligned to the health system building blocks (leadership and governance, human resources, information, medicines and technologies, service delivery and financing). Table 6.1 outlines the implemented health recovery interventions' alignment to health system blocks. The interventions addressing leadership and governance focused on coordination of health actors done by WHO through the Health Cluster. While effective leadership and governance plays a key role during health recovery, these functions seemed to be somewhat weak. At the time of the health crisis coordination of health stakeholders had ceased, health planning and management at provincial and district levels was almost non-existent. There was also a policy vacuum as the National Health Strategy (1997 – 2007) had come to an end and there were no resources to develop a successor policy, which was later finalised in 2009/10 period, "the 2009-2013 National Health Strategy".

While coordination was effectively done by the Health Cluster coordinator, there were persistent constraints on implementing leadership interventions. Policies and strategies did not contain sufficient detail. The study revealed that rehabilitation capacity building initiatives were short and had no sustained funding support. Health information continued to be weak due to unfilled posts of health staff responsible for data and information management. Radio and communication infrastructure that was placed in some health care facilities for information coordination had broken down.

Thus the study revealed that, at least sixteen health interventions were implemented to address the health crisis (humanitarian) and ensure that the health situation recovers (rehabilitation). Of the sixteen interventions implemented, thirteen overlapped between humanitarian and recovery (rehabilitation) phases while three had a developmental focus. The interventions were aligned to health building blocks but their effectiveness in addressing the needs of each block varied. The weakness in addressing some health blocks could have been the reasons for sporadic health humanitarian issues, which was

characterised by outbreaks. In summary therefore, while interventions could be clearly identified, their effectiveness remained a significant worry.

7.2.3 Study objective 3: Analyse health actors' interventions to determine their focus on health rehabilitation

The health actors' interventions varied and overlapped but interventions implemented by each actor were clearly discernible. The donors provided funding for rehabilitation activities. WHO and UNOCHA together with MoH&CW provided coordination. At policy level, MoH&CW provided medical products, policy direction, capacity building of implementing staff, and refurbished health facilities. At implementation level, nursing and other frontline MoH&CW staff implemented interventions that were aimed at improving health facilities. NGOs implemented community health information sharing as well as health facility infrastructure improvements, water quality system improvement, and installation of communication radios. While each health actor implemented particular focused rehabilitation interventions, there were overlaps. MoH&CW, WHO and UNOCHA coordinated activities. UNOCHA through CERF provided funding like a donors such as ECHO. NGOs and MoH&CW implementing staff were involved in community outreach and information sharing. This situation caused some confusion leading to conflicting reports and duplication. Experiences from the actors who implemented rehabilitation activities suggests that while an actor may have a particular area of focus, in times of disaster and rehabilitation the roles extend and flexibility is advised.

7.2.4 Study objective 4: Determine the common elements that characterised Zimbabwe's 2009-2011 health rehabilitation as well as discern a shared understanding of the same.

Objective four aimed to draw some common elements that characterised Zimbabwe's 2009-2011 health care rehabilitation phase as well as recommend a shared constructive understanding of the same. The study revealed that there are some factors that exposed as well as made communities physically susceptible to health hazards, socio economic fragilities that conspired to fan health crisis, factors that weakened

communities' resilience or ability to cope with and recover from various diseases. These factors interplayed to contribute to health crisis (figure 6.15). To address the above situation, diverse interventions were implemented with varying degrees of impact. The common thread that characterised health rehabilitation was a shared understanding across all development actors that rehabilitation interventions should satisfy the following criteria: reduce exposure and physical susceptibility (risk reduction), address socio economic fragilities, improve people's resilience to health hazards, and address health destructive systemic factors (figure 6.13). The various development actors implemented interventions that broadly fall under these four rehabilitation categories (figure 6.6; figure 6.13).

However, despite the encouraged focus to prepare people for long term health development through addressing socio – economic fragilities, this aspect was poorly addressed. Health financing from government remained far below 10% against the Abuja Declaration target of 15% budget investment in health. Nonetheless, the identified common features of health rehabilitation indicated that the interventions indeed fell within health LRRD framework whereby interventions should focus on stopping the health disaster (humanitarian), prepare communities in case similar or related health disasters occur in short or long-term future (LRRD) as well as prepare people for long term stable and sustainable health development. Thus while the basic shared characteristics of rehabilitation were identified by development actors to mark a shared and agreed framework, effective and thorough implementation of the interventions was not very satisfactory.

7.3 Overall study conclusion

This section makes a conclusion for the overall study. The conclusions from individual objectives above lead to the question of extent to which the Zimbabwe health rehabilitation interventions; (1) fostered 'health development' that reduced the need for future health emergency; (2) focused on 'health relief' that contributed to health development; and (3) 'rehabilitated' health care in a way that eased the transition between health development and relief. In responding to this main study question, the

overall study objective is answered. The main study objective was to determine the health rehabilitation interventions employed by health development actors between 2009 and 2011 in Zimbabwe and ascertaining the extent to which the interventions met criteria for effective health rehabilitation (recovery).

Clearly from the implemented interventions, Zimbabwe is on a recovery path. However, there were significant outbreaks of communicable diseases that still occurred with predictable seasonality in various parts of the country. These included diarrhoeal diseases (cholera, dysentery, rotavirus); typhoid; malaria, and others. Water and sanitation infrastructure (and provision) in urban areas was still poor. Government allocation to health by 2012 was about 9% of total budget while the ideal is 15%, according to Abuja declaration.

Thus while Zimbabwe was clearly out of a health crisis, the path to health development state still appeared to be distant. There was still evidence of weak health system areas such as abnormally high doctor –patient ratio, high nurse-patient ratio, hurdles and high costs in accessing medical services despite the Health Transition Fund (2011), delays in delivery of basic medicines in rural clinics, and low level community engagement. The communication radios that were provided were no longer functional.

The above situation therefore revealed that while efforts were made and achievements scored in responding to the causes of health disaster, progress of the health situation from a health crisis situation to health recovery (rehabilitation) phase was marred with instability and significant relapses back to health crisis situation (humanitarian). This on the one hand fits contiguum situation but the interventions could have been better coordinated. Thus while this fuzziness is characteristic of LRRD, a clear progress pathway needs to be agreed by all actors, which seemed to be a weak area in Zimbabwe health actors as evidenced by a plethora of overlapping and repetitive recovery policies.

7.4 Recommendations

(Objective 1)

- While the developed policies were necessary, useful and applicable to the Zimbabwe health recovery situation, their multiplicity made them confusing. Health recovery policies should be harmonised and integrated. They should be fewer in number – say, at most two. There is need to have one common policy framework rather than many that confuse actors.
- To the extent possible, in cases of health disaster such as the one experienced in Zimbabwe, MoH&CW (GoZ) should at least develop a particular health recovery (rehabilitation) policy that is separate and not integration with other recovery policies. This will ensure clear and detailed guidance.

(Objective 2)

- MoH&CW should take over the coordination processes and raise financial resources that address recovery issues. Efforts should be made among actors to provide resources to support the recovery processes to strengthen achievements of humanitarian to avoid relapse as well as prepare ground for health developmental phase. It is critical for the coordination responsibilities to be transferred to MoH&CW to ensure country ownership and build government coordination capacity for any future health disasters. Health crisis response and health recovery was being coordinated by WHO through the Health Cluster Coordinator. As a result the MoH&CW seemed reluctant to take over the coordination role.
- There is need to lobby donors to continue funding health recovery interventions to ensure that recovery interventions become a solid foundation for health development. With donors who provided most of health humanitarian funding stopping to fund health activities because they view the health situation to be no longer a crisis, there was a threat of relapse of the health system to a humanitarian situation. There was evidence of residual health humanitarian issues in Zimbabwe as evidenced by sporadic disease outbreaks.

(Objective 3) Development actors involved in health disaster should develop capacities within their systems to traverse the LRRD continuum. This will ensure flexibility, accommodation and integration with other actors in times of crisis.

(Objective 4)

- Health recovery interventions should respond to systemic health disaster causes of which leadership and socio economic effects are central. Leadership and health economic factors are critical enablers that should be targeted for effective health rehabilitation interventions.
- Health actors should make efforts to develop a common understanding or at least an appreciation of health LRRD as a preventive and preparatory measure to combat future health crisis.

7.4 Areas for further study

- LRRD as a subject is mostly studied in the context of serious conflict and natural disasters but least in social and economic disasters caused by poor governance and economic meltdown. Thus, enquiries into the understanding of the dynamics of disasters that arise due to poor governance needs to be further studied.
- With health decline in poorly governed countries not usually considered as a LRRD issue, it is worthwhile to consider further inquiry into health LRRD.

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ANNEXURE: DATA COLLECTION INSTRUMENTS

Questionnaire 1: Donors

1. What is your understanding of LRRD and rehabilitation/early recovery?
2. Which early recovery interventions did you fund more than others? What is the reason of providing more funding for this/these interventions?
3. In what ways and to what extent was the World Bank was involved in post crisis i.e. recovery in Zimbabwe?
4. From your determination to what extent (as a percentage) is Zimbabwe in humanitarian, recovery and development phases?

Questionnaire 2: UN Agencies

1. In what ways were the UN agencies were involved in LRRD/rehabilitation interventions in Zimbabwe?
2. In what ways were the UN agencies involved in health rehabilitation interventions in Zimbabwe?
3. To what extent has the health recovery process in Zimbabwe met the guidelines for a health recovery process? (Rating of each guideline)

Scale	Poor										Strong									
Health recovery guideline	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
i. Reduce the overall health worker vacancy levels																				
ii. Increase vital drug availability																				
iii. Improve availability and functionality of basic medical equipment & infrastructure																				
iv. Improve availability of reliable transportation and telecommunication systems																				
v. Reduce number of deaths due to epidemic prone diseases and natural disasters through increased access to safe drinking water and sanitation																				
vi. Mobilisation and efficient/effective use of resources																				
vii. Improved governance and management																				
viii. Each level of care providing package of basic services																				

4. What are the major challenges you experienced in the coordination of health recovery?

Questionnaire 3: GoZ (MoH&CW) - Policy makers and Managers

1. What health recovery interventions are being implemented/or have been implemented?
2. Which early recovery interventions have received more funding than others? What could be the reasons for such more funding support?
3. In what different ways are these interventions being implemented to ensure that similar challenges will not occur in the future?
4. Which aspects of the recovery process are more advanced than others that should be consolidated to long term development?
5. In what ways have the targeted humanitarian interventions contributed to long-term health development?
6. In what ways are the targeted rehabilitation/early recovery interventions being designed and implemented to ease the transition between humanitarian long-term health development?
7. In what ways are the targeted long term health development interventions reduce the need for emergency relief?
8. How are the identified and implemented health recovery interventions augment emergency health programmes and ensure that their inputs become long-term assets
9. In what ways are the identified and implemented health recovery interventions formed a foundation for long-term development of the health system?
10. From your experience and best of knowledge in implementing health recovery interventions, on a rating of 1 to 10, how have the interventions strengthened each of the following six health system building blocks that get affected in a health crisis:

Scale	Poor Strong									
Health recovery area	1	2	3	4	5	6	7	8	9	10
i. Leadership and governance										
ii. Human resources										
iii. Information										
iv. Medicines and technologies										
v. Service delivery										
vi. Financing										

11. How long do you foresee/envisage the recovery process to take?

12. Who are the donors who are financing health recovery in Zimbabwe?
13. From your determination to what extent (as a percentage) is Zimbabwe in humanitarian, recovery and development phases?
14. To what extent has the health recovery process in Zimbabwe met the guidelines for a health recovery process? (rating of each guideline)
15. What capacity building interventions did you receive between 2009 and 2011, and who provided it?
16. What capacity building interventions were done to MoHCW to strengthen its institutional and human capacity?
17. In what ways did the capacity building (above) address the underlying causes of the experienced health sector crisis to avoid future relapse?
18. What activities/interventions are being implemented to ensure health sector resilience?
19. What did the GoZ achieve from the Emergency Funding Request For Public Health Sector: Jan – Dec 2009.

Questionnaire 4: GoZ (MoH&CW) - Nursing staff

1. From your experience and best of knowledge in implementing health recovery interventions, on a rating of 1 to 10, how have the interventions strengthened each of the following six health system building blocks that get affected in a health crisis:

Scale	Poor										Strong									
Health recovery area	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
vii. Leadership and governance																				
viii. Human resources																				
ix. Information																				
x. Medicines and technologies																				
xi. Service delivery																				
xii. Financing																				

2. How long do you foresee/envisage the recovery process to take?
3. Who are the donors who are financing health recovery in Zimbabwe?
4. From your determination to what extent (as a percentage) is Zimbabwe in humanitarian, recovery and development phases?
5. To what extent has the health recovery process in Zimbabwe met the guidelines for a health recovery process? (rating of each guideline)
6. What capacity building interventions did you receive between 2009 and 2011, and who provided it?
7. What capacity building interventions were done to MoHCW to strengthen its institutional and human capacity?
8. In what ways did the capacity building (above) addresses the underlying causes of the experienced health sector crisis to avoid future relapse?
9. What activities/interventions are being implemented to ensure health sector resilience?

Questionnaire 5: NGOs

1. What are the NGO activities that were implemented to ensure health care resilience?
2. What capacity building interventions did you receive between 2009 and 2011, and who provided it?
3. From your experience and best of knowledge in implementing health recovery interventions, on a rating of 1 to 10, how have the interventions strengthened each of the following six health system building blocks that get affected in a health crisis:

Scale	Poor										Strong									
Health recovery area	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
i. Leadership and governance																				
ii. Human resources																				
iii. Information																				
iv. Medicines and technologies																				
v. Service delivery																				
vi. Financing																				

4. How long do you foresee/envisage the recovery process to take?
5. Who are the donors who are financing health recovery in Zimbabwe?
6. From your determination to what extent (as a percentage) is Zimbabwe in humanitarian, recovery and development phases?
7. To what extent has the health recovery process in Zimbabwe met the guidelines for a health recovery process? (rating of each guideline)
8. What capacity building interventions did you receive between 2009 and 2011, and who provided it?
9. What capacity building interventions were done to MoHCW to strengthen its institutional and human capacity?
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11. What activities/interventions are being implemented to ensure health sector resilience?