

Mission and State Health Institutions: “Invisible” Public-Private Partnerships in Zimbabwe, 1980–1999

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Abstract

This article argues that Zimbabwe’s independence in 1980 marked not the end of the missionary era, but its high point. Government’s poor rural health infrastructure forced it to partner missionary health institutions in order to run preventive health programmes and improve access to health services for the majority of the population. Mission health institutions formed the mainstay of rural African health care needs in the colonial period and continued to do so in the post-colonial period; with 97 clinics and 70 hospitals, and 13 of the country’s 42 designated district hospitals compared to 1 032—largely small and urban based—government, council and private health facilities. Mission health institutions were regulated by the Ministry of Health and were partly funded by the government. However, the significance of the mission health endeavour was overshadowed by an overarching government development agenda and narrative. This study establishes the nature and forms of public-private health partnerships in the development of Zimbabwe’s public health system and highlights the importance of the church’s healing mandate. It also refracts on church-state relations and the broader development and policy issues during the 1980s and 1990s.

Keywords: medical health; state; development; mission hospitals; partnership

Introduction

Zimbabwe’s independence in 1980 witnessed increased government responsibility in the provision of social services for the majority African population, who had been neglected under British colonial rule. In particular, education and health were key areas of government focus and agents for economic development. In line with the new policy changes, the government expanded existing infrastructure and increased capital investments in social



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services. However, government policy realignments and financial investment in key sectors of the economy engendered an overarching narrative that overshadowed the function of non-state actors in the development agenda (Agere 1990, 31–38). Indeed, under the government’s socialist experiment and populist policies of the 1980s, scholars analysed the development strategy largely within the confines of government programmes. This dominant narrative precluded a nuanced picture that characterised partnerships between government and other private players in achieving set targets. For example, the “invisible” nature of public-private partnerships in health during this period was at two levels. First, scholars overlooked the critical links between government and missionaries in the provision of public health, often giving credit to the former for gains that were made. In addition, contrary to Kendall’s 1978 book title, *End of an Era: Africa and the Missionary*, the role of missionaries was increasing towards the end of the twentieth century (Kendall 1978, 24). Secondly, the Zimbabwean government co-opted and treated its partners as juniors and this reinforced their “peripheral” status in the development process. In an environment marked by euphoria for independence and high expectation within the population, it was politically prudent for the government to be seen to be doing everything for the people. Although the government was clearly the single largest investor in social services, the history of Zimbabwe’s public health system will be incomplete without acknowledging the role of mission hospitals.

This study argues that public-private partnerships were key in the implementation of new policies and in understanding why the Zimbabwean public health delivery system significantly transformed in a space of a decade. Debates on the Zimbabwean socialist experiment of the 1980s have highlighted discrepancies in policy and execution. For example, scholars like Astrow and Mandaza illustrate how the post-independence Zimbabwean government accommodated capitalism while advancing a socialist rhetoric (Astrow 1983, 47; Mandaza 1986, 8). The government peddled the rhetoric of its unwavering commitment to providing free health care, yet in reality it lacked the financial and infrastructural capacity to carry this out. For example, government financial support for mission hospitals gradually declined in the late 1980s and even more so under the Structural Adjustment Programmes of the 1990s. This happened at a time when there was increased demand for health services on mission hospitals due to HIV/AIDS and other non-communicable diseases. In the 1990s, there was a marked urban-rural drift as urbanites sought cheaper health options, leaving the missions’ health facilities to assume a greater role in the provision of health care. To this extent, the government capitalised on the church missions’ social and spiritual obligation to provide healing to fashion a manipulative partnership with the church. The government-church partnership was not mutually beneficial because the government was unwilling to formalise its relationship with its “junior” partner, while making them shoulder an increasing burden in health provision without corresponding government financial assistance.

Contrary to the immediate post-independence period where literature on missionary activities dissipates, their role in the colonial health services has been fairly documented. Michael Gelfand and Chengetai Zvobgo chronicle the pioneering role of missionaries in Western medicine amongst Africans (Gelfand 1973, 1976, 1988; Zvobgo 1996, 3–23). In particular,

Gelfand highlights the ambivalent and secondary role of the colonial state, which was confined to administering the 1924 Public Health Act and the state grants to mission hospitals starting in 1927. Hallencreuntz and Moyo offer broader perspectives on church and state relations in Zimbabwe and how these developed from the colonial period into the first decade of independence (Hallencreuntz and Moyo 1988). Their work demonstrates that the state-church relationship was multi-faceted and not always amicable. Invariably, however, social services emerge as one of the strongest areas of cooperation. Analysis of the church as a development partner and moral campus of society re-emerges during Zimbabwe's post 2000 crisis. For example, Matikiti's Calvinist analysis of church-state relations concludes that the former has exercised a moral influence on the latter in Zimbabwe's democratic process (Matikiti 2009, 208). He further emphasises that church and state cannot develop in isolation from each other. Analysis of the "invisible" partnerships in health indicates that the two institutions have not only co-operated but were sometimes interdependent.

While it is true that the almost total collapse of government-provided health delivery in Zimbabwe in the post-2000 period paved the way to a "new" scenario, where mission hospitals filled the gap to avoid a possible human catastrophe (Mhike 2017, 201), this paper demonstrates that mission health institutions have always been critical. A calculated government development narrative was deliberately crafted in the 1980s and 1990s to amplify the role of government over other development partners. During this period, the role of mission hospitals in human resource training, drug provision, health care funding and sourcing for health grants from international aid agencies, increased significantly.

Independence, Policy Changes and Infrastructural Development

The independent Zimbabwean government inherited a racially divided health sector, skewed towards urban, curative health care. As a result, it sought to redress colonial racial inequalities and improve social services provision and the infrastructural base of the economy. For the majority of black Africans, health and education were key areas which had suffered decades of neglect and underfunding. State-funded colonial formal health care was largely a preserve of the white community and marginally directed towards African health. Health resources distribution followed the pattern of white settlement, mainly in towns and mining areas. Successive colonial governments adopted a curative health policy for Africans, which was cheaper to operate as compared to preventive health. Colonial health policy was predicated on a racialism which categorised the African as a second-class citizen to whom the state had no obligation. The neglect of African health care needs was most glaring in infrastructural disparities between the white dominated urban centres and the rural areas where the majority of Africans lived. Africans operated without the most basic of health services and mortality rates were high due to untreated diseases and conditions. To fill this lacuna, the colonial state relegated social services provision for Africans from a state function to being the responsibility of voluntary bodies such as missionary institutions. Summing up government health policy towards Africans in 1916, the Medical Director for Southern Rhodesia, Dr Andrew Fleming, admitted that: "The medical treatment of the native is a recognised part of the missionaries' work and is one of the methods adopted for attracting

natives [for evangelism]” (Gelfand 1976, 15). This policy underpinned the subsequent proliferation of mission health institutions in the colony’s rural areas where the bulk of the African population lived.

The flagship policy of post-independence Zimbabwe, “Growth with Equity,” was a framework which entailed, inter alia, the improvement and expansion of social services and consumption levels in the local economy (Government of Zimbabwe 1981, 6). Equity in health—as enunciated in health policy—entailed improved distribution of and access to health services (Ministry of Health and Child Welfare 1987, 4; 1984, 16). The majority of the, hitherto, neglected African population gained access to basic care, and government launched a range of cost-effective preventive health programmes. This involved improvement of allocative efficiency by directing more funds into child immunisation, safe motherhood, family planning, water and sanitation (Ministry of Health and Child Welfare [*Health for All Action Plan*] 1987). At hospital level, government improved inward efficiency through staff deployment, drug consumption and vehicle usage, among other things (British Development Division in Africa, 1990, iii). Overall, government sought to augment the urban-based curative approach by emphasising preventive care in rural areas, where “90 per cent of the cases of disease was preventable” (Agere 1986, 84). In this regard, health sector reforms became one of many instruments for social equality and poverty reduction.

The Zimbabwean government supported policy changes with capital investment, human resources and infrastructural development. The improvement of health service delivery was largely financed through an expansion of government spending. Between 1980 and 1990 the Zimbabwe government consistently provided an average of four to six per cent of its total expenditure to health provision (British Development Division in Africa 1993, 27). The Ministry of Health became the largest provider of health care and employed about 23 000 health personnel by 1987, and provided funding to local authorities and other voluntary organisations (British Development Division in Africa, 1993). The base for the delivery of comprehensive primary health care was the provision of health care centres and 273 were constructed between 1980 and 1989, giving a total of about 927, including local government, mission and industry-owned facilities. This improvement in infrastructure fed into government health policy and strategy for the period 1980–1990, aimed at building and upgrading district level hospitals and clinics. These health care centres were largely located in rural areas for the benefit of some of the poorest and vulnerable sections of Zimbabwean society.

However, the structure of the health delivery system could not be changed overnight. Health infrastructure still remained inadequate at a time when government’s development thrust was gathering momentum. Similarly, increased health funding did not translate to any radical shift in health policy. Government spent about 12 per cent of health funding on preventive services and 82 per cent on medical care services, which bears evidence that government policy reflected continuity of the largely curative orientation in health policy. The system also remained top-heavy and urban-oriented, given the large financial allocations to tertiary institutions in the urban areas. For example, in the 1980/81 financial year, government

allocated 44 per cent of its health budget to urban-based central hospitals serving about 15 per cent of the population, while 24 per cent was allocated to primary and secondary level rural services for the majority of the population (Davies and Saunders 2007, 14). In view of this fact, the new policy thrust was not being effectively implemented, partly due to the reality of infrastructural inadequacy in rural areas. In order to close this gap, government had to partner with mission hospitals which were strategically located, in order to serve hard-to-reach areas and meet the health needs of the rural populace.

Zimbabwe's health policy was informed by two main factors. Firstly, the health sector was characterised by inadequate health infrastructure, and provision of such consumed a considerable part of the available resources to the extent that government, by the mid to late 80s, was financially hamstrung to effect a paradigm shift from curative to preventive health. Secondly, the rhetoric of socialism and the euphoria of independence had a bearing on health policy. Government considered health care provision as one avenue through which it could alleviate poverty and, therefore, decisions on health became entangled in the political cycle. Hammer and Berman argue that governments, trapped in five-year electoral cycles, are increasingly driven by short-term pressure and considerations (Hammer and Berman, 1995, 47). A health agenda as mediated, partly, by preventive health programmes demands a longer term horizon, and there are risks in expecting too much short-term progress. This process pushes governments to be consumed by a search for short-term palliatives to problems that may, in fact, require a longer time frame and a wholly different approach. Owing to the crisis of expectation, as mediated by the socialist experiment of the post-independent state, the public was impatient for results and expected immediate relief from decades of poor health delivery. Given the paternalistic and populist orientation of the Zimbabwe government and its sensitivity to the media, curative health offered an opportunity for them to appear successful and to be regarded as high achievers. While preventive health ensured a sound human capital base, the reverse was true for political capital.

State and the Zimbabwe Association of Church-related Hospitals (ZACH) Partnership in Public Health

As part of its development drive, the post-colonial government fostered partnerships with non-governmental organisations (NGOs)—including religious ones—in an effort to harness resources in order to create a sound economic base. In particular, government recognised the work that the church accomplished in socially beneficial functions (Gundani 1988, 217). Mission health institutions under the Zimbabwe Association of Church-related Hospitals (ZACH) became a strategic partner of government in the running of national programmes to expand on both preventive and curative health services. Their geographical location and referral level in the health structure were especially important in driving the new policies. In addition, ZACH was not wholly financed by the government and sometimes instituted own programmes that augmented those run by the state.

ZACH is an NGO founded by the Heads of Christian Denominations (HCD) in 1973 with a mandate to assist and support member institutions in providing good quality healthcare,

especially to the vulnerable rural population (Interview 2013b). The HCD comprise the Evangelical Fellowship of Zimbabwe (FZ); the Zimbabwe Council of Churches (ZCC); Zimbabwe Catholic Bishops Conference (ZCBC); and Union for development of Apostolic Churches in Zimbabwe (UDACIZA). ZACH was formed as the secretariat which would oversee the operations of the mission health institutions. It sought to achieve a sustainably high quality health care through a holistic approach to health and healing, which encompasses principles of equity, equality and accessibility (ZACH 2004, 11). The organisation, while sometimes working with government, remained autonomous and kept its philosophy and independent sources in financing its hospitals. Indeed, mission institutions had provided healthcare in colonial Zimbabwe for the greater part of the twentieth century, but the post-independence era ushered in a new period of closer cooperation with government.

ZACH was a strategic government partner in health because its formation was an attempt to plug the gaps in financing, infrastructure development and other key needs of mission hospitals, which the government was not able to immediately work on (Interview ZACH 2013b). The secretariat coordinated cooperation between its member institutions and the Ministry of Health and other partners. It worked in line with the Ministry of Health's National Strategic Plan on priority objectives and its values of equity and accessibility dovetailed with the thrust of "Equity in Health" which government set to achieve after 1980. In addition, the organisation sourced for funding for its member institutions and was involved in advocacy. ZACH operations were financed through various sources, which included external partners, a government grant, well-wishers and member subscriptions. This move strengthened the coordination of the operations of mission hospitals, while at the same time improving their image and capacity to engage the donor community and government.

The government sought to harness the decades' long experience of mission hospitals as well as their strategically located health institutions as a counter weight to rural infrastructure limitations. The institutional make-up of Zimbabwe's health sector was highly heterogeneous, with the central government, municipal and local authorities, church missions and other NGOs, industries and mines, private practice and traditional healers all playing a role. Of infinitely greater significance is the fact that Zimbabwe operated on a four-tier system in health care provision. Level four comprised the five central hospitals (including a specialised psychiatric hospital) located in Harare and Bulawayo and these served as national referral facilities. Level three consisted of eight provincial and four general hospitals. At level two were 55 designated district hospitals (Ministry of Health and church mission run, of which 26 met the regulations, providing a first line of referrals). Level one comprised 86 rural hospitals and 927 health centres (122 Ministry of Health; 510 local governments; 70 missions; 35 urban; and 160 industry owned facilities) providing a range of curative care as well as some preventive services (ZACH 1990, 4). In light of government policy, the health institutions in tier one and two were most critical, given the primary health care drive that it had adopted and the need to have efficient first-line-of-referral health institutions. The mission health institutions were concentrated in tiers one and two, providing services throughout about 97 clinics and 70 clinics/hospitals, and 13 of the country's 42 designated district hospitals. More significantly, all but two of the 126 mission health hospitals were in

the rural areas, with the exception St Anne's Hospital in Harare, and Mater Dei Hospital in Bulawayo (ZACH 2004, 15).

Mission health institutions became a primary vehicle for preventive health programmes in Zimbabwe. The critical role of the mission health institutions to government policy goals became apparent in the early 1980s. They spearheaded national programmes such as the Zimbabwe Expanded Programme for Immunisation (ZEPI), Diarrhoeal Disease Control Programme (DDCP) and the National Nutrition Programme (Davies and Saunders 2007, 16). The strategic location of rural mission hospitals made them a fundamental partner to government in providing health care to the remote areas of the country, which had suffered neglect prior to independence. ZACH was also involved in human resources development. Nurse training in church hospitals started in the early 1900s with the training of nursing orderlies by white nuns. Training programmes expanded to include state registered nurses and midwifery (Mhike 2007, 13).

In the 1980s and 1990s the church was also actively involved in the fight against the emergent HIV and AIDS scourge at a time when treatment of the disease was not standardised. Zimbabwe recorded its first HIV case in 1985 and missionaries were some of the leading advocates of behavioural change. At their 1987 and 1990 Interdenominational Aids Conferences, the church emphasised the preaching of morality to prevent infection, abstinence among the youth, fidelity in marriages, and they condemned other sexual unions that did not amplify God's name (*The Herald* 8 April 2011). When the HIV/AIDS treatment became standardised in the 1990s, the government chose mission hospitals to run awareness campaigns and dispense drugs in affected rural communities.

The ZEPI, DDCP and the HIV/AIDS programmes were central to the new preventive health development initiative adopted after independence. Mission institutions provided health care facilities which were points of access to the health system in rural and other remote areas of Zimbabwe. Following a zero national economic growth rate in 1982, negative growth in 1983 and inflation, the grants given to health institutions fell in real terms (Mandaza 1986). The net effect was that in the 1984/85 financial year, mission hospitals had to limit their outreach work following financial constraints, which particularly affected their travel. Although the reduction in grants constrained service delivery in the outlying areas, most mission hospitals continued running these programmes because they had an obligation to provide service to people in need. In this respect, under a constrained national budget, the existing infrastructure in mission hospitals was critical for national programmes in preventive health.

Mission hospitals' religious and spiritual connection attracted patients from areas beyond their areas of service. In addition to receiving medication, the faithful believed that mission hospitals' daily routine of morning prayers and hymns were spiritually uplifting and added to the process of physical healing. Often, the terminally ill would choose to spend their last days at a mission hospital where they could receive prayer, talk to a priest and attend church services (Interview Chigumira 2013a). Even non-believers sometimes requested to be taken to a mission hospital in the hope that whatever miracles of healing were said to exist at these

hospitals, would also help them overcome illness. In view of this fact, mission hospitals became the institutions of choice because they offered their patients physical healing and spiritual upliftment.

The relationship between government and these mission establishments was complicated. The former was the policy maker and single largest financier of health services up to the late 1990s, and the latter occupied a strategic position in the implementation and delivery of set targets, but at the same time remained semi-autonomous. Government undertook to pay for the salaries of qualified personnel and those in training programmes in mission health institutions as well as the purchase of drugs (*Medical, Dental and Pharmacy Act 1927*). Individual missions received significant financial assistance from government for the purchase of drugs and some of them worked with the National Health Service. However, government financial support did not translate to the Ministry of Health's control over the missions. This was, in large measure, a result of the fact that mission establishments continued to rely on church funding and were partly subsidised by external charities (Interview ZACH 2013b). In addition, some donors did not accept the conditions of employment regulations of the public sector, making it difficult for the government to entirely control mission institutions' activities.

The Ministry of Health was in charge of the national health policy framework and implementation of activities in the public sector was organised through provincial medical directorates and district health bodies, public and private care providers (ZACH 2004, 29). Interestingly, mission health care providers were officially regarded as part of the "private medical sector" but in practice they functioned as part of the public health sector (Interview ZACH 2013b). To this end, a 1992 World Bank report recommended that government should seek to induce non-governmental institutions to assume greater responsibility for providing and paying for health services, by encouraging church missions, in particular, and other private practitioners, commercial enterprises and health insurance (World Bank Report 1992, 16). This recommendation was made in light of the fact that church missions accounted for a significant share of health services nationally, especially in the rural areas, and did so at relatively low cost (World Bank Report 1992). Allowing them more initiative would augment government efforts for fiscal stability and enhance service delivery. Notwithstanding this call, the Zimbabwe government had by 1996 not formalised its relationship with mission health institutions.

Mission hospitals also worked as alternative sources of public health financing. The private-public nature of mission hospitals was expedient for government. During the first decade of independence the government received up to 12 per cent of its health expenditure from donors intended for mission hospitals (British Development Division in Africa 1996, 14). Secondly, government conveniently weaned off mission institutions in times of financial strain because it is not under any legal obligation to support these institution. For example, due to low economic growth rate in the late 1980s and a high expenditure in social services, the government was forced to adopt fiscal austerity in the form of Economic Structural Adjustment Programmes (ESAPs) between 1990 and 1996. Social services expenditure in

health, social welfare and education was severely reduced. This rolled back the existing levels of staffing, salaries and conditions of service for professionals in the health sector. The situation also triggered a health personnel haemorrhage as doctors and nurses left government service for the private sector, while others left Zimbabwe altogether (Gaidzanwa 1999, 33). Mission institutions were not spared, since their doctors and nurses were on the government pay roll. In addition, there was a shortage of drugs and equipment that had debilitating effects on service delivery. Notwithstanding these developments, government continued to peddle the rhetoric of its socio-political commitment to providing “free” medical and health care for all, but in practice it backed out on its financial and other commitments to the health sector, in general, and particularly to mission establishments (Interview ZACH 2013b). This was based on the premise that missions were semi-autonomous and, therefore, could stand alone. The meagre government resources were now being directed towards critical areas in government-administered health institutions.

From the above analysis one can deduce a number of realities that build a nuanced appreciation of the development of Zimbabwe’s public health system and the nature of church-state relations during this period. ZACH constituted 35 per cent of the public health infrastructure, so much that they were, in reality, public institutions (Ministry of Health and Child Welfare 1995, 8). In addition, partnership in health was testimony of a steady co-operation and interdependence between the state and church-based NGOs. However, the relations between mission institutions and the state did not really mature in terms of the legal provisions and obligations that could have further strengthened their cooperation. To the extent that church institutions remained semi-autonomous, the state was not legally obliged to support them and only did so on a voluntary basis. In times of fiscal constraints, the state conveniently “weaned-off” these “private” entities to fend for themselves. Invariably, the Zimbabwe African National Union Patriotic Front (ZANU PF) government and its populist approach to development of the 1980s, claimed credit for the strides made in health delivery and rarely acknowledged its partners. This attitude undermined the mutual trust and closer cooperation that could have further enhanced efficiency in public health delivery.

The absence of a legally binding agreement between the state and ZACH on such a critical partnership is as surprising as it is worrying. A manipulative relationship of patronage emerged where the government used NGOs and other entities not directly under its control as tools in pursuing its developments goals. While the government provided the overall policy framework in which these entities operated, legally these institutions could not demand anything from government. The government co-opted organisations as junior partners in the national development agenda. There were no assured funding commitments from government and involvement of the church with health policy development. Health service provision could have been more efficient and effective if there had been a greater focus on strengthening the partnership between national governments and church health service providers. The government’s treatment of its development partners was reflective of an aggressive hegemonic discourse advanced by the ZANU PF government designed to control everything. According to Muzondidya, in the same fashion the state also sought to control labour, students and civic forces (Muzondidya 2009, 179–180). As a result, state utilisation of

mission health institutions became haphazard and inconsistent. Clearly, the government found it convenient to maintain an ambivalent relationship with its development partners, although these partnerships could have been used to improve service delivery even during years of good fiscal balance.

Conclusion

The church in Zimbabwe has been an important cornerstone in the development of the health delivery system. Beyond providing spiritual wellbeing, the church has healed Zimbabwe through its mission health institutions, in order to satisfy the teachings of and reflect on the life of Jesus Christ as a Healer. This paper demonstrates that contrary to their “invisibility” in Zimbabwe’s health development literature, missionaries were a strategic ally of the government and their activities in health were critical to the development agenda. Their contribution in health was at different levels, including providing the necessary infrastructure in remote rural areas, development of a health care human resource base, and provision of private health financing. Indeed, the success story of Zimbabwe’s health delivery system—and indeed its development agenda during the first 15 years of independence—was partly a product of the church’s call to meet physical human needs. This study suggests that although the partnership between missionaries and the state yielded remarkable results, the state manipulated the church’s social and spiritual mandate to provide healing. The mission health institutions showed great capacity and willingness to provide good quality health services, sometimes with limited if any government support. Overall, the state-missionary partnerships in health care indicate that the church remains a critical development partner in the post-colonial state and that social service provision is a key area of co-operation. Such public-private partnerships may be key to unlocking potential to handle fiscal constraints and the disease burden which Africa faces. Even as the international development agenda moves from Millennium Development Goals (MDGs) to Sustainable Development Goals (SDGs), the position and function of the church in the development agenda can only increase.

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