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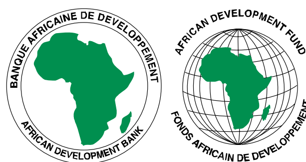

ZIMBABWE

RURAL HEALTH CENTRES PROJECT

Project Performance Evaluation Report (PPER)

OPERATIONS EVALUATION DEPARTMENT
(OPEV)

10 March 1995

ABSTRACT OF EVALUATION REPORTS

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ZIMBABWE

RURAL HEALTH CENTRES PROJECT
(LOAN N°: CS/ZBW/H/83/3)

1. **Zimbabwe gained independence in 1981 and inherited institutions which reflected the values of the prior regime.. The provision of health services was urban-biased and rural areas were under-served. The policy of the new Government was to ensure an equitable distribution of health care services to all levels of the population. A decision was taken to locate 316 new rural health centres (RHCs) in the under-served areas of which 82 (26%) were subsequently to be constructed and equipped with the help of an ADF loan.**

2. **The Rural Health Centres Project was identified in August 1980 and was prepared and appraised for ADF funding during September/October 1981. The planned sector goal was to improve the health status of the concerned target populations.**

3. **The envisaged project objective was to provide more and improved rural health care services on a sustainable basis. The planned outputs were the construction of 82 (later 83) RHCs and 246 (later 249) staff houses, and the installation and utilization of associated equipment, furniture and vehicles.**

4. **The total planned cost was the equivalent of UA 9.03 million of which UA 7.37 million would be funded by ADF and UA 1.66 million by the Government of Zimbabwe (GOZ). The Borrower was the GOZ and the Executing Agency, at appraisal, the Ministry of Health (MOH). In May 1983 it was decided that the project would be jointly executed by the MOH and the then Ministry of Construction. The planned implementation period was the three calendar years 1982 to 1984 inclusive.**

5. **The ADF loan entered into force in Feburary 1985. However civil works construction commenced in January 1984 well before the entry into force of the loan. Civil works construction activities were completed, in early 1986.** The Executing Agencies had embarked on civil works construction using

standard designs for buildings is sound, yet a degree of flexibility is needed to meet varying conditions and needs and (d) close collaboration with users and their representatives at District level is essential - from the earliest possible stage in the project planning process.

13. Recommendations for the consideration of the ADB Group are that (a) at the time of project preparation and appraisal, more care is needed concerning analyses of the institutional capacities and capabilities of all concerned agencies - particularly when coordination is required between several Government Ministries (eg: MOH, Water Affairs and Rural Development); (b) efforts should be made to ensure that the regulations for the procurement of civil works contractors are followed - such that contractors are technically equipped and adequately funded to carry out the work in hand; (c) the construction of civil works must be adequately and properly supervised; (d) ADB Group staff should check to see whether Loan Conditions have changed between the dates of loan approval and loan signature; (e) PCRs should report fully on the achievement of the project objective and sector goal; (f) technical supervision's staff should visit project sites armed with well considered checklists. Recommendations made by mission's staff should be followed up to ensure that they are put in hand and; (g) efforts should be made to achieve Borrower compliance with Loan Conditions concerning reporting and loan audit.

PROJECT PERFORMANCE AUDIT REPORT

RURAL HEALTH PROJECT

ABBREVIATIONS

ADF	Africa Development Fund
AIDS	Acquired-Immune Deficiency Syndrome
CB	Citizens Band Radio-Telephone
CIDA	Canadian International Development Agency
DANIDA	Danish International Development Agency
DHMT	District Health Management Team
EEC	European Economic Commission
FUA	Fund Unit of Account
GOZ	Government of Zimbabwe
HIS	Health Information System
HMIS	Health Management Information System
MOH	Ministry of Health
MPDE	Methodology for Project Design ahd Evaluation
MPCNH	Ministry of Public Construction and National Housing
NGO	Non-Governmental Organization
ODA	Overseas Development Agency - United Kingdom
PCR	Project Completion Report
PHC	Primary Health Care
PPAR	Project Performance Audit Report
PSIP	Public Sector Investment Programme
RHC	Rural Health Centre
SIDA	Swedish International Development Agency
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United High Commission for Refugees
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WHO	World Health Organization

ZIMBABWE: PROJECT PERFORMANCE AUDIT REPORT

RURAL HEALTH PROJECT

TABLE OF CONTENTS

		Page
Preface		vi
Basic Loan/Project Data		viii
PROJECT PERFORMANCE AUDIT REPORT		
I.	Summary	1
II.	Performance Evaluation	3
A.	Proiect Conception, Design. Prenaration and Appraisal	3
2.1	Introduction	3
2.2	GOZ Health Policy	4
2.3	Project Concept and Design	5
2.4	Project Preparation and Appraisal	7
B.	Proiect Implementation	8
2.5	Delays, Revisions and Other Difficulties	8
2.6	Project Costs	9
2.7	Reporting and Supervision	10
C.	Proiect Achievements	11
2.8	Project Outputs	11
2.9	Project Objective: Provision of Effective and Sustainable Health Care Services	13
D.	Ooerational Performance	14
2.10	Constraints	14
2.11	Institutional Arrangements	15
2.12	Health Financing	16
2.13	Replicability	20

ZIMBABWE: PROJECT PERFORMANCE AUDIT

RURAL HEALTH PROJECT

ANNEXES

ANNEX

i. METHODOLOGY FOR PROJECT DESIGN AND EVALUATION (MPDE)

2. PLANNED BUDGET EXPENDITURE

3. NON-GOVERNMENTAL ORGANIZATIONS

4. CONTRIBUTIONS BY PROVIDERS OF HEALTH CARE

5. DEMOGRAPHIC, MORBIDITY, AND MORTALITY DATA

6. ACCESS TO HEALTH SERVICES

7. ESTIMATED NUMBER OF BENEFICIARIES

8. HEALTH PUBLIC SECTOR INVESTMENT PROGRAMME (PSIP)

TABLES

TABLE

3.1 Total Health Expenditure

3.2 Sector Allocation of Central Government Expenditure

PROJECT COMPLETION REPORT

This Project Performance Audit Report is based on the findings of a Bank Group post evaluation mission mounted in April/May 1994 comprising Mr H.D. AKROYD, Principal Post Evaluation Officer and Dr E.O. PRATT, MD MPH FWACP, Public Health Physician Specialist. Enquiries concerning the content of the report should be addressed to Mr. I.B.C. JOHN, Director, Operations Evaluation Office on Extension 4089.

9. The Project Completion Report (PCR) reviews the design, scope, implementation and operational aspects of the project. The main purpose of the Project Performance Audit Memorandum (PPAM) prepared by the ADB Group's Operations Evaluation Office (OPEV) is to complement the findings of the PCR, examining in greater detail various aspects of the project and describing the findings of the Post Evaluation Mission which conducted studies in Zimbabwe in April/May 1994. The PPAR presents conclusions regarding the results of the project together with lessons and recommendations drawn from the experience of the project.

10. Copies of this report have been circulated to the Operational Departments of the Bank and to the Borrower and Executing Agency. Comments received have been reflected in the text.

2. Financing Plan (October 1981 exchange rates)

	FUA Million		
	Foreign Exchange	Local Cost	Total Cost
ADF	1.82	6.18	8.00
GOZ		1.80	1.80.
Totals	1.82	7.98	9.80

	Z $ Million		
	Foreign Exchange	Local Cost	Total Cost
ADF	1.44	4.87	6.31
GOZ		1.42	1.42
Totals	1.44	6.29	7.73

3.	Deadline for First Disbursement	31 March 1983
	First Extension	31 March 1984
	Second Extension	30 June 1985
4.	Effective Date of First Disbursement	2 August 1985
5.	Effective Date of Last Disbursement	26 January 1989
6.	Deadline for Last Disbursement	31 December 1986
	First Extension	31 December 1988
	Second Extension	31 December 1990
7.	Commencement of Works*	Early 1984
8.	Completion of Works	Early 1986
9.	Project Completion Date	February 1993 (PPAM, para 2.5.3)

* Civil works construction commenced in January 1984 well before the entry into force of the ADF loan.

C. PERFORMANCE INDICATORS

			%
1.	Cost Under-Run (FUA terms)	FUA 3.05 million	-31
2.	Cost Over-Run* (Z$ terms)	Z $ 3.13 million	+ 41

* as a result of the devaluation of the Z$ against the FUA.

		Monihs
3.	Time Over-Run:	
	* Entry into Force	37
	* First Disbursement	43
	* Last Disbursement	49
	* Physical Completion of Works	12

4.	Implementation Status	Completed
5.	Institutional Performance	Unsatisfactory
6.	Contractor Performance	Unsatisfactory
7.	Suppliers Performance	Satisfactory
8.	Overall Performance	Partially satisfactory

PROJECT PERFORMANCE AUDIT REPORT

ZIMBABWE: RURAL HEALTH CENTERS PROJECT

LOAN N": CS/ZBW/H/83/3

1. SUMMARY

1.1 Zimbabwe gained independence in 1981 and inherited institutions which reflected the values of the socio-economic order of the previous regime. The delivery of health services was heavily skewed to the urban areas and the predominant hospital sector. The rural areas were mostly underserved and the Government health policy was to ensure an equitable distribution of health care to all levels of the population. By so doing, it expected to eliminate disparities between the urban and rural sectors. The Ministry of Health (MOH) thereupon embarked on an "Equity in Health" programme. Its strategy was to increase coverage by expanding the network of primary health care (PHC) facilities in the rural areas. A decision was taken to locate 316 rural health centers (RHCs) in the peripheral areas in which there was poor programme coverage, where over 76% of the country's population lives and where health needs were largely unmet. Within this context, the Rural Health Centers Project was prepared and appraised in September/October 1981.

1.2 The planned sector development goal was to improve the health of the rural population. The project objective, at appraisal, was to support the Government of Zimbabwe (GOZ) health sector strategy of expanding.and strengthening the basic health care delivery system (PCR 2.4.2); in terms of the Bank Group logical frame work (Annex 1), which is being applied retrospectively, this was to provide more and improved health care services on a sustainable basis. The planned outputs were the construction of 82 (later 83) rural health centers (RHCs) and 246 (later 249) associated staff houses and the installation and utilization of associated equipment, furniture and vehicles. Project activities included the approval of buildings designs, the approval of contractors, consultants and suppliers, the procurement of equipment, furniture and vehicles and the recruitment of staff for civil works and project implementation. The indicators provided in the logical framework (Annex 1) are used to evaluate the achievement of the project's goal and objective.

i.3 The Borrower was the Government of the Republic of Zimbabwe (GOZ). The Executing Agency specified at appraisal in 1981 was the Ministry of Health (MOH). In May 1983, Joint Executing Agencies were agreed: these were the Ministry of Construction, later becoming the Ministry of Public Construction and National Housing (MPCNH), and the MOH.

1.4 The planned project implementation period was the three calendar years 1982 to 1984, inclusive. The total planned project cost was FUA 9.80 million (UA 9.03 million) to be funded by ADF (FUA 8.00 million) and the Government (FUA 1.80 million). The ADF loan entered into force in February 1985. Civil works construction commenced in January 1984 well before the entry into force of the loan and were completed in early 1986.

constraining factors, such as, inadequate provision of water, telephone and electricity in some 30% of RHCs; the achievement of the project objective is satisfactory. Regarding sector goal, demographic and epidemiologic data show that morbidity and mortality rates and life expectancy have improved between 1982 and 1992; the achievement of the sector goal is satisfactory. With respect to institutional performance, construction activities were poorly supervised, there was weak monitoring of project implementation by the. Executing Agencies and progress reporting was deficient. There was also weak follow-up on supervision missions; institutional performance is unsatisfactory. All sites have been completed, RHCs are commissioned and operational (with few exceptions being partially so). The project is closed and an undisbursed amount of FUA 4.07 million cancelled. An ADF project completion mission (September 1992) has submitted its report (PCR); project imolementation is completed. Thus overall oroiect performance is deemed nartiallv satisfactory.

II. PERFORMANCE EVALUATION

A. Proiect Conception, Desien. Preoaration and Aooraisal

2.1 Introduction

2.1.1 When ADF's Board of Directors met on March 18, 1982, to consider the proposed loan, the plight of Zimbabwe must have been uppermost in all of their minds and therefore there was the strong hope that the loan process would be expedited with less of the usual procedural snags. The project was presented as one of construction and, that at the time, seemed a simple, direct and uncomplicated intervention which would meet a very urgent need. Although the period of preparation was dramatically short, there were no questions raised about the design of the project,for the good intent to give speedy assistance to the new Zimbabwe was justification enough. The meeting at the Zimbabwe Conference on Reconstruction and Development held in March 1981 had already laid the foundation in which ADF's financing was requested for a construction programme (PCR 1.3).

2.1.2 The project design was concerned with the physical aspects of the project, i.e., construction and no attention was paid to institution strengthening inputs to ensure that project objective and sector goal would be realized, as indicated in the ADF's retrospective, logical framework for project design and evaluation. In fairness, the framework had not been introduced then, but there were explicit guidelines for the project cycle.

2.1.3 After the Loan was approved, it took 37 months to set up the institutional base required to enter into force. First disbursement was similarly delayed by 43 months. The last disbursement was over-run by 49 months with cancellation of an undisbursed amount of FUA 4.07 million of the loan. The PCR also reports procurement delays resulting in the non-procurement of vehicles (PCR 1.9). Most of these problems arose from GOZ's unfamiliarity with Bank Group procedures and a Joint Executing Agency not having a strong institutional base. The planned outputs were (a) the establishment, on an operational basis, of 82 RHCs and 246 staff houses and (b), the utilization of procured equipment, furniture, vehicles and spare parts. Eighty-three (83) RHCs and 249 staff houses were completed, furnished and equipped; there was no procurement of vehicles and spare parts.

2.1.4 Regarding the operation of the RHCs, the OPEV mission which visited 15 RHCs agrees with the PCR's findings presented in paragraph 3 of the PCR. These are mainly problems affecting the optimum operation and sustainability of the project; the most critical

2.2.4 MOH carries the prime responsibility for implementing GOZ national health policies in terms of the delivery and maintenance of sustainable health care. The main thrust was, and still is, to effect a reasonable balance between the rural and urban populations, ensuring equity in services delivery and significantly levelling out rural disparities in (while improving) morbidity and mortality.

2.2.5 Health care delivery was also carried out by church related. mission hospitals and clinics primarily at the rural or district level. These played an important, though limited, role in bridging the gaps in care. These would eventually tit into an organized pattern within the public sector health delivery strategy, although they are primarily non-governmental organizations (NGOs) (Annex 3). For example, some NGO hospitals are being designated as "district" hospitals by MOH to provide referral support to the PHC; also, nearly 100% of funding support for all of these institutions comes from MOH annual subventions.

2.3 <u>Project Concept and Design</u>

2.3.1 In 1981-1982, immediately after independence, GOZ's priority was to expand health coverage as expeditiously and as comprehensively as far as resources would allow. In that context, the conceptual framework for extended coverage over a wide periphery of the country was well conceived. Through that process, the high risk population of mothers and children will be critically covered.

2.3.2 Results have shown that the criteria for siting and locating of the health service delivery points or RHCs, which are the key elements in a PHC system, should be carefully reviewed in detail. The underlying development strategy was based on the development of "growth points" which should serve as springboards for social services - schools, health centers, local industry, community development programmes, etc. Among the criteria considered for the development of a growth point was the provision of water as a prime necessity.

2.3.3 In fulfilling the need of health "coverage", it was wrongly presumed that <u>siting criteria</u> (which demonstrated GOZ health policy for equitable distribution of health services at the periphery) were analogous with <u>location criteria</u> (which includes as determinants, land availability, accessibility, provision of water and electricity, acceptability by beneficiaries and relationship to other community facilities. Of all these, <u>water</u> assumes the highest priority). Siting criteria may be fulfilled whilst deficiencies in location criteria (e.g., lack of water supply) would make the establishing of a facility untenable.

2.3.4 <u>The design failed to articulate. more specifically, siting and location criteria. with the result that the general assumption that water would be available at each growth point was not subjected to rigorous examination and therefore was not well founded.</u> The PCR proved that a significant proportion of RHCs[3] was without water supply (PCR 3.2.11 and, PPAR mission); the Appraisal Report had indicated that piped water provision in each health

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[3] One-third (33 1/3%) of sample of facilities visited by PPAR mission (05/1994) had no water.

and programmes which, by their very nature, would have the desired effect. These essential elements are to be clearly identified and defined and not to be subsumed; implied or generally, taken for granted - if a design and plan are to be developed empirically. At least they should be highlighted as risk factors which should have been carefully pursued from the start.

2.4 Project Preparation and Appraisal

2.4.1 In the Appraisal Report, there is a clear definition of the project objective to "support the Government's health sector strategy which consists of expanding and strengthening the basic health care delivery system" (PCR 2.4.1 and Appraisal Report). it was further stated that a network of RHCs would increase access to PHC. by the.. rural poouIation. The connotation is that such RHCs are operational,[6] and are the key elements in the PHC strategy for the delivery of basic health care in terms of need-oriented services: Provision of a center must be coupled with services in order to be effective.

2.4.2 The attainment of the objective in terms of providing sustainable health care services would, by inference, lead to achievement of the health sector goal of improved health of the population, especially that of the rural, as stated in GOZ'S National Health Policy.

2.4.3 The appraisal document is silent on assumptions involving staffing and other institutional arrangements which would render each RHC operational. It also did not provide baseline indicators to measure achievements with regard to project objective.

2.4.4 Verifiable indicators for project objective (and, incidentally, for sector goal) were not prepared because no institutional elements were built into the project to minimize risks of dysfunctional RHCs that would impact adversely on provision of services. This would detract from contribution to achieve the goal of improvement of the health status. The fact that the nroiect did contribute significantly to nroiect objective (and sector goal, in consequence) i.e., provision of health services,improved morbidity and mortality rates etc. ,is due primarily to Zimbabwe having had. in place. some institutional planning and capacity building framework. In other developing countries with less technical attributes, the chances for success would have been greatly reduced without critical attention being paid to institutional strengthening to ensure operational. effectiveness. The Retrospective MPDE has portrayed these indicators.

2.4.5 While, for this specific project, there was a rush to support a newly independent regional member country, nevertheless project preparation and appraisal would also have benefitted from a health sector review or study that would have provided relevant indices on, user views and felt needs of beneficiaries, more precise situational analyses pertaining to population, health and nutrition status, with statistical information on health services, manpower or human resources development, facilities and support systems, potential number and type of beneficiaries, trends and pattern of health expenditure, as well as information on agencies and relevant studies in the field. Some of this information was cursory at appraisal and had little reflection on the nature of the project.

[6] Operational. See footnote on page 6 above

2.5.2 Some of the delays are a reflection of a hastily prepared project with very little time allowed for preparation (see para 2.4.7 above). Problems of site selection, architectural designs and drawings could be competently dealt with during a preparatory and pre-project period. Especially that the TAF facility of ADF provides for such preparation activities if necessary funds are not available.

2.5.3 Although entry into force was delayed considerably, much construction had proceeded during the period of hiatus, without ADF's approval, review or clearance resulting in completion of most construction within 11 months of entry into force and without ADF benefiting from progress reports. The original estimate for works completion was three calendar years after entry into force. MOH had used funds other than those from the project. This anomaly led to difficulties experienced by GOZ in its inability to retrieve and provide relevant information and source documents, acceptable to ADF, to support reimbursement claims. The matter dragged on, unresolved, with over 50% of the loan undisbursed. This portion of the loan was finally cancelled, at the request of GOZ, after a lapse of 48 months following the last disbursement.

2.5.4 These problems persisted because GOZ/MOH were unfamiliar with Bank Group procedures during that early period of Bank-Borrower relationship. The serious implications of not strictly adhering to project time-table of actions was not apparent to. GOZ, and was also indicative of weak management control and/or orientation. The problems could have been averted if ADF had organized a "project launch" at the onset of the project. The PPAR mission was informed that Regional Office in Harare scheduled a few seminars, at the time, on procurement, disbursement and other relevant Bank Group procedures.

2.6 Project Costs

2.6.1 Considerable delays as discussed in para 2.5.1 above should inevitably lead to increased costs escalation. The project was closed in 1993 and drawing from loan proceeds was 3 1% less. This was mainly due to the cancellation of an undisbursed amount of FUA 4.07 million from the loan proceeds, the cancellation of vehicle procurement from the project and the devaluation of the Z$ against the FUA. See Basic Loan/Project Data. It is evident that GOZ utilized other unidentified sources of funds to assist in the financing of project civil works and construction; this should therefore not detract from the actual value of the investments. In this regard, the cost under-run is apparent and not real. Efforts by ADF to resolve this issue were unsuccessful because of unsatisfactory history of recall both at MOH and MPCNH, as well as, weak accounting practices and lack of proper orientation to Bank Group procedures (see para 2.5.4 above). There was nothing wrong with the ADF'S disbursement system as GOZ had otherwise indicated in its completion report submitted to ADF. The fault lay with GOZ in failing to fulfil the requirements for disbursement. Technically, there is an undisbursed amount which would indicate incomplete project implementation, or inability to utilize project funds, when, in fact, the evidence suggests otherwise. In an ADB loan, commitment charges occupying such a long period (four years) between the last disbursement and the closing of the loan with no project activity, are unwarranted cost on Government. Uses for the undisbursed amount could have been found prior to the cancellation of the loan balance in February 1993

from the frequency of these missions, as evidenced by: a) no improvement on project accounting; b) hardly any progress reports submitted - there were only two (PCR 3.1.4, Table 3.1) during the entire project period, in 30/10/1987 and 31/03/1991; c) disbursement problems remained unresolved; d) project coordination committee remained moribund; e) counterpart funding activities remained unmonitored..

2.7.3 A critical outcome from one of ADF's supervision missions was a complete review of the entire construction and procurement implementation by a team of consultants (occupying 135 man-days) in 1986. This was a useful exercise which produced a valuable report on progress, deficiencies and recommendations for rectifications. There is little information available concerning actions taken to remedy construction and operational problems encountered; however evidence adduced shows that MOH/MPCNH had generally carried out the rectifications. An ADF follow-up mission took place 14 months after the consultants' reports and only after considerable difficulty in eliciting a favourable response from GOZ/MOH to agree on the fielding of the supervision mission. This shows, also, .how the regional office could have contributed to a close follow-up with the Borrower to assist in solving the problem of Bank Group-Regional Member Country coordination.

2.7.4 Supervision of civil works and construction would have been more effective if the GOZ had contracted this activity to the five consultants provided for in the loan agreement, since the 83 RHCs were widely dispersed. This would have been further strengthened through decentralizing supervisory management to the provincial offices. MOH, as user, should also have participated fully in the supervision of the RHCs, not only to ensure that facility design would be functional, but to provide useful indicators of utilization and institutional capacity, in terms of project "objective" (see MPDE) and sector "goal" and reflect these in progress reports.

2.7.5 There is also weak evidence of ADF follow-up after supervision missions; e.g., on lack of audit and progress reports etc. The experience gained indicates that a supervision mission is not only monitorial, advisory and a provider of technical assistance, but also serves to preserve the linkage and dialogue between the Borrower and Bank Group during the life of a project. By this means, mission findings and recommendations, when effectively followed up, are reinforced leading to timely actions or remedial measures. This is the main contributory factor to effective project implementation. The lesson learnt is that the Bank Group should make it a routine practice to follow up promptly with communications, after every supervision mission and to pursue timely responses, from the Borrower.

C. Project Achievements

2.8 Project Outputs

2.8.1 ADF financed the construction, equipping and furnishing of 83 RHCs and 249 associated staff houses. These RHCs formed 26% of the national target of 316 RHCs and have been completed, commissioned and, in varying degrees, operational. The efficiency and effectiveness of about one third of these are threatened by lack of water supply (paras

proportion of potential beneficiaries than would have been present when the project was appraised in 1982 (i.e.. 37% more WBCY and about 50% more children) (Annex 7). The lesson is that planning health coverage must critically assess demographic trends and analyze the potential effects of population increases. This should be adequately reflected in the project design.

2.9 Project Objective: Provision of Effective & Sustainable Health Care Services

2.9.1 The PCR (2.4.1) states that the objective of the appraisal was to support the Government health sector strategy of expanding and strengthening the basic health care delivery system. Thereafter, the PCR evaluated the implementation of the construction of the ADF supported 83 RHCs. In a restrictive sense this would suffice for what was considered the "objective" of the project - to build RHCs to strengthen, physically, the network of PHC facilities. However, further examination of the retrospective MPDE (also see paras 2.4.1 - 2.2.4 above) describes the objective as being more than the mere construction of RHCs; it covers the provision of effective health care services on a sustainable basis.

2.9.2 MOH planning was attentive to capacity building for the provisioh of PHC services. Multidisciplinary training schools were provided for designated staff (MAS later SCNs, maternity assistants later upgraded to SCMNs, and HAs later EHTs). Village health workers were trained for outreach health posts; these were later made redundant and were replaced by community development workers. A patient referral system was built into the delivery system with the district hospital or rural hospital providing first line referral support. The PPAR mission found this generally satisfactory, depending on ambulance availability or access to local transportation. RHC staff received instructions in medical records keeping, and a system for the transmission of clinic data to district, provincial and central MOH levels is installed, starting at the RHC level, as part of a health information system(HIS) which is in process of full institutionalization.

2.9.3 A full range of curative, preventive and promotive services is uniformly provided through a PHC delivery system. More emphasis is being placed on preventive and promotive care, as most of the endemic diseases encountered (infectious. and parasitic diseases) are preventable thereby minimizing the cost of care.

2.9.4 All services are on a cafeteria regimen in which no specific day or time is allocated for any particular service. The services are, mother and child care (MCH),[10] with particular attention given to ante-natal and post-natal care, and whenever possible to maternal deliveries (non-existent in some RHCs due to lack of water and/or trained midwife). Also provided are immunizations of children against childhood diseases (BCG, DPT, polio and measles) and tetanus toxoid immunization of pregnant mothers. Services also include family planning, nutrition surveillance and rehabilitation, growth monitoring, supplemental feeding, nutrition education and food demonstration. Regular health education is provided at the centers, and in conjunction with environmental health work, at the village level. Outreach work, however, is irregular due to lack of means of transportation to outlying villages.

[10] Mother and Child Care (Survival) - see footnote on page 12

a project, would no longer be required. The Borrower will assign to the project, within the MPCNH, a project manager/engineer. Supervision would be carried out by at least five site supervisors, who, if necessary, will be consultants hired by the MPCNH. Medical supplies could be procured directly from UNICEF (Loan Agreement page 1, para 3). ADF missions appeared to have been euided more bv the original agreements at appraisal than by the amendments in the loan agreement.

2.10.2 A project manager/engineer was not specifically assigned by MPCNH; five site supervisors were not appointed. The amended version for the Executing Agency did not specify who was responsible for furnishing progress reports, for the day-to-day supervision and coordination of the accounting system for the financial control of the project in conjunction with the Ministry of Finance (MOF), etc. These and many project related administrative functions had been delineated under the PIU as conceived at appraisal. The failure of the executing agency, as reorganized, emphasizes the fact that roles and responsibilities of such an agency must not be shared; that accountability should be firmly placed along with management responsibility in an executing agency. It is apparent that displacement of the PIU was a bad decision.

2.10.3 A second constraint was technical which involved staffing shortfalls. This constrained optimum effectiveness in some of the RHCs resulting in them not delivering pregnant mothers because of the absence of trained midwives, while in others patient underutilization was experienced. The situation has been compounded, in some cases, by the lack of water supply which, as a functional problem, has a critical impact on clinic operations (paras 2.3.2-2.3.5 above). Shortage of environmental technicians (formerly health assistants) has caused a gap in services in some catchment areas served by an RHC. Regular supervision of RHCs by pharmacists could not be guaranteed because of staff shortages due to inability to recruit trained pharmacists.

2.10.4 'The Economic Structural Adjustment Programme (ESAP) has made it increasingly difficult for the GOZ to provide adequately for on-going budgetary support in the health sector - particularly, recurrent expenditures. Consequently, although there is a current demand for nurses in view of the manpower planning needs, and although there is a readily available pool of nurses, many remain unemployed as a result of budgetary constraints. MOH has no other option, in order to preserve the quality of health delivery, but to plan a more streamlined and efficient system through rationalization and consolidation of the service delivery system. These measures would increase efficiency and improve value for money in the provision of services. These constraints could have been minimized: a) if the responsibility for project execution was firmly placed on one ministerial body; b) if a PIU had been established to carry the administrative burden of project implementation; and c) greater detail had been given to project design as regards water supply. In the case of staffing constraints, the recent ESAP is a factor which is being addressed by MOH in its health reform programme

2.11 Institutional Arrangements

2.11.1 MOH, through its introduction of the DHMT has strengthened the evaluative aspect of health center performance. However, this could become more effective when the

adjusted to a lower real rate. This is reflected in MOH's allocation of total government expenditure being reduced from 5.6% to 5.4%. Although the decrement is minimal, MOH will be unable to plan for growth, as such. In order to maximize its resources to ensure, at least, maintaining health levels already attained, MOH would have to revise its planned objectives, critically evaluate effects of downsizing and institute measures for increasing efficiencies. The ESAP will make it increasingly difficult for GOZ to provide adequately for on-going recurrent local and foreign exchange costs in the health sector. (see para 2.10.4 above).

2.12.3 Because of the prevailing economy, GOZ has reviewed certain policy actions in the health sector to enable optimum utilization of scarce financial resources, as well as exploiting alternate methods for health financing. The following are the three scenarios which have evolved:

1.1 Cost Recovery Scheme

2.12.4 The scheme currently rationalizes user fees and payment exemptions as well as improving billing and collection procedures. It was first introduced in 1980 at the onset of the health equity programme in which individuals and families earning less than Z$ 150 per month received free medical care.

2.12.5 As the economy grew, the GDP became less skewed, the health care disparities gradually declined in response to the vigorous application of the health policy, GOZ evaluated its fee structure and by 1994 everyone was expected to pay for medical care with exemptions only allowed for individuals and families earning less than Z$ 400 monthly who had been referred for treatment - this became a control mechanism for the referral system.

2.12.6 The revenue in 1992 from cost recovery amounted to Z$ 15 million but without direct benefit to MOH as all monies recovered were paid into government treasury. This has become an issue With MOH who cannot possibly derive direct relief from its recurrent cost burden from the accrued revenue which is "lost" to government chest. GOZ should at least allow MOH to keep a significant proportion of revenue (e.g. with respect to certain categories of services such as clinic, maternity deliveries, in-patient, surgical operations etc., while excluding others like mortuary fees, ambulance fees etc.). It is estimated that were MOH to retain all such revenue, it would need to collect an additional Z$ 13 million (i.e., a total of Z$ 28 million) to remain at the real growth rate of 4.7% (noted above; paia 2.12.1) experienced in 1980-1990. Obviously, user charges alone would not meet health financing needs.

2.12.7 GOZ has further amplified cost recovery to include:

- health insurance: by which it hopes to "broaden the financial base by ensuring that everyone in the formal salaried sector is covered by some form of health insurance";

- community financing: through which communities and their local authorities are organized "to participate fully in the financing of health development in their own areas, particularly infrastructural development";

of US$ 42 is the highest in sub-Saharan Africa, excluding the Republic of South Africa. Its health sector allocation, however, is modest when compared with its other sectors such as, economic services, education. (See Tables 3.1 and 3.2 below).

Zimbabwe Health Sector

Table 3.1
Total Health Exoenditure

	Country	US$ Per Can	% of GDP Pub.Sec	Priv.Sec	Total
1.	Kenya	16	2.8	1.6	4.3
2.	Zambia	14	2.2	1.0	3.2
3.	Malawi	11	2.9	2.1	5.0
4	Zimbabwe	42	3.2	3.0	6.2
5.	Senegal	29	2.3	1.4	3.1
6.	Ghana	14	1.7	1.8	3.5
7.	Cote d'Ivoire	28	1.7	1.6	3.3
8.	Nigeria	9	1.2	1.6	2.8

Source: World Development Report, 1993

Zimbabwe Health Sector

Table 3.2
Sector allocation (%) of Central Government Exoenditure

	Sectors	1980	1991
1.	Education	15.5	23.4
2.	Health	5.4	1.6
3.	Housing, Social Security, Social Welfare	7.8	3.9
4.	Economic Services	18.1	22.4

Source: World Development Report, 1993,

detection, diarrhoeal diseases etc. The USAID and UNFPA have provided major support for the national family planning programme. Donors programmes of assistance[13] contribute much to the sustainability of the provision of health care at the different levels of services.

2.15.2 During the post-independence period, along with the Bank Group, the EEC, USAID, World Bank, SIDA, UNHCR were major contributors to the development of rural health programmes. Part of this assistance was directed, conjointly, with strengthening of the district hospitals to provide effective referral support for cases from the RHCs. Many donor interventions have continued in follow-up projects. Donor activities are mainly supplementary and GOZ could derive maximum benefit from developing a well coordinated plan of action for donor narticioation as well as to enhance sustainability. Resources will be better maximized and each donor assistance will fit into a pattern that would prevent overlaps, duplications etc. The Health Public Sector Investment Programme (PSIP) (Annex 8) presents a frame of reference that should prove useful in this area. It is recommended that GOZ should strengthen its donor coordination secretariat to provide a more cohesive plan for donor assistance.

F. Long Term Impacts

2.16 Effect on Poverty. Productivity. Women. Environment

2.16.1 Due to the considerable strengthening of rural health services and the general upgrading of health care, the health status of the whole population has significantly improved over the last ten years (1982-1992).

2.16.2 The present trend is to sustain the health gains at the level achieved and to further improve on them. Health benefits accrue over time if the aualitv of care is sustained. The long term impact is both psycho-social and economic, the former relating to a state of well-being and the latter demonstrated by improved productivity. The equity for health strategy had planned benefits which are social and economic.

2.16.3 The GOZ health policy carried the premise that poverty was the mainspring of disease. To this should be added - ignorance. The present health strategy, fully supported by the Bank Group and other donors has produced remarkable results in the health of the population, The consequences are that people are more knowledgeable in health matters, salience to self-care deficit has increased, and there is greater patient compliance.

[13] Currently, in addition, the following are the bilateral donors engaged in various programmes of assistance in the health sector, ranging from hospital rehabilitation, hospital/health center construction, equipment supply, to AIDS research and control, fellowships and technical assistance: China, CIDA, Japan, SIDA.

2.18 Ministrv of Health (MOH)

On the whole, MOH's performance could have been better even though its role was limited in the implementation of the project which was appraised as a construction project. Its valuable asset was, as a user, to supervise the physical progress of the health center construction - this was not done satisfactorily. MOH's institutional preparedness to provide staff, drugs and programmes and to critically assess equipment needs at the RHC/PHC level to ensure full commissioning is noteworthy; this is primarily responsible for achieving project objective and sector goal (see references to MPDE, above and in Annex 1). There were, however, administrative lapses in terms of preparation and submission of progress reports, lack of prompt response to ADF's communications and slow follow-through subsequent to Bank Group missions. Part of MOH's problems resulted from the conflict over the executing agency's roles and responsibilities.

2.19 Bank Group - ADF

Technical supervision was frequent but despite this fact, the quality of the project is partially satisfactory. There is no evidence encountered of ADF's follow-up, with particular diligence, on the failure of GOZ to submit audit reports and progress reports, or with regard to timely actions for certain provisions in the Loan Agreement. Communication which is the effective tool to preserve linkage with the Borrower appears to be weak. The& may be strong extenuating contributory factors, but this is a situation which, for obvious reasons, requires to be redressed.

2.20 Suppliers and Contractors

Document5 and other collateral evidence show that suppliers' performance was satisfactory, however, that of the contractors was unsatisfactory, varying from extremely poor to acceptable. Prime factor was lack of experience by some of the contractors during 'the early years of emergence into the post-independence era. PCR pages (iv) to (xxxiii).

H. Sustainability and Development

2.21 Essential Factors

2.21.1 The ESAP has caused GOZ to review critically options for the financing of health care. Sources of finance (Annex 4) cannot be dependent indefinitely on donor financing. The NGO sector can make a significant contribution towards sustainable health care. Although GOZ provides almost 100% of their subventions, the mission hospitals and health centers can relieve MOH appreciably of the direct costs of care by being allocated a greater share of services. (Annex 3).

2.21.2 GOZ has initiated cost recovery and other schemes (paras 2.12.4 - 2.12.12 above) to provide sustainable financing for the provision of health care. Demanding urgent review is the provision of funds to meet local, capital and recurrent costs including replacement items, consumable stores, wages and salaries etc. The main objective is to secure or maintain health gains at an appreciable level and, if possible, to improve on them, on a continuing basis.

2. The fact that the Water Affairs Department was not consulted concerning the location of boreholes and RHC sites contributed to operational problems encountered - this despite the fact that the project had identified the need for a Project Coordinating Committee (paras 2.3.2-2.3.5 and 2.11.3).

3. The fact that ADB Group staff put more reliance on the Appraisal Report than on the Loan Agreement which is the legal instrument of the project gave rise to misunderstandings during and beyond the implementation period of this project (para 2. IO. 1).

4. The fact that the PCR contains little or no information concerning the achievement of the project objective and goal in terms of verifiable indicators which would have facilitated the post-evaluation process (paras. 2.4.3 and 2.4.4).

5. The fact that inadequacies in project accounting and subsequent confusion over disbursement which were the result of shortcomings in the Joint Executing Agency (MOH and MCNPH) made it almost impossible to get actual investment costs (paras 2.6.1 and 2.6.2). Also, this situation was compounded by the fact that financial problems and inconsistencies were encountered due to the project and loan not having been subjected to a financial audit (para 2.6.2).

6. Despite the fact that project was visited by nine ADF technical supervision missions, the overall performance of the project is still only partially satisfactory, which means that it is pot the number of supervision missions or existence of a regional office that counts but other factors (para 2.7.2).

7. Poor quality reporting and the irregular scheduling and submission of progress reports contributed to difficulties encountered in the supervision of this project (paras 2.7.1 and 2.7.2).

8. The use of asbestos construction materials could be construed as an environmental health hazard (PCR 3.2.18). More evidence is required as staff of the MPCNH assured PPAR mission that Zimbabwean asbestos is of acceptable health standards.

2.24 Recommendations

2.24.1 Recommendations for the consideration of the GOZ are as follows:

1. Key government technical departments should be consulted when boreholes are to be located and drilled for those centers where boreholes are not yet provided. Where underground water is not available other means should be expedited.(para 2. 11.3).

10. Efforts should be made to ensure that the construction of civil works is adequately and properly supervised (paras 2.7.1. 2.7.2; 2.7.4. 2.7.5).

11. ADB Group staff should verify whether or not Loan Conditions have changed between the dates of Loan approval and the signing of the Loan Agreement (2.10.1).

12. Project Completion Reports should report fully on the achievement of the project outputs, objective and sector goal as contained in "Guidelines on Integrated Operations, Evaluations, Policies and Procedures, and the PCR format" (para 2.4.7 and 2.4.8).

13. Technical supervision's staff should visit project sites armed with checklists based on the indicators, risks and assumptions listed in the MPDE logical framework matrix. They should also promptly follow up on recommended actions resulting from such supervision missions and ensure that Borrower responses are timely (paras 2.4.7 and 2.7.2).

14. Projects should be carefully reviewed during implementation and uses should be sought for loan balances.

15. The ADB Group should ensure that Borrowers and Executing Agency comply with Loan Conditions concerning the timely processing and submission of project progress and audit reports (paras 2.6.2 and 2.7.1).

16. The ADB Group should satisfy itself that asbestos materials are not incorporated into the construction of project buildings which would likely pose a health hazard (para 2.5.4).

REPUBLIC OF ZIMBABWE
RURAL HEALTH CENTRES PROJECT 1982
RETROSPECTIVE LOGICAL FRAMEWORK MATRIX

ive Summary	Indicators	Verification	Assumptions
Goal ed health of the rural tion.	a) Demographic Data 1982-1992 - Population. - Reduced birth rate. - Reduced death rate. - Reduced fertility rate. - Slower population growth rate. - Increased life expectancy. b) Epidemiologic Data 1982-1992 - Analysis of morbidity of patients. - Analysis of mortality of patients,. - Leading causes of hospital admissions.	- MOH statistical trends and annual reports. The appraisal report provided some historical data but no projections.	- Linkages between the sector goal and higher level development goals: the latter including an increased capacity to work. produce and earn income.
ive ion of effective rural care services on a sus- le basis.	- Staffing of RHCs in relation to tasks to be performed* - Attendances at: o ante-natal meetings o AIDS awareness meetings o family planning meetings - Environmental inspections. - Immunisation coverage - Number of women of child-bearing age using contraceptives. - Referrals to District Hospitals. - Analysis of the costs of services rendered (by cost centre and patient).	- MOH statistical trends and reports. No projections given in the appraisal report.	- Health Management Information Systems in place. - Effective public health campaigns maintained specifically in rural areas. - Means of transport to hospitals exist in rural areas. - Programmes for communicable disease control in place in rural areas. - Effective referral system in place. - Effective patient compliance.

ZIMBABWE: PROJECT PERFORMANCE AUDIT REPORT

RURAL HEALTH CENTERS PROJECT

PLANNED BUDGET EXPENDITURE
(Z$)

	1981 / 1982	199211993	
GOVERNMENT (GOZ)	2,013,484,000	14,683,519,100	58% per annum average increment over 11 year period 1982-1993
MOH	108,936,000	688,660,000	48% per annum average increment over 11 year period 1982-1993
% of GOZ allocation to MOE	5.4	4.7	

II. GROWTH OF HEALTH BUDGET ALLOCATIONS 1982-1993

ZIMBABWE

SUB-SECTORAL ALLOCATIONS

Minister of Health – Vote 20

VOTE 20. HEALTH $108 936 000

Sub-heads under which this vote will be accounted for by the Secretary for Health	1981-82	1980-81
	$	$
I. ADMINISTRATION AND GENERAL S3 R87 000		
A. Salaries, wages and allowances	2 300 000	1 510 900
B. Subsistence and transport	166 000	83 000
C. Incidental expenses	393 000	265 200
D. Grants	5 000	2900
E. Furniture and equipment	23 000	6 000
F. Loans	1 000 000	657 000
II. MEDICAL CARE SERVICES 695 802 000 (*a*)		
A. Salaries, wages and allowances	23 916 000	17 942 500
B. Subsistence and transport	9.34 000	803 500
C. Incidental expenses	190 000	103 000
D. Supplies and services	12 000 000	8 550 000
E. Grants to local authorities, missions and voluntary organizations	33 453 000	22 175 000
F. Other grants	21 720 000	21 537 000
G. Payments for Government responsibility patients	750 000	719000
H. Payments to non-government institutions	1 805 000	1 729 000
J. Furniture and equipment	10.34000	1 347 000
III. PREVENTIVE SERVICES $8 442 000		
A. Salaries, wages and allowances	3 895 000	2 4sn 200
B. Subsistence and transport	1 218 nnn	769 000
C. Field operations	1 820 000	1 000 000
D. Grants	1 476 000	1 289 800
E. Buildings, furniture and equipment	33 000	59 000
IV. RESEARCH $805 000		
A. Salaries, wages and allowances	605 nno	52 1 000
B. Subsistence and transport	174 000	152 000
C. Incidental expenses	14 onn	17 000
D. Furniture and equipment	12 000	10 000
	$108 936 000	$83 729 000

ZIMBABWE: PROJECT PERFORMANCE AUDIT REPORT

RURAL HEALTH PROJECT

NON-GOVERNMENTAL ORGANIZATIONS (NGOs)[1]

The NGOs

1. There are 297 NGOs working in Zimbabwe and these form a coordinating body called the National Association of Non-Governmental Organizations or NANGO. NGOs represent an extremely large variety of bodies from church missions, religious entities to secular bodies in the social, economic and political sectors. These are all private organizations.

2. NGOs had existed in Zimbabwe long before independence but in subsequent years have increased considerably in numbers. Under the coordination of NANGO, they are organized into five regions, namely, Eastern, Midlands, Northern, Southern and Western. The Northern Region is, by far, the largest and with its several headquarters offices based in Harare, the nation's capital.

3. NANGO's purpose is to facilitate collaboration and cooperation among, between and with NGOs. Its objectives are:

1. To promote, coordinate and organize participation and cooperation among NGOs in terms of:

   - collaborative planning and action
   - sharing activities and strategies
   - research and evaluation
   - training and technical assistance
   - programme planning and implementation

2. To promote and facilitate cooperation between NGOs and Government in:

   - policy development and advocacy
   - consultation
   - gathering and disseminating information

========================

[1] Source: NANGC Publication. 1992.

ZIMBABWE PROJECT PERFORMANCE AUDIT REPORT

RURAL HEALTH PROJECT

Contributions By Providers of Health Care'

Exoenditure

1. In 1987, the Government of Zimbabwe (GOZ) was responsible for 63% of expenditure on health care; the private sector carried 37% of the expenditure.

2. The following table shows the distribution of total expenditures in health in the public and private sectors:

Public Sector	%
Ministry of Health (MOH)	40
- Water and Sanitation	13
Municipalities	6
Local Government (Rural)	2
Private Sector	
Private Providers	27
Mines & Private Industries	8
Mission Hospitals	3
NGOs	1
	100

3. Central Government expenditure was 49% of total expenditures. Of this sum, 43% is allocated to ministries (other than MOH) for health related activities. Twenty seven percent also was allocated to the Municipal Health Department.

'Sources: MOH/MOF. Expenditures For Medical Care Services. 1987

ZIMBABWE: PROJECT PERFORMANCE AUDIT REPORT
RURAL HEALTH CENTERS PROJECT

HEALTH STATUS
BASIC INDICATORS

Indicators	1982	1992
Mortality Rates (per 1000)		
Infant Mortality Rate (0-1 years) (IMR)	a3	48
Under 5 years Death Rate (0-5 years)		
Maternal Mortality Rate (per 100,000)	130	77
Crude Death Rate (CDR)	11	a
Demographic Data		
Crude Birth Rate (CBR)	40	36
Total Fertility Rate (TFR)	5.6	4.7
Life Expectancy at Birth (Years)	57	60
Population Growth Rate (%)	3.0	3.4
Contraceptive Prevalence Rate (CPR) (%)	13.0	43.0
General Health Data		
Population per Doctor	N.A	7,800 (1990)
Population per Nursing Person	N.A	1,000 (1990)
Beds per 1000 population	(1985-1990)	2.1

% Population Access to Safe Water (1988-1991)

Rural	80
Urban	95
Total	a4

% Population Access to Adequate Sanitation (1988-1991)

Rural	22
Urban	95
Total	40

% Population Access to Health Services

Rural	80
Urban	96
Total	a5

Malnutrition Under 5-years of Age	16 (1982)	12 (1992)

Sources: Central Statistics Office
MOH: Health Statistics Section
World Development Report (1993)
UNICEF

ZIMBABWE: PROJECT PERFORMANCE AUDIT REPORT

RURAL HEALTH CENTERS PROJECT

10 LEADING COURSES OF 0-5 YEARS CHILDREN OUTPATIENT ATTENDANCES

1987 Rank	Diseases	1992 Rank	Diseases
1.	Respiratory Infections	1.	Respiratory Infections
2.	Dlarrhoea	2.	Diarrhoea
3.	Eye Diseases	3.	Skin Conditions (other)
4.	Skin Conditions (other)	4.	Trauma
5.	Malaria	5.	Scabies
6.	Trauma	6.	Eye Diseases
7.	Malnutrition	7.	Malnutrition
8.	Scabies	8.	Clinical Malaria
9.	Schistosomiasis (Bilharziasis)	9.	Schlstosomiasis (Bilharziasis))
10.	Measles	10.	Unspecified Conditions (largest proportion of cases).

JO LEADING COURSEs OF MORTALITY 0-5 YEARS

1986 Rank	Diseases	1992 Balk	Diseases
1.	Acte Respiratory Infection (ARI)	1.	
2.	Prematurity	2.	
3.	Malnutrition	3.	
4.	Diarrhoea	4.	
5.	Menlngltles	5.	
6.	Asphysia	6.	
7.	Cardiac Disease	7.	
8.	Measles	a.	
9.	Gastro-enterltes	9.	
10.	Neonatal Tetanus	10	

Source: Mlnlstry of Health (MOH)

ZIMBABWE: PROJECT PERFORMANCE AUDIT REPORT

RURAL HEALTH CENTERS PROJECT

ACCESS TO HEALTH SERVICES

1992

Provinces	GEN. OPD Attendances	Hospital Referrals	BCG	Polio	DPT	Measles
			% Immunication Coverage			
Manicaland	3.3 million	51.971 (1.6%)	87	78	69	61
Midlands	2.0 million	38.773 (2%)	75	73	73	62
Masvingo	3.7 million	36,190 (1%)	90	73	75	64
Mashonaland W	1.8 million	27,577 (1.5%)	82	76	76	67
Mashonaland E	1.7 million	35,519 (2%)	82	73	73	69
Mashonaland C	1.3 million	13,220 (1%)	78	76	79	64
Matabeleland N	0.9 million	10,061 (1%)	91	85	84	72
Matabeleland S	0.7 million	11,723 (1.7%)	78	70	71	66
Total (Provinces)	15.4 million	225,033 (1.5%)				

Total for whole country including Harare and Bulawayo = 18.3 million General OPD attenance.

Population: 10.6 million
Ratio of clinic (OPD) attendance to population = 18.3: 10.6.
Therefore the average visit per person is 1.6 times.
The % of referral from the provinces (districts) averages 1.5%

Source: Ministry of Health (MOH)

ANNEXE 7

ZIMBABWE: PROJECT PERFORMANCE AUDIT REPORT
RURAL HEALTH CENTERS PROJECT

ESTIMATED NUMBER OF BENEFICIARIES 1982-1992

182 ROVINCE	POPULATION	MOH TOTAL POTENTIAL 1/	ADF/RHCs AS % OF TOTAL MOH-RHCs	ADF/RHCs 2/ POTENTIAL BENEFICIARIES SERVED	1992 POPULATION	MOH TOTAL POTENTIAL BENEFICIARIES	ADF/RHCs AS % OF TOTAL MOH-RHCs	ADF/RHCs 3/ POTENTIAL BENEFICIARIES SERVED
ınicaland	1,103,837	662,302	0.0	0	2,537,676	1,522,606	7.0	106.582
dlands	1,086,284	651.770	0.0	0	1,302,214	781.328	16.0	125,012
ısvingo	1.029.504	617.702	0.0	0	1,221,845	733.107	6.0	43.986
ıshonaland W	854.098	512.459	0.0	0	1,116,928	670.157	8.0	53.613
ıshonaland E.	647.265	388,359	0.0	0	1.033.336	620.002	6.0	37.200
ıshonaland C.	560.847	336,508	0.0	0	857.318	514.391	15.0	77,159
ıtabeleland N.	466,747	280,046	0.0	0	640.957	384.574	9.0	34,622
ıtabeleland S.	515,298	309,179	0.0	0	591,747	355.046	5.0	17,752
	6,363,880 4	3.758.327	0	0 2 1339.670)	9,302,021 4/	5,581,213		495,926

(a) 60% of total population = beneficiaries (Women of child-bearing age (WCBY)/age 15-45 years: and children 0-14 years).

(b) Beneficiaries: 1982 - Ratio of WCBY to children = 47% : 53%
1992 - Ratio of WCBY to children = 44% : 56%

Potential Beneficiaries that could have been served if ADF's RHCs were present in 1962 = 339,670 (or 46% of 1992 population).

ADF's potential beneficiaries as per distribution of its RHCs.

46% increase in population (1982-1992).

.: Population Census and PPAR mission working papers.

ZIMBABWE: PROJECT PERFORMANCE AUDIT REPORT
RURAL HEALTH PROJECT.

HEALTH PUBLIC SECTOR INVESTMENT PROGRAMME

HEALTH PSIP 1993/94 APPROVED ALLOCATIONS

($ 000)

	CONSTRUCTION VOTE				MINISTRY'S VOTE			
	WIP GVT	NW GVT	WIP VOC	NW VOC	WIP GVT	NW GVT	WIP VOC	NW VOC
	0	Complete	0	0	0	0	0	0
			0	0	0	0	0	0
ernity	0	Complete	0	0	0	0	0	0
on of CIDA Clinics	0	Complete	0	0	0	0	0	0
nity	0	Complete	0	0	0	0	0	0
	0	Complete	0	0	0	0	0	0
Hospitals	0	Complete	0	0	0	0	0	0
B RHC			0	0	0	0	0	0
MCP/FP	0	Complete	0	0	0	0	0	0
raining	0	Complete	0	0	0	0	0	0
a Public Health Laboratory	0	Complete	0	0	0	0	0	0
Rectifications	0	Complete	0	0	0	0	0	0
are	0	Complete	0	0	0	0	0	0
rch	0	Complete	0	0	0	0	0	0
rading	220	To complete		0	0	0	0	0
Hosp Maternity Unit	0	To complete with savings		0	0	0	0	0
	500	To complete		0	0	0	0	0
D/Casualty	0	To complete		0	0	0	0	0
ts	320	To complete		0	0	0	0	0
com-Lupane	120	To complete		0	0	0	0	0
-Mutare	0	420 to complete		0	0	0	0	0
al Hospital-incenerator	720	To complete		0	0 Need to come back with Equipment Figures			
rcy ~~and OPD~~	500	To complete		0	0	0	0	0
et and Kitchen	0	To liase with Acc.Gen.on authorisation to increase capital base					17000 EEC	0
Medical Stores-Additional capital	0	0	0	0	0 Under Recurrent Expenditure			0
[illegible]	320	To confirm outstanding works			0	0	0	0
th Centres	0	0	0	0	(2000) Under MLAWD			0
h centres-source water	1500	0	0	0	0	0	0	0
-reticulation	0 ←——	700 To complete			0	0	0	0
vincial Hospital-Civil works plus OPD	0	0	0	0	(1400) MOH to provide costs			0
- Equipment	1000	0	0	0	0	0	0	0
acilities								
ovincial Hospital-Shortfalls($17.812m)	54000	Required to verify terms of the contract & justify increased costs & interest charges						
-contract($39.317m)								
-cost increase($15.576m)								
	0		contribution		0	0	0	0
rovincial Hospital-equipment	600	Confirm chinese	0	0	0	0	0	0
	100	0	0	0	0	0	0	0
oratory	3000	0	0	0	0 Equipment defered to 1994/95			
/Pharmacy	(100)	Pending Court Ruling		0	0	0	0	0
Boundary Wall	0	0	1100 SIDA	0	0		0	0
itchen	0	0	500 GOZ	0	0	0	0	0
	0	To come back with requirement for Phase II			0	0	0	0
rnity-Phase II	0	0	2800 Kellog	0	0	0	0	0
es Training	0	Confirm donor funding		0	0	0	0	0
ral Health Centre	1000	0	0	0	0	0	0	0
awayo Hospital mortuary	0	0	15000 CIDA	0	0	0	0	0
diatric Unit-Phase I	0	0	0 Solicit Japan		0	0	0	0
-Phase II	0	0	0	0	0	0	400 GOZ	0
Funded								

AFRICAN DEVELOPMENT FUND

PROJECT COMPLETION REPORT

RURAL HEALTH CENTRES PROJECT

ZIMBABWE
(LOAN No. CS/ZBW/H/83/3)

AGRICULTURE AND RURAL
DEVELOPMENT DEPARTMENT
SOUTH REGION

JANUARY 1993
SARD.3

CURRENCY EOUIVALENTS

Currency Unit	Z$ (Zimbabwe Dollar)
1 Z$	FUA 1.2686004 (December 1981)
1 FUA	Z$ 0.7882205 (December 1981)
1 Z$	FUA 0.1451463 (October 1992)
1 FUA	Z$ 6.88960 (October 1992)

WEIGHTS AND MEASURES

1 metre	=	3.28 feet (ft)
1 square metre	=	10.76 square feet
1 hectaure	=	2.47 acrea
1 kilometre	=	0.62137 mile
1 square kilometre	=	0.3861 square mile

ABREVIATIONS

ADF		African Development Fund
AIDS		Acquired Immune Deficiency Syndrome
BUA		Bank Unit of Account
CMED		Central Mechanic Equipment Department
EDF		European Development Fund
EEC		European Economic Commission
FUA		Fund Unit of Account
DGP		Gross Domestic Product
GOZ		Government of Zimbabwe
ICB		International Competitive Bidding
MCH		Mother and Child Health
MEPD		Ministry of Economic Planning and Develoipment
MMPD		Ministry of Manpower Planning and Development
MOCNH	:	Ministry of Construction and National Housing
MOF		Ministry of Finance
MOH		Ministry of Health
MONRWD	:	Ministry of Natural Resources and Water Development
MOPW		Ministry of Public Works
PCR		Project Completion Report
PHC	:	Primary Health Care
PIU		Project Implementation Unit
RHC		Rural Health Centres
STD		Sexually Transmitted Diseases
ZIMCORD	:	Zimbabwe Conference on Reconstruction and Development

FISCAL YEAR

1 July - 31 June

TABLE OF CONTENTS

	PROJECT BASIC DATA		(i-xxxiii)
1.	INTRODUCTION		1
2.	PROJECT BACKGROUND		3
	2.1	Socio-Economic Setting	3
	2.2	Sector Setting	8
	2.3	Project Formulation	11
	2.4	Project Description	12
3.	PROJECT IMPLEMENTATION		15
	3.1	Project Management	15
	3.2	Physical Implementation	16
	3.3	Fulfillment of Loan Covenants	21
4.	PROJECT COSTS AND FINANCING		23
	4.1	Project Costs	23
	4.2	Project Financing	24
5.	PROJECT OPERATING OUTPUT AND OUTCOMES		27
	5.1	External Productivity	27
	5.2	Effectiveness	28
6.	INSTITUTIONAL PERFORMANCE		29
	6.1	Bank Group Performance	29
	6.2	Borrower's Performance	29
7.	CONCLUSIONS AND RECOMMENDATIONS		30
	7.1	Conclusions	30
	7.2	Recommendations	30

This report was prepared by Mr. M. M. Youssouf (Senior Health Expert, SARD.3) and Mr. J. Kouakou (Health Architect Consultant) following their mission to Zimbabwe in September 1992. Section 2.1 was written by Mr. 0. FAJANA (Senior Economist, SCPR.5)

PROJECT BASIC DATA

1.	COUNTRY		The Republic of Zimbabwe
2.	PROJECT:		Rural Health Centers
3.	LOAN NUMBER		**CS/ZBW/H/83/3**
4.	BORROWER		The Government of the Republic of Zimbabwe
5.	GUARANTOR	:	Not Applicable (N.A.)
6.	BENEFICIARY		The Ministry of Health
7.	EXECUTING AGENCY	:	The Ministry of Construction and National Housing
8.	LOANS		
	A. AMOUNT ADF		FUA 8.00 million
	B. TERMS i) Duration		Fifty (50) years including a ten (ten) year grace period.
	ii) Service Charge	:	0.75% per annum on the amount disbursed and outstanding.
	iii) Repayment		1% of the principal each year from the eleventh to the twentieth year inclusive, and 3 per cent each year thereafter.
9.	LOAN NEGOTIATION DATE		8 December 1981
10.	LOAN APPROVAL DATE	:	18 March 1982
11.	LOAN SIGNATURE DATE	:	6 April 1985
12.	LOAN EFFECTIVENESS DATE	:	7 April 1985

13. PROJECT DATA

	At Appraisal (in million)	Actual
A. TOTAL COST		
In FUA	9.80	6.75
In Z$	7.77	10.86

		A	B	C	D
24.	CONTRACTORS PERFORMANCE				
	Rural Health Centers		X		
	& Staff Houses		X		
25.	SUPERVISION AGENCY				
	M.C.N.H.			X	
26.	SUPPLIERS PERFORMANCE		X		
27.	OPERATING PERFORMANCE				
	Rural Health Centers		X		
	& Staff Houses		X		

A = Very Good, B = Good, C = Fair, D = Unsatisfactory

28. MISSIONS

Identification	:	March 1981
Appraisal	:	September/October 1981
Supervision	:	November 1982
		November 1984
		September 1985
		February to April 1986
		May 1987
		September 1989
Follow-up	:	May 1985
		August 1986
		November 1990
PCR		28.08.92 - 11.9.92

29 DISBURSEMENTS

Summary of Total Planned and Actual Disbursements
(in FUA million)

	At Awwraisal	Actual	Balance
ADF	8.00	3.93	4.07
GOZ	1.80	2.82	-1.02
Total	9.80	6.75	

Contract Duration 6 years
Programmed Contract Amount : **Z$ 90,500.00**
Actual Contract Amount **Z$ 116,345.97**

Name Mutindori Builders, **Mutare.**
Nationality 100 % Zimbabwean
Responsibility : Construction of **KOPERA RHC,** 3 Staff Houses, Fencing and erection of Water Tank
Date of Contract Award 10 January 1984
Programmed Date of Commencement August 1982
Programmed date of Completion June 1983
Compl. **Insp./Final** Certificate None
Works Retention Fee Paid on : 1 October 1985
Date of Project Completion August 1992
Contract Duration : 8 years
Programmed Contract Amount : **Z$ 80,626.91**
Actual Contract Amount **Z$ 111,631.22**

Name C.H. Construction, **Mutare.**
Nationality : 100 % Zimbabwean
Responsibility Construction of **MABEE RHC,** 3 Staff Houses, Fencing and erection of Water Tank
District : Chipinge
Date of Contract Award : 10 January 1984
Programmed Date of Commencement August 1982
Programmed date of Completion June 1983
Compl. Insp./Final Certificate None
Works Retention Fee Paid on N.A.
Date of Project Completion August 1992
Contract Duration : 8 years
Programmed Contract Amount **Z$ 94,055.00**
Actual Contract Amount **Z$ 114,378.97**

Name **Crispen** Mavunga, Highfields.
Nationality : 100 % Zimbabwean
Responsibility : Construction of **RUPINDA** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District Chitepo
Date of Contract Award 10 January 1984
Programmed Date of Commencement : August 1982
Programmed date of Completion June 1983
Compl. **Insp./Final** Certificate None
Works Retention Fee Paid on N.A.
Date of Project Completion August 1992
Contract Duration 8 years
Programmed Contract Amount **Z$ 83,071.12**
Actual Contract Amount **Z$ 117,977.31**

Name		Tazvida Brothers Construction, Zaka.
Nationality		100 % Zimbabwean
Responsibility	:	Construction of **MAHENYE** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District	:	Gazakomanani
Date of Contract Award	:	10 January 1984
Programmed Date of Commencement		August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on		N.A.
Date of Project Completion	:	August 1992
Contract Duration	:	8 years
Programmed Contract Amount		**Z$ 95,000.00**
Actual Contract Amount	:	**Z$ 116,740.29**

Name	:	E & J **Construction**, Marondera
Nationality		100 % Zimbabwean
Responsibility	:	Construction of **MAPARURA** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District		Maungwe
Date of Contract Award	:	10 January 1984
Programmed Date of Commencement		August 1982
Programmed date of Completion		June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on		16 April 1985
Date of Project Completion	:	August 1992
Contract Duration		8 years
Programmed Contract Amount	:	**Z$ 88,990.00**
Actual Contract Amount		**Z$ 118,360.11**

Name		E & J Construction, Marondera
Nationality	:	100 % Zimbabwean
Responsibility	:	Construction of **MASVOSVA RHC,** 3 Staff Houses, Fencing and erection of Water Tank
District		Maungwe
Date of Contract Award	:	26 November 1984
Programmed Date of Commencement	:	August 1982
Programmed date of Completion		June 1983
Compl. Insp./Final Certificate		None
Works Retention Fee Paid on		N.A.
Date of Project Completion	:	August 1992
Contract Duration	:	8 years
Programmed Contract Amount	:	**Z$ 91,895.00**
Actual Contract Amount		**Z$ 117,616.67**

Name	:	F.A.B **(Pvt)** Ltd., **Harare**
Nationality	:	100 % Zimbabwean
Responsibility	:	Construction of **KAPONDORO** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District	:	Mutoko
Date of Contract Award	:	10 January 1984
Programmed Date of Commencement	:	August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on	:	15 May 1985
Date of Project Completion	:	August 1992
Contract Duration	:	8 years
Programmed Contract Amount	:	**Z$ 95,589.07**
Actual Contract Amount	:	**Z$ 106,202.13**

Name	:	FACHACO Construction, **Harare**
Nationality	:	100 % Zimbabwean
Responsibility	:	Construction of **KARIMBIKA RHC,** 3 Staff Houses, Fencing and erection of Water Tank
District	:	Zvataida
Date of Contract Award	:	10 January 1984
Programmed Date of Commencement	:	August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on	:	15 April 1985
Date of Project Completion	:	August 1992
Contract Duration	:	8 years
Programmed Contract Amount	:	**Z$ 89,550.00**
Actual Contract Amount	:	**Z$ 116,593.79**

Name	:	FACHACO Construction, **Harare**
Nationality	:	100 % Zimbabwean
Responsibility	:	**Construction** Of **KAFURA** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District	:	Zvataida
Date of Contract Award	:	26 November 1984
Programmed Date of Commencement	:	August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on	:	N.A.
Date of Project Completion	:	August 1992
Contract Duration	:	8 years
Programmed Contract Amount	:	**Z$ 90,550.00**
Actual Contract Amount	:	**Z$ 115,686.95**

Name	Mbire Construction, P.O. Highfield
Nationality	100 % Zimbabwean
Responsibility	Construction of **CHIMBWANDA** WEBT **RHC,** 3 Staff Houses, Fencing and erection of Water Tank
District	Rudhaka
Date of Contract Award	10 January 1984
Programmed Date of Commencement	August 1982
Programmed date of Completion	June 1983
Compl. Insp./Final Certificate	None
Works Retention Fee Paid on	12 March 1985
Date of Project Completion	August 1992
Contract Duration	8 years
Programmed Contract Amount	**Z$ 85,500.00**
Actual Contract Amount	**Z$ 110,073.62**

Name	Tandi Enterprises **(Pvt)** Ltd., **Harare**
Nationality	100 % Zimbabwean
Responsibility	Construction of **JEKWA** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District	Murewa
Date of Contract Award	10 January 1984
Programmed Date of Commencement	August 1982
Programmed date of Completion	June 1983
Compl. Insp./Final'Certificate	None
Works Retention Fee Paid on	26 February 1985
Date of Project Completion	August 1992
Contract Duration	8 years
Programmed Contract Amount	**Z$ 90,000.00**
Actual Contract Amount	**Z$ 126,599.76**

Name	Ndlovu Construction, **Harare**
Nationality	100 % Zimbabwean
Responsibility	Construction of **ZHAKATA** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District	Murewa
Date of Contract Award	10 January 1984
Programmed Date of Commencement	August 1982
Programmed date of Completion	June 1983
Compl. Insp./Final Certificate	None
Works Retention Fee Paid on	N.A.
Date of Project Completion	August 1992
Contract Duration	8 years
Programmed Contract Amount	**Z$ 79,015.59**
Actual Contract Amount	**Z$ 116,615.24**

Name		Quick Service Builders, Highfield
Nationality	:	100 % Zimbabwean
Responsibility		Construction of **MUKOSA** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District		**Rushinga**
Date of Contract Award	:	10 January 1984
Programmed Date of Commencement		August 1982
Programmed date of Completion		June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on		27 August 1985
Date of Project Completion	:	August 1992
Contract Duration		8 years
Programmed Contract Amount		**Z$ 95,000.00**
Actual Contract Amount		**Z$ 137,758.20**

Name		Eagle Construction, **Harare**
Nationality		100 % Zimbabwean
Responsibility		Construction of **RUSHINGA** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District		**Rushinga**
Date of Contract Award	:	26 November 1984
Programmed Date of Commencement	:	August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on		N.A.
Date of Project Completion	:	August 1992
Contract Duration	:	8 years
Programmed Contract Amount		**Z$ 94,950.00**
Actual Contract Amount	:	**Z$ 147,256.20**

Name	:	Two Boy Construction, Seke
Nationality		100 % Zimbabwean
Responsibility		Construction of **MUONWE** RHC, 3 Staff Houses, Fencing and erection of Water **Tank**
District		Bindura
Date of Contract Award		10 January 1984
Programmed Date of Commencement		August 1982
Programmed date of Completion		June 1983
Compl. **Insp./Final** Certificate		None
Works Retention Fee Paid on		19 October 1984
Date of Project Completion		August 1992
Contract Duration		8 years
Programmed Contract Amount		**Z$ 92,500.00**
Actual Contract Amount	:	**Z$ 117,920.20**

Name		Tiger Builders, **Harare**
Nationality	:	100 % Zimbabwean
Responsibility	:	Construction of **KAMUTSENZERE** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District		Pfura
Date of Contract Award		10 January 1984
Programmed Date of Commencement		August 1982
Programmed date of Completion	:	June 1983
Compl. **Insp./Final** Certificate		None
Works Retention Fee Paid on		6 March 1985
Date of Project Completion		August 1992
Contract Duration	:	8 years
Programmed Contract Amount	:	**Z$ 96,250.00**
Actual Contract Amount		**Z$ 137,631.20**

Name		Ponesai Wanhu Construction, **Harare**
Nationality		100 % Zimbabwean
Responsibility		Construction of **NYAMAHOBOGO** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District		Mt. Darwin
Date of Contract Award		2 April 1984
Programmed Date of Commencement	:	August 1982
Programmed date of Completion		June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on		26 August 1985
Date of Project Completion		August 1992
Contract Duration		8 years
Programmed Contract Amount		**Z$ 89,563.74**
Actual Contract Amount		**Z$ 107,613.85**

Province: **MASHONALAND** WEBT

Name		Super Builders, **Harare**
Nationality	:	100 % Zimbabwean
Responsibility	:	Construction of **NBUYA NEHANDA** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District		Chegutu
Date of Contract Award		26 November 1984
Programmed Date of Commencement		August 1982
Programmed date of Completion		June 1983
Compl. Insp./Final Certificate		None
Works Retention Fee Paid on		N.A.
Date of Project Completion		August 1992
Contract Duration		8 years
Programmed Contract Amount	:	**Z$ 88,500.00**
Actual Contract Amount		**Z$ 113,215.36**

Name		E.M. Kumboedza Construction, **Harare**
Nationality		100 % Zimbabwean
Responsibility		Construction of CHIVENDE RHC, 3 Staff Houses, Fencing and erection of Water Tank
District	:	Karoi
Date of Contract Award		14 January 1984
Programmed Date of Commencement		August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on	:	13 April 1984
Date of Project Completion	:	August 1992
Contract Duration		8 years
Programmed Contract Amount	:	**Z$ 89,500.00**
Actual Contract Amount	:	**Z$ 114,714.02**

Name		Muzondo Brothers, Kwekwe
Nationality	:	100 % Zimbabwean
Responsibility	:	Construction of NYABANGO RHC, 3 Staff Houses, Fencing and erection of Water Tank
District	:	Karoi
Date of Contract Award		10 January 1984
Programmed Date of Commencement		August 1982
Programmed date of Completion		June 1983
Compl. Insp./Final Certificate		None
Works Retention Fee Paid on		9 May 1985
Date of Project Completion		August 1992
Contract Duration	:	8 years
Programmed Contract Amount		**Z$ 89,950.00**
Actual Contract Amount	:	**Z$ 110,684.42**

Name		Takichi Investments, **Harare**
Nationality	:	100 % Zimbabwean
Responsibility		Construction of CHIVERE RHC, 3 Staff Houses, Fencing and erection of Water Tank
District		Lumagundi
Date of Contract Award		10 January 1984
Programmed Date of Commencement		August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate		None
Works Retention Fee Paid on		11 April 1985
Date of Project Completion	:	August 1992
Contract Duration	:	8 years
Programmed Contract Amount		**Z$ 89,950.00**
Actual Contract Amount		**Z$ 126,094.63**

Name	:	African Construction, **Harare**
Nationality		100 % Zimbabwean
Responsibility	:	Construction of **NYAMHERE** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District	:	Chivu
Date of Contract Award		10 January 1984
Programmed Date of Commencement	:	August 1982
Programmed date of Completion		June 1983
Compl. Insp./Final Certificate		None
Works Retention Fee Paid on		18 December 1984
Date of Project Completion		August 1992
Contract Duration		8 years
Programmed Contract Amount	:	**Z$ 97,055.65**
Actual Contract Amount		**Z$ 161,400.50**

Name		Maringe **Brothers, Gweru**
Nationality		100 % Zimbabwean
Responsibility		Construction of **GUNDE** RHC, 3 Staff Houses, '"Fencing and erection of Water Tank
District	:	Gweru
Date of Contract Award		10 January 1984
Programmed Date of Commencement		August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on	:	7 January 1985
Date of Project Completion		August 1992
Contract Duration	:	10 years
Programmed Contract Amount		**Z$ 79,909.79**
Actual Contract Amount		**Z$** 113.017.50

Name	:	Tangabawaya Construction, Gweru
Nationality		100 % Zimbabwean
Responsibility	:	Construction **of VURASHA (MUNYAMANI) RHC,** 3 **Staff** Houses, Fencing **and** erection of Water Tank
District	:	Mberengwa
Date of Contract Award		10 January 1984
Programmed Date of Commencement	:	August 1982
Programmed date of Completion		June 1983
Compl. Insp./Final Certificate		None
Works Retention Fee Paid on		7 March 1985
Date of Project Completion	:	August 1992
Contract Duration	:	8 years
Programmed Contract Amount	:	**Z$ 86,240.70**
Actual Contract Amount		**Z$ 145,047.50**

Responsibility		Construction of **MATETA** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District		Gokwe
Date of Contract Award	:	10 January-1984
Programmed Date of Commencement		August 1982
Programmed date of Completion		June 1983
Compl. **Insp./Final** Certificate	:	None
Works Retention Fee Paid on		N.A.
Date of Project Completion		August 1992
Contract Duration		8 years
Programmed Contract Amount	:	**Z$ 84,500.00**
Actual Contract Amount		**Z$ 153,875.50**

Name		Chilinianzi Construction, **Harare**
Nationality		100 % Zimbabwean
Responsibility	:	Construction of **NYAUTONGWE** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District	:	Nvuma
Date of Contract Award	:	10 January 1984
Programmed Date of Commencement	:	August 1982
Programmed date of Completion		June 1983
Compl. **Insp./Final** Certificate		None
Works Retention Fee Paid on	:	15 April 1985
Date of Project Completion		August 1992
Contract Duration		8 years
Programmed Contract Amount	:	**Z$ 90,950.00**
Actual Contract Amount		**Z$ 158,718.50**

Name		Tongorara Builders, Shurugwi
Nationality	:	100 % Zimbabwean
Responsibility		Construction of **RUSIKE (CHIKENYU) RHC,** 3 Staff Houses, Fencing and erection of Water Tank
District		Shurugwi
Date of Contract Award	:	10 January 1984
Programmed Date of Commencement		August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate		None
Works Retention Fee Paid on	:	3 January 1986
Date of Project Completion		August 1992
Contract Duration	:	8 years
Programmed Contract Amount	:	**Z$ 82,448.59**
Actual Contract Amount	:	**Z$ 101,956.50**

Name		Well Done Builders & Paint, Gweru
Nationality		100 % Zimbabwean

Nationality	:	100 % Zimbabwean
Responsibility	:	Construction of **MUKANGA** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District	:	Bikita
Date of Contract Award	:	3 November 1984
Programmed Date of Commencement	:	August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on	:	N.A.
Date of Project Completion	:	August 1992
Contract Duration	:	8 years
Programmed Contract Amount	:	**Z$ 89,990.00**
Actual Contract Amount	:	**Z$ 115,721.86**

Name	:	Sonny Builders & Contractors, Masvingo
Nationality	:	100 % Zimbabwean
Responsibility	:	Construction of NGORIMA RHC, 3 Staff Houses, Fencing and erection of Water Tank
District	:	Bikita
Date of Contract Award	:	10 January 1984
Programmed Date of Commencement	:	August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on	:	11 December 1984
Date of Project Completion	:	August 1992
Contract Duration	:	8 years
Programmed Contract Amount	:	**Z$ 94,932.00**
Actual Contract Amount	:	**Z$ 132,886.86**

Name	:	Chikukwa & Son Construction, **Mutare**
Nationality	:	100 % Zimbabwean
Responsibility	:	Construction of **MUTEYO** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District	:	Gazakomanani
Date of Contract Award	:	10 January 1984
Programmed Date of Commencement	:	August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on	:	N.A.
Date of Project Completion	:	August 1992
Contract Duration	:	8 years
Programmed Contract Amount	:	**Z$ 94,050.00**
Actual Contract Amount	:	**Z$ 114,039.86**

Name	:	Masvingo Rural Building Contractors, Masvingo
Nationality	:	100 % Zimbabwean
Responsibility	:	Construction of CHIBI OFFICE RHC, 3 Staff Houses, Fencing and erection of Water Tank
District	:	Nyaningwe
Date of Contract Award	:	10 January 1984
Programmed Date of Commencement	:	August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on	:	2 May 1985
Date of Project Completion	:	August 1992
Contract Duration	:	8 years
Programmed Contract Amount	:	**Z$ 85,500.00**
Actual Contract Amount	:	**Z$ 104,593.11**

Name	:	**Chuma** Builders, Masvingo
Nationality	:	100 % Zimbabwean
Responsibility	:	Construction of **CHIRINDI** RHC, 3 Staff Houses, Fencing, and erection of Water Tank
District	:	Mwenezi
Date of Contract Award	:	10 January 1984
Programmed Date of Commencement	:	August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on	:	N.A.
Date of Project Completion	:	August 1992
Contract Duration	:	8 years
Programmed Contract Amount	:	**Z$ 92,590.00**
Actual Contract Amount	:	**Z$ 127,465.86**

Name	:	Zaka Building Contractors, Zaka
Nationality	:	100 % Zimbabwean
Responsibility	:	Construction of **SVUURE** RHC, 3 staff Houses, Fencing and erection of Water Tank
District	:	Zaka
Date of Contract Award	:	10 January 1984
Programmed Date of Commencement	:	August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on	:	15 March 1985
Date of Project Completion	:	August 1992
Contract Duration	:	8 years
Programmed Contract Amount	:	**Z$ 95,590.00**
Actual Contract Amount	:	**Z$ 130,185.86**

Name		Mutual Construction, Bulawayo
Nationality		100 % Zimbabwean
Responsibility	:	Construction of **CHINEGO (TINDE)** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District		Binga
Date of Contract Award		10 January 1984
Programmed Date of Commencement		August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate		None
Works Retention Fee Paid on	:	N.A.
Date of Project Completion		August 1992
Contract Duration	:	8 years
Programmed Contract Amount		**Z$ 95,710.68**
Actual Contract Amount		**Z$ 126,671.00**

Name		Guqula Co-operative Society, Bulawayo
Nationality	:	100 % Zimbabwean
Responsibility	:	Construction of **SINAMAGONDE** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District		Binga
Date of Contract Award	:	10 January 1984
Programmed Date of Commencement		August 1982
Programmed date of Completion		June 1983
Compl. **Insp./Final Certificate**	:	None
Works Retention Fee Paid on		30 May 1985
Date of Project Completion		August 1992
Contract Duration		8 years
Programmed Contract Amount		**Z$ 91,000.00**
Actual Contract Amount		**Z$ 111,928.00**

Name	:	Kusile Builders co-operative, Bulawayo
Nationality		100 % Zimbabwean
Responsibility	:	Construction of **GOMOZA** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District		Lupane
Date of Contract Award		10 January 1984
Programmed Date of Commencement		August 1982
Programmed date of Completion		June 1983
Compl. Insp./Final Certificate		None
Works Retention Fee Paid on		N.A.
Date of Project Completion		August 1992
Contract Duration		8 years
Programmed Contract Amount		**Z$ 88,537.15**
Actual Contract Amount		**Z$ 122,723.00**

Name		Guqula Co-operative Society, Bulawayo
Nationality		100 % Zimbabwean
Responsibility		Construction of **KANYAMBEZI** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District		Hwange
Date of Contract Award		5 December 1984
Programmed Date of Commencement	:	August
Programmed date of Completion		June 1983
Compl. Insp./Final Certificate		None
Works Retention Fee Paid on		N.A.
Date of Project Completion	:	August 1992
Contract Duration		8 years
Programmed Contract Amount	:	**Z$ 92,500.12**
Actual.Contract Amount		**Z$ 121,815.00**

Province: **MATABELELAND** SOUTH

Name		S.A. Chibaira Building Construction, Bulawayo
Nationality	:	100 % Zimbabwean
Responsibility		Construction of **BEULA** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District	:	Matobo
Date of Contract Award		14 December 1984
Programmed Date of Commencement	:	August 1982
Programmed date **of Completion**		June 1983
Compl. Insp./Final Certificate	:	None
Works Retention Fee Paid on		N.A.
Date of Project Completion	:	August 1992
Contract Duration	:	8 years
Programmed Contract Amount	:	**Z$ 100,003.80**
Actual Contract Amount	:	**Z$ 108,877.43**

Name	:	Provincial Operations Office of Ministry of Construction & National Housing, Matabeleland South, Bulawayo
Nationality		100 % Zimbabwean
Responsibility		Construction of HOMEBTEAD RHC, 3 Staff Houses, Fencing and erection of Water Tank
District	:	Matobo
Date of Contract Award	:	14 December 1984
Programmed Date of Commencement		August 1982
Programmed date of Completion	:	June 1983
Compl. Insp./Final Certificate		None
Works Retention Fee Paid on		N.A.
Date of Project Completion		August 1992
Contract Duration		8 years
Programmed Contract Amount		**Z$ 85,000.00**
Actual Contract Amount		**Z$ 117,173.43**

Name		Ngwabi Building Contractors, Bulawayo
Nationality	:	100 % Zimbabwean
Responsibility		Construction of **SIMBUMBUMBU** RHC, 3 Staff Houses, Fencing and-erection of Water Tank
District		Gwanda
Date of Contract Award		18 December 1984
Programmed Date of Commencement		August 1982
Programmed date of Completion		June 1983
Compl. Insp./Final Certificate		None
Works Retention Fee Paid on		28 May 1985
Date of Project Completion		August 1992
Contract Duration		8 years
Programmed Contract Amount	:	**Z$ 78,032.00**
Actual Contract Amount	:	**Z$ 96,167.43**

Name		Ngwabi Building Contractors, Bulawayo
Nationality		100 % Zimbabwean
Responsibility	:	Construction of **MATJINGE** RHC, 3 Staff Houses, Fencing and erection of Water Tank
District		Alimangwe
Date of Contract Award		3 January 1985
Programmed Date of Commencement		August 1982
Programmed date of Completion		June 1983
Compl. Insp./Final Certificate		None
Works Retention Fee Paid on		N.A.
Date of Project Completion		August 1992
Contract Duration		9 years
Programmed Contract Amount		**Z$ 92,416.48**
Actual Contract Amount		**Z$ 103,413.43**

EOUIPMENT / FURNITURE SUPPLIERS
(Additional to UNICEF Provision)

Province: **MANICALAND**

Names		Alpha Steel; Monarch Prod.; J.W.W. Wilson; Vitafoam CA; R. Macdiamid.
Responsibility		Supply RHC's and Staff Houses with Equipment and Furniture
Date of Last Invoice	:	9 April 1985
Programmed Date of Installations	:	January 1983
Final Date of Completion		August 1992
Programmed Contract Amount		Z$ 68,029
Actual Contract Amount		Z$ 93,015

Date of Last Invoice 9 April 1985
Programmed Date of Installations January 1983
Final Date of Completion : August 1992
Programmed Contract Amount : **Z$** 62,796
Actual Contract Amount : **Z$** 85,860

Province: **MASVINGO**

Names Alpha Steel; Gruenth & BEK; Monarch Prod.; J.W.W. Wilson; **Vitafoam** CA; R. Macdiamid.
Responsibility **Supply** RHC'S and Staff Houses with Equipment and Furniture
Date of Last Invoice : 9 April 1985
Programmed Date of Installations January 1983
Final Date of Completion : August 1992
Programmed Contract Amount : **Z$** 57,563
Actual Contract Amount : **Z$** 78,705

Province: NATABELELAND NORTH

Names : Alpha Steel; Gruenth & BEK; Monarch Prod.; J.W.W. Wilson; **Vitafoam** CA; R. Macdiamid.
Responsibility : **Supply** RHC'S and Staff Houses with Equipment and Furniture
Date of Last Invoice : 9 April 1985
Programmed Date of Installations January 1983
Final Date of Completion : August 1992
Programmed Contract Amount : **Z$** 52,330
Actual Contract Amount : **Z$** 71,550

Province: **MATABELELAND SOUTH**

Names Alpha Steel; Gruenth & BEK; Monarch Prod.; J.W.W. Wilson; **Vitafoam** CA; R. Macdiamid.
Responsibility **Supply** RHC'S and Staff Houses with Equipment and Furniture
Date of Last Invoice : 9 April 1985
Programmed Date of Installations January 1983
Final Date of Completion : August 1992
Programmed Contract Amount **Z$** 41,864
Actual Contract Amount : **Z$** 57,240

1. INTRODUCTION

1.1 At independence (April 1980) Zimbabwe inherited a health care system characterized by a grossly disproportionate allocation of government resources to the provision of care to the minority white population. To tackle this problem the Government adopted a health policy that would take into account, as the main objective, the reasonable demands of the urban and rural African populations for an array of services to which they have traditionally been denied.

1.2 To achieve the above objective, the Government announced on September 1, 1981 that all health services would be free for all people earning Z$ 150.00 or less a month. To further improve the rural population's access to health care and to increasingly diminish the urban-rural dichotomy, the Government issued an official policy for an increase in the number of the rural health centers. Hence, the Rural Health Centers Project was designed to strengthen the rural health services by (i) the construction of 83 rural health centers, and (ii) the construction of 249 staff houses.

1.3 The project was identified during a general identification mission launched in August 1980. During the Zimbabwe Conference on Reconstruction and Development (ZIMCORD) held in March 1981, the Government made a request for ADF financing of the health center construction programme. Subsequently, the Bank mounted an appraisal mission to Zimbabwe in the 4th quarter of 1981.

1.4 On 18 March, 1982, an ADF loan of FUA 8 million was extended to the Government of Zimbabwe. The loan was signed on 11 November, 1983, construction of the health centers and staff houses started in August 1982 and the project was completed in August 1992.

1.5 In February 1986, the Bank sent a supervision team to perform a physical evaluation of each of the 83 rural health centers (RHC) and 249 staff houses. The mission prepared a complete inventory of outstanding construction works, quality of construction, and assessment of functionality of each RHC.

1.6 At the 1992 ADB/ADF annual meeting in Dakar, the Government of Zimbabwe (GOZ) Delegation agreed with the Bank to consider the project completed. In a telex of 21 July, 1992, the Government had requested for the cancellation of the undisbursed loan balance. Furthermore, the Board of Directors of the Bank approved in August 1992 the utilization of the savings of the project to assist some of the non-food aid requirements in the Government's drought relief programme.

1.7 Subsequently a PCR mission was fielded in September 1992. The Government submitted the Borrower's Completion Report to ADF during the PCR mission in September 1992. The mission comprised of a health expert and an architect consultant. The mission concluded that the quality of the construction of the health centers was generally good. Hence the mission proposed that some of the shortcomings of the project should be rectified immediately in order to allow the health centers to be fully operational.

2. PROJECT BACKGROUND

2.1 Socio-Economic Setting

2.1.1 Zimbabwe, a land-locked country with a total area of 389,000 km, lies in South Central Africa between the Limpopo and the Zambesi rivers. It is bordered on the north and north-west by Zambia, on the south by South Africa and on the east and south-west by Mozambique and Botswana respectively. While Harare is the administrative capital, the country is divided into 8 provinces: Mashonaland Central, Mashonaland West, Mashonaland East, Masvingo, Midlands, Manicaland, South Matebeleland, and North Watebeleland.

a) At Awwraisal

2.1.2 In December 1979 the population of Zimbabwe was estimated at 7.3 million, with a growth rate of about 3 per cent per annum. As at that date 96.1 per cent of the population was African, 3.3 per cent: European and the rest was Asian or of mixed race. About 80 per cent of the population lived in rural areas and of those in the urban areas more than 70 per cent lived in the two main urban centers, Salisbury (later renamed Harare) and Bulawayo.

2.1.3 A former colony of Britain, Zimbabwe became independent in April 1980 after a protracted costly war between African nationalist liberation movements in the country and the European settlers. The performance of the economy fairly reflected the costly effects of the struggle for independence and the years of political and economic isolation of the country by the international community. Between 1975 and 1978 several factors ranging from escalation of the war to the effects of the oil price increase of 1973 led to a decline in all areas of economic activity with an estimated overall fall of 12% and 29% of real GDP per capita respectively.

2.1.4 As at 31 December, 1980, the total outstanding debt. of the Government was Z$ 1,840.2 million of which 77 percent was internal debt. The external debt rose from Z$ 88.5 million in 1977 to Z$223.8 million in 1978 and by 1980 was Z$ 414.8 million representing a 342 per cent increase from 1975 in which it was Z$ 93.8 million.

2.1.5 The growth rate of the GDP, in nominal terms, rose annually at an average rate of 12% between 1975 and 1980. In real terms, however, the GDP was estimated to have declined at an annual rate of 2.5% over the same period. The largest decline in economic activity has been in the construction sector where the volume of activity fell by about 60% between 1975 and 1978. Within the next few years, however, the real growth in this sector was likely to rise rapidly given the massive construction and rehabilitation programme which the Government had embarked upon.

2.1.6 In 1980 the dominance of the manufacturing sector vis-a-vis agriculture in the formation of GDP was largely due to the ruinous effects of the war in the rural sector where much of the economic and subsistence output significantly declined, in the wake of a severe curtailment of agricultural extension and other services. The war

2.1.14 Given: the magnitude of the financial requirements for the country's mammoth development programme and the relatively fairly developed structure of the economy, the Government has appealed to donor countries and international lending agencies to provide a significant proportion of grants and loans in local currency in order to prevent overwhelming budgetary deficits and reliance on massive inflationary short-term domestic borrowing.

b) A t

2.1.15 The Macroeconomic Situation in the 1980s: In the decade, the GDP grew at an average annual rate of 3.4 per cent while the population grew at about 3.0 per cent, thus, the standard of living of the people did not improve much over the decade. However, there were huge differences in the growth rates from year to year reflecting good weather conditions and the extent to which appropriate policy measures were taken.

2.1.16 The trend in the balance of payments mirrored the trend in the GDP. While it was favorable between 1984 and 1988, it became negative after that date, despite the demand management measures undertaken by the Government including the continuous devaluation of the exchange rate, and the tight foreign exchange allocation system. Debt service ratio was 25.9 per cent in 1989, and reserves were equivalent to only two months of imports.

2.1.17 The Public Sector continued to be a net dis-saver. Its overall deficit increased from 8 per cent of the GDP in 1981/82 to 11 per cent in 1990/91. Because the deficit was financed largely from private sector savings, it was possible to keep the inflation rate at only 14 per cent in 1989.

2.1.18 A major problem that affected growth was the declining level of investment. There was an acute shortage of foreign exchange in the country, and hence obsolete equipments could not be replaced. Another problem of investment was the inefficient allocation system. Unlike in 1983 when fixed investment was 23 per cent of the GDP, by 1989, it had declined to only 11 per cent, an amount considered inadequate for the maintenance of the then existing stock of capital.

2.2.19 A major adverse effect of declining investment was the rising level of unemployment. To arrest the deteriorating situation, the Government embarked on a comprehensive reform programme in 1991 called the Economic Structural Adjustment Programme (ESAP), covering the period 1991-1995. The programme included policy reforms in areas such as trade liberalization, price decontrol, domestic deregulations, reduction of budget deficits, and parastatal loses, civil service reforms, and measures to assist the poor and the vulnerable people.

2.1.20 Since Zimbabwe started implementing this reform programme in 1991, the major destabilizing factor has been the 1991/92 drought, covering the whole region. It is said to be the most severe in the region, and in the century. As a result of the drought; the GDP in 1992 is estimated to have declined by at least 9 per cent compared to a growth of 3.6 per cent in 1991. About 4 million. people (close to

of the relevant population. About 75 per cent of the population still lives in rural areas with poor health and housing facilities. Infant mortality rate in still as high as 61 per 1000, **while life** expectancy at birth is still under 60 years. About 80 per cent of -the urban dwellers have access to potable water while only 40 per cent **of** the population in the rural areas has similar access. Sanitation is **extremely** poor in the rural areas **where less than 25 per cent** of **the** rural dwellers have access to good sanitation. There are still as much 'as 7,060 persons to a doctor, and 550 persons to a hospital bed.

2.1.26 Employment opportunities during-the 1980s has been **far** from. adequate to absorb the large numbers entering the work force. At the end of the **1980s,** there were about 200,000 school leavers each year; but only about 70,000 formal sector **job** openings. As a result, over, 25 per cent of the **labour** force is currently unemployed.

2.1.27 The Government is taking measures to redress the **environmental** problems of the country.' Nevertheless/a significant **proportion of** the nation's non-renewable resources has **been depleted,** and **soil** degradation has occurred particularly in the' **rural areas where the use** of wood.for fuel and housing has **led** to deforestation. Overcjrazing and overcrowding. in the **rural** areas. have **also led to severe** 'soil erosion.

2.1.28 Amongst the external problems of the economy are the drought, the landlocked position of the country which leads to **high** transportation costs, and makes the country vulnerable to the political situation in both-the.RSA and **Mozambique, adverse terms** of' **trade** 'for its exports and oil price hikes. Internally, the acute **shortage of** foreign- exchange.still.remains-a serious **limiting** factor to **investment** in modernization and replacement of worn-out parts, and the **policy** environment has not yet become fully supportive **of private** sectorinitiative.

2.2.6 Following **independence,** the Ministry of Health embarked on a primary health care (PHC) approach based on a referral structure consisting of village health posts at the very base and rural health centers as the immediate referral facility linking the village post with the district hospitals. The **Ministry** was structured into three **main** administrative divisions: Health Planning, Rural Health Care, and Medical Services. To administer more effectively its programmes, the Ministry has divided the country into five provinces: Matebeleland, Victoria, Manicaland, Mashonaland and Midlands. The Government health facilities were classified as Central (Referral) Hospitals, General (Provincial) Hospitals, District Hospitals, Rural Hospitals and Rural Health Centers.

2.2.7 The disease pattern in Zimbabwe was similar to that found elsewhere in Africa and such was dominated by the communicable diseases. The main causes of mortality were measles, pneumonia, malignancies, heart diseases, diarrhoeal diseases, nutritional disorders, perinatal mortality, motor accidents, tuberculosis and tetanus. The major causes of infant mortality were pneumonia, diarrhoeal diseases, measles and tetanus.

2.2.8 Total health expenditure for **1980/81** was **Z$** 83.7 million, approximately 2.5% of GDP, with a 45% increase from 1980 to 1981 **in** the recurrent expenditure. An increase of this magnitude **was** considered as an anomaly explainable by the impact of the Government's new policies during the first year of independence. The capital expenditure in the health sector for the period 1981-84 was approximately **Z$ 28.8** million to be financed mainly through foreign assistance.

b) At PCR

2.i.9 Since appraisal, Zimbabwe has made impressive gains in providing health care to its ten million people. Progress has been especially **great in** redressing the marked inequities in health care that existed prior to independence. The Government has extended basic health care to underserved rural areas, by constructing and **staffing** about 290 clinics, reconstructing about 160 war-damaged clinics, and upgrading an additional 160 facilities. To provide preventive and curative services at the grass-roots level, more than 4,400 village health workers (now 'community development workers) were trained between 1980 and 1985. To staff the clinics, large numbers **of** unqualified personnel were retrained as State Certified Nurses.

2.2.10 The Government's emphasis on primary health care (PHC), combined with other measures to improve the quality of life in rural **areas,** has already started to bear fruit. The percentage of fully immunized children increased from 25% in 1980 to 42% in 1984, 67% in 1987, and 80% in 1991.

2.2.11 Since appraisal, there was a major restructuring of the Ministry of Health with the creation of departments. charged with developing health programmes to deal with priority public health problems. To ensure adequate access, a balance of preventive and curative care, and an efficient chain of patient referral, the Government has organized the public **and Non-Governmental Organizations**

- Ensure value for money through efficient and **effective services;**

- Plan and manage its resources effectively;

- Form strong links with the community at all levels in the delivery of appropriate health services in acceptable ways; and

  Mobilize more resources for the health sector whilst ensuring their optimum utilization.

The priority areas identified by MOH for planning are maternal and child health (MCH), AIDS/HIV and STD, environmental health, epidemiology, disease control and infrastructure development.

2.2.16 Zimbabwe has no official population policy though this does not imply any reluctance on the part of the Government to support family planning activities. The current population of Zimbabwe is close to 9.8 million growing by between 2.9% and 3.1% per annum. At the later rate the population would take a mere 23 years to double.

2.2.17 One of the main health strategies adopted in Zimbabwe is the PHC approach with emphasis on decentralization of the health administration and integration of health programmes at all levels of the health systems. The implementation of the PHC policy involved the creation of 163 rural health centers (RHC), and the upgrading of 450 primary care clinics to function as rural health centers. For the period 1986 to 1990 the MOH capital development programme amounted to Z$ 67 million.

2.2.18 The implementation of the PHC policy will be pursued during the 1992-95 period. The strategy is to strengthen further the rural health care delivery system and preventive services, tighten up management, improve efficiency and strengthen the cost recovery measures.

2.3 Project Formulation

2.3.1 At appraisal the Government inherited a health care system characterized by a grossly disproportionate allocation of resources to the provision of care to the minority of European population. As discussed earlier, the Government's strategy has been to redress the inequities found in the health care system. Hence, to, increase the population's access to health care, the MOH announced that all health services would be free and called for an increase in the number of rural health centers.

2.3.2 The project was first identified during a general identification mission launched in August 1980. During the ZIMCORD Conference in March 1981, the Government made a special request to ADF for Financial assistance in the construction of rural health centers. Subsequently an appraisal mission was sent to Zimbabwe in the fall of 1981. The ADF loan related to this project was approved by the Board on March 18, 1982, and the loan agreement was signed on May 11, 1983.

. presence of an access road and piped water or bore hole provided by the Rural Water Development Program.

2.4.7 The design of MOCNH for a health center was described as follows:

a) A clinic building with a gross floor area of 195.10 m2 to **include:**

waiting/mass education shed,
consulting room,
pharmacy,
treatment room,
health assistant's office,
nurses's office or store room,
linen store,
delivery room,
sluice room,
store room or labor washroom,
maternity ward,
female observation ward,
male observation ward,
2 **WC's** and shower,
laundry area.

b) Three staff houses, each with a gross floor area of 62.08 m2 consisting of:

living room,
kitchen,
bathroom,
WC,
bedroom 1,
bedroom 2,
bedroom 3.

2.4.8 The **construction** details were defined as follows:

solid foundations in brick work laid in the soil with cement mortar;
walls to be constructed with bricks in majority of cases locally formed and baked;
corrugated asbestos roofing sheets as **"Endurit"** on laminated soft wood timber coated with wood preserving component before fixing;
asbestos slate ceilings to be provided in clinic buildings and the staff houses;
standard glazed mild steel windows;
standard mild steel frame doors with flush or battened doors;
concrete flooring with steel trowelled finish.

2.4.9 **Equipment and Furniture** - The detailed lists of equipment and furniture submitted at appraisal were to complement maternal and

3. PROJECT IMPLEMENTATION

3.1 Project Management

3.1.1 The project management was not in accordance with the terms of reference in the appraisal report. The PIU was never set up as envisaged to direct and coordinate the project activities. The Government instead decided to set up a coordination unit, comprising an officer each from the MOH and the MOCNH to manage the project. Since the loan was not yet declared effective and time was running out, ADF approved the government's proposal. This resulted in the poor monitoring of the progress of the project, the procurement of goods and services and also led to the excessively long implementation period. The MOCNH assumed the responsibility of the PIU in monitoring and supervising the construction works and also coordinating with the MOH in disbursements with the MOF, while the MOH was responsible for the procurement of equipment, furniture, vehicles and spare parts.

3.1.2 At appraisal, the proposal to engage a consultant supervisor for the project was not adhered to, instead the MOCNH assumed the role of the supervising agency in implementing this project as well as the other current government projects. The duties included the following:

- design drawings and tender documents;
- tender for construction works;
- supervision;
- construction;
- monitoring, evaluating and reporting on the progress of construction works.

3.1.3 There were serious problems encountered in the implementation of the project especially the absence of a PIU and a consultant supervisor as foreseen at appraisal. These problems affected all aspects of the project implementation including the procurement of all goods and services and the implementation period. The MOCNH was unable to carry out effective and constant supervision of the RHC's for the following reasons:

a) heavy work-load of other current government projects;
b) manpower constraints;
c) the great number of RHC's, their remoteness and the distances apart.

3.1.4 The quality of monitoring the project was very poor. Progress reports were irregular and not detailed with individual site meetings. Construction works took too long to be implemented. There were also many construction defects in almost all the RHC's and the staff houses. Accounting on the project was poorly kept. The progress reports lacked up-to-date accounting at various stages of the project. The reports submitted to date were as follows:

the health centers make it convenient for accompanying mothers to stay and cater for their wards as long as necessary. The PCT site visits noted the complaints of the health staff to this effect.

3.2.6 The **Waiting** Shed - It is a simple structure with basic concrete floor and corrugated asbestos roofing sheets supported on steel tubular columns. One design has short walls with concrete seats and a black board, while the other has **none** of these.

3.2.7 **The Maternity and In-patient Block** - This consists of the delivery **room,** the sluice room, a store or labor washroom depending on the type, maternity ward, female observation ward and male observation ward. There were two types of design for this block. The first design has the delivery room with a store room completely isolated from the sluice room and the ante-natal ward, whilst the other has a delivery room with a communication link with the sluice room and labor washroom as well as the ante-natal ward. Health workers of first type complained on the inconvenient of use and the lack of labor washroom. On-site visits also indicated of some wards at certain centers serving as storeroom for foodstuffs or as temporary accommodation for nursing students on practice.

3.2.8 The Toilet Block - This block is adjacent to the out-patients' and in-patients' blocks. It contains two water closets and a shower. On-site visits indicated that this block at various centers is not properly utilized for absence of running water or due to defective plumbing system. Therefore, it is usually utilized as storage for grounds tools, refrigerators and bicycles for out-reach.

3.2.9 The Laundry Block - The laundry block is a small simple structure with concrete wash basin for the washing of linen by hand.

3.2.10 Staff Houses - Each **RHC** has three staff houses. These houses, which are standard types of the MOCNH, were built in accordance with the appraisal report and have proved to be very satisfactory accommodation for the staff. None of the staff interviewed on site had complaints about space or the facilities. provided. However, some users remarked about defects in the houses such as roof leakage, defective plumbing system and cracks in walls. The correction of these defects before the closing of the project **will** help enhance the quality and efficiency of the project.

3.2.11 Water Tank and **Fencing** - At appraisal the sites to be selected for the project were to be within areas of piped water and the presence of a good access road. Due to remoteness of most of the sites, bore-holes were to be drilled within or around the premises to provide water. Water tanks of appropriate sizes were to be erected on steel or brick stand. Each site was to be furnished with a mechanical. pump from the bore-holes to the tanks to provide running water to the **centers.** However, on-site visits observed the absence of mechanical Pumps at certain centers, as well as shallow bore-holes which could not produce sufficient water for the centers. The absence of running water at some of the centers made it difficult for them to function effectively, especially in running the maternity ward.

3.2.12 Each **RHC** is provided with iron grilled fencing about a meter

3.2.17 The supervision was carried out by the MOCNH instead of engaging a consultant as was envisaged at appraisal.

v) Construction

3.2.18 All buildings were constructed in conformity with specifications of the appraisal report, including:

concrete strip foundations without reinforcements except where abnormal bad ground conditions were encountered;
walls constructed with burnt bricks;
corrugated asbestos roofing sheets as **"Endurit"** on laminated soft wood timber treated with wood preserving component before fixing;
asbestos slate ceilings in clinic buildings and the staff houses;
standard glazed mild steel windows;
standard mild steel frame doors with flush or timber battened or **panelled** doors;
concrete flooring with steel trowelled finish.

3.2.19 The design drawings were not adapted to local conditions such as provisions for reinforced concrete in the buildings to take care of differential settlements. This resulted in many construction defects in almost all the centers.

3.2.20 The quality of construction works, in general, is good. However, there are a few centers where the quality of workmanship is low. This reflects the inexperience of the contractors at that period and inadequate supervision. The following are two examples visited by the PCT mission:

Chitate RHC in Murewa district:

The first water tank was erected on brick walled stand which could serve also as store room for grounds equipment. However, the concrete slab on which stood the tank was not provided with steel reinforcement. Therefore, when water was pumped into the tank, the concrete slab, unable to support the load, collapsed and the tank fell to the ground. Another water tank has been erected beside it on steel stand.

Zumbara RHC in Chirorodziva district:

The proportion of cement in mortar for plaster and floor **screed** was very low. As a result some parts had been washed off; the external wall paint of all the buildings at the center had been pealing off.

3.2.21 The PCR team visited 15 of the 83 health centers in six provinces during the short mission in the country. Some of the major physical problems revealed during the visits to the health centers,

B. Eauioment and Furniture

3.2.25 The lists of equipment and furniture were provided during appraisal and appear in **Annex** XVI of that report. The equipment and furniture supplied **were** a complement to **MCH** equipment donated by UNICEF.

C. Vehicles

3.2.26 At appraisal six vehicles were proposed to be procured for the project to ease transportation costs. However, these vehicles were not procured as planned because the **MOH** and the **CMED** could not agree on the type of vehicles.

3.3 Fulfillment of Loan Covenants

3.3.1 At appraisal several covenants were established to ensure the effective implementation of the project. The special covenants stipulated as conditions to first disbursement were as follows:

i) give an undertaken that it will make adequate budgetary allocations to meet its share of the project costs;

ii) give an undertaken that it will assume the responsibility to meet any cost overrun of the project;

iii) establish a Project Implementation Unit within the Ministry of Health, appoint a Project Manager' and two assistants whose qualifications and experience shall be acceptable to ADF, and provide necessary office space and support staff to the PIU;

iv) present an acceptable list of sites, selected and approved by the concerned government agencies.

3.3.2 The following special covenants were included as other conditions of the project at appraisal:

i) ensure that no taxes, levies or duties, whatsoever are financed out of the proceeds of the ADF loan;

ii) undertake to provide an adequate water supply to all health centers established under the project which are located in rural service center areas.

3.3.3 The Government of Zimbabwe did not establish the PIU within the Ministry of Health as indicated. Indeed, the absence of a PIU affected the monitoring of the progress of the project, the procurement of goods and services and the implementation period. Instead, the **MOCNH** was made responsible for the supervision of construction works and also the coordination with the MOH and MOF in disbursements for construction, while the MOH was responsible for the procurement of equipment and furniture, as well as vehicles and spare parts.

4. PROJECT COSTS AND FINANCING

4.1 Proiect Costs

4.1.1 The planned total cost of the project at appraisal was FUA 9.80 million or Zimbabwe Dollar 7.77 million. A comparison of the planned and actual costs is as follows:

Table 4.1

Planned and Actual Proiect Costs
(in millions)

Catesory	At Appraisal FUA	Z$	Actual FUA	Z$
A. Construction	7.72	6.12	6.42	10.26
B. Equip./Furn.	0.55	0.44	0.33	0.59
C. Vehicles/S.P.	0.42	0.33		
D. P.I.U.	0.06	0.05		
E. Supervision	1.05	0.83	-	-
Total	9.80	7.77	6.75	10.86

4.1.2 There were no expenditures made under the categories of vehicles and spare parts, project implementation unit and supervision.

4.1.3 Table 4.2 'below shows the planned and actual financing plan by source of finance and category of expenditure as well as the corresponding percentages of participation.

Table 4.2
Planned and Actual Proiect Costs by
Source of Finance and Cateoorv of Expenditure
(in FUA millions)

	At Appraisal			Actual		
Cateaorv	ADF	GOZ	Total	ADF	GOZ	Total
A. Construction	7.31	0.41	7.72	3.88	2.54	6.42
B. Equip./Furn.	0.28	0.28	0.56	0.05	0.28	0.33
C. Vehicles/S.P.	0.41	-	0.41	-	-	-
D. P.I.U.		0.06	0.06	-	-	-
F. Supervision	-	1.05	0 5	-	-	-
Total	8.00	1.80	9.80	3.93	2.82	6.75
%	81.6	18.4	100	58.24	41.76	100

load and manpower constraints of the MOCNH which was the supervising agency for the construction works. The actual expenditures were made between 1985 and 1990. The main construction works took place in 1985 to 1986. Defective and incomplete works were implemented between 1987 and 1990 (see Table 4.4). To date, there is a few amount of incomplete works yet to be executed before closing the project.,

Table 4.5
Planned and Actual Total Cost by Source of Finance
(in millions)

	---At Appraisal---		-----Actual------	
	FUA	Z$	FUA	Z$
ADF	8.00	6.35	3.93	6.29
GOZ	1.80	1.42	2.82	4.57
Total	9.80	7.77	6.75	10.86

4.2.3 The planned and actual cost of the project, especially in local currency, is very striking as shown in Table 4.5. While the actual cost of the project in FUA is lower than the planned (since all expenditures were not made), the actual cost of the project in local currency is higher than planned. This is primarily attributable to fluctuations in the exchange rates. For example, the FUA/Zimbabwe Dollar equivalent at appraisal was 0.788270 as opposed to 2.357701 at last disbursement in 1989, almost three times as much. This is mainly due to the fact that the implementation period of three years vas prolonged to 10. As a result of this depreciation in the value of the local currency accounts, it can be concluded, therefore, that even if all expenditures were made as planned, there would still have been project savings.

Table 4.6
Planned and Actual Percentage of Participation in FUA
by Category of Expenditure

	----At Appraisal----			---Actual-		
Category	ADF	GOZ	Total	ADF	GOZ	Total
A. Constr.	94.7	5.3	78.8	60.4	39.6	95.2
B. Equip/Furn	50.1	49.9	5.6	15.2	84.8	4.8
C. Vehicles/S.P.	100	-	4.2	-	-	-
D. P.I.U.		100	0.7	-	-	-
E. Supervision	-	100	10.7	-	-	-
Total	81.6	19.4	100	58.2	41.8	100

5. PROJECT OPERATING OUTPUT AND OUTCOMES

5.1 External Productivity

5.1.1 To assess the external productivity of the project requires reliable and valid measures of project outcome, and baseline measures must be obtained and criteria defined to determine whether and to what extent the project has achieved its objectives. Neither condition is easy to obtain for a health project of this kind in a developing country, or within the vaguely defined time parameter of the services being assessed. In spite of the paucity of the data one can attempt to assess the external productivity of the project using such parameters as accessibility to health care, range of services provided and physical status of the facilities;

5.1.2 The Government's goal at appraisal was to improve the health care system which was characterized by a grossly disproportionate allocation of resources to the provision of care to the minority European population. Hence, the Government came up with the policy calling for an increase in the number'of rural health. centers so as to increase the accessibility of the predominant African population to health care. The construction of the 83 health centers,, well distributed- throughout the country, improved the accessibility to health care and. equity in health by targeting resources to the most vulnerable group.

5.1.3 At appraisal there were only 248 rural health. centers that were operational, while at PCR the number increased to 1101. These health centers are evenly distributed by province to ensure the accessibility.

Table 5.1

Distribution of Rural Health Centres by Province

Province	At PCR	At Appraisal	Financed by ADF
Manicaland	183		13
Mashonaland Central	75		11
Mashonaland East	195		11
Mashonaland Nest	105		8
Masvingo	195		11
Matabeleland North	109		10
Matebeleland South	135		7
Midlands	73	--	12
Total	1101	248	83

Source: MOH reports. (-) information not. available

5.1.4 The 83 health centers now provide a range of outpatient services including general consultations, immunizationprogramme, MCH, health education, and environmental inspection. The maternity services were less utilized because of the shortage of water. Each of

6. INSTITUTIONAL PERFORMANCE

6.1 Bank Group Performance

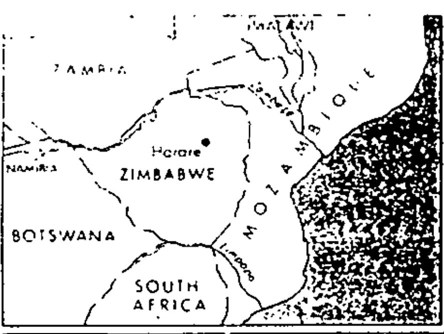
The Bank Group performance on the project has been generally good. Most of. the major problems discussed above could'have been avoided if the Bank Group had pressurized the Government to strictly follow the terms set at appraisal for the creation of the PIU and for the use of a consultant for the supervision of construction works before the first disbursement. The Bank supervision of the project was less frequent. Furthermore, most of the problems were detected during the early stages of the project and no decision was taken to resolve the problems. Despite these observations, the project achieved the objectives that were set and has assisted the Government of Zimbabwe in meeting some of its health sector objectives.

6.2 Borrower's Performance

In spite of delays and problems of project management, the Borrower can be rated fair. The major cause of the delay of the implementation of the project was due to the weak management of the project resulting from the absence of a PIU. A special unit with staff signed on contract for the duration of the project should have been created within the MOCNH for the supervision of the' construction works'. Nonetheless, the health centers are operational in spite of few shortcomings which the Government promised to correct very soon.

The Regional Offices of the Bank should play an active role in monitoring Bank projects particularly in the countries where the Offices are located.

The Government should be advised to include the provision of water and fencing among the activities to be considered in the drought relief programme.



ZIMBABWE
RURAL HEALTH CENTERS PROJECT
ADF FUNDED RURAL HEALTH CENTERS
Major State Roads
Secondary State Roads
Other Roads
Railways
Main Airports
Rivers
Communal Lands
Province Capitals
Province Boundaries
International Boundaries
0 50 100 150 KILOMETERS
Venues for Existing Mobile Clinics
Approximate Venues for Mobile Clinics Under FHP-2.
CF Commercial Farms
R/U Remote/Unserved Areas
ZAMBIA
ZIMBABWE
Harare
BOTSWANA
SOUTH AFRICA
MOZAMBIQUE
NAMIBIA
MATABELELAND
NORTH
MASHONALAND
CENTRAL
MANICALAND
HARARE
CHINHOYI
GWERU
BULAWAYO
MASVINGO
MUTARE
GWANDA
CHIREDZI
Hwange
Kadoma
Kwe Kwe
Marondera
Beitbridge

REPUBLIC OF ZIMBABWE

RURAL HEALTH CENTERS

SOURCES OF FINANCE "Y CATEGORY OF EXPENDITURE

(In Million)

CATEGORY	APPRAISAL		ACTUAL ADF		GOVT OF ZIMBABWE		TOTAL	
	FUA	ZIMB. $	FUA	ZIMB. $	FUA	ZIMB. $	FUA	ZIMB. $
a) CONSTRUCTION	7.72	6,28	3,88	6.20	2.64	4,06	6.42	10.26
b) EQUIPMENT / FURNITURE	0,55	0.45	0.05	0,09	0.26	0,51	0,33	0.66
c) VEHICLES, SPARE PARTS	0,42	0,34	0,00	0.00	0,00	0.00	0.00	0,00
d) PROJECT IMPLEMENTATION UNIT	0.06	0.06	0.00	0.00	0,00	0.00	0,00	0,00
e) SUPERVISION	1,05	0,85	0,00	0.00	0,00	0.00	0.00	0.00
TOTAL COST	9,80	7.66	3,93	6,29	2,82	4.67	6.74	10,86
PERCENTAGE			66.24	67.64	41.76	42.06	100,00	100,00

ANNEX III

ZIMBABWE: Rural Health Centre Project – Analysis of Status of Implementation

(Zimbabwe Dollars)

OVINCE	CONTRACTOR	DISTRICT	CENTRE '84	CENTRE '92	CONTRACT SUM	EXPENDITURE	REPAIRS	EQUIPMENT FURNITURE	WATER / FENCING	TOTAL RHC COST
aland	S. Tabvirira Builders	Bohera	Betera	Betera	91.950,00	90.950,00	7.591,80	7.155,00	25.708,46	131.405,26
	S & T Development Company	Bohera	Mazimbamuto	Mazimbashuro	94.500,00	94.500,00	8.148,73	7.155,00	22.470,90	132.274,63
	Takura Builders	Bohera	Mombeyarara	Mombeyarara	90.500,00	90.500,00	7.375,89	7.155,00	18.470,08	123.500,97
	Mutindori Builders	Chipinge	Kopera	Kopera	80.626,91	80.626,00	8.534,32	7.155,00	22.470,90	118.786,22
	C.H. Construction	Chipinge	Mabee	Mabee	94.055,00	84.531,00	12.392,35	7.155,00	17.455,62	121.533,97
	Crispen Mavunga	Chitepo	Rupinda	Rupinda	83.071,12	100.591,00	8.377,11	7.155,00	9.009,20	125.132,31
	Tabaiwa Construction	Chimanimani	Muchadziya	Muchadziya	90.000,00	90.000,00	7.639,40	7.155,00	22.470,90	127.265,30
	Domba Construction	Chimanimani	Chayamiti	Chayamiti	87.000,00	87.000,00	7.410,16	7.155,00	22.470,90	124.036,06
	J. & B. Construction	Chimanimani	Chikukwa	Chikukwa	90.481,00	81.998,00	25.147,23	7.155,00	9.254,20	123.554,43
	Tazvida Brothers Construction	Gazakimanani	Mahenye	Mahenye	95.000,00	87.000,00	7.270,21	7.155,00	22.470,08	123.895,29
	E. & J. Construction	Maungwe	Maparura	Maparura	88.990,00	88.990,00	6.899,21	7.155,00	22.470,90	125.515,11
	E. & J. Construction	Maungwe	Masvosva	Masvosva	90.895,00	90.895,00	4.250,77	7.155,00	22.470,90	124.771,67
	APC Partners Construction	Mutare	Muromo	Muromo	89.990,00	89.990,00	9.346,87	7.155,00	22.470,90	128.962,77
					1.167.059,03	1.157.571,00	120.384,00	93.015,00	259.663,94	1.630.633,94
naland t	Nyadoro Builders	Murewa	Chitate	Chitate	84.891,00	84.891,00	11.352,53	7.155,00	14.041,20	117.439,73
	Kubatana Construction	Goromonzi	Mwanza	Mwanza	80.200,00	80.200,00	12.682,75	7.155,00	16.791,20	116.828,95
	F.A.B. (Pvt) Ltd	Mutoko	Kapondore	Kapondoro	93.589,07	93.590,00	8.470,93	7.155,00	4.141,20	113.357,13
	FACHACO Construction	Zvataida	Karimbika	Karimbika	89.550,00	89.550,00	12.402,59	7.155,00	14.641,20	123.748,79
	FACHACO Construction	Zvataida	Kafura	Kafura	90.550,00	82.343,00	15.652,75	7.155,00	17.691,20	122.841,95
	Budirirai Construction	Wedza	Garaba	Garaba	82.458,07	82.458,00	13.168,38	7.155,00	4.141,20	106.922,58
	Biawa Construction	Mudzi	Kondo	Kondo	94.550,00	94.550,00	10.371,93	7.155,00	32.744,20	144.821,13
	Ngu-Jobbing	Mudzi	Chiunye	Chiunye	90.091,00	73.480,00	13.747,03	7.155,00	27.752,20	122.134,23
	Mbire Construction	Rudhaka	Chimbwanda	Chimbwanda	85.500,00	85.500,00	12.622,42	7.155,00	11.951,20	117.228,62
	Tandi Enterprises (Pvt) Ltd	Murewa	Jekwa	Jekwa	90.000,00	90.222,00	12.236,56	7.155,00	24.141,20	133.754,76
	Ndhlovu Construction	Harava	Zhakata	Zhakata	79.015,59	73.203,00	17.531,04	7.155,00	20.881,20	118.770,24
					960.394,73	929.987,00	140.238,89	78.705,00	188.917,20	1.337.848,09

ZIMBABWE: Rural Health Centre Project – Analysis of Status of Implementation

(Zimbabwe Dollars)

VINCE	CONTRACTOR	DISTRICT	CENTRE '84	CENTRE '92	CONTRACT SUM	EXPENDITURE	REPAIRS	EQUIPMENT FURNITURE	WATER / FENCING	TOTAL RHC COST
go	Mangami Construction	Gutu	Matizha	Matizha	81.573,11	91.064,00	14.371,86	7.155,00	22.769,00	135.359,86
	Chiwora Brothers Construction	Gutu	Chitando	Chitando	90.550,00	90.550,00	14.976,86	7.155,00	4.606,00	117.287,86
	Sonny Builders	Bikita	Mukanga	Mukanga	89.990,00	89.990,00	18.625,56	7.155,00	7.106,00	122.876,56
	Sonny Builders	Bikita	Ngorima	Ngorima	94.932,00	94.932,00	17.898,86	7.155,00	20.056,00	140.041,86
	Chikukwa & Son	Gazakomanani	Muteyo	Muteyo	94.050,00	87.876,00	19.057,86	7.155,00	7.106,00	121.194,86
	J.M. Mwasiya	Masvingo	Musvosvi	Musvosvi	81.073,11	81.073,00	13.397,48	7.155,00	22.769,00	124.394,48
	M.R. Building Contractors	Masvingo	Mandamabwe	Mandamabwe	85.407,00	93.336,00	13.827,86	7.155,00	4.606,00	118.924,86
	Chikukwa & Sons	Batanai	Chizumba	Chizumba	94.500,00	91.350,00	14.932,86	7.155,00	22.769,00	136.206,86
	M.R. Construction	Nyaningwe	Chibi Office	Chibi Office	85.500,00	85.508,00	14.479,11	7.155,00	4.606,00	111.748,11
	Chuma Builders	Mwenizi	Chirindi	Chirindi	92.590,00	75.607,00	29.089,86	7.155,00	22.769,00	134.620,86
	Zaka Building Contractors	Zaka	Svuure	Svuure	92.590,00	92.590,00	17.539,86	7.155,00	20.056,00	137.340,86
					982.755,22	**973.876,00**	**188.198,00**	**78.705,00**	**159.218,00**	**1.399.997,00**
leland h	Mutual Construction	Tsholotsho	Makhasa	Makhasa	96.556,00	102.880,00	24.149,80	7.155,00	13.956,20	148.141,00
	Eric Builders	Tsholotsho	Mutshayeli	Mtshayeli	92.000,00	98.874,00	12.463,80	7.155,00	19.956,20	138.449,00
	Ngoma Victor Building Constru	Nkayi	Ngwaladi	Gwalazi	93.500,00	92.995,00	18.263,80	7.155,00	4.956,20	123.370,00
	Mutual Construction	Binga	Tinde	Chinego	95.710,68	93.566,00	13.148,80	7.155,00	19.956,20	133.826,00
	Guqula Co-operative	Binga	Sinamagonde	Sinamagonde	91.000,00	91.758,00	15.213,80	7.155,00	4.956,20	119.083,00
	Kusile Builders Co-operative	Lupane	Gomoza	Gomoza	88.537,15	89.038,00	13.728,80	7.155,00	19.956,20	129.878,00
	Tyili Builders	Lupane	Benzies Bridge	Benzies Bridge	98.053,00	100.077,00	10.963,80	7.155,00	18.456,20	136.652,00
	J.M. Builders	Hwange	Chisume	Chisume	93.000,00	93.333,00	12.988,80	7.155,00	11.456,20	124.933,00
	MPCNH	Hwange	Mawambe	Mawembe	85.000,00	85.000,00	14.637,80	7.155,00	16.306,20	123.099,00
	Guqula Co-op.	Hwange	Kanyambizi	Kanyambezi	92.500,00	92.500,00	11.463,80	7.155,00	17.851,20	128.970,00
					925.856,83	**940.021,00**	**147.023,00**	**71.550,00**	**147.807,00**	**1.306.401,00**
leland h	S.A. Chibaira	Matobo	Beula	Beula	100.003,00	99.204,00	4.713,43	7.155,00	4.960,00	116.032,43
	MPCNH	Matobo	Homestead	Homestead	85.000,00	85.000,00	4.713,43	7.155,00	27.460,00	124.328,43
	Mupindu Construction	Beitbridge	Manjini	Manjini	93.785,00	94.109,00	4.713,43	7.155,00	4.960,00	110.937,43
	Mpindu Construction	Beitbridge	Chikwarakwara	Chikwarakwara	89.581,18	89.801,00	4.713,43	7.155,00	12.960,00	114.629,43
	S.A. Chibaira	Filabusi	Nyamini	Nyamini	96.226,00	93.100,00	4.713,43	7.155,00	27.460,00	132.428,43
	Ngwabi Building Contractor	Gwanda	Simbumbumbu	Simbumbumbu	78.023,00	78.494,00	4.713,43	7.155,00	12.960,00	103.322,43
	Gwabi Construction	Alimangwe	Matjinge	Matjinge	92.416,00	92.740,00	4.713,43	7.155,00	5.960,00	110.568,43
					635.034,18	6S2.4.6.66	**32.994,00**	60.066.00	**96.720,00**	**812.247,00**
					7.498.543,62	**7.342.213,00**	**1.267.729,89**	**593.865,00**	**1.652.398,53**	**10.856.206,42**