CIVIC MONITORING PROGRAMME

Quarterly Community Assessment of the Socio-economic Situation in Zimbabwe: Health and Education

March 2004

This report is the first of a series of more detailed monitoring of specific areas of social and economic conditions at community level by the Civic Monitoring Programme to supplement the monthly monitoring programme. Proposals for issues to monitor and feedback on this report are welcomed and should be sent to fsmt2@mweb.co.zw

Background

Civic organizations have through the monitoring Group of the National NGO Food Security Network (FOSENET) been monitoring food security in Zimbabwe since July 2002.

In 2004 this monitoring has been widened to cover other social and economic conditions, recognizing the wide range of conditions influencing social and economic wellbeing. The Civic Monitoring Programme is implemented through NGOs based within districts and community based monitors. Monthly reports from all areas of the country are compiled to provide a monthly situation assessment of food security and social welfare to enhance an ethical, effective and community focussed response to the current situation. Quarterly reports such as this one complement the monthly monitoring and provide more detailed information on specific areas of social and economic conditions at community level. Queries and feedback on these reports is welcomed and should be directed to the Civic Monitoring Programme at fsmt2@mweb.co.zw. This is the first round of such quarterly monitoring and continuous measures are being implemented to improve data quality and relevance, including training and peer review, so feedback is welcomed.

The issues to be monitored are defined by the civic groups and proposals from other agencies. The monitoring information is collected from sentinel wards within districts through community and NGO sentinel site monitors of the Civic Monitoring programme as described in other reports of the CMP.

This first round of NGO and community based monitoring on **health and education conditions** was carried out in March 2004 from **80 monitoring reports** from **53 districts** from all provinces of Zimbabwe, with an average of **1.5 reports per district.**

Health

The civil society groups in the Civic Monitoring Project note that health is one of the most important and valued areas of social and economic rights for ordinary people in Zimbabwe. Discussions at community level carried out by civic groups have identified that people view certain rights to health as central to protecting our humanity, dignity, sovereignty and progress:

- Everyone has a right to life, to live a life in dignity and to the highest standard of health reasonably possible.

- This means that the state has duty to ensure a basic level of health services, where every person can access basic health care and humane treatment financed from taxes, without being charged fees that we cannot afford.

- The state has a duty to put in place policies that ensure that everyone has access to adequate food, water, sanitation, shelter and transport, and to access public services that are accountable and free from corruption.

- The state has a duty to use public funds in an equitable, fair, non partisan and transparent way to meet social needs.

- We have a right to health services that provide for confidentiality and privacy, for reasonable choice of care and safety and that provide adequate information to and consent by patients on medical procedures. We also have a right to public information and education on health and education issues.

- We have an obligation to participate in our social services and thus a right to representation in decision making on them.

At a time when people's health is negatively affected by HIV/AIDS, rising costs of basic goods, food insecurity and unemployment, provision of accessible, affordable quality health services and public health programmes are very important to promote health, prevent ill health and treat illness.

The quarterly monitoring found that tha**t 58% of sites nationally reported having a health facility, usually a clinic, within 5km of people's homes in the ward.** The national goal is for all people to have a clinic within 5km. A quarter of sites reported that people have to travel 6-25 km to get to a health facility and **16% reported having to travel more than 15km.** (See Table 1)

The provinces with best coverage of health facilities from reports were Mashonaland Central and the cities, while those worst served in terms of distance to facilities were Mashonaland East, Midlands and Matabeleland North and South.

Table 1: Distance to a health facility with staff and drugs by province

Province	No sites	% sites reporting distance to health facility(km)		
		0-5	6-15	>15
Manicaland	5	60	40	0
Mashonaland East	12	42	25	33
Mashonaland Central	4	100	0	0
Mashonaland West	6	50	33	17
Midlands	11	36	36	18
Masvingo	6	66	33	0
Matabeleland North	7	43	43	14
Matabeleland South	9	33	56	11
Bulawayo, Harare	17	100	0	0
Total	80	58	26	16

The longest distances to a clinic were reported from sites in Hwedza (20km); UMP (35km), Makonde (35km), Zvishavane (45km) Hwange (35km) and Beitbridge (30km).

Most people come from far away places in the morning for treatment. People reach the place fainting and collapsing.

Binga

In areas where clinics were closer other access problems were reported. **In the cities for example the time to treatment was noted as a problem.**

There are long queues and people have to wait for several hours before they get treated.

Bulawayo.

Cost was a further reported barrier. Monitors reported on the share of people living in their ward who could afford the health services provided (See Table 2).

Table 2: Share of people reported to be able to pay for the health services provided

Province	Number sites	% sites reporting response			
		All	Some	Few	None
Manicaland	5	20	40	40	0
Mashonaland East	12	0	42	58	0
Mashonaland Central	4	0	25	75	0
Mashonaland West	6	0	33	50	17
Midlands	11	0	64	18	0
Masvingo	6	0	71	29	0
Matabeleland North	7	14	71	14	0
Matabeleland South	9	0	78	0	0
Bulawayo, Harare	17	0	71	29	0
Total	80	4	58	33	4

(*)non responses make up the balance

Only 4% of sites nationally said that *all* people in their wards could afford the health services provided, 58% said some could, and 33% said few could. Cost barriers were most commonly reported from Mashonaland West and Mashonaland Central.

The **major cost that people reported was the cost of drugs.** It was commonly reported that the clinics do not have drugs so that people have to buy these on prescription after a consultation. This was the cost seen to be most unaffordable.

Mostly people don't get medication at the clinic sometimes goes without any medicine and people are referred to pharmacies to buy which they cannot afford.

Bindura

The **clinics are the primary point of care for people** as reported from the sites (See Table 3). Nationally 68% of sites reported that the facility people use when they fall ill is a clinic, with 18% reporting use of a district hospital and 14% reporting use of a provincial hospital. Few people report using private medicine. The sites did not report use of traditional health services although this is clearly widespread and a common source of health care. The question was understood by monitors to refer to western services so that they did not interpret this to cover traditional health care. Similarly the question referred to 'facilities' and so excluded self help as an option, again a common response when people fall ill.

Table 3: Reported facility used when people fall ill

	% sites reporting response			
Province	**Clinic**	**District hospital**	**Provincial hospital**	**Other (*)**
Manicaland	60	60	20	0
Mashonaland East	83	8	0	8
Mashonaland Central	0	50	50	0
Mashonaland West	100	50	0	0
Midlands	63	9	27	0
Masvingo	100	50	0	0
Matabeleland North	71	14	0	0
Matabeleland South	78	0	0	0
Bulawayo, Harare	59	0	29	6
Total	68	18	14	3

(*) town centre; private doctors

The monitoring round indicates that within the current health service structure **two thirds of people depend on quality of care at clinic level** to ensure their access to health care.

How far do they feel that this is being delivered on?

There seems to be **roughly equal levels of satisfaction and dissatisfaction with the quality of health services reported in communities,** with highest levels of satisfaction in Manicaland and Midlands and highest levels of dissatisfaction in Mashonaland Central and Mashonland East (See Table 4)

Table 4 Share of wards reporting satisfaction with quality of health services

Province	Number sites	% sites reporting response		
		Very dissatisfied	Satisfied	Very satisified
Manicaland	5	0	100	0
Mashonaland East	12	67	17	8
Mashonaland Central	4	100	0	0
Mashonaland West	6	67	16	16
Midlands	11	36	55	0
Masvingo	6	57	43	0
Matabeleland North	7	29	43	0
Matabeleland South	9	33	44	0
Bulawayo, Harare	17	47	53	0
Total	80	46	43	3

(*)non responses make up the balance

Dissatisfaction arose in almost all cases from shortages of drugs, lack of qualified staff or high costs of care, particularly drugs. Poor staff attitudes towards patients was reported as a cause of dissatisfaction in two provinces. (See Table 5).

There is only one qualified nurse and at times she is not there since she has to travel to Murambinda for other things.

Buhera

Table 5: Reasons given for dissatisfaction with quality of health services.

Province	Reason reported
Manicaland	Shortages of staff and drugs . Rudeness of staff to patients
Mashonaland East	Shortage of drugs and lack of qualified staff
Mashonaland Central	Shortage of drugs.
Mashonaland West	Hospital fees very high, drugs very expensive and drugs not available in clinics
Midlands	Shortages of qualified staff and negative nursing staff attitudes to patients. Patients have to buy their own drugs.
Masvingo	No drugs in clinics
Matabeleland North	Shortages of drugs and staff
Matabeleland South	Clinic fees not affordable. Shortages of staff and drugs
Bulawayo	Absence of doctors, shortages of drugs
Harare	People have to buy own drugs. Staff shortages.

Generally people feel that **everyone in the community suffers from these problems,** although there is some perception that those on medical aid or wealthier people in the ward get better treatment. Notably the monitoring is done within wards, where there is likely to be greater similarity within the community. One factor that was identified as a **cause for differential treatment even within income groups was favouritism or political influence**. (See Table 6). This was noted to be a factor in securing better treatment in Guruve, Mazowe, Norton and Bulawayo.

Table 6: Differential treatment at health facilities

Province	% sites reporting that some people get better treatment than others at health services	Groups identified as treated better
Manicaland	0	n.a
Mashonaland East	17	People with money can go straight to hospitals
Mashonaland Central	50	People known at the health centre of friends with health staff
Mashonaland West	50	Politically influential people and those with money
Midlands	9	Employed people can afford better services
Masvingo	0	n.a
Matabeleland North	0	n.a
Matabeleland South	0	n.a
Bulawayo, Harare	18	People on medical aid schemes or those who earn more money. Also those who are related or well known to clinic staff and the councilors.
Total	13	

Fee barriers were in contrast the major reason reported for why people do not use or access services. (See Table 7). It was also reported that **services used in the community (primarily clinic and district hospital) do not provide medicines for AIDS** so that people suffering from AIDS related illnesses have to travel to towns or higher level services to secure treatment.

Table 7: People not accessing treatment at health facilities

Province	% sites reporting that people do not access treatment	Groups identified as not accessing treatment
Manicaland	60	Because there are no drugs for AIDS at the clinic people with AIDS have to go to the mission hospital. Poor people cannot afford services
Mashonaland East	17	People unable to pay cannot use the services
Mashonaland Central	0	Not specificed
Mashonaland West	33	People unable to pay cannot use the services
Midlands	18	People with AIDS cant get treatment in their areas. Poor people cannot afford services
Masvingo	0	
Matabeleland North	0	
Matabeleland South	0	
Bulawayo, Harare	12	Poor people cannot afford services
Total	15	

Given that poor communities face the highest barriers to health care services and to treatment, primary health care (PHC) programmes in communities are extremely important poverty reducing measures and health intervention for poor communities. Immunisation programmes are one of the central PHC programmes for disease prevention and are delivered through clinics and immunization campaigns and outreach programmes. **Immunisation programmes were reported in the last six months in 51% of sites nationally,** with highest levels in Manicaland and Mashonaland Central and lowest in Mashonaland East and Midlands. (See Table 8)

There is need to start health intervention programmes for widows.

Mberengwa

PHC programmes are strengthened where community participation in health decision making is stronger. One of the vehicles for this are the health centre committees (HCCs) found at clinics and in wards. **Only 30% of sites reported having functioning health centre committees.** (See Table 8). The cities had a higher share of sites with HCCs, particularly due to the string provisions for these mechanisms of community participation in Bulawayo. In rural areas, Matabeleland North and Manicaland also had a high share of sites with HCCs, while in Mashonaland East and Central there were no sites reporting these structures. (Notably this does not mean that these provinces do not have HCCs, but that the monitoring round indicates that they are less common).

Table 8: Primary health care services

Province	% sites reporting	
	Functioning health centre committee	Immunisation programme in the past six month
Manicaland	40	100
Mashonaland East	0	25
Mashonaland Central	0	75
Mashonaland West	17	50
Midlands	27	36
Masvingo	14	71
Matabeleland North	57	57
Matabeleland South	22	44
Bulawayo, Harare	65	59
Total	30	51

Summary: What does the monitoring show on meeting health rights?

In terms of the priority areas of health rights articulated by communities and civil society, the monitoring round provides reports from community level that

- Rights to the highest standard of health reasonably possible are affected by where people live, by their incomes and by differences in the quality of health care provided. Nearly a half of areas reported dissatisfaction with the current quality of health services.

- A basic level of health services, ie a clinic, is accessible within the policy standard of 5km for about half the population.

- The right to health care is limited by the availability and costs of care, particularly due to shortages of medicines and of adequate qualified staffing at primary care levels of the health services.

- The biggest cost barrier to curative services is that of drugs. When these are not available in clinics or public hospitals poor households find it difficult to afford these from commercial facilities. Medical aid or insurance cover is limited.

- For the large group of low income people ill with AIDS and other common diseases the shortfalls in the public sector at local level mean that they have to seek care elsewhere at costs that they may not be able to afford. People with influence and money are reported to be able to overcome these barriers.

- Generally people are happy with the treatment they get from health workers (with a few exceptions) noting that the constraints causing dissatisfaction with services are to do with resources.

- Primary health care programmes are taking place, although not uniformly across all communities.

- Mechanisms for community participation and representation in decision making such as health centre committees are underdeveloped or poorly functioning and thus need to be strengthened.

Education

Next to health, education is an equally highly valued area of social rights in Zimbabwe.

Community and civil society discussions have identified areas that people feel should be addressed as a nation regarding education, including:

- a basic level of education services, where every child of school going age is enrolled in school and where every person can access basic education financed from taxes, without being charged fees that we cannot afford.

- a state funded basic education up to the fourth year of secondary school (O level) without discrimination on the basis of sex, religion, race, tribe, creed or ability.

Geographical access to secondary schools is obviously much better than health services, with children having to cross these distances daily. While **46% of sites had schools within 4km,** however, a further 33% reported schools further away than 4 km, with sites in Beitbridge, Hwange and Mwenezi having schools further than 20km away. The emergence of 'bush borders' where children camp around secondary schools has been reported in some areas. (See Table 9)

Table 9: Distance to a secondary school

Province	No sites	% sites reporting distance to secondary school (km) (*)		
		0-4	5-9	10+
Manicaland	5	20	80	0
Mashonaland East	12	25	58	0
Mashonaland Central	4	75	25	0
Mashonaland West	6	50	50	0
Midlands	11	9	27	9
Masvingo	6	33	33	33
Matabeleland North	7	14	0	28
Matabeleland South	9	11	0	11
Bulawayo, Harare	17	100	0	0
Total	80	46	25	9

(*) shortfalls on 100% are non responses

Costs are less of a reported barrier to schooling than to health care. In 60% of sites while not all were reported to be able to pay for schooling, most were (Table 10).

Table 10: Share of people who can afford to pay for secondary schooling

Province	Number sites	% sites reporting response			
		All	Some	Few	None
Manicaland	5	0	60	40	0
Mashonaland East	12	0	50	50	0
Mashonaland Central	4	0	25	75	0
Mashonaland West	6	0	67	33	0
Midlands	11	0	82	9	0
Masvingo	6	0	86	14	0
Matabeleland North	7	0	100	0	0
Matabeleland South	9	0	88	11	0
Bulawayo, Harare	17	0	76	24	0
Total	80	0	60	40	0

Satisfaction with secondary schooling is reported to be is higher than with health services, with 56% of sites nationally reported to be satisfied and 29% dissatisfied (Table 11). Highest levels of satisfaction were reported in Manicaland and lowest in the cities and in Mashonaland East.

The degree of satisfaction related to the qualifications and service of teachers and the availability of teaching resources, with complaints from districts about poor quality teaching, inadequate text books and low pass rates (see below). It was reported that high enrolments have made people satisfied with education but that this is then compromised by lack of resources. Children are reported to have to put in effort and discipline to overcome resource shortages. **In relatively few districts was the level of fees or levies reported as a problem.**

Box 1: Reported issues related to quality of education in sites

Manicaland: Improvements and higher pass rates depend on qualified staff with higher degrees and availability of textbooks and learning resources. Quality of schools in newly resettled areas need to be improved.

Mashonaland East: Dissatisfaction comes from poor results and decreasing standards of education, due to lack of text books and learning materials, a shortage of qualified teachers, and poor conditions of teachers. Enrolment is high so people are happy but quality is poor. Some day secondary schools enrol even those who do not qualify. Three sites reported high school fees and levies as a problem.

Mashonaland Central: It was noted in one site that children can go for some days without lessons or with inadequate teaching.

Mashonaland West: **L**ow pass rates are a cause for concern. More pupils are now getting into secondary school, but schools lack books. High school fees and levies were cited in one site.

Midlands: People are satisfied unless children fail to find schooling places at nearby schools and have to go to schools some distance away or that cost more. Some districts have too few secondary schools (eg Gokwe) and inadequate qualified teachers.

Masvingo: Reports of children going for days without lessons or inadequate teaching. Poor pass rates at O level were a source of dissatisfaction, attributed to poor learning resources and the level of student discipline.

Matabeleland North: Levies were reported to have risen from $1500 to $7000 since last year. Books are in short supply.

Matabeleland South: Books are in short supply.

Cities: Teachers concentrate in well established schools. In the more peripheral urban school there are inadequate teachers, schools are too few, there is hot seating and schools are congested and overcrowded, lack text books, classrooms and adequate teaching staff.

Table 11 Share of wards reporting satisfaction with quality of schooling

Province	Number sites	% sites reporting response		
		Very dissatisfied	Satisfied	Very satisified
Manicaland	5	40	20	40
Mashonaland East	12	50	50	0
Mashonaland Central	4	25	75	0
Mashonaland West	6	33	67	0
Midlands	11	9	73	0
Masvingo	6	17	83	0
Matabeleland North	7	0	100	0
Matabeleland South	9	11	67	0
Bulawayo, Harare	17	53	29	6
Total	80	29	56	5

(*)non responses make up the balance

Access to secondary school is thus less of a problem that quality, with orphans, those facing difficulties with fees and levies and those failing to produce birth certificates identified as having problems accessing schooling. (See Table 12).

Table 12: People not accessing schooling

Province	% sites reporting people not accessing school	Reported reasons for not accessing schooling
Manicaland	40	Impassable rivers for young children.
Mashonaland East	58	Difficulty with paying fees. Children are sent home until fees are paid. Orphans have problems with fees
Mashonaland Central	25	Difficulty with paying fees
Mashonaland West	50	Difficulty with paying fees
Midlands	18	Difficulty with paying fees
Masvingo	33	Difficulty with paying fees. Orphans have problems with fees
Matabeleland North	14	Difficulty with paying fees Orphans have problems with fees and no-one to represent their interests
Matabeleland South	11	
Bulawayo, Harare	12	Difficulties in accessing BEAM and other support funds Failure to pay fees and levies. Failure to produce birth certificates
Total	26	

There is need for information to be disseminated on issues such as the AIDS levy and BEAM so as to make people aware of their rights for such public facilities.

Goromonzi

Difficulties with accessing BEAM and other public assistance funds for education was reported in some areas, particularly Mashonaland Central and Masvingo (Table 13).

Table 13: School support services

Province	% sites reporting	
	Functioning School Development Association	Problems with access BEAM or public assistance funds
Manicaland	100	0
Mashonaland East	83	50
Mashonaland Central	75	100
Mashonaland West	100	17
Midlands	45	27
Masvingo	83	83
Matabeleland North	14	71
Matabeleland South	44	56
Bulawayo, Harare	47	71
Total	60	51

Households were reported to not know how to access these funds and to be not adequately informed. People do not know how to apply for the funds, applications are reported in some sites to be unanswered, some children do not have birth certificates limiting their access and the funds available do not match the demand. (Table 14). If correct, it would appear that there is need for significantly wider public information and assistance to vulnerable households on these funds.

Table 14: Problems accessing BEAM

Province	Reported problems
Manicaland	Very few manage to get assistance
Mashonaland East	Insufficient funds. Procedures not clear. Reports of political bias in disbursement in Hwedza and Marondera rural.
Mashonaland Central	Procedures not clear
Mashonaland West	Very difficult to access.
Midlands	Very few pupils assisted. Inadequate funds
Masvingo	People do not know how to apply. Most orphans do not get it. Headmasters do not tell people what to do. Reports of favoritism in Zaka.
Matebeleland North	Applications not replied. Scheme has not been introduced to households.
Matebeleland South	Some children do not have birth certificates, particularly orphans. Inadequate funds.
Bulawayo. Harare	Too many applicants against inadequate funds. People do not know who qualifies.

The School Development Association (SDA) is an important vehicle to deal with such issues, and ensure that schools deal with issues of quality and access. **In 60% of sites nationally the SDA was reported to be functional**. While some areas were thus reported to be relatively well covered with SDA's, the worst performance was noted in Matabeleland North where coverage was reported to be much lower than average (Table 13).

Summary: What does the monitoring show on rights to education?

How far then are we achieving the prioritized rights to education?

- Education services are reported to be provided without discrimination on the basis of sex, religion, race, tribe, creed or ability. Again the sites were from areas where incomes are relatively similar, so the income disparities in access to or supply of education would not show in this monitoring.

- Children generally have access to these services without discrimination. The exceptions to this reported in about a quarter of sites are those who face barriers due to inability to pay fees or who don't have birth certificates and orphans.

- There are constraints reported to public assistance programmes dealing with these vulnerable groups both due to inadequate funds and due to the lack of public information on the funds and thus public knowledge on how to access funds. A more effective public assistance programme would appear to be needed to overcome barriers to access.

- The constraint in education is less one of access than one of quality of education, particularly in terms of qualified staff and learning resources.

- School Development Associations are generally (but not always) found and functional. There is a mechanism for participation in addressing these issues but their effectiveness, composition or role in community outreach was not explored.

HIV/AIDS

With HIV prevalence levels at around a quarter of the adult population the HIV and AIDS epidemic is a major factor affecting social wellbeing. There are many aspects of the epidemic and the response to it could be included in the community monitoring. However, given the need for focus, the increase in illness and the new attention being given to treatments for AIDS, this round was used to examine knowledge of and access to treatment.

In about a third of sites nationally people are reported to have heard of treatment for AIDS, although in nearly two thirds they are reported to have heard about Ante-retrovirals (ARVs). (See Table 15). This rather odd finding needs further exploration: particularly given that people report 'treatments' for AIDS as including (exactly as stated)

- Antiretrovirals
- Betadene,
- Depo provera
- Traditional medicine
- Pain killers
- DDI (sic)
- 'Niverapine' (sic)

The findings suggest that there is a need for public information and treatment literacy on ARVs and their use.

Table 15: Access to treatment for AIDS, knowledge of Antiretrovirals

Province	% sites where people have heard of treatment for AIDS	% sites where people have heard of ARVs	% sites reporting share of people accessing treatment for AIDS		
			Some	Few	None
Manicaland	0	60	0	0	0
Mashonaland East	17	50	0	0	0
Mashonaland Central	0	0	0	0	0
Mashonaland West	50	67	16	16	67
Midlands	67	72	18	9	27
Masvingo	43	71	14	0	43
Matabeleland North	29	14	0	0	43
Matabeleland South	44	89	11	11	33
Bulawayo, Harare	29	76	29	6	24
Total	33	64	13	5	46

(*) shortfalls on 100% are non responses

total more than 100?

Even noting the wide definition of treatment above, only 13% of sites reported that some people could access treatment for AIDS, and 5% reported that a few people

could access this treatment, while **46% of sites reported that no-one could access treatment for AIDS.** (See Table 15). Where treatment access is reported this is reported to be from hospitals or private pharmacies.

Given the weak access to treatment reported in many parts of the country many people rely on relief and caring activities. The AIDS Levy Fund has been a focus of attention for its possible role in financing community prevention and caring activities.

The sites report a lack of knowledge on the fund and its use, with **16% of sites nationally reporting that they know how the funds are used.** (See Table 16). The lack of knowledge was widespread, with only the cities reporting higher levels of knowledge on how funds are used.

Table 16: Knowledge on and decision making on the AIDS levy fund

Province	**% knowing how funds are used**	**sites response on**		
		Decision makers on the fund	**Beneficiaries of the fund**	**People not benefiting from the fund**
Manicaland	0	WAAC, ward representatives	Do not know	Do not know
Mashonaland East	8	Councilors, DAAC, Politicians, Min of Health	School children and PLHWA	Ill people, orphans
Mashonaland Central	17	WAAC, Authorities; politicians	Don't know	Ill people, orphans
Mashonaland West	0	Ward Committee, Min of Health	Orphans	Ill people, orphans
Midlands	9	WAAC, MASO, DAAC, AIDS committees	PLWHA and orphans	Ill people, orphans, youth
Masvingo	29	DAAC, Council, Civil servants	PLWHA and orphans	Orphans
Matabeleland North	14	DA, AIDS committee, Headman Red Cross.	PLWHA and orphans	Orphans
Matabeleland South	11	WAAC, DAAC, Councilors	PLWHA and orphans	Ill people, orphans
Bulawayo, Harare	53	Councilor, DAAC, WAAC, CBOs, PAAC, government	PLWHA and orphans	Ill people not identified
Total	16			

(*)non responses make up the balance

The HIV fund seems not to be reaching the grass roots. No meetings are being held in connection with these issues.

Chimanimani

The decision makers on the fund come from community level (WAAC, DAAC, Councilors) so the lack of information could signal that **those on the committees making decisions may not be adequately informing communities**. People in two provinces where therefore note sure who the beneficiaries were, although in others they identified people with AIDS and orphans. At the same time the same group of people, ie **those with illnesses and orphans were reported in almost all areas to not be adequately benefiting from the fund.**

Summary: What does the monitoring show on AIDS issues?

In the case of ARV treatment there is knowledge about the issue, lack of adequate literacy on what treatment is, but an absence of resources for treatment at local level.

In the case of the AIDS Levy Fund, while resources *are* flowing to community level, there is inadequate public information on where they are going and report from communities that deserving beneficiaries are still not accessing.

In both cases the results suggest an important role for information and literacy on the systems supporting the community response to AIDS.

Social conditions

Civic organisations have identified a wide range of social conditions that enable citizens to effectively exercise rights and fulfill their responsibilities. These include

- Functional social networks and organizations within which we can discuss and be informed on issues and can make our inputs;
- Access to information and to civic education to ensure informed participation in laws, policies and programmes

Using social services and accessing public assistance and social funds also requires that people have birth certificates and identity documents (IDs) as a basis for any schemes or services that provide individual access.

The monitoring found that NO sites reported ALL youth having IDs or ALL children having birth certificates and NO sites reported few adults with IDs. The most common response for these documents was that 'some' people in the ward have these documents. As shown in Table 17 however there **about a tenth of sites reported 'few' children having birth certificates or youth having IDs, indicating problems in access in those sites.** This was more common in Mashonaland Central and East.

Conversely **about a fifth of sites reported that ALL adults had IDs.** This was most commonly found in Mashonaland East and Masvingo.

Table 17: Access to citizenship documents

Province	% sites reporting FEW having access to		
	Birth certificates	Youth with IDs	% sites with all Adults having IDs
Manicaland	0	0	0
Mashonaland East	33	17	42
Mashonaland Central	50	50	0
Mashonaland West	17	17	17
Midlands	9	0	18
Masvingo	14	14	29
Matabeleland North	0	14	14
Matabeleland South	11	11	22
Bulawayo, Harare	6	6	6
Total	14	11	18

(*)non responses make up the balance

These findings indicate that access to basic citizenship documents is not universal. Further if older people have better access than younger the reasons for falling access in young people would need to be identified and addressed.

Two other indicators of social networking were assessed in this round: the costs of transport and whether people feel free to speak their minds. Costs of public transport to the nearest urban centre ranges from $146 (Manicaland) to $521 (Mashonaland East). (See Table 18) The costs and variability across sites will be compared with information in future rounds.

Table 18: Social Conditions: Transport and Information

		% sites reporting people feeling free to speak their minds			
Province	Median Transport costs to the nearest centre (Z$)	Always	Sometimes	Rarely	Never
Manicaland	$146	20	80	0	0
Mashonaland East	$521	0	25	33	42
Mashonaland Central	$223	0	25	75	0
Mashonaland West	$196	0	17	50	33
Midlands	$222	0	64	8	0
Masvingo	$282	14	43	14	14
Matabeleland North	$151	0	86	0	0
Matabeleland South	$253	0	33	0	11
Bulawayo, Harare	$359	18	47	23	0
Total		6	45	20	13

Few sites report that people always feel free to speak their mind and few that they never feel free to speak their mind (See Table 18). Most sites indicate that people sometimes fell free to speak their mind. The level of perceived freedom to speak reported in the monitoring was reported to be higher in Manicaland, Matabeleland North and the cities than in other parts of the country and lowest in Mashonaland East and West.

In terms of other indicators of participation, in these two provinces **where perceived freedom to speak is higher there is also a higher presence reported of mechanisms for participation** in health services, of functioning school development associations, more people are reported to have heard of ARVs and a lower share of sites report problems with accessing public assistance funds.

This round of monitoring examined whether people felt life was getting better or worse and for whom. The results are summarized in Tables 19 and 20. The two tables together indicate the *perception* in communities that **life has improved for those with secure formal employment and incomes, for those engaged in trading, for businessmen and those with political influence**, as they are perceived to be able to secure their family needs. Those whose **lives are perceived to have got worse are unemployed people, former farmworkers, elderly people, orphans, and those who are ill.** They are perceived to have suffered from insecure incomes, especially with food shortages, inflation and AIDS.

Public assistance, food relief and remittances from abroad were reported to have helped life improve in the cities and in Matabeleland South, but not in other provinces. Political factors were mentioned in either improving or worsening life in three provinces.

People live in this ward because they wanted place to live only . No shops, nearby clinic is too far from the community, the councilor is far from the people

Beitbridge

Table 19: People for whom life has got better

Province	People	Reported reasons
Manicaland	Teachers, nurses, traders. employed workers and new farmers	Salaries earned (and improved), additional incomes from selling produce, traders are able to make good profits (esp from Mozambique)
Mashonaland East	successful communal farmers, employed people, senior party and government officials, business community. For ordinary people nobody	Farmers who got inputs are enjoying a good harvest. Party officials are paid by the party, have access to everything and do whatever they want with people under the umbrella of the party. Business people and senior officials have good salaries and have all one needs in life.
Mashonaland Central	Employed workers and those connected to the ruling party	They can afford to send children to school and buy food. They have got resources from the white farmers.
Mashonaland West	Employed workers and business people	They have an income, and can access basic necessities cheaper and easier
Midlands	Politicians and the business community	Those giving loans and selling produce make money. People with salaries have secure incomes

Masvingo	Employed workers and traders. No-one else	They can afford to send children to school, buy food and get what they need.
Matabeleland North	Employed workers and traders. No-one else	They can support their families, and pay fees for services.
Matabeleland South	Employed workers with incomes above the poverty line and traders. Those with relatives working abroad. Those who receive food relief.	They can afford to buy goods they need.
Bulawayo, Harare	Teachers and nurses, employed workers, business owners, traders, people getting government public assistance, ruling party members.	They have access to food, money and projects. They get support from relatives.

Table 20: People for whom life has got worse

Province	People	Reported reasons
Manicaland	Peasant farmers, former farm workers, the elderly and orphans	Insecure income and production. No secure place to stay
Mashonaland East	Unemployed people, orphans, widows. The majority of ordinary people. Those who do not support the ruling party	They suffer food shortages between harvests, especially where there are poor rains. People do not have money or secure income to buy basics. Some face political discrimination. grounds.
Mashonaland Central	Former farm workers, the elderly, unemployed, widows, and orphans Business people	
Mashonaland West	The majority of ordinary people. Workers who have been retrenched.	They cannot afford farming, cannot look after their families, have no homes, no jobs. People who used to work in the surrounding farms now have no work. Businesses have lost customers.
Midlands	Unemployed youths. former farm workers, orphans, terminally ill people. The majority of people	Inflation and high prices mean they cannot afford basic necessities. Orphans have nobody to look after them. People depending on produce who do not get good harvests. Cannot afford medicines
Masvingo	Old people, widows, orphans. AIDS patients, women and youth.	They cannot afford ploughing fields for food and cannot look after their families. No secure income. Cannot afford medicines
Matabeleland North	AIDS patients the disadvantaged	Inflation has made buying essentials unaffordable. Cannot afford medicines
Matabeleland South	Orphans, unemployed people, women, youth and the elderly. The majority	They can't afford their needs. There has been no job creation for youth. Elderly people are nursing grandchildren.
Bulawayo, Harare	Unemployed people. Pensioners opposition party members. widows, orphans, vendors. Ill people. Most of the people.	They are not given assistance because they are not working and have no reliable source of income. Vendors are being arrested by municipal police. People cannot afford food and medicines.

Summary

This first round of NGO and community based monitoring on health and education conditions was carried out in March 2004 from 80 monitoring reports from 53 districts from all provinces of Zimbabwe, with an average of 1.5 reports per district.

Health

In terms of the priority areas of **health rights** articulated by communities and civil society, the monitoring round provides reports from community level that

- Rights to the highest standard of health reasonably possible are affected by where people live, by their incomes and by differences in the quality of health care provided. Nearly a half of areas reported dissatisfaction with the current quality of health services.
- A basic level of health services, ie a clinic, is accessible within the policy standard of 5km for about half the population.
- The right to health care is limited by the availability and costs of care, particularly due to shortages of medicines and of adequate qualified staffing at primary care levels of the health services.
- The biggest cost barrier to curative services is that of drugs. When these are not available in clinics or public hospitals poor households find it difficult to afford these from commercial facilities. Medical aid or insurance cover is limited.
- For the large group of low income people ill with AIDS and other common diseases the shortfalls in the public sector at local level mean that they have to seek care elsewhere at costs that they may not be able to afford. People with influence and money are reported to be able to overcome these barriers.
- Generally people are happy with the treatment they get from health workers (with a few exceptions) noting that the constraints causing dissatisfaction with services are to do with resources.
- Primary health care programmes are taking place, although not uniformly across all communities.
- Mechanisms for community participation and representation in decision making such as health centre committees are underdeveloped or poorly functioning and thus need to be strengthened.

Education

In terms of rights to education,

- Education services are reported to be provided without discrimination on the basis of sex, religion, race, tribe, creed or ability. The sites were from areas where incomes are relatively similar, so the income disparities in access to or supply of education would not show in this monitoring.
- Children generally have access to these services without discrimination. The exceptions to this reported in about a quarter of sites are those who face barriers due to inability to pay fees or who don't have birth certificates and orphans.
- There are constraints reported to public assistance programmes dealing with these vulnerable groups both due to inadequate funds and due to the lack of public information on the funds and thus public knowledge on how to access

funds. A more effective public assistance programme would appear to be needed to overcome barriers to access.

- The constraint in education is less one of access than one of quality of education, particularly in terms of qualified staff and learning resources.
- School Development Associations are generally (but not always) found and functional. There is a mechanism for participation in addressing these issues but their effectiveness, composition or role in community outreach was not explored.

AIDS treatment and care

In the case of ARV treatment there is knowledge about ARVs, but lack of adequate literacy on exactly what treatment is and few resources for treatment at local level.

In the case of the AIDS Levy Fund, while resources *are* flowing to community level, there is inadequate public information on where they are going. Communities report that deserving beneficiaries are still not accessing.

In both cases the results suggest an important role for information and literacy on the systems supporting the community response to AIDS.

Other social conditions

The monitoring round reported that

Access to basic citizenship documents (birth certificates and IDs) is not universal. In about a tenth of sites there were reported problems of access for many in the site. The monitoring reported findings that suggest that older people have better access than younger to these documents. If this indicates falling access in young people the reasons would need to be identified and addressed.

Most sites report that people sometimes feel free to speak their mind. The provinces with highest perceived freedom to speak also had a higher reported presence of mechanisms for participation in health services, of functioning school development associations, more people reported to have heard of ARVs and lower reporting of problems with accessing public assistance funds.

Communities perceive that life has improved for those with secure formal employment and incomes, for those engaged in trading, for businessmen and those with political influence. They are perceived to be able to secure their family needs.

Those whose lives are perceived to have got worse are unemployed people, former farmworkers, elderly people, orphans, and those who are ill. They are perceived to have suffered from insecure incomes, especially with food shortages, inflation and AIDS.

The Civic Monitoring Project welcomes feedback on these reports.
Follow up queries and feedback to
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